Structural adjustment: source of structural adversity. Socio-economic stress, health and child nutritional status in Zimbabwe
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User fees, quality and utilisation of health services

This chapter examines changes in the process of health service delivery in the public sector and in people’s appreciation of those services. It takes the case of Chitungwiza and Murehwa district and analyses trends in the level of utilisation of various health services as the primary indicator of people’s appreciation of those services.

In the conceptual framework presented in Chapter 1, availability, accessibility and quality of health services are presented as process factors that are likely to influence service utilisation, which is considered an output factor. After an introduction to some key concepts and the methods used, the current chapter describes changes in health service utilisation and analyses these by relating them to specific events that have occurred in the health sector – especially changes in the user fee policy (discussed in Chapter 3) – as well as to events in society in general – especially the economic crisis, structural adjustment measures, drought and HIV AIDS (discussed in Chapter 2).

In order to provide an insight into the functioning of the health sector in Chitungwiza and Murehwa district and into the quality of care that is provided, we will further present the results of a more qualitative type of research, based on focus group discussions conducted with nurses and community women in the two study areas in December 1993. The results of the focus group discussions have been published earlier in a journal article: Bassett, Mary Travis, Leon Bijlmakers and David M. Sanders (1997). Professionalism, patient satisfaction and quality of health care: experience during Zimbabwe’s structural adjustment programme. Social Science and Medicine 45 (12), 1845-1852.
The final section will present some conclusions with regard to one of the central questions of the present thesis: has the government of Zimbabwe been able to ensure adequate health service delivery during the period of structural adjustment?

Concepts and methods

Concepts

It is widely recognised that biomedical health care is just one alternative that people can choose from when they are ill. In most cultures traditional medicine is at least as important as biomedical care and preferred for certain afflictions. Before seeking any outside advice or treatment, people will often apply self-medication, especially for minor or less acute ailments, in which they can use biomedical as well as traditional ingredients.²

The utilisation of biomedical services is therefore influenced by several factors. The actual need for health care which is determined by the occurrence of disease and disability in society – and people’s willingness and ability to utilise such services as far as they are available, are two major factors (see conceptual framework in Chapter 1).

Changes in service utilisation may indicate a change in the need for health services at the household level – because of changes in the incidence of disease or in people’s willingness and ability to use them. The latter change may in turn be influenced by changes in the availability, accessibility or quality of the services, including possible alternative forms of treatment. In the context of the present thesis it is therefore relevant to investigate not only whether there have been any changes in health service utilisation but also what may explain these changes, if any. Especially when changes in health service utilisation are abrupt, one would expect these to be due to either epidemic disease outbreaks or to a changed socio-economic or policy environment.

The effects of user fees on clinic attendance in low-income countries have been documented extensively in the international literature. Some of the earlier studies (Waddington and Enyimayew, 1989; Moses et al., 1992) have recorded major and long-lasting declines in the use of health services as a result of user fees. Others have claimed that after an initial period of decline, utilisation gradually reverted to ‘normal levels’ after some time (for example Nyonator and Kutzin, 1999) or even that there was no significant decline (Chawla and Ellis, 2000).

Creece (1997) argues that user fees have detrimental effects in two ways: they don’t reduce costs and they increase inequity. He points out that proponents of user fees recommend them in two situations. Firstly, when health spending is low or falling and fees are expected to mobilise more money for health care than existing resources provide.

² Foster and Anderson (1978), Helman (1990) and Kleinman (1988) are some of the standard works in medical anthropology; Gelbard et al. (1985) is a standard resource on the traditional medical practitioner in Zimbabwe.
Secondly, paradoxically, when health expenditure is high or rising fast and higher fees might improve efficiency by moderating demand and containing costs. Opponents of user fees attack them as a political strategy for shifting health care costs from the better off to the poor and the sick. They point to the trade off between this method of raising revenue and maintaining access to care based on need, rather than ability to pay.

One of the very outspoken opponents of user fees is Turshen (1999), who asserts that in Zimbabwe “... too many studies examine the impact of charges on the use of health services.” She argues that these studies represent an excessive drain on intellectual and financial resources for a foregone conclusion, namely that structural adjustment policies are designed to reduce demand, and user fees are a mechanism of rationing care. She claims that most studies confirm what is already known, namely that user charges deter the patients at greatest risk of disabling and fatal illnesses, the very patients for whom cost-effective interventions both preventive and curative are required. The statement is interesting but ignores the more complex rationale behind some of the changes in user fee policies in Zimbabwe, as will be demonstrated in the next section.

The research conducted in Chitungwiza and Murehwa district, which will be discussed in the present chapter, adds to the existing literature on user fees and service utilisation and brings in the dimension of quality of care to help explain the relation between the three (user fees, quality of care, clinic attendance).

A universally accepted definition of quality of health care does not exist (Campbell et al., 2000). Different stakeholders — users, health care providers, health care managers — have different perspectives of quality of care. They therefore include different dimensions in their definitions, such as availability of physical structures, adequacy of staff, technical quality of clinical care, nature of interpersonal interaction between the provider and the user, efficacy or outcome of treatment and user satisfaction.

This chapter does not define quality of care as a technical concept, in which the actual practice is assessed against a yardstick of technical interventions that need to be applied. It rather looks at perceived quality of care, in terms of opinions about the adequacy of structures that are available, the process of care delivery — including client-provider interaction — and the perceived efficacy or outcome of the care that is provided.

**Methods used**

This chapter examines trends in health service utilisation in the public sector — including the mission health facilities in Murehwa district — during the 1990s. It tries to relate the observed changes to specific events and trends that have occurred in the health sector — especially changes in user fee policies and in (perceived) quality of care — or in society in general — with a focus on the economic crisis and the occurrence of drought and HIV AIDS.

Health service utilisation data were collected from all health institutions that are administered by the central government in the two study areas (through the Ministry of Health and Child Welfare), local government (municipality or rural district council) and missions. The services involved are: outpatient clinic attendance for curative services (first visits only); antenatal clinic attendance (first visits only, popularly called *booking*
for delivery): live deliveries at the health institution; and home deliveries reported by the same institutions. For Chitungwiza the data that will be presented are from the city’s general hospital and the four municipal clinics; for Murehwa district they are from the district hospital, the mission hospital and twelve rural health centres. Where possible, changes in patient attendance are related to population growth. The findings for the urban and the rural area are presented separately.

The methods used did not allow for an examination of trends in the utilisation of health services in the private for-profit sector. Data from private clinics and hospitals are not part of the routine health information system of the Ministry of Health and no special effort was made to collect such data. Chapter 4 did present some data, though, on the increase of private health institutions in Chitungwiza and Murehwa district, which suggests a tendency of people turning away from the public sector when they seek health care.

Further, focus group discussions with nurses and community members were used to investigate whether in their perception any changes has occurred in the quality of care and, if so, whether this had affected their satisfaction as a provider or as a recipient of health care. The discussions were held in December 1993, about three years after the start of ESAP and almost two years after the severe 1991-92 drought. Prior to the study, decline in morale among health staff had already been evidenced by nurse strikes and numerous reports in the popular press about community dissatisfaction with health services, particularly the behaviour of nurses. The major increase in user fees of January 1994 had not yet been announced at the time of the focus group discussions.

The participants in the focus group discussions were women of childbearing age and nurses. Women rather than men were selected because we considered that women were more likely to have recent experience with the formal health care system. They were recruited through women’s clubs and market places, with the assistance of the Town Clerk (in Chitungwiza) and the District Administrator (in Murehwa district). The discussions with nurses in Chitungwiza involved personnel from the municipal clinics. In Murehwa district, separate discussion groups were formed with nurses from the district hospital, the mission hospital and from the rural health centres.

