PRIMARY HEALTH CARE IN A DEVELOPING ECONOMY:
ISSUES OF JOB AUTONOMY, RESOURCES, QUALITY OF CARE
AT THE DISTRICT LEVEL IN ZIMBABWE

By

EDWARD MAKWARIMBA, M.A.

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AUTHOR: Edward Makwarimba, B.Sc. (University of Zimbabwe)
Cert. Ed. (Mutare Teachers' College, Zimbabwe)
M.A. (McMaster University)

SUPERVISOR: Dr. R. Jack Richardson

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PRIMARY HEALTH CARE IN A DEVELOPING ECONOMY
ABSTRACT

Primary Health Care (PHC) is a structural expression of an alternative form of health-care provision whose central philosophy is equity. Since the appearance of this institution on the scene in the late 1970s, numerous developing countries have embraced its tenets in a bid to either replace or counteract the curative approach characteristic of Western biomedicine with varying degrees of success. Concomitant with this is the proliferation of studies, most of which have focused on: the cultural acceptability of PHC technologies; the inequitable distribution of health resources; accessibility of health care facilities, etc. - all of which are germane and laudable attempts to make health a basic human right. However, such research foci neglect some organisational structures upon which the effectiveness of PHC programmes is contingent. Furthermore, the personal experiences of both providers and consumers are often neglected.

The purpose of this exploratory and qualitative study is to investigate the relationship between job autonomy/participation in policy decision making and (a) the quality of health care provision and (b) the effectiveness of the PHC programme, with burnout and job satisfaction/dissatisfaction as the intermediate variables. Empirical research was undertaken in the district of Mutoko (Zimbabwe), with Mutoko District Hospital as the primary site. Data were collected through unstructured interviews, observation and government records.

Analysis of the data reveals that, apart from those with supervisory and managerial responsibilities, most personnel do not show much desire for greater job autonomy/participation in policy decision making. However, the analysis shows that job autonomy/participation in policy decision making and resources have both a direct and an
indirect (through the intermediate variables) effect on the quality of health care and the effectiveness of the PHC programme. Furthermore, the analysis indicates that lack of resources, personnel shortages (which lead to work/role overload) and low salaries are the major causes of job burnout and job dissatisfaction in the district health system.

Analysis of consumers’ situations and experiences to determine quality of care suggests that the effectiveness of PHC and the utilisation of health services cannot be simply assumed by encouraging people to use them. Therefore, addressing the major concerns noted above is essential to ensure geographical, economic, intellectual and psychological accessibility and that primary health care services become effective in practice.
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To Enice and Anna.
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<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<tr>
<td>ASMH</td>
<td>All Souls Mission Hospital</td>
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<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>DEHO</td>
<td>District Environmental Officer</td>
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<tr>
<td>DHSA</td>
<td>District Health Services Administrator</td>
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<tr>
<td>DHE</td>
<td>District Health Executive</td>
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<tr>
<td>DNO</td>
<td>District Nursing Officer</td>
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<tr>
<td>EHT</td>
<td>Environmental Health Technician</td>
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<tr>
<td>ESAP</td>
<td>Economic Structural Economic Adjustment Programme</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GNP</td>
<td>Gross National Product</td>
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<tr>
<td>HC</td>
<td>Health Centre</td>
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<tr>
<td>HE</td>
<td>Hospital Executive</td>
</tr>
<tr>
<td>MDH</td>
<td>Mutoko District Hospital</td>
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<tr>
<td>MHCW</td>
<td>Ministry of Health and Child Welfare</td>
</tr>
<tr>
<td>NMH</td>
<td>Nyadiri Mission Hospital</td>
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<tr>
<td>PEHT</td>
<td>Principal Environmental Health Technician</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHEO</td>
<td>Provincial Environmental Health Officer</td>
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<tr>
<td>PMD</td>
<td>Provincial Medical Director</td>
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<tr>
<td>QWL</td>
<td>Quality of Working Life</td>
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<tr>
<td>SCN</td>
<td>State Certified Nurse</td>
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<tr>
<td>SEHT</td>
<td>Senior Environmental Health Technician</td>
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<tr>
<td>SRN</td>
<td>State Registered Nurse</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>T H</td>
<td>Traditional Healer</td>
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<tr>
<td>TM</td>
<td>Traditional Medicine</td>
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<tr>
<td>T &amp; S</td>
<td>Travel and Subsistence</td>
</tr>
<tr>
<td>VCW</td>
<td>Village Community Worker</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WUSC</td>
<td>World University Service of Canada</td>
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<td>ZNA</td>
<td>Zimbabwe Nurses’ Association</td>
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Chapter One

INTRODUCTION

1.1 OVERVIEW

A desire and an effort to meet the basic health needs of the world population culminated in the 1978 World Health Organisation (WHO)-sponsored conference in Alma Ata, Soviet Union, and the declaration of that conference “...asserted that health is a human right and that [it]...should be accessible, affordable and socially relevant” (Mosley, 1989:222). The goal is to achieve ‘Health for All by the Year 2000’. According to Muhondwa

[t]he promotion of Primary Health Care... in less developed countries....is essentially a result of the frustration with the ‘trickle down’ approach to health development which emphasized centres of medical excellence based in urban areas and left the majority of the people virtually untouched [1986 : 1247].

It is in the light of these developments and the burgeoning international interest in PHC that this qualitative and exploratory study takes a closer look at the organisation of health-care services at a district level in Zimbabwe. Of central concern to the study are the effects that lack of job autonomy/participation in policy decision making and lack of resources have on the quality of health-care services provided in this particular district of Mutoko.

Phillips (1990) asserts that growth of PHC is dependent on the development of local (or close to the periphery as possible) professional and managerial support. He goes on to say that the district health-care system should “have considerable managerial autonomy within a national health framework in order to use local resources most
effectively to meet district needs” (Phillips, 1990: 283). According to Amonoo-Lartson and associates (1984: 45) “the district hospital and its medical officers is more in the nature of being supportive, managerial and administrative” when it comes to PHC strategy. The District Medical Officer, working together with village health workers and birth attendants, should try to develop the quality of these health personnel resources through training and professional support as well as good administration, evaluation, and reorientation. Amonoo - Lartson et al. (1984) posit that these workers’ involvement in decision-making and professional support (from the top) helps improve the quality of the care they provide. That is, with good organisation the health personnel are able to work to their full potential, and different aspects of health care carried out by these different people can be integrated for maximum effect. Entrenchment of positions and privileges is detrimental to the development of a practical district health-care system. In this respect, Navarro has criticized the WHO report, (from which many countries have drawn inspiration for their PHC initiatives) for failing to “...mention that what is needed for the liberation of women is a redefinition of the power of women and men within the context of a ...redefinition of power...relations in society” (1984: 471).

According to Phillips (1990), most Third World governments fund public institutions based on a pyramidal hierarchy (for both administration and facilities) consisting of central urban hospital, smaller regional or district hospitals and, rural health centres. The service and support systems are often short of resources, personnel, equipment and drugs, and “often overburdened as to provide less than the minimum realistic care” (Phillips, 1990: 64; MacPherson, 1982; MacPherson and Midgley, 1987). Distributional inequalities are said to exacerbate pressures on services and, Phillips (1990) says this has a negative effect on qualitative access to health care.
Thus social policies in the Third World have been called 'incremental models' "in which existing provisions are expanded in an ad-hoc, linear fashion" and, fail to redistribute resources on the basis of need (MacPherson and Midgley, 1987: 122). Larger percentages of health budgets are spent on urban curative services (Conyers, 1982; Barnum and Kutzin, 1993). In Lesotho, one national referral hospital absorbed 42 percent of the total health expenditure in 1986-87 (Barnum and Kutzin, 1993). Barnum and Kutzin (1993) also cite the cases of Kenya and Jamaica where, throughout the 1980s curative services (mostly hospitals) overspent their annual budgets, whereas primary health-care programmes (and rural health services) averaged less than the amounts budgeted for PHC activities. In 1987, for example, Zimbabwe's four central hospitals consumed 45 percent of the Ministry of Health's budget (Barnum and Kutzin, 1993).

Barnum and Kutzin (1993) point to the difficulty that district hospitals and health centres have in fulfilling their roles if their recurrent resource needs continue to be underfunded, especially if this results in shortages in basic resources. They go further to argue that a district administration that receives sufficient budgets is given an incentive to make early detection of illness.

Like the 'affective behaviour of health-care personnel', other dimensions of the quality of hospital services include the availability of supplies, staff, equipment, etc. (Barnum and Kutzin, 1993). Hence Barnum and Kutzin posit that "the absolute level of resources flowing to the health sector and the quality of health services are also determinants of the structure of effectiveness of the health sector" (1993: 12). Therefore it would not be wrong to say

the impact of PHC is yet to be felt [in Africa], especially in correcting the ills of the health system ... [and that] most efforts ... today fail to suggest an intent to achieve the minimum requirement of PHC [Falola, 1992: 25].
For the majority of people in the Third World "modern health care may be quantitatively, qualitatively or economically unavailable" (Phillips, 1990: 1). Because of the mismatch and maldistribution of health resources, "the poor usually receive too little and the wealthy can receive too much" (Phillips, 1990: 300). Such conditions are summed up by Hart (1977) as 'the inverse care law', that is, provision of health care is inversely related to the need for it.

When the Government of Zimbabwe embarked on a health care reform (after political independence in 1980) based on primary health care (PHC) principles, it intended to correct the glaring class, racial and geographical inequalities in health-care provision. It also recognized that health care is not merely the provision of health services but is related to broader environmental socioeconocultural and development issues and it became committed to an equitable distribution of health resources according to need (Agere, 1986; Manga, 1988; Loewenson and Sanders, 1988; Loewenson et al., 1988; Stoneman and Cliffe, 1989). Some of the key ideas in the government policy paper include a rural bias in the redistribution of health-care resources: ensuring equitable access to health services; limiting the influence of the private medical sector; involvement of local populations in health planning and gearing the human resource development to the tenets of a primary health-care system (Manga, 1988).

Due to these efforts there have been some positive qualitative and quantitative changes in the health sector, especially in the orientation towards PHC and a greater focus on preventive and rural health care. A number of achievements have been made in the reduction of infant mortality rates and child under-nutrition, contraceptive use, maternal health care, immunization against childhood diseases ¹, the number of deliveries in health units, growth monitoring of children, initiating an Essential Drug Programme, the training of village health workers, the introduction of free health care for those earning below

However, despite all these efforts, it is noted that the trend in the rural biased resource distribution reversed in the late 1980s (Loewenson et al., 1991). It has been argued that fee charging (reintroduced in 1991) prejudices the access of those most in need of access to care, especially in the rural areas (Loewenson et al., 1991; Stoneman and Cliffe, 1989). The principle of equity has also been negated because "...some districts still do not have either a district or a mission hospital...while others [have] more than one hospital of 'district level' status" (Loewenson et al., 1991: 1084). The envisaged referral system that should be providing a chain of increasingly sophisticated facilities as one moves from a rural clinic to a central hospital has made a dismal performance (Manga, 1986; Loewenson et al., 1991) because it is not benefiting the rural poor but those living close to the large hospitals (Loewenson et al., 1991). While more than 70 percent of the population is in rural areas, the health-care facilities there remain poorly staffed, with most categories of staff being absorbed by city hospitals (Bloom, 1985; Agere, 1986; Loewenson et al., 1991). The policy paper acknowledges the importance of non-health sector inputs, that health is a development issue, not a disease problem. Manga (1988), however, argues that it says little about the need for inter-sectoral and inter-ministerial planning and coordination.

According to the 1987 PHC Review Group, "the health information system [at the national level] remains generally insufficient at all levels of the health services to enable adequate monitoring and evaluation of PHC activities to take place" (U.N.E.S.C.O et al., 1987: 4). The Group also notes the problems of inadequate staff levels and insufficient training for nearly all of the PHC components; lack of coordination of inter-sectoral
collaboration at the central level (except for specific components like Water and Sanitation, a point that had been noted in the 1984 review); a rather small health education unit; constraints to service delivery and management due to staff shortages and turnover; inadequate technical support, drugs and other resources and facilities like transportation, office and staff accommodation from provincial to health centre level; weak administrative, political and social structures/mechanisms within the provinces; ignorance of other PHC components among district level staff who were vague about the objectives, strategies, as well as lacked the understanding (and did not make use) of indicators (either service or impact); inadequate supervision (at district level) due to shortage of manpower and training in supervisory skills; poor inter-sectoral cooperation concerning general poverty and the drought situation in several districts (U.N E.S.C.O et al., 1987). This goes a long way in pointing out the huge gap that always exists between ideology (in this case the PHC ideology and its attendant principles) and what actually takes place at the central district and local levels.

Thus, in the words of Hollnsteiner (1982 : 36) one could say 'troublesome growing pains persist', despite the formulation of such a meaningful health policy. The situation is perhaps best summed up by recent press statements made by the Deputy Minister of Health, who said the state of affairs as far as health services were concerned, were fast becoming a national disaster (The Sunday Mail, January 16, 1994, page 6). The Minister of Health also said that the government could end up spending money on building mortuaries if current investment levels in the health sector continued, and, another eminent minister also expressed fear that the country could actually be leading towards "Death for all by the Year 2000" and not "Health for All" (The Sunday Mail, January 16, 1994, page 6).
Rakowski and Kastner's study (see Phillips, 1990) of a health service module in Caracas, Venezuela also paints a similarly dismal picture. During a reorganisation, the autonomy of the centre's staff was usurped, and this led to dissatisfaction. Channels for patient referrals and administrative matters were found to be unclear and "in terms of supplies, the centre coordinator had no direct access to petty cash but had to follow a complex requisition routing, even for small requirements" (Phillips, 1990: 136).

Reid has studied a Maternal and Child health programme in a single province in Papua, New Guinea, and observed brief encounters averaging about two minutes between mothers/children and staff (see Phillips, 1990). He argues that that allows little opportunity for staff to assess risks and give advice or health education. The staff had become task oriented, focusing on specific problems. Some of the reasons for such behaviour were inadequate supervision, and complex reporting systems. Overall, Habicht and Berman (1980: 129) contend that "... the problem limiting the spread of effective primary health care" does not lie in the technology itself. "... the limiting factors are organisational."