After elaboration and testing of the discussion guides, two facilitators with prior qualitative research experience conducted the focus group discussions. The discussion guide for nurses covered their perceptions regarding nurse-patient relationships, staffing levels and the adequacy of supplies, including drugs. Views were also solicited on the general welfare and social standing of nurses, as well as on the actual and potential role of collective organisation. For community women, the discussion guide covered views on

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1 The data from three rural health centres that until 1995 formed part of another district are not included; the data from the new health centre that was opened at Murehwa growth point in May 1996 are unlinked, as the interest here is in the trends in service utilisation in a specific geographical area.
2 The health infrastructure in the two areas has been described in chapter 4.
3 The Herald (1993).
the quality of services, health worker attitudes and behaviour toward patients, and the occurrence of illicit sale of services or supplies by health workers. In all discussions, participants were asked to comment on recent trends.

A total of 11 focus group discussions were conducted: seven in Chitungwiza and four in Murehwa district. In total, 54 nurses and 60 women from the local communities participated. The findings are presented separately for nurses and community women.

Changes in user fees in Chitungwiza and Murehwa district

Chapter 3 has described the government’s policy with regard to user fees in the health sector during the 1990s, bringing to light the changing rationale for charging user fees and applying exemptions. Table 5.1 provides details about the fees that were applied in Murehwa district at various times for selected services. The fee for an ordinary outpatient visit (for curative care) at the district hospital increased 16-fold between 1992-93 and late 1996 and even 37-fold between 1992-93 and late 1999. Other fees increased five or six-fold between 1992-93 and 1998 and eight to ten-fold between 1992-93 and 1999. This, of course, is all in nominal terms. But even in real terms, taking inflation into account, most of these are substantial increases, since they are higher than the general increase in the cost of living.⁷

<table>
<thead>
<tr>
<th>Service Description</th>
<th>1992-93</th>
<th>Jan '94</th>
<th>March '95</th>
<th>Oct. '96</th>
<th>Nov. '99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient consultation fee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• district hospital</td>
<td>1.50</td>
<td>17</td>
<td>17</td>
<td>24</td>
<td>56</td>
</tr>
<tr>
<td>• mission hospital</td>
<td>3.00</td>
<td>6.50</td>
<td>free</td>
<td>24</td>
<td>32</td>
</tr>
<tr>
<td>• rural hospital, RHCs</td>
<td>1.50</td>
<td>3.00</td>
<td>6.50</td>
<td>free</td>
<td>free</td>
</tr>
<tr>
<td>Maternity fee (booking for delivery)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• district hospital</td>
<td>Varied</td>
<td>60</td>
<td>60</td>
<td>80</td>
<td>141</td>
</tr>
<tr>
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<td>12</td>
<td>60</td>
<td>free</td>
<td>60</td>
<td>106</td>
</tr>
<tr>
<td>• rural hospital, RHCs</td>
<td>Varied</td>
<td>10</td>
<td>free</td>
<td>free</td>
<td>free</td>
</tr>
<tr>
<td>Inpatient fee (general ward; per day)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• district hospital</td>
<td>10</td>
<td>50</td>
<td>50</td>
<td>60</td>
<td>106</td>
</tr>
<tr>
<td>• mission hospital</td>
<td>10</td>
<td>50</td>
<td>free</td>
<td>40</td>
<td>80</td>
</tr>
</tbody>
</table>

⁷ For children up to 12 years half rates were charged

The real value of the Zimbabwe currency decreased 2.3-fold between 1992 and 1996 and 5.8-fold between 1992 and 1999 (deflator ratio’s based on mid-year consumer price indices).
It is important to emphasise that in the early 1990s the cost of drugs was included in the consultation fee. Also, laboratory investigations and X-rays at hospitals were not charged for separately. This policy was changed in 1993-94 (at most of the mission hospitals even earlier, around January 1992), such that for many patients from that time onwards the cost of specialist investigations and treatment outweighed the consultation fee or the admission fee.

For people in urban areas, three changes in user fee policies were relevant: the elevation in exemption levels in late 1992, the dramatic fee increases in January 1994 and the fee increases in 1998. The latter change was a direct result of the abolition of government health grants to municipalities. Chitungwiza municipality, for example, was compelled to apply an extra annual increase in user fees so as to offset part of the loss in income. The outpatient consultation fee for adults at municipal clinics in Chitungwiza saw an eight-fold increase in nominal terms over a period of seven years – from ZWD 10 in 1992-93 to ZWD 80 in early 2000. The maternity fee increased seven-fold over the same period. Here also, the increases were steeper than the general increase in the cost of living, as indicated by the consumer price index.

Health service utilisation in Chitungwiza

For Chitungwiza town, data will be presented about three types of clinic attendance at public health institutions (four municipal clinics and the government hospital); attendance at the outpatient departments for curative care, utilisation of antenatal services and institutional deliveries. Furthermore, some data are presented on in-patient statistics of Chitungwiza General Hospital.

Outpatient attendance

The numbers of patients attending outpatient departments for curative care in Chitungwiza town, displayed in Figure 5.1, have been grouped for the four municipal clinics for the period 1991 to 1999, along with the number of patients attending the outpatient department (OPD) of the general hospital. Figure 5.2 projects the attendance at municipal clinics broken down by age category. The figures allow an assessment of changes over time and specific events that may have caused these changes.

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2. Approximately six-fold over the same period.
3. Before 1995, a distinction was made between children below five years of age and all other clients (above five years). Since 1995 three age categories are being used: children below 5 years of age, children 5 to 14 years of age and adults (15 years and above).
The two graphs suggest a fairly strong responsiveness of clinic attendance to changes in user fees and exemption levels: the increase in exemption levels (in late 1992) has had a positive effect on OPD attendance, while the increase in user fees in early 1994 has had a strong negative effect.

Because of population growth one would expect an increase in clinic attendance over the decade. This has clearly not been the case in reality. The straight line in figure 5.1
indicates the expected increase in clinic attendance based on a population growth rate of 3.4° per annum, which is the national average.\textsuperscript{11} The population growth rate for Chitungwiza town not being known exactly, it is somewhat arbitrary to impute any figures, but the graph clearly shows that clinic attendance has fallen behind what one would expect during the mid-1990s (1994-96) and from late 1998 onwards. Assuming that those who attend clinics are genuinely in need of professional health care, this suggests that a large proportion of the population went without (biomedical) treatment during these periods. Limited financial access due to deteriorating socio-economic conditions may be responsible for this.

There is no clear change in user fee policy to which the recovery in clinic attendance in 1997 can be attributed (Figures 5.1 and 5.2). While socio-economic conditions did not improve (see Chapter 6) and people’s confidence in the quality of health services declined rather than improved (as we will demonstrate later in this chapter), it is suggested that there may have been an increase in the incidence of diseases, both among adults and children.

Figure 5.1 further clearly reveals that the share of the general hospital in total OPD attendance for the municipality as a whole has declined. If we could be sure that primary health care is of sufficient quality, we might interpret this as a positive development, since it would allow the hospital to concentrate on its role as a referral centre.

\textit{ANC attendance}

Antenatal clinic attendance can best be expressed in terms of the number of women who come for antenatal care the \textit{first} time during their pregnancies. In Zimbabwe, such visits are also referred as ‘booking for delivery’, since women are expected to deliver at the same institution where they went for antenatal check-ups.

Figure 5.3 shows the trend in first visits for antenatal services in Chitungwiza by type of health facility and by quarter, for an 11-year period (1989-99).\textsuperscript{12} Again, the straight line indicates the expected attendance based on an annual population growth of 3.4°. In this case, clinic attendance does not appear to respond to changes in user fee policies and in 1999 it is close to what one would expect based on population growth. The year 1996 shows a decline in clinic attendance, similar to the decline in OPD attendance, but of a shorter duration.

\textsuperscript{11} At a population growth rate of 3.4° per annum one would expect an increase of around 30° over nine years. The growth rate in Chitungwiza, however, could well be more than that.

\textsuperscript{12} Data from the hospital are not available for the first two years and for the last quarter of 1996.
Figure 5.3: First ANC visits in Chitungwiza by type of facility and by quarter, 1989-1999 (actual and expected based on population growth)

Institutional deliveries
The third type of clinic attendance for which we collected data to investigate trends over time concerns institutional deliveries. Figure 5.4 shows that the number of deliveries taking place at public health institutions started falling behind population growth from late 1992 onwards.