What is most important for this research is to investigate the reactions (and effects of such reactions) of health personnel working under such systems. Maslach (1982) argues that when one is caring for so many people, especially in institutions faced with understaffing and shortages of other resources with which to care for patients, they suffer from emotional overload. The usual response is to cut back on one's involvement with others (in this case patients). She asserts that as a result, "patients get care or treatment without any personal caring" (1982: 4). Mechanic has found that "[p]hysicians with a heavy case load considered more complaints as trivial, reported more unreasonable consults and felt less responsibility for psychosocial problems of their patients" (see Stevens et al., 1992: 298). Carers begin to focus on people's problems only because
there is not much time for complete and adequate service. This 'work/role overload' is said to lead to loss of self esteem and lack of empathy, growing dissatisfaction with one's job, low motivation, discourtesy, increased personal conflicts; a decline in enthusiasm, a cynical attitude, low staff morale, outbursts of anger, longer coffee/tea and lunch breaks, more time spent socializing with workmates, and knocking off early (Maslach, 1982; Cherniss, 1980). These kinds of reactions to objective conditions and subjective states reduce the effectiveness of health services, both quantitatively and qualitatively. Maslach (1982) has posited that many burned-out service workers, instead of doing their work badly, do less of it. Over time, it is argued, the burned out person will withdraw physically from the job. Thus, levels of absenteeism and turnover will increase (Maslach, 1982; Cherniss, 1980).

Whatever the exact sources, burnout and job dissatisfaction affect the quality of care, and I am putting the blame squarely on societal structures and the structures of the health-care system that put a low value on the health needs of the population, especially the rural poor. Davies has strongly argued that the behaviour of nurses, whether rigid, passive, or defensive, is "a direct response to powerlessness" (1992 : 233). For example, Pearlin's study found that dissatisfaction and alienation in nurses were influenced by the extent to which they could influence formal sources of power, with those further down the hierarchy experiencing more alienation (in Cherniss, 1980). An increase in decision-making power has been found to bring satisfaction from work, to increase productivity, and to reduce absenteeism, turnover and anti-social behaviour (Chernomas, R. and W. 1989), and, lighter work loads and a good working environment have been found to have a positive effect on health workers' satisfaction (Breslau et al., 1978; Stevens et al., 1992).

With regard to field staff in the Third World, Conyers (1982 : 106) reports that:
communication is often seriously inadequate, confined to the issuing of
orders or instructions from headquarters to the field and the submission
of regular reports on routine matters in the opposite direction.

Such top-down communication signifies the nonexistence of a democratic working
atmosphere. This and other concerns that I have raised above regarding resources and
working conditions have therefore partly been the basis of my research objectives.

1.2 RESEARCH OBJECTIVES

The primary objective of this research is to investigate the possible combined
effects of lack of job autonomy/participation in policy decision making and resources
(manpower and otherwise) on the quality of health care and effectiveness of the PHC
programme in Mutoko district.

Research on burnout (Maslach, 1982; Cherniss, 1980; Burke and Greenglass,
1989) job stress (Karasek and Theorell, 1990, Ford, 1988) and work satisfaction has
pointed towards the arousal of feelings of dissatisfaction in (over-centralized)
organizations where there is lack of autonomy to influence decisions and policy formation.
Most importantly, for this research, is the effect all this has on the quality of service
provided by health-care personnel. Maslach (1982) and Cherniss (1980) have asserted the
significance of the negative effect of stress and burnout on the quality of service in social
service organizations/programmes. Therefore burnout and job satisfaction/dissatisfaction
logically become the study’s mediating variables.

The study therefore seeks to investigate:

a. the programme managers’ own experiences and views of their working conditions,
   particularly their satisfaction with the allocation of resources from central government,
   and the amount of influence they have in that process and, the extent to which they think
   this affects the efficacy of PHC programs, and how they cope with these issues;
b. the health-care personnel's concerns regarding their views on the impact of insufficient resources on their daily duties and the quality of care they can provide, and how they cope. Thus the impact of these variables on the quality of care is sought from two angles: the direct result of inadequate resources and, the indirect result of inadequate resources (through powerlessness, work overload burnout and job satisfaction/dissatisfaction).

A second set of objectives investigates:

a. the major health situations, experiences and concerns of a sizable systematically selected sample of in and out-patients and their satisfaction with the services being provided by health personnel - both institution and field based;

b. the major health concerns of a sizable (randomly and purposively selected) sample of non-patients in a sample of villages and their satisfaction with the services being provided by institution based and field based health personnel. The latter forms the basis for my evaluation of the quality of care being provided in the district.

This study is not a gender analysis per se, but nevertheless, in a few places I have made an effort to raise questions regarding this issue because the majority of health care providers whose experiences I am concerned with are women. Also, the rural population in Zimbabwe is largely comprised of women.

1.3 CONCEPTUAL FRAMEWORK

It has been pointed out that little scholarly work brings an organizational perspective to health issues, and Medical Sociology is blamed for dismissing organization theory (Davies 1979). My approach, owing much to the work of Weber, pays attention to the societal context within which organizations exist (Aldrich, 1979; Salaman, 1981; Gross and Etzioni, 1985; Scott, 1992). His successors like Gallie (1981) and
Crozier (1964) have also paid considerable attention to macro-structural variables external (and internal) to the organization. Weber's sociology therefore allows us to see work behaviour (of health-care personnel and PHC program managers) and patterns in their wider political, social and economic context.

Therefore, the structuralist approach that I have adopted stresses the need to consider phenomena in relation to the totality of society and enables me to bridge the two Sociologies of organizations and health care. Thus, "...the organization, distribution and consumption of health care services are guided, at both .... national and local scale, by the broad politico - economic structures ... [and] the ... causes of health inequality are ... found .. in the organization of society" (Jones and Moon, 1987: 263, 309). A structural approach also enables me to explain the social phenomenon of health and illness by using a social model of ill-health that transcends biological explanations. For example, illness can be caused by many structural and environmental factors (Renaud, 1978; Ehrenreich J. ,1978; Mechanic, 1980; Locker, 1991; Navarro, 1980). More often than not, individuals have no resources and autonomy or power to control (Conrad and Kern, 1990; Walters, 1980; McIntyre, 1986; Eyles and Donovan, 1990; Coburn et al, 1981) such factors. McKinlay has called these factors 'manufacturers of illness' (in Renaud, 1978, Castillo-Salgado, 1987). In my case, the job stress or burnout (and the resultant ill-health) that health personnel might experience are caused by structural factors over which workers have no control. Therefore, treatment of the problem should not be the stress but the organizational structural conditions.

Within the district people might be suffering from preventable illnesses but cannot do anything about it because of the absence of (income generating) employment creation and the attendant poverty; and yet are blamed for leading unhygienic life styles. McKinlay (1990) underscores the futility of spending resources (like health education) on superficial
tinkering with the symptoms, which he calls, "downstream endeavours". More effort should, therefore, go into dealing with the illness producing conditions. Hence the need to "...shift...focus from the internal environment of individuals to the interactions between [that internal environment of the human body and] external environments in which people live ...[in order to understand] disease causation and prevention" (Conrad and Kern, 1990:70; cf. Jones and Moon 1987).

The advantage of this framework is the way in which it blends with the philosophy of PHC. As defined in the 1978 Alma Ata conference, it should be a "...mixture of curative, preventive and promotive activities of a basic nature, involving many segments of the economy and society that have a bearing on health and welfare, not solely (primary) medical care" (Phillips, 1990:151). Research has demonstrated that medical interventions alone are not enough (Phillips, 1990; MacPherson, 1982; MacPherson and Midgely, 1987), as well as not cost effective (Barnum and Kutzin, 1993), in improving the health status for most health conditions in developing countries. Wider development strategies are needed so that treated individuals "...will not be returned to squalid, reinforcing environments in which under nutrition, socioeconomic disadvantage continue to threaten their health" (Phillips, 1990:23). Emphasis, here, is on preventive and promotive measures. This is why Environmental Health Technicians (EHTs) and Village Community Workers (VCWs) play an important role in the district health-care system, and why inadequate intersectoral efforts nullify the efficacy of PHC strategies, and why the likely result is more patients in hospitals and heavier workloads for institution-based personnel (as well as more burnout).

One of the key issues in PHC is a shift from the centralised to a decentralised approach, whereby local programme managers and administrators should be able to plan, to make autonomous decisions and to control the allocation of resources based on local
conditions and needs. Centralized health care services are considered inadequate in meeting the basic needs of all people (MacPherson and Midgley 1987, Philips, 1990), therefore, decentralization and democratization entails a shift in power distribution within the health-care system (Jones and Moon, 1987). Top-down bureaucratic/hierarchical health-care systems, with referral up a hierarchy, with the district hospitals as the first referral level, have historically been supported by curative medicine (Phillips, 1990), and the PHC approach favours a horizontal model as well as the overall management of the district health-care system. Otherwise district administrative and supervisory positions without power will most likely encounter job dissatisfaction and lack of commitment.

A horizontal model is superior because district managers and field workers (ETHs, VCWs) can adapt strategies and resources to local situations. This brings me to the work of other structural theorists who have influenced my approach. Merton (1968), Selznick (1948), Gouldner (1954), Crozier (1964). Burns and Stalker (1961) have criticised bureaucratic hierarchies as dysfunctionally rigid and they argue in varying ways that, in practice, organisations could be less bureaucratised. Karasek and Theorell argue that hierarchical: "...organization systems lead to dissatisfaction, boredom, or disengagement from work" (1990:26). Hence workers like Ramsay and Parker assert that every organisation needs to find a way of accommodating the variable nature of its material and human resources, and of negotiating its social environment: "...Structure does not have to be visualized as an iron cage" (1992:269). Conditions change now and then and rigid rule systems cannot handle special cases well. Westley (1984) argues that hospitals have variable inputs in the form of both patients and staff. The variability in: degrees of illness, responses to treatment, characteristics of staff, ever-changing medical and technical knowledge, and social demands for control over health care are important.
Hence Westley (1984), therefore, calls for flexible organisational forms that permit effective work.

A flexible health-care system can deal well with the onset of demographic and epidemiological transitions (since these can be area specific in the same country) as well as the impact of AIDS which is having a serious impact on health-facility infrastructures and personnel. Such a system would be able to fulfill the basic PHC requirements of a multisectoral approach to health care since managers will not have to constantly ask for approval of plans and budgets from higher levels of authority.

Many organisational theorists have emphasized the importance of looking at an organisation as both affecting and being affected by its environment (e.g. Perrow, 1986). But firstly, an analogy can be made between this and the view that individuals are affected by their environment in the social production of illness model. This allows me to look at the district health-care system itself and analyse the way the quality (or lack of it due to the effect of my two main variables) of service in the health centres affects the district hospital. Poor service means self-referrals and more work for the hospital. Poor quality service by outreach teams and field workers could mean possibly more preventable illnesses in the communities and more work for health centres. Inequitable distribution of drugs and equipment to health centres is bound to affect the quality of their services. Secondly, the approach allows me to look at the wide role of the state in the distribution of health resources (Phillips, 1990) as well as the "controlling of budgets and the quality and quantity of care" (Westley, 1984: 270). Last, I can also analyse the role played by other ministries and public agencies in the intersectoral approach to PHC that can put a burden on the health-care system if the other sectors are not providing enough effort and resources. Poor quality health services could also indirectly have an impact on the other sectors through, for example, absences from jobs and other income generating activities.
The district health-care system would ideally try to lobby central government, the central and provincial offices of the ministry of health's (Ministry of Health and Child Welfare - MHCW) hierarchy for more resources and speedy communication of policy decisions. It would also try to influence other sectors to play their part in improving living conditions in the district. ²

This organisation - environment mutual influence model helps me to bring in the wider societal structures into this framework. For example, one can analyse what most theorists (Acker, 1991; Acker and van Houten, 1974; Davies, 1992; Kanter, 1977) argue is an often neglected area in organisational analysis: sex differences in organisational behaviour, through patriarchal relations ³ and gender socialisation. Gender socialisation is also said to be responsible for the emphasis put on self-sacrifice and feminine traits like empathy, non-assertiveness, love and compassion for service workers, especially women and more so for nurses, rather than individual autonomy, freedom and achievement (Horman et al., 1987; Maslach, 1982). According to Davies (1992), this emphasis on self-sacrifice and feminine traits results in the trivialisation of nurses and nursing work as well as low salaries and poor career structures. The implication, therefore, is that health-care personnel's behaviour and their reaction to work overload, job stress, job satisfaction/dissatisfaction, low morale and self-esteem should be placed in a wider set of social relations and structures. This approach is even more important in analysing the attitudes and behaviour of VCWs, who occupy the lowest position in the health-care system's secondary labour market.

A mere look at the individual behaviour of personnel (the symptoms) will result in victim blaming (Maslach, 1982) and treatment of the symptoms, or the desire to change their behaviour and not the social structures (Karasek and Theorell, 1990). This approach to solving problems is more akin to biomedicine ³, which emphasizes specific aetiology,
that is, focuses on specific organic pathology in individual patients (Bolaria, 1988; Renaud, 1978; Bolaria and Dickinson, 1988; Townsend et al., 1988; Conrad and Kern, 1990), ignoring the role played by political and socio-economic-cultural factors in disease causation (Schwartz, 1987; Conrad, 1987; Mishler, 1989; Smith, 1989; Hillier, 1991).

My research intends to investigate the individual and organisational sources of job satisfaction/dissatisfaction and the work of social psychologists on job stress and burnout is one logical starting point in bridging the gap between subjective experiences and objective working conditions. My research is supported by work of writers like Maslach (1982); Cherniss (1980); Duxbury and Armstrong (1984); Miller (1991) and Ross and Seeger (1988), who have related experienced burnout in social services workers (including health-care personnel) to organisational structures. Within Sociology, this is supported by Ford (1988); Coburn (1983a & b); Westley (1984) who have related job-stress, alienation and satisfaction to objective and subjective working conditions.