Figure 5.4: Institutional deliveries in Chitungwiza by type of facility and by quarter, 1989-1999 (actual and expected, based on population growth)
Like for antenatal visits there is no clear association with specific changes in user fees, which suggests that people’s perception of the quality of services obtained, in combination with the amount of money they expect to pay for a delivery, is a more important determinant of people’s preference for their place of delivery. Women who decided not to deliver in one of Chitungwiza’s health institutions may have delivered at home or may have opted to go to a public health institution elsewhere (in nearby Harare or in a rural area) or to a private clinic (in Harare). Statistics on home deliveries started to be reported from 1995 onwards. During the period 1996 and 1999, between 110 and 150 home deliveries were reported every quarter by the five health institutions of Chitungwiza town, the equivalent of 5-6% of the institutional deliveries. These figures do not allow the establishment of any trend over time, because of possible underreporting.

**In-patient statistics**

We selected two indicators to investigate trends over time in hospital in-patient statistics at Chitungwiza general hospital: the number of hospital admissions and the average length of stay of patients. The two measures are considered sensitive to changes in the disease profile in the community, people’s willingness to report to the hospital for conditions that may require hospitalisation, as well as to changes in hospital policy and management, such as for instance changes in user fees or in criteria for admission to or release from hospital.

Figure 5.5 illustrates that the number of hospital admissions remained fairly constant during the decade at 1200 to 1500 admissions per month, except for the last quarter. It seems as though the population increase did not lead to an increase in hospital admissions and that some other influence has restricted this parameter. The patients’ average length of stay, however, shows a marked decrease, starting from the second half of 1992. This is remarkable in view of the gradual increase in the number of TB and HIV/AIDS patients requiring relatively long treatment periods – that has been reported for the country as a whole (see Chapter 3). Informal discussions with health authorities and nursing staff confirmed that the hospital management aimed at shortening the duration of stay so as to limit the cost to patients, many of whom were reluctant to stay for a long period because of the high ward fee and other expenses. Apart from the health personnel strike in late 1996, which led to a marked temporary reduction in the average length of stay, it is not possible to attribute any trends to other specific events in the health sector, such as changes in the user fee policy. As far as hospital admissions are concerned, this reflects that people with acute health problems (or their relatives) make a maximum effort to secure hospital care, even if this requires a financial effort that prevents the fulfilment of other felt needs.

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13 Any delivery that takes place outside a health facility is considered a home delivery. It includes deliveries assisted by trained or untrained traditional birth attendants, as well as unassisted deliveries, some of which may take place on the way to a health facility.

14 Personal communication, June 1995.
Some overall conclusions with regard to trends in health service utilisation in Chitungwiza will be drawn in the last section of this chapter.

Health service utilisation in Murehwa district

Statistics on health service utilisation in Murehwa district were collected from 1991 up to the end of 1998. Changes in user fee policies were more frequent than in the urban area of Chitungwiza, as discussed earlier in this chapter. The rural area allows the calculation of coverage figures (for antenatal and delivery services) since the catchment areas and populations of the health institutions concerned are better defined.\(^\text{15}\)

**Outpatient attendance**

Figure 5.6 shows trends over the years in the number of new outpatients for curative services in three types of health facilities: the district hospital, the mission hospital and the rural health centres (total for 12 centres). It clearly reveals that the total clinic attendance increased over the eight-year period, with a few important fluctuations related to changes in service conditions.

\(^\text{15}\) In health management, the term catchment area (and catchment population) refers to the geographical area (and the population within that area) that is served by a certain health institution. In an urban area, where the population usually has a wider choice between several providers of care, and where population estimates are usually less accurate, the term catchment area/population is less meaningful.
Clinic attendance at rural health centres decreased in the 1991-92 period. The enforcement of user fee collection during that time is likely to have played a role. Clinic attendance then suddenly increased in the first half of 1993 at all types of health facilities due to the temporary abolition of fees at rural health facilities. This was a measure taken by the government to cushion the adverse effects of the drought (see Chapter 3). After the reinstatement of user fees in June 1993, attendance levels at rural health centres fell back significantly, but to a level still about 20% higher than they were at in late 1992. The significant increase in user fees – at all levels of the health system – in January 1994 led to a decrease in clinic attendance for the district as a whole, but did not affect the attendance at rural health centres.

From the second quarter of 1995 onwards attendance levels started increasing. This is attributed to the abolition of user fees at rural health facilities (rural health centres and the mission hospital) in March 1995. The opening of an urban clinic at Murehwa growth point, in May 1996, which was a deliberate attempt to alleviate the district hospital of its relative high burden of clients who used the facility as its primary source of care, did have the desired effect. Outpatient clinic attendance at the district hospital dropped by
about a third, although the decline appears to have started already prior to the opening of the new clinic.

*Figure 5.7: Share of district hospital, mission hospital and RHCs in total volume of OPD clinic attendance in Murehwa district, by quarter, 1991-1998*

The relative share of the district hospital, the mission hospital and the rural health centres in the total volume of OPD clinic attendance for the district as a whole over the eight-year period has changed considerably (see Figure 5.7) The share of rural health centres declined in the period 1991-93 from about 60% to just 40% in the last quarter of 1993. After abolition of rural clinic fees it increased – almost steadily – to about three quarters in early 1996 and to between 80 and 90% in 1997-1998. The share of the district hospital, which in late 1993 catered for almost half of the total volume of OPD clinic attendance in the district, declined to around 20% in 1996 and 10% in 1997-1998, after the further increase of hospital outpatient fees. Changes in the share of the mission hospital were less dramatic, but overall there was a decline, with two turning points that coincided with the abolition of user fees at rural health centres. In early 1993 the mission hospital’s share dropped from 18% to 11%, and in the second quarter of 1995 it further dropped to around 5%. Since that time, it has been relatively constant (at 4-6%). These findings suggest that the role division between health centres – taking care of primary level care – and hospitals – mainly concentrating on referred patients – has been strengthened by the user fee policy. This is a positive development from a management point of view, as it may point at a more efficient use of available resources. Like in Chitungwiza, however, the overall public health effect will depend on whether the services rendered at the rural health centres were of the required quality.
Antenatal clinic attendance

Figure 5.8 illustrates that the number of first visits of pregnant women reporting for antenatal care has increased over time: from 800 to 1000 per quarter in 1991-92, to 1000 to 1200 per quarter during the second part of the decade. This increase can be attributed entirely to the population growth. Overall, there has been a drastic shift in the place of booking for delivery from hospitals to clinics over the eight-year period: in 1991 only about one third of the antenatal women booked for delivery at rural health centres, while in 1998 this had risen to 80-85%. In absolute terms, the two hospitals have seen their numbers of first antenatal clinic visits decrease from around 400 per quarter at the district hospital and 200 per quarter at the mission hospital in 1991-92, to less than 100 per quarter at each of the two hospitals in 1997-98. At the same time, the total volume of ANC first attendances at rural health centres has tripled, from just over 300 per quarter in 1991 to more than 900 in 1997. Again, this trend is what health managers aim to achieve through the manipulation of user fees.

In terms of population coverage there was a slight upward trend in the early 1990s until a peak of 87% was reached in 1996, with a temporary dip in 1995 (Table 5.3). After

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16 At a population growth rate of 3.4% per annum – the national figure – one would expect an increase in the number of deliveries of 26% over eight years.

17 Coverage was calculated by dividing the actual number of reported first antenatal clinic visits by the number of expected visits. The expected number was derived from the total population of Murehwa
1996, the coverage declined to just over 70% in 1998, indicating that fewer pregnant women went for antenatal care. The figures should be interpreted with care, though, in view of the fact that some women may go for antenatal services outside their home area. In the mid 1990s, for instance, there were reports of women from Harare going to health centres or hospitals in rural areas in an effort to avoid the high clinic fees in town. While it was not possible to confirm these reports, it may explain the relatively high coverage in 1996.