1.4 RELEVANCE OF THE STUDY

There cannot be sustainable development when populations are not healthy and vice versa. Ill-health has an impact on economic and social activities. Research on PHC to date has focused on shortages of staff, drugs and inadequate communication systems. My research seeks to put such issues into perspective by including the human element. In this regard, the views of the populations affected by poor quality services and the health-care personnel who are forced to work under stressful conditions are regarded as of paramount importance. Therefore, my study highlights how health-care personnel and consumers see things and would like to see them changed.
Studies in self-referrals and accessibility have largely been conducted in isolation considering patients' views only, and my study seeks to put the providers into the equation, as well as the health-care system. It is hoped the outcome will form a basis for further research that will help health planners in Zimbabwe (and Africa as a whole) to understand the health-care system's aspects that can constrain the quantitative and qualitative provision of health care services, as well as contribute to fresh debates on PHC priorities in Africa (whose as-of-now 'Health for All by the Year 2000' goal has been elusive). A 1989 study reported that a quarter to a third of the beds in some central African hospitals were occupied by AIDS patients. The WHO projects the cases in Sub-Saharan Africa to grow from less than 300 000 in 1991 to over 450 000 in 1994 (Barnum and Kutzin, 1993). Zimbabwe has recently become one of the leading African countries in the number of HIV/AIDS cases. Therefore, I felt that central systems that provide enough resources as well as autonomy to local managers and health teams would enable HIV/AIDS patients to get adequate care and counselling. Last but not least, my study will contribute in some small way to the debate on women's work roles and the rewards they get, a debate so important in African societies where patriarchal relations are still quite dominant.

1.5 ORGANISATION OF THE THESIS

Chapter Two traces the development of Zimbabwe's health-care system, from the colonial period (when traditional medicine was suppressed) to the post-independence era, and the major current challenges/problems that it is facing. Furthermore, the status of women (societal and in the labour force) is discussed.
Chapter Three discusses the research methodology utilised in the study. This includes a discussion of: the research sites and study population; sampling procedures; data collection techniques, and the major concepts that guided the study.

Chapter Four presents a brief discussion of the concept of job autonomy/participation in policy decision making, after which it presents a detailed discussion of a wide range of some prominent organisational perspectives on this topic. Furthermore, structures that threaten the realisation of job autonomy/participation in policy decision making in Third World organisations are analysed. Furthermore, the chapter presents a detailed analysis of the respondents' (Mutoko District's health personnel) perceptions of job autonomy/participation in policy decision making, as well as the objective existence of job autonomy within the Mutoko district health-care system.

After a brief discussion on financial and health resource constraints in developing countries, Chapter Five focuses on health resource allocation problems in Zimbabwe in general, and then on respondents' (health personnel and consumers) views regarding the shortage (or inadequacy) of resources are presented. Furthermore, traditional healers are presented as an additional but neglected human resource in the formal health-care system and other issues (medicalisation of childbirth and commodification of health) that put an unnecessary strain on the available resources are discussed.

Chapter Six focuses on the existence of job satisfaction/dissatisfaction among health-care personnel in the study's sample. It also explores the existence of job burnout among these workers. These two aspects are explored in relation to the effect of the two independent variables (job autonomy/participation in policy decision making and resources) as well as other organisational and societal structures.

Chapter Seven analyses the potential effect of the independent and intermediate variables (burnout and job satisfaction/dissatisfaction) on the quality of health care and
effectiveness of the district's PHC programme. This analysis is centred on the health-care personnel's and consumers' own perceptions of quality of care. Furthermore, the chapter explores other loopholes in the district's PHC intersectoral approach that have a potential to have an impact on the effectiveness of the PHC programme.

Chapter Eight. the concluding chapter, presents a summary of the findings. The limitations of the study are discussed, as well as the directions for future research and implications of the findings.
ENDNOTES

1 The Childhood Immunisation Programme has made considerable progress, such that by 1993 the rate of childhood immunisation had become higher than that of the United States (Cable News Network, October 22, 1993).

2 According to Phillips, "the WHO stresses the need for more initiative by the health sector in enhancing intersectoral collaboration..." (1990: 27).

3 Patriarchal relations have been called a "power multiplier" on female employees, hence they face a double oppression when employed (Acker, 1991; Armstrong and Armstrong, 1983). Their subordinate position in the labour market reinforces their responsibility for domestic work and vice versa (Armstrong, 1991). Furthermore, gender socialisation is argued to "reflect and reinforce gender ideology and hence supports the unequal distribution of resources and gendered division of labour ..." (Davies, 1992:264).

4 Biomedicine gave rise to the curative approach that is being criticized by proponents of PHC with its preventive and promotive approach.
Chapter Two

ZIMBABWE, AN OVERVIEW

2.1 INTRODUCTION

This chapter has two objectives. It introduces Zimbabwe, its health-care system and the research site. Second, it gives the historical and socio-economic background that accounts for the present health climate and policy in Zimbabwe, as well as lay the foundation for the discussion of the findings of the study. After giving a brief profile of Zimbabwe, the development of western medicine alongside the colonial system and the suppression of traditional medicine are discussed. Following this, the pre-independence health-care system (and its shortfalls) and the post-independence health-care system (as a corrective to the former), the current pattern and levels of disease burden, and other health concerns like AIDS are discussed. The chapter finishes with a discussion of the historical and present status (including in the labour force) of women in Zimbabwe. This is important since it lays the groundwork for most of my analysis, because the majority of health-care providers that I am dealing with in the study are female.

2.2 Profile of Zimbabwe

Zimbabwe is a landlocked country, bordered by Mozambique in the east, South Africa in the south, Botswana in the west and Zambia in the north and north-west. (see Appendix II.1) It covers an area of just under 400 thousand square kilometers (MHCW, 1991), divided into 8 provinces.

The country was a British colony (then known as Rhodesia) from the 1890s to 1965 when the white minority proclaimed a unilateral declaration of independence (UDI)
from Britain. It attained political independence in 1980 after a protracted armed struggle. It is regarded as one of the most industrialized and self-sufficient countries in Africa (WUSC, 1987), having well developed commercial, industrial, agricultural and mining sectors (MHCW, 1991; WUSC, 1987). However, some recent social indicators of development signify what one might call a downturn in the development process. The average annual rates of inflation for the periods 1970-1980 and 1980-1991 are 9.4 percent and 12.5 percent respectively (World Bank, 1993 : 238). GNP per capita for 1991 is given as (US) $650, which is one of the highest on the African continent (World Bank, 1993) but much lower than those of the following six African nations, viz. South Africa; Botswana; Cameroon; Congo, People's Republic and Mauritius (World Bank, 1988). What is most significant is that the GNP per capita annual growth rate for the period 1980 - 1991 was -0.2 percent (World Bank, 1993), hence the current report puts it at (US) $570 (World Bank 1994 : 79). Furthermore, Zimbabwe is given as one of three countries (together with The Gambia and Sierra Leone) where the implementation of a reform programme is said to be on track, but have "... nonetheless experienced low GDP growth rates due to the deterioration of their terms of trade, weather conditions, the lingering effects of the 1991 - 92 drought ..." (World Bank, 1994 : 81).