Table 5.2: Coverage of antenatal services and institutional deliveries in Murehwa district, 1991-1998 (hospitals and health centres combined)

<table>
<thead>
<tr>
<th>Year</th>
<th>Antenatal services</th>
<th>Institutional deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>77%</td>
<td>61%</td>
</tr>
<tr>
<td>1992</td>
<td>76%</td>
<td>56%</td>
</tr>
<tr>
<td>1993</td>
<td>81%</td>
<td>56%</td>
</tr>
<tr>
<td>1994</td>
<td>82%</td>
<td>62%</td>
</tr>
<tr>
<td>1995</td>
<td>77%</td>
<td>60%</td>
</tr>
<tr>
<td>1996</td>
<td>87%</td>
<td>53%</td>
</tr>
<tr>
<td>1997</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>1998</td>
<td>70%</td>
<td>58%</td>
</tr>
</tbody>
</table>

The influence of changes in user fee policies is not as evident as expected. There was a noticeable increase in ANC attendance in the first half of 1993, which coincided with the temporary abolition of fees at rural health centres. But other changes in user fee policies, especially the abolition of fees at rural health centres in March 1995, and to a lesser extent the fee increase in January 1994, seem not to have affected ANC attendance patterns. The fee increases at the hospital level in October 1996 may have had an effect, though, since the share of the district hospital in the total volume of ANC visits for the district as a whole started falling from that time onwards.

Deliveries

It is important then to investigate trends in the number of institutional deliveries and whether deliveries actually take place at the health institutions where they have been booked. Figure 5.9 shows that, similar to antenatal clinic attendance, the number of deliveries taking place at health facilities has increased over time, from around 700 per quarter in 1991 to between 800 and 900 in 1998. Again, this increase can be expected because of population growth. The share of rural health centres is much smaller than one would expect on the basis of the antenatal clinic attendance data. From less than 100

district found in the 1992 census (152,505 people) and the district’s crude birth rate (32.64 per 1000; CSO, 1993).
deliveries per quarter that took place at rural health centres during the early 1990s – representing 10 to 15% of the total volume of institutional deliveries for the district as a whole – it increased to more than 200 deliveries per quarter during most of 1997, or around 25% of the district’s total. The year 1998 showed a fall in deliveries that took place at rural health centres. This could be due to staff shortages at that level.

Population coverage for institutional deliveries is much lower than for antenatal services (Table 5.2), with less than two-thirds of the expected deliveries taking place within a health institution. This indicates that many women deliver at home, although it cannot be excluded that some go to a health institution outside the district.

The influence of changes in user fee policies is again not evident. The abolition of fees at rural health centre level in March 1995 does not seem to have attracted a substantial extra number of deliveries. Overall, there was a decrease in institutional deliveries in 1996, which is difficult to relate to any changes in user fees and which seems in contradiction with the larger number of first antenatal visits in that year. On the one hand, it is possible that increased poverty forced urban women (from Harare) to go for relatively cheap antenatal care in rural areas – Murehwa district, for instance – and that these women were subsequently not able to deliver their babies in rural institutions. On the other hand, one may expect a possible increase in the number of home deliveries to corroborate increased poverty in the rural area itself.

Home deliveries started to be reported by rural health centres in Murehwa district in 1992, but only in 1994 did all health facilities report them as a routine. It is obvious that a certain number of home deliveries may initially have remained unnoticed, since health staff was previously not asked to provide such information. The increasing trend in
reported home deliveries observed between 1994 and 1996 (Figure 5.10), may therefore not represent a real increase. It is clear though that the number of reported home deliveries is high: it represents a quarter to a third of the number of institutional deliveries (from mid-1994 onwards), and partly explains why the coverage of institutional deliveries is low.

Figure 5.10: Home deliveries in Murehwa district reported by various types of health facilities in Murehwa district, by quarter, 1991-1998

In-patient statistics
The two hospitals in Murehwa district cater for in-patient care of clients who need to be hospitalised. St Paul’s hospital at Musami has a bed capacity of 150 beds, of which 117 are for general outpatients and 33 for maternity patients. In the 1980s it was at least as important as Murehwa district hospital, which has an official establishment of 60 beds, of which eight are designated as maternity beds.

The monthly statistics that are kept by the two hospitals on admissions and bed occupancy indicate some important changes over the years. Although data for some years are not available, it is clear that the number of admissions has decreased considerably since the mid 1990s. The average length of a patient’s stay increased at the district hospital towards the end of the decade, while it fluctuated at the mission hospital (see Table 5.3).

During the period 1991-95, the district hospital was seriously overcrowded. For most of that period an additional 24 to 29 beds were used (over and above the official number of 60 beds) so as to be able to absorb the large numbers of patients admitted to the
hospital. Since this was still insufficient, almost continuously some patients were using so-called floor-beds, which resulted in a bed occupancy rate of more than 100\% \textsuperscript{18}.

Table 5.3: Admissions (average per month) and average length of stay (in days) at Murchwa district hospital and St Paul's mission hospital (general wards), 1991-1999

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<th>District hospital</th>
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Note: n a means that records were poorly kept or not available.

The number of patients staying at the mission hospital decreased towards the end of 1991 and into 1992, following increases in ward fees and a new measure of levying separate fees for operations, X-rays, plasters, laboratory investigations and physiotherapy, which had previously been included in the outpatient or in-patient fee. In 1993, there was a dramatic increase in both the number of admissions and the average length of stay, which lasted for about nine months, after which the situation reversed to what it used to be. This was at a time when the effects of drought were at its height, but it has not been possible to assess whether the observed increases were indeed drought related. The presence of two very dedicated expatriate doctors may also have played a role. From the end of 1993, the average duration of stay decreased more markedly than the number of patients who were admitted. It is not clear whether the shorter duration of stay was due to a change in disease profile, or the departure of one of the medical doctors (in the course of 1994), or whether it reflects deliberate attempts on the side of hospital staff and or patients to reduce expenditure. For the district hospital the picture was different. Here the number of admissions peaked in 1994, at a time when the mission hospital already experienced a decline.

Between 1995 and 1998, the number of admissions and the average number of patients per day staying at the two hospitals fell to unprecedented low levels, with many beds remaining unoccupied. At the district hospital this happened despite a significant increase

\textsuperscript{18} During most of 1994, for instance, the official figures from the hospital indicate a bed occupancy rate of around 120\%. 

in the average length of stay, which is most likely due to a change in the disease profile (more chronic conditions, such as TB and AIDS related infections). Senior hospital staff suggested that the high ward fees and the high cost of medical treatment, in combination with falling incomes, deterred many patients from reporting to the hospital.\footnote{Box 5.1: A local initiative to rationalise health service utilisation}

The purchasing power of the large majority of Murehwa district residents fell during the same period, as will be demonstrated in Chapter 6, and did not keep pace with the large increases in health service fees. As a result, in-patient care appears to have gradually fallen beyond the financial reach of many. In the year 2000, less than 10\% of patients admitted to the district hospital received an exemption status and were hence treated free of charge.\footnote{\textit{As a reminder: the ward fee at the district hospital, for example, was increased from ZWD 10 per day in 1992-93, to ZWD 50 per day in January 1994 and ZWD 60 per day in October 1996. In November 1999 the fee was increased further, to ZWD 106 per day.}} The described fall in inpatient care suggests that in reality there may be many more who have had to forego treatment because of expense.

\begin{boxedquote}
In principle, it makes sense for people to use the nearest facility for primary care. Not only is it more convenient and cheaper for the individual client, it is also important for hospitals to concentrate on their function as an institution where referred patients are treated. In fact, the district health management team of Murehwa district recognised in 1993-94 that the hospital, with its crowded outpatient department, was too much involved in the provision of first-level care. This jeopardised the delivery of adequate care for referred patients, who needed the hospital’s technology and expertise. The team then started working on a comprehensive coverage plan so as to strengthen the network of health centres and the effectiveness and efficiency of the district hospital’s operations (Criel \textit{et al.}, 1996). As a result of this plan, the construction of a new health facility at Murehwa growth point was realised. This facility, which started operating in May 1996, provided an opportunity to introduce the concept of an ‘urban’ health centre, which was rather unique to Zimbabwe. Along with the national policy of user fees, this local initiative has contributed to a diminished patient load at the hospital’s outpatient department. Whether or not it has indeed enabled the district hospital to successfully concentrate on its referral function is a different issue.