Zimbabwe has a population of 10, 401, 767 (according to the 1992 census) and a growth rate of 3.13 percent (MHCW, 1993). About 80 percent of this population is rural, and 55 percent are below 15 years of age (WUSC, 1987). Also, about 98 percent of that population is of African origin (MHCW, 1991). Life expectancy is 64 years, infant mortality is 53/1000 live births and maternal mortality is about 90/100 000 deliveries in health facilities (Hecht et al., 1993).
2.3. THE INTRODUCTION OF WESTERN MEDICINE AND THE COLONIAL HEALTH-CARE SYSTEM

The present nature of health and health-care systems in most Third World countries are said to be a legacy of imperialism and colonialism (Doyal, 1979; Johnson, 1973). Zimbabwe also falls into this category (cf. van Onselen, 1976; Bloom, 1985; Agere 1986). The incorporation of most of these states into the world capitalist system through colonialism led to the spread of Western medical practices during the colonial era (Bonsi, 1992; Fanon, 1978; Harding, 1988; Brown, 1978; Paul, 1978; Navarro, 1981).

The early Western medical doctors were attached to the British South Africa Company that settled in Zimbabwe in 1890, (van Onselen, 1976; Agere, 1986). This was before the colonial administration took over from the company, to which they were later attached and were subject to its patronage. In these early stages, the doctors were part of the exploration teams and were what Agere (1986) calls ‘agents of colonialism’. These people sought the expropriation of raw materials for the benefit of the metropolis. Some were both missionaries and explorers.

The goal of colonial medicine was aimed at protecting the colonial agents and white administrators (van Onselen, 1976; Johnson, 1973; Agere, 1986). Initially, medical care was provided for the colonial elite and those in their direct employment. As colonial control expanded into the hinterlands, and with the growth of agriculture and mining, Western medicine was extended to the labour force in these industries, (van Onselen, 1976; Gilmurray et al., 1979; Bloom, 1985; Agere, 1986). This was done largely in order to maintain the productivity of the labour force and to ensure its social reproduction. Those whose ill health might jeopardize the welfare of the colonists, for example through the spread of epidemic and infectious diseases, were also touched by this selective and rudimentary provision of health care.
2.3.1. *The Distribution of Health Services and Resources*

The indigenous people were afforded western medical care only if they worked and came into contact with the settlers. Mines and farms which had priority were visited by medical officers who educated farmers and miners on how to prevent malaria (Webster, 1972). Although health services were provided in the mines, the provision hardly matched the need created by the appalling living and working conditions which caused an extremely high death rate, especially in the early part of the century (cf. van Onselen, 1976; Gilmurray et al., 1979; Bloom, 1985). In 1904, mining companies spent 2 shillings per month, per worker, on the provision of health services. Before the late thirties most mines had no hospital and most miners died from 'diseases of employment' (van Onselen, 1976).

Gilmurray and his associates (1979) state that early attempts to bring health care to rural areas were hampered by a shortage of trained nursing personnel and medical officers to staff the hospitals. Affected were rural government and missionary dispensaries and hospitals that were established between 1909 and 1915. The government legalized the subsidization (in form of grants-in-aid) of missionary organisations in 1927 and started to 'accept some responsibility for health services in rural areas' (Gilmurray et al., 1979: 33). According to Gilmurray and associates (1979), this policy led to the establishment of only five dispensaries in 1928 and two small hospitals shortly afterwards. These were at Ndanga and Mutoko, the primary site of this study. The latter has since been upgraded and accorded a 'district hospital' status. From 1931, the government divided the country into large areas, providing each with a medical unit comprising a rural hospital (supervised from general hospitals in the main towns) and several dispensaries about 50 miles apart (Gilmurray et al., 1979).

Health-care services (government, local government and missionary) in rural areas, where more than 80 percent of the population live (mostly, if not all indigenous people),
were uncoordinated and very limited throughout the colonial period. A large part of the “health vote was spent on running hospitals and clinics, on treating preventable disease [a curative approach] rather than on preventive measures” (Gilmurray et al., 1979 : 34). Since more of these health facilities were located in towns, an urban bias in provision was inevitable. For example before independence in 1980,

44 percent of publicly funded services went to the urban-based sophisticated central hospitals serving about 15 percent of the population, while only 24 percent went to primary and secondary level rural health services for the majority of the population [Sanders and Davies, 1988 : 196; cf. Bloom, 1985].

Mission hospitals, which took care of most rural populations, were heavily underfunded, as were government district rural hospitals (Gilmurray et al., 1979; Bloom, 1985). For instance, “in 1977 mission hospitals which accounted for 66 percent of rural hospital beds (and 30 percent of the entire [national] beds...). ... received only 9 percent of the health budget” (WUSC, 1987 : 18).

The distribution of personnel also had an urban bias before independence, with 79 percent of doctors and 55 percent of nurses working in urban hospitals, (Bloom, 1985). As a result, the rural population had only one doctor for every 100,000 people (Agere, 1986). According to Gilmurray and associates, the urban - rural gap in the provision of medical services widened with the coming of “private practice and medical aid societies that flourished in the towns almost entirely to serve the European population” (1979 : 34). As time went on, however, middle-class Africans were soon covered by these services. At the time of independence “the average annual expenditure per head for private sector medical aid society members was SZ144 compared to SZ31 for the urban population using public services and SZ4 for the rural population” (Sanders and Davies, 1988 : 196). 6

For Europeans, health care was delivered by doctors in better equipped European (government and private) hospitals (Bloom, 1985; Agere, 1986). For example, the second
largest city (Bulawayo) with an "African population of 410,000 in 1976 was served by one general hospital...[while]...the European population of 69,000 was served by three general hospitals" (Agere, 1986:361). In these sophisticated hospitals Europeans were guaranteed treatment. In fact, those who could not afford the fee for service were supported as 'Government Responsibility Patients' (Bloom, 1985). This was not available to Africans, who earned (on average) less than a quarter of what Europeans earned. At the time of independence, then, "there was one hospital bed for every 255 whites; but only one for every 1,261 blacks" (WUSC, 1987:18).

The working conditions for health-care personnel were greatly influenced by racism. European health-care personnel could work in any health facility, while African health-care personnel could not work in European hospitals (government or private) before independence. In 1977, "of the 14,500 health sector employees, 10,200 (70%) were African and 4,300 (30%) were European; yet the African employees receive[d] only 40% of the total wage bill" (Gilmurray et al., 1979:41).

The development and distribution of health-care resources were therefore determined by European settlement patterns in cities, industrial and agricultural estates, and mines. The provision of adequate services to the colonists, some health services for workers for the sake of productivity, and barely enough for the rest of the population, signaled the beginning of the provision of unequal health-care services that Zimbabwe inherited at independence. That was the beginning of the hospital-based system of Western Medicine as well as the racial and urban bias in health-care provision (that the new government had to deal with at independence), because colonists lived in towns and other areas of colonial settlement.
2.3.2. The Suppression of Traditional Medicine

By traditional medicine I mean the indigenous system of medicine, while scientific/western medicine refers to medicine originating in developed countries. Prior to the coming of Western medicine "traditional healers were the only medical practitioners in Zimbabwe" (Chavunduka, 1986: 29, cf. Nyazema, 1984; Mutambirwa, 1985). In those early years of colonial rule when mines provided just enough medical services to keep work force going, we are told that most workers ran away from these primitive mine hospitals and turned to African traditional medical practitioners (van Onselen, 1976).