On a side note, the health authorities in Murehwa district did develop ideas about how best to manage the health system under the prevailing circumstances. It is important to point out that the observed shift in health service provision from the district hospital to the health centres was to some extent an intended shift. A large number of patients used the hospital as their primary source of care rather than as a referral institution, implying a less than optimal use of available resources. Box 5.1 describes a concrete initiative to rectify this situation, which was undertaken by the local health authorities in conjunction with an external project (Medicus Mundi Belgium).
\end{boxedquote}

\footnote{\textit{As a reminder: the ward fee at the district hospital, for example, was increased from ZWD 10 per day in 1992-93, to ZWD 50 per day in January 1994 and ZWD 60 per day in October 1996. In November 1999 the fee was increased further, to ZWD 106 per day.}}

\footnote{\textit{Personal communication with senior staff from the two hospitals, April 2000.}}
Health workers’ professionalism and job satisfaction

This section describes the findings of the focus group discussions that were held in December 1993 with nurses in Chitungwiza and Murewa district.

In the rural area, the nurses who participated in the research identified problems with infrastructure as a major source of patient dissatisfaction. Facilities were overcrowded and some clinics had inadequate water supply and no electricity. Communication and transport for patient transfers provided permanent problems. The nurses believed that the public held them responsible for these deficiencies.

In both urban and rural areas, failure to provide drugs at the clinic was seen as the main patient complaint. The nurses suggested that this complaint was due in part to a nearly universal patient demand for treatment with drugs, even when none were required. All agreed, however, that chronic shortages of even the most basic drugs and supplies formed a major problem indeed.

*We often have no paracetamol, no bandages.*

When a drug was out of stock, the patient was told to purchase it elsewhere, usually in a pharmacy (in the urban area) or to try another health facility (rural areas). Such referrals generated enormous patient hostility:

*I have even heard of a nurse being assaulted by a patient who felt she was being robbed.*

The nurses generally sympathised with patient anger at paying for a service that is supposed to include drugs, only to be told later to purchase the drug:

*I think the main problem is lack of money. They sacrifice to pay to come to the clinic and then they are told to pay more.*

Many nurses tried to avoid this situation by treating some complaints and not others, or offering less ideal but still appropriate drugs, for example by substituting one antibiotic with another:

*Our patients usually have multiple complaints, so that we can usually find some drug in stock to treat them.*

*Sometimes you know that a patient is not able to buy a drug, so you try something that is on the shelf.*

In both urban and rural areas, nurses reported that the problem of certain drugs being out of stock at the Government Medical Store started in 1991. The situation had worsened since that time and there was no sign of improvement.

Long waiting times were seen as the next most important complaint about services. The long wait often compounded patient frustration at being told a drug was out of stock. Long wait was seen as due to the shortages of staff. However, some nurses commented that the public sometimes perceived the nurses as lazy, rather than overworked:

*The public think that nurses spend most of their time having tea. They don’t know that nurses are not made of iron and wood. And if you don’t get a break, you get irritable. But the patients don’t feel good and that is what they are thinking of.*
The group of rural health centre nurses did not bring up long waiting times and shortage of staff.

In both rural and urban areas the nurses did not recognise the quality of nurse-patient interaction as a possible source of public concern. Indeed, in rural areas there was an initial reluctance to enter into a discussion of the topic and confrontations with patients were reported as infrequent. In contrast, nearly all urban nurses could recall an altercation with a patient. The nurses in Chitungwiza freely acknowledged that stress of the work environment had a negative impact on the nurse-patient interaction, but instead of focussing on how such interactions made patients feel, they concentrated on their own perspective and saw the erosion of courteous nurse-patient encounters as contributing to job dissatisfaction within their own profession:

*Sometimes the queue is too long and you end up answering the patient in the wrong way. They don't respect us as they used to.*

*The nurse is the doctor, the nurse, everything. No wonder she becomes irritable.*

There was broad agreement that public respect for nurses was declining. Nurses at rural health centres seemed least perturbed by concerns with falling prestige. Low pay was central to professional dissatisfaction, both because of the resulting financial strain and the implicit lack of value attached to the nursing profession. Stagnant salaries were a source of great bitterness. Nurses described themselves as being “cheated” and “used”:

*Nurses are so underpaid among professionals. We do three years of training, but a secretary with six months or one year earns more than we do. We do the work of doctors in the clinics but we don’t get paid accordingly.*

In urban areas and at the rural district hospital, nurses described a loss of their valued place as “healers”, and described a transition from being viewed as “professionals” to being viewed as “workers”:

*A nurse used to be seen as a saviour, but nowadays she is seen as a worker who must do her own job, like anyone else working in the industrial sector.*

*A motor mechanic is paid well for saving the life of a car, but a nurse who saves human lives gets far less.*

A nurse with a long experience described with deep feeling her disillusionment with the nursing profession:

*Years ago I became a nurse because of a sick uncle. I was so impressed with the nurses and I wanted to be a nurse too. Today it is no longer a calling. It’s a means of earning bread. If you asked any of us if we could have a good job at Air Zimbabwe, we would all take it.*

In both the urban and the rural area, participants in the focus group discussions described additional sources of income as the norm among nurses. Although generating extra income was not new, it had become nearly universal since 1991 with the advent of ESAP:

*We are struggling. We end up selling vegetables after work. Some sell eggs. Others who have a deep-freeze sell drinks or “freeze-its”.*
You work in the clinic until 4 p.m. and somewhere else afterwards.

One nurse summed it up as follows:

No one is just waiting for a pay-cheque. You have to do something else to make ends meet.

Nurses were of the opinion that these income generating activities had an effect on their work in clinics and hospitals. Growing economic pressures were seen as part of the erosion of job commitment and a professional ethos, which negatively affected quality of care.

The nurse is living a pathetic life. When she is off duty and supposed to rest, she is busy doing something else, like travelling to neighbouring countries (for trade) to make ends meet. By the time she reports back for duty to deal with human lives, she is already mentally and physically tired and she will work under stress.

If I am doing a night duty, when do I sleep? I see a patient the next day and I am nearly sleeping.

Some nurses expressed sadness at the way earning money had taken over their lives:

Before ESAP, nurses discussed medicine. Now all they talk about is how to deal. Instead of giving health education to a patient, you find a nurse busy asking a patient where this or that can be procured.

We have resorted to being dealers now, instead of honest and dedicated nurses.

The facilitators of the focus group discussions asked directly about pilfering of clinic supplies, including such arrangements as nurses administering injections or selling drugs privately. Most nurses believed that such activities occurred rarely, if at all. Some nurses in the urban area, though, suggested that the practice was becoming more tempting. They pointed out that doctors engaged in pilfering of supplies from clinics for their private surgeries. Rather than actually setting up her own practice, it was more common for a nurse to take away supplies (for example family planning tablets) and to give or sell them to someone else. The general opinion was that such practices would be completely unprofessional as well as illegal. There were instances when a nurse accepted a gift from patients as a token of appreciation, but both the urban and the rural nurses expressed disapproval of this practice.

The nurses further expressed pessimism about their ability to improve their own working conditions. Their preferred strategy included lobbying for legal and administrative changes. In Chitungwiza, nurses were represented by a trade union. Although the nurses had recently held a work action to protest against the failure of the Town Council to keep its promises regarding privileges and benefits, there was little discussion in either the urban or the rural groups of the role of collective action. Some nurses expressed their unhappiness that as professionals they had been left with no alternative but to strike.
Client satisfaction

This section presents the results of the focus group discussions held with women from the communities in Chitungwiza and Murehwa district. These discussions were held in the same period (December 1993) as those with nursing staff. All the women who participated in the research had prior experience with government health services.

In the rural area, community members identified the same problems that were mentioned by nurses: poor infrastructure, staff shortages and shortages of drugs and supplies. In spite of these problems, many rural participants expressed appreciation for services provided, such as ambulance services, provision of materials for the construction of pit latrines and assistance to the needy through the provision of free medical care and the organisation of the supplementary feeding programme.

The concerns of the urban community women centred on clinic fees and drug shortages. The clinic fees were generally viewed as fair, as long as the necessary drugs were provided along with the consultation. The booking fee for antenatal care and delivery was seen as too high:

_We are being made to buy our own children._

The process of getting exemptions for paying clinic fees from the Social Welfare Department was reported to be difficult and unwieldy. As a result, people were not likely to try to qualify for free care before some illness or injury prompted them to seek health care. Some women cautioned against enforcing fees without looking at the case of each individual client:

_Poverty has grades and scales. They (the nurses) should not use this rigid system where there are no exemptions. An old man brought to the clinic in a wheelbarrow was sent home without treatment. They wouldn't even let his relatives appeal to the sister in-charge._

The women complained bitterly for being forced to pay 5 dollars for a clinic visit only to be told that there were no drugs available at the clinic. In their view, this experience was the rule rather than an exception.

Both the urban and the rural groups were of the opinion that clinic services had deteriorated since the early 1980s, but the process was believed to have accelerated in 1992-93 “due to ESAP and the drought”. The women felt that in trying to provide free health care to those in need the government had made promises it could not keep:

_It was like promising a delicious meal when there was nothing in the granary._

_The only thing that is free is the sun._

In addition, the women complained about long waiting times. These problems were seen mainly as a problem of nurse indiscipline. While shortages of staff were acknowledged (when raised by the facilitator), the root cause was believed to lie with nurse conduct. However, participants living in the vicinity of rural health centres were generally pleased with the way nurses handled the patients. Their remarks reflect gratitude and respect:
There are few nurses, so they have a lot of work to do, but they listen to the patients' complaints, they give adequate information and they also screen for the feeding programme.

One of the nurses has helped many people by providing his own transport to evacuate patients to the hospital.

These comments form a striking contrast to the views of women recruited near the district and the mission hospital and those of urban women. These participants described nurses overwhelmingly as hardened and indifferent toward patients and their problems. They lacked sympathy, respect and patience. These problems were particularly rife among younger nurses, although older nurses showed similar rude behaviour, which made clinic visits unpleasant and even demeaning.

Urban women unanimously reported that municipal clinics were unofficially closed after lunch and barely functioned during weekend days. During busy mornings, the nurses would close down the clinic to take a tea break. When services were provided this was done selectively. The women suggested that a nurse might pick out friends or relatives from the queue and give them special treatment, even to the point of ensuring that the pharmacy dispensed scarce drugs.

These statements were met with general agreement from all participants and bolstered by recounting stories of nurse misconduct or abuse. In one discussion group the incidents centred almost exclusively on the labour and delivery wards. Nurses were described as haranguing and insulting patients, rather than assisting them. Mothers were reportedly left to deliver unattended ...

... while the nurses were busy with their knitting.

Some of the stories represented the direct experience of participants, although most appeared to be part of community lore. One woman recounted how another woman in labour had been brought to the maternity clinic by car:

Later, one nurse called to another: "The one who was brought in her husband's nice car is now bellowing like a cow."

Several themes emerge from the stories. First, nurses were believed to practise favouritism, giving preferential treatment to personal friends and relatives. Next, nurses were seen as very class conscious. They might be rude to wealthier patients, because of jealousy, or to poor patients, because they looked down on the poor. For example, a patient might be denied care because of being unkempt and told to return to the clinic after having taken a bath.

Similar problems were voiced concerning the two hospitals in Murchhwa district:

Staff relatives and the elite get first preference, while the very ill ones and the poor wait for their turn. There is also favouritism in who gets drugs and who doesn't.

One rural participant summed up her bitter impression of nurses:

Nurses are no longer nurses. They do not want to be in direct contact with patients. All they like is to be proud and to look smart outside, but they are dirty inside.
When asked about trends in nurse attitudes, the general response in the urban area was that a steady deterioration in nurse behaviour had occurred. Several participants noted a generational difference, suggesting that young nurses were especially haughty. They further saw a clear change over time in shortages of drugs and other supplies, especially since 1991. A few participants hastened to suggest that not only nurses behaved badly:

> Patients sometimes also lose their tempers and do not appreciate the health workers' hard effort. We should be hard on the dog as well as on the hare.

Participants also noted that the nurses’ salaries were too low and uncompetitive, which meant that nurses were not motivated to work hard. Further the volume of work was believed to be large and conditions made it difficult to perform well.

All focus groups denied having any direct knowledge of private arrangements between nurses and patients, and most participants did not think this was happening. In addition, the women were emphatic that there was no “tipping” system, with nurses expecting a reward from patients for the care provided. Nurses were believed to even refuse gifts.

The women expressed a strong belief that health care should remain a responsibility of government and the poorest should be entitled to free care. Some could readily articulate their vision of improved government health care:

> We want thorough examination of patients so that the right diagnosis is made. Then we need appropriate medication, which means the right drugs in the right quantities.

> We do not want to pay again when we are referred to the hospital. We expect all drugs to be in stock. We want to pay a flat fee for screening and treatment. The amount should be 2 dollars for adults and 50 cents for children. The poorest must be exempt.

To address problems in nurse-client communication, participants offered a range of possible changes: improved supervision of young nurses, more emphasis during training on how to interact with patients, and establishment of a grievance mechanism. Patients should be educated about their rights and there should be more openness among health staff to criticisms. But the community women who participated in these discussions were not hopeful that their complaints and suggestions would result in changes:

> ‘Health for all by the year 2000’ will not be achieved. Instead, because of ESAP, it is going to be ‘Death for all by the year 2000’. The elite will not die, but they will be very lonely. There will be no one to live with them.

Quality of services as an overarching issue

Through qualitative research, based on focus group discussions, of which the results are described in the two previous sections, we sought to understand the impact of structural adjustment and economic stress on health services beyond the issue of user fees, to

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21 At the time of the study the clinic fee in Chitungwiza, where this comment was made, was ZWD 3.60.
include issues of nurse professionalism and job satisfaction, client satisfaction and perceived quality of care. A comparison of the views of nursing staff with those of patients recruited from the community in the same areas resulted in several shared views and some interesting contrasts.

All groups interviewed made similar assessments of the state of health services. Drug shortages and long waiting times in combination with high clinic fees were identified as signs of declining quality of care and major sources of dissatisfaction. These problems were not seen as new, in fact some were long standing, dating to the early 1980s. However, all groups noted a marked decline in service quality beginning in 1991, when adjustment policies started to be implemented. Nurses shared with community residents a recognition that most clients had limited and declining financial resources because of unemployment and a general increase in the cost of living. Both expressed the wish that fees be lowered and drugs be included again in the cost of a consultation. Further evidence to support the proposition of a growing concern among health professionals with deteriorating services around that time comes from several studies conducted by various groups of health professionals between 1989 and 1992. Rather than focussing on diseases, such as malaria or tuberculosis, which usually are favourite topics for health research, these studies dealt with health management and quality of care issues.

In contrast to the above areas of agreement between the focus groups of nurses and women from the community, there was a striking divergence of perspectives regarding the interaction between the nurse and the patient. To community women, from the urban as well as from the rural area, nurse attitudes toward the client population followed a consistent pattern of indifference. While nurses acknowledged that they might be irritable and rushed with patients, they failed to identify the erosion of the nurse-patient relationship as a major patient complaint.

To community women, the expectation of abrupt or rude treatment was the main complaint about the health services. Complaints were most strongly voiced in the urban area, where accusations of patient neglect and even abuse suggested a heightened hostility between the clinic and the community setting. Several explanations for this behaviour of nurses were put forward, chief of which was elitism.

The complaint that nurses treat patients harshly and with contempt has been noted repeatedly in Africa, including Zimbabwe, although initially this was only rarely further explored (Gilson et al., 1994). In a summary of patient satisfaction studies in Sub-Saharan Africa, Scuccatto (1992) notes that these near universal complaints occur in such varied cultural settings as Nigeria and Tanzania, pointing to an underlying social basis of

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22 These studies were conducted in the context of Health Systems Research training, supported by the Joint HSR Project for Southern Africa, based in Harare. Examples of topics investigated are overcrowding in hospital wards (Bossum et al., 1991; Munzawafa, 1991; Zindowe et al., 1992), staff inadequacy (Moyo et al., 1989), maintenance problems (Dhlakama et al., 1989; Zingoni et al., 1992) and community perceptions of quality of care (Nkomo et al., 1992).

conflict. He suggests that ‘westernisation’ and upward mobility form the basis for this conflict. It is in urban areas indeed that class differentiation is most advanced, and economic stress may further aggravate this problem in present day Zimbabwe.