According to Chavunduka (1978, 1986), traditional healers were regarded as specialists, and were expected to deal with many social problems troubling their patients. A traditional healer, therefore, had many roles, "he was a religious consultant, a legal and political adviser, a marriage counsellor and a social worker" (Chavunduka, 1986: 29). The traditional healer dealt with a patient's problems from a perspective that sought to understand their socio-economic and cultural causes.

Both traditional healers and their patients believe illnesses are caused by many factors, ranging from witchcraft and spirits to bacteria and germs (Chavunduka, 1978: 1986). Hence traditional medicine investigates the contexts (physical, social and spiritual) of diseases (Mutambirwa, 1985). It deals with the physical, mental, social, moral and the spiritual well-being of individuals. This is the reason why Eaudo (1985) asserts that traditional medicine is in the realm of 'biopsychosocial health'; it caters to the whole person and reflects the definition of health given by the WHO as a guideline in the PHC strategies in order to achieve health for all by the year 2000.

There is great contrast in the way the Traditional and Western Medical systems deal with a patient's problems. Western Medicine is premised on the germ theory, hence the treatment entails curing the individual's body (Conrad and Schneider, 1980; Agere,
1986; Frideres, 1988; Mishler, 1989; Waitzkin, 1989). This approach reinforces the tendency to consider illnesses and their cures as the problems of individuals and not in relation to their social, economic or political contexts (Agere, 1986; Frideres, 1988; Mishler, 1989).

Despite these shortcomings, advances in Western medical science along with the inroads of Christianity, Western education, and colonialism signaled the loss of prestige and status of traditional healers (Chavunduka, 1986: 29). For a number of reasons, colonial governments and missionaries discouraged the indigenous people from using traditional medicine. Not knowing the efficacy of traditional medicine and blinded by their ethnocentrism, colonial settlers saw traditional medicine as the stumbling block that prevented people from seeking for modern drugs in government mission hospitals. Second, traditional healers were regarded as encouraging witchcraft beliefs and the worshiping of ancestors instead of God (Chavunduka, 1986; Agere, 1986). These were regarded as a major stumbling block in Christian missionary work. Chavunduka (1986) further argues that there was also an economic motive. Colonial administrators wanted indigenous people to depend on Western medicine because this would benefit the pharmaceutical companies.

For these reasons, colonists undertook a number of measures in order to weaken traditional medicine and remove it from the scene while at the same time modern medicine was barely satisfying the health needs of the indigenous people. Provision of Christian education was expected to weaken people’s traditional ideas and faith in traditional healers (Chavunduka, 1986). The building of more mission and government hospitals was also expected to lure more people away from traditional medicine.

Good (1991) reports that many Protestant missions made attendance at religious instruction a condition of medical treatment throughout the nineteenth century. Thus,
Collins argues that "...medical missions have been the imposers of self-satisfied Western culture upon weaker societies..." (1979: 137). This forced acculturation occurred on two fronts, for example, the first, as described above, involved attempts at stopping visits to traditional healers. The second was the suppression (statutory and de facto) of traditional healers themselves. The 1899 Witchcraft Suppression Act aimed at outlawing and preventing the activities of traditional healers. According to Chavunduka (1986), the wording of this Act misconstrues the meaning of 'throwing of bones' by some traditional healers as an attempt to identify witches. In fact, it is done to determine who or what caused an illness or misfortune experienced by 'clients'.

Despite all these efforts, however, many people have continued to use the services of traditional healers (Chavunduka, 1978; 1986; Agere, 1986; Mutambirwa, 1989; Bloom, 1985; Nyazema, 1984). Agere (1986) notes that 80 percent of the population still use some form of traditional medicine. People tend to use traditional approaches under specific conditions, along with the modern health-care practices where they are available (Chavunduka, 1978).

In Mutambirwa's (1989) study, 96.6 percent of women regarded modern and traditional health-care systems as complementary. Only 3.05 percent said they had more trust in the modern health-care system. According to Nyazema (1974: 1554), patients turn to Western medicine when the benefit is "immediate and dramatic", and "for removal of the cause of [the] illness to the traditional practitioner". So apart from the cost of each type of treatment, accessibility, knowledge of the probable effects of each kind of treatment, one's choice to consult a practitioner from either system is also determined by "the definition given to that particular illness at that particular time by the individual and members of the social group" (Chavunduka, 1986: 32). And the fact that "traditional beliefs explain personal illness as a result of disharmony with one's ancestors due to some
inappropriate behaviour on the part of the sick person” (WUSC, 1987: 18) or neighbours, co-workers or malignant kinsman (Chavunduka, 1986) brings forth somewhat common definitions of illnesses among the traditional healers and the indigenous people.

In 1980 when the new government decided to adopt a global concept of primary health care in order to correct the inequalities that prevailed in the health-care delivery system during the colonial era, it recognized and legalized traditional medicine. The *Traditional Medical Practitioners Act* of 1981 established a Traditional Medical Practitioners Council whose purpose is to supervise and control as well as promote traditional medical practice through research and development of knowledge (cf. Chavunduka, 1986; Mutambirwa, 1989). The Act defines the practice of traditional medicine as “every act, the object of which is to treat, identify, analyse or diagnose, without the application of operative surgery, any illness of body or mind by traditional methods” (Chavunduka, 1986: 35). The Zimbabwe National Traditional Healers Association (formed in 1980) issues licenses to its members and regulates their activities, including sanctioning them for malpractice. It operates a college for its members (Chavunduka, 1986). Because of these developments, the stigma attached to traditional medicine during colonial times has begun to disappear.

2.4 THE CURRENT HEALTH-CARE SYSTEM

In 1980 at the eve of independence the new government had the huge task of correcting, among other things, the social inequities that prevailed in the health-care system. This entailed restructuring the system, ensuring fair distribution of health resources, developing appropriate personnel policies, reorienting personnel attitudes and introducing new categories of health workers.

To begin with, the government issued a White Paper outlining the new national health policy advocating the “adoption of the primary health care (PHC) approach whose
key components are appropriateness, accessibility, affordability and acceptability of the care provided” (Ministry of Health, 1986: 5). In order to implement the new health policy, the government prepared the ‘Zimbabwe Health for All Action Plan’, which “incorporates the health programmes addressing the priority health problems of the population” and was hoped to guide the nation towards achieving health for all by the year 2000 (Ministry of Health, 1986: 2).9

The fragmented health-care system that the new government inherited at the time of independence comprised five sub-sectors, all providing ‘modern’ medical care. These were: the ministry of health and local government, missions, the industrial medical services, and the private medical sub-sector (Ministry of Health, 1986). Various voluntary organisations also provided care in specific areas. Each of these sub-sectors had “its own character, structure and system of financing, [with]...little coordination among them” (Ministry of Health, 1986: 152). To rectify this, the Zimbabwe Government set up a four-level health-care scheme with four levels: village/community, district, provincial and national (Ministry of Health, 1986: WUSC, 1987: Maybin, 1988). This made it easier to coordinate the activities of the various providers.

2.4.1. **Levels of Planning and Tiers in the Health-Care System**

The colonial model of health-care service was highly bureaucratized, with all planning being done at the central offices of the ministry of health. For the provision of preventive health services, the country was divided into five provinces, each with a health team headed by the Provincial Medical Officer of Health (Gilmurray et al., 1979). The team was basically entitled with responsibility for environmental health, epidemic and disease control, special services such as tuberculosis and leprosy, health promotive services and school health services (Gilmurray et al., 1979). The various sub-sectors and the health institutions such as hospitals and clinics, “often worked quite independently
without much co-ordination with other institutions" (Maybin, 1988: 13). At the local level for example, it is said "District Hospitals would not know what was going on in the rural clinics" (Maybin, 1988: 13).

Out of the heterogeneous health care services it inherited at independence, the Zimbabwe Government has

...organized the public and NGO institutions plus some private facilities into a four-tiered system of national health service delivery, to ensure adequate access, a balance of preventive and curative care and an efficient chain of patient referral [Hetch et al., 1993: 218].

While national planning is still done at the central level, the new organisational structures also allow planning to be carried out at Provincial, District and Community levels, making it possible to respond to local needs. This kind of planning allows for grassroots participation, which is a key component of the PHC strategy. Planning at a lower level is supposed to be approved or authorised by authorities at the next level, with major issues having to be decided at the central level.

At the first level, the major focus is on primary health care, and on community involvement and preventive health practices (Hetch et al., 1993). Rural health centres and rural hospitals play a significant role at this level. Apart from doctors, nurses, nurse-aides and other health-care personnel manning these facilities, health-care workers such as village health workers (now called village community workers [VCW]), environmental health officers and technicians also play a significant role.

The District (second level) offers support and supervision, as well as providing referral for the primary level (Ministry of Health, 1986). Each district has a district hospital and there are about 7 districts in each of the 8 provinces in the country. In total, there are 55 district hospitals operated by the Ministry of Health and Child Welfare (MHCW) and church missions. Each provides district hospital care, mainly for patients
referred from the rural health centres and rural hospitals (Ministry of Health, 1986). At this level "[a] District Health Executive, headed by the District Medical Officer and District Nursing Officer, work to integrate preventive and curative services and to promote intersectoral collaboration" (Hecht et al., 1993 : 218). The District Health Committee, a body made up of local representatives of all ministries and development agencies, and local political systems (like Ward Development Committees) is regarded as the "key body for providing local political control on health activities, for intersectoral coordination between the District Health Services Authority and other district health-related agencies, and for stimulating community health involvement" (Ministry of Health, 1986 : 158). At the village/community level, the local political organisation that helps to coordinate development projects is the Village Development Committee. So "[e]very level collaborates with corresponding structures in the socio-political system to ensure that health care is included in overall political planning" (Maybin, 1988 : 13).

The third level is the Provincial level or the tertiary level (MHCW, 1991). At this level, there "are 8 provincial and 4 general hospitals that ... provide specialist services to deal with most medical/surgical problems, as well as obstetrics, gynaecology and paediatrics" (Hecht et al., 1993 : 218). In each province, a Provincial Medical Officer is head of a Provincial Health Executive which is responsible for the planning and supervision of health services.

The last level, the national, central or quaternary level comprises central hospitals located in the capital city (Harare) and Bulawayo (2 in each) which serve as national referral facilities (Hecht et al., 1993). A medical school is affiliated to one of the central hospitals in Harare. It is at this central level that one finds the top officials of the MHCW, headed by the Minister of Health.
The whole system is "supposed to provide a chain of increasingly sophisticated facilities so that patients with more complex conditions can be referred up the line" (Ministry of Health, 1986). PHC is "regarded as the main vehicle through which health care programmes [should] be implemented" at all levels (MHCW, 1991). The PHC strategy has, therefore, made it essential to transform the management and delivery of health-care services in order to achieve equity in health. Services and structures at community, district, and provincial levels have been made accountable to the higher levels of the health-care system as well as to the local government structures (Sanders and Davies, 1988).

2.4.2 The Burden and Pattern of Diseases

This section explores some of the health problems faced by those working in the structures described. It is the ability of the health-care system to deal with these problems that should be used as the yardstick for measuring the success or failure of the PHC policy.

Gilmurray et al. (1979) posit that the burden of disease in Third World countries falls heavily on children, about one-third of whom, if born alive, die before age five. They die mostly from nutritional deficiencies and communicable diseases. These two usually act together and reinforce each other. They account for about 80 percent of disease problems in the Third World (Gilmurray et al., 1979). In a study conducted at one of the central hospitals in the late 1970s, malnutrition "was the first, second or third diagnosis for about one-third of all children admitted..." (Gilmurray et al., 1979:25). Air-borne diseases, measles, pneumonia and tuberculosis, were also quite common among children and adults before independence. In fact, measles was one of the major killers of African children. (cf. Sanders and Davies, 1988; Gilmurray et al., 1979). According to Sanders and Davies (1988), undernutrition was most prevalent in rural areas.
About fourteen years later we still hear that “the major causes of mortality and morbidity among children are respiratory infections, malnutrition, diarrhoea, meningitis, measles and malaria” (Hecht et al., 1993). Sanders and Davies (1988) report that the Childhood Morbidity and Mortality Survey of 1983 showed that, taken together, diarrhoea and respiratory tract infections caused 48 percent of deaths, while measles and neonatal tetanus each result in 15 percent of deaths. Malnutrition is said to be an important associated cause, especially in cases of diarrhoea and measles. While infant and young child mortality have improved sharply, 14 the levels of childhood undernutrition have remained static or improved only slightly (Sanders and Davies, 1980). A 1990 national survey highlighted that “moderate rates of malnutrition generally increase when weaning starts and peaks soon after children are removed off the breast around 18 months” (MHCW, 1991: 38). Among adults, “the leading causes of death and illness … include respiratory diseases, tuberculosis, AIDS and sexually transmitted diseases, malaria, pregnancy-related complications, accidents and cardiovascular diseases” (Hecht et al., 1993: 217).

A more recent health problem of major concern in the country is AIDS. This is an epidemic which, according to Mhloyi (1991), is making the attainment of health for all by the year 2000 an impossible goal. It is estimated that there will be 10 million children orphaned by AIDS in sub-Saharan Africa by the end of the decade (Mhloyi, 1991). In Zimbabwe, concerns have already been voiced that “[t]he elderly are increasingly being burdened by the problems of AIDS, as they have to look after their grandchildren” (The Herald, 21 Sept., 1993, p. 7). It is said “…Zimbabwe has the fifth highest cumulative number of AIDS cases in Africa…[w]ith 10 551 cases recorded [by 1991] since official records were published in 1987 …” (The Herald, 