Rural health centres formed an exception to the general chorus of complaints about nurses in our study. Rural nurses appeared to be better integrated in the communities concerned. Here, general contentment with nurses may be due to a combination of lower community expectations and more appreciation of the simple presence of a health centre. since many of the communities had very limited or no health care services at all prior to independence. The nurses probably also experience greater acceptance as respected members of the community.

There is a great deal of poignancy in the words of the nurses. They are not merely concerned about their personal livelihoods, which they perceive as increasingly insecure. They also yearn for an ideal of nursing that envisions nurses as knowledgeable, up-to-date, efficient and well supplied, providing care, which reflects quality training. Instead, they witness a transformation of nurses from elite professionals to the workhorses of primary health care. They described working conditions in which nothing promotes the professional values they were taught. Each day they face seemingly intractable problems over which they have no control. They must implement service fee schedules, knowing that community members are increasingly short of cash. Overwork and low salaries promote the adoption of the attitude of an industrial worker: to do what is required and no more. Most nurses have economic side activities, not to get rich but to survive. As elsewhere, efforts to ‘professionalise’ nursing have benefited only a few.

The members of the community recognised the social basis of conflict between nurses and patients more readily than the nurses. The introduction of adjustment policies and financial restraint in the health sector did not create these conflicts, but the resulting economic hardships appear to have sharpened them.

The social forces arrayed against nurses are indeed powerful and ‘proletarisation’ of the lower echelons of professionals has progressed relentlessly. In late 1996, longstanding grievances of health workers over their conditions of service led nurses and junior doctors to go on strike. The government reacted by dismissing all those involved in the strike and closing down for some time two of the major referral hospitals in the country. Numerous reports in the popular press in the same period suggest that the escalating conflict may have further undermined public support of both nurses and doctors.24

Gaidzanwa (1999) studied the history of the modern medical profession in Zimbabwe and investigated the reasons for nurses and doctors to enter into private practice or to immigrate for employment elsewhere. She found that a combination of dissatisfaction with the domestic working environment, including the limited career opportunities in Zimbabwe, and the existence of much more attractive employment opportunities in neighbouring countries – Botswana, South Africa and Namibia – was responsible for the high rate of attrition of government medical personnel. She also demonstrated how much

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more profitable it can be for a medical doctor to set up a private practice, rather than remain a civil servant, although by 1997 there were signs of saturation of the private market for medical services, partly because of the public’s limited financial capacity.

It thus appears that much of the situation in 1993 depicted above in quite some detail for Chitungwiza and Murehwa district does not stand on itself. Other parts of the country also experienced problems with the quality of care, while it is clear that primary health care centres as well as referral hospitals were affected, as suggested by the variety of studies that have been conducted (cf. footnote 22). Although most studies have focussed on the role of nurses in relation to quality of care, doctors are implicated as well. Since 1993, the crisis in the government health sector appears to have worsened rather than resolved, triggering the already mentioned strikes in late 1996.

The World Bank commissioned a study among clients and providers to investigate prevailing attitudes towards the Zimbabwe health system (Reed and Associates, 1997). This study found that the public in Zimbabwe - both in urban and in rural areas - held the government responsible for the deterioration of the quality of health care. It confirmed the general frustration of clients who felt they had to sacrifice money and effort to take a patient to a health institution only to be confronted with staff, “especially nurses”, who took out their own anger and frustration on patients and their visitors. Community members also suggested that private health facilities were not always a good alternative, and they questioned the fact that in the private sector they were required “to pay so much more money, just to be attended to by the same doctors” (ibid.).

Several other observations can be made with regard to resource availability and accessibility of health services in Zimbabwe. They are based on the authors’ own findings in Chitungwiza and Murehwa district and on studies conducted by others.

Resource availability and use
At least three studies indicate that the referral system in Zimbabwe is not functioning well. Ellis (1997) found that the public’s perception that hospitals provide better health care than health centres continues to prevail. As a result, patients often bypass the lower levels of care as they perceive, rightly or wrongly, the care provided at those levels to be of low quality. Sanders et al. (1998) examined the hospital referral system for two tracer conditions - pneumonia in children and malaria in adults - in two rural districts not far from Harare. They found that the majority of patients admitted to referral hospitals - tertiary and quaternary level - were admitted inappropriately and could have been treated at a lower level of care. The majority of patients presenting at a hospital had come to that facility as their first or second point of contact with the health services. The study concluded that the referral hospital served a similar case mix of patients as the health facilities at the district level, but at six times the cost. This illustrates that the poorly functioning referral system constitutes an important weakness both in terms of efficiency

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Footnote 25: One of the main reasons for long patient waiting times at the outpatient department of one of the central hospitals in Bulawayo was the physical absence of doctors who attended to their private practices during working hours (Zindove et al., 1992).
of resource use and effectiveness of treatment procedures. It implies that people who use health services at the primary level of care – the rural health centre or urban clinic – often do not receive the right treatment, which exacerbates the problem of inequity. The third study, conducted in Murehwa district in early 1995, found that the referral system for maternal services was not functioning adequately. In addition, basic equipment for antenatal care, intra-partum and neonatal care was inadequate; essential laboratory facilities for obstetric care were lacking; and skills for intra-partum monitoring and neonatal resuscitation were inadequate (Kambarami et al., 2000a, 2000b).

It is relevant as well to consider some of the changes that have taken place with regard to drugs and staffing levels, especially at the primary care level. There is evidence that drug availability, which is an important indicator of quality of care, has decreased at rural health centres, especially since 1998, while at the level of district hospitals it has been consistently better for many years (ZEDAP, 2000). Anecdotal evidence suggests that, also since 1998, even at Chitungwiza municipal clinics drug shortages are a common phenomenon. Nurses become frustrated as they can no longer provide the drugs they prescribe. Patients are advised to buy drugs from private pharmacies, which charge higher prices than government outlets.26

With regard to staffing levels, we observed that Murehwa district, like most other parts of the country, has a large number of vacancies in the health sector. Only the two hospitals have posts for medical doctors, but the mission hospital, which used to have two (expatriate) doctors, had only one during the period 1995-98, and did not have any from late 1998 onwards. Among nurses, the overall vacancy rate in early 2000 was 22%. The main shortage, however, was at the mission hospital and at rural health centre level, where 41% and 28% of the posts were vacant, respectively, compared with 10% at the district hospital.27

In Chitungwiza, the official staff establishment has not changed since 1990. Because of financial problems, the municipality stopped filling vacancies in 1995. Nurses and other staff who transferred, retired or died were no longer replaced. This has lead to gross understaffing, with vacancy rates of around 50% in early 2000. For example, in early 2000 one of the clinics in Chitungwiza had only 20 nurses while there are 42 posts. There were no nurse aides (four posts), and about half of the posts of other support staff, such as clerks, messengers and cleaners, were vacant. The 1996 strike did not result in any significant improvement in employment conditions.

Financial access and exemption
Access to hospital services is limited to those who can afford to pay and those who manage to get an exemption status. Initially, districts could claim reimbursement of money foregone because of exemptions through the Social Development Fund, which was created in the early phase of structural adjustment. However, the fund has never

26 Personal communication with health staff. April 2000.
27 Personal communication with district health authorities. April 2000.
operated satisfactorily (Kaseke, 1993; Kaseke et al., 1998), and as a result Murehwa district health authorities stopped claiming reimbursements in 1996. Instead, the district has enforced the requirements for exemption, and at times the health staff does turn away patients who fail to pay the required hospital fees.24

In Chitungwiza, free care is only provided in case of an emergency. People who can provide proof that they are unable to pay the high clinic fees do not receive free care but are still required to pay a certain amount of money. At one of the clinics in early 2000, on average about 20 patients per day pay ZWD 20 for an outpatient consultation rather than the official fee of ZWD 80. This represents less than 10% of all visiting patients. No records are kept of the number of patients who are exempt from paying for medical care.

It is relevant to learn from the experience gained elsewhere, for example in Ghana, where cost recovery was introduced in the 1980s. Nyonator and Kutzin (1999) found that health facility managers had been very active in setting and collecting fees and using the revenues to purchase essential inputs. At the same time, however, official exemptions were largely non-functional. In 1995, less than one in 1000 patient contacts in the Volta region was granted exemption. With estimates that between 15% and 30% of the population lives in poverty, the failure of exemptions to function means that fees are preventing access to the poor, or are imposing significant financial hardships on this part of the population. The authors conclude that the user fee system has brought about a certain degree of stability in the region, with fees enabling service provision to continue, but concurrently preventing part of the population from using these services.

The situation in Zimbabwe appears to be somewhat different, since the country has no tradition of local retention of fees, which could be reinvested to improve the quality of services. Fee retention at the district level has been authorised only since the start of the Health Services Fund in January 1997. During 1998, Murehwa district hospital generated about ZWD 30,000 per month from user fees, and this amount has gradually increased to about ZWD 150,000 per month in early 2000.25 At first sight this seems a positive development. At the end of 1998, the Health Services Fund of Murehwa district had more than ZWD 2 million in its account, which could be used for repairs and maintenance of infrastructure, the provision of food to in-patients and for buying drugs, linen and other supplies. These are measures that have the potential to improve the quality of care and make clinic attendance more attractive. It has not been possible to assess what improvements have been realised and their possible effects on service utilisation. Anecdotal reports and an essential drugs survey (ZEDAP, 2000) suggest that rural health centres have limited access to the Health Services Fund, which is controlled at the district level. Even though health services are free in rural areas and no revenues are collected at that level, it is clear that the quality of services at the primary level of care needs to be

24 Personal communication with health staff, April 2000.
25 Donors contribute ZWD 300,000 per quarter to the Health Services Fund of Murehwa district (or ZWD 100,000 per month; personal communication with Ministry of Health officer).
It would therefore be appropriate to ensure that a certain proportion of the Health Services Fund is spent on improvements at the rural health centre level.

Several other studies have been conducted in Zimbabwe, none of which involved periods of more than two or three years, though. Renfrew (1992), who was at the time working as a medical officer at St Paul’s hospital at Musami mission in Murehwa district, demonstrated that two fee increases during 1991 led to a reduced patient load at the hospital’s outpatient department and fewer patients receiving prescriptions for drugs. She also found a decrease in first attendance at antenatal clinics with a concurrent increase in the number of newborn babies brought to the hospital but delivered by the mother without professional assistance. Hongoro and Chandiwana (1994) also found negative effects of the enforcement of user fees on clinic attendance levels, although their evidence was less convincing.

Community based sentinel site surveys conducted by the Ministry of Public Service, Labour and Social Welfare, together with UNICEF (1996), indicate that cost recovery tends to have reduced access to and use of health services. The proportion of children with diarrhea who were not treated at the clinic more than doubled between 1993-94 and 1995. This was attributed, at least in part, to the increase in user fees in January 1994. The same surveys found that the Social Development Fund (SDF), which was meant to assist people who were unable to pay school fees or clinic fees, had difficulties in reaching large parts of its target groups. Many people interviewed did not know of the SDF or how to access benefits from it.

The 1994 Demographic and Health Survey (DHS) found that 91% of urban women and 61% of rural women had delivered at a health facility, virtually the same as in the 1988 DHS (CSO, 1988; CSO, 1995). The 1999 DHS showed a slightly different picture, with a lower figure for urban women (89%) and a small improvement among rural women (64%; CSO, 2000). Iliff (1995), however, showed that Harare Central Hospital experienced an increase in the number of babies born before arrival (BBA), following the price increases of 1991 and 1994, and increased death rates among BBA babies. This suggests that the price increases caused some women to deliver at home or delay seeking assistance. It is well possible that such trends, which are based on local hospital-based statistics, do not emerge from nationwide community-based surveys, such as the DHS. In 1999 the DHS for the first time questioned women about possible problems in accessing health care for themselves and found that financial accessibility was a major but not the sole problem. While a quarter of the urban women (26%) considered getting money for treatment as a big problem, the second biggest problem was fear of verbal abuse by a health provider (14%). The same percentage of rural women mentioned the latter as a big problem (14%), although distance (45%), having to take transport (43%), getting money for treatment (39%) and not wanting to go alone (16%) were mentioned more frequently.

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30 This has been demonstrated earlier by Abel-Smith and Rawal (1992) in the case of Tanzania.
31 The study involved several health facilities in different geographical areas; the study did not look at possible opposite shifts in attendance levels at nearby facilities.
32 The proportion rose from 9% in 1993-94, to 22% in 1995.
Conclusion

Most of the studies on the effects of user fees, in Zimbabwe or elsewhere, considered individual health institutions in different locations, or even single health institutions. Our study is different in that it looked at changes in the relative contribution of the various health institutions within (two) defined geographical areas, allowing conclusions not only about trends in total attendance but also about possible shifts in the distribution of service utilisation.

Total service utilisation levels in Chitungwiza and Murehwa district have not fallen dramatically during the 1990s – except for inpatient care – but they have not kept up with population growth. While changes in user fee policies have had some effects on service utilisation – especially on outpatient clinic attendance – the general deterioration in socio-economic conditions during the 1990s appears to have affected people’s willingness or ability to pay for health services.

We have demonstrated that it was a policy of the Ministry of Health and Child Welfare to use user fees as an instrument to bring about a shift of emphasis from hospitals to clinics in the provision of first-level care, with a view to a more rational use of available resources. The changes found in Chitungwiza and especially in Murehwa district confirm that this shift has taken place indeed. However, since the quality of services at the primary health care institutions – the urban clinics and the rural health centres – has not improved, the responsiveness and hence the performance of the health system as a whole has been negatively affected.

In Chitungwiza, outpatient clinic attendance started declining after the general fee increase in early 1994 and remained low for three years because of economic difficulties and a fallen confidence among the public in the quality of care provided. Although it has not been possible to conduct focus group discussions with clients and health care providers before structural adjustment (in 1991) and to repeat these towards the end of the 1990s in the same areas, it has become sufficiently clear that the quality of care has deteriorated. Shortages of drugs and medical supplies, long waiting times and irritable staff, due to an increased workload, have led to strained client-provider relations, which in turn, and in addition to high clinic fees, have affected clinic attendance. The partial recovery in clinic attendance in early 1997, which persisted during the beginning of 1998, is more likely a reflection of an increase in the incidence of diseases than of a restoration of people’s confidence in public health services.

In Murehwa district a pronounced shift has taken place in the distribution of total outpatient clinic attendance, much more pronounced than in Chitungwiza. The rural health centres have clearly taken over the role of the two hospitals as the main provider of both curative outpatient care and antenatal care. As pointed out earlier (see Box 5.1), the district health authorities wanted this shift to take place. Its overall public health effect cannot be quantified, but the continued poor quality of service suggests that it has been negative. Total attendance for antenatal care and deliveries has not been influenced much, indicating that the price elasticity for maternal health services is much more limited than for curative outpatient care. One of the likely explanations is that most Zimbabweans see
the need for supervised pregnancies and deliveries, because they recognise that there are hardly any cheaper alternatives that are equally safe, especially in rural areas.

Inpatient care statistics have followed different patterns in the urban and the rural area. In Chitungwiza the average length of stay at the hospital was strongly reduced in 1993-94 following the increase in user fees in early 1993. Hospital admissions have remained relatively unaffected by fee increases and economic stress on households during the decade. In Murchwa district, the number of admissions strongly reduced after 1995, reflecting a loss of people's confidence in the services provided, their inability to pay for hospital admission or a combination of the two. The duration of hospital stay increased in the second half of the decade, because of a different disease profile.

These findings, along with the observed changes in quality of care and people's satisfaction, demonstrate that a serious erosion of the health services has occurred during the period of structural adjustment, a development that the government of Zimbabwe has not been able to avert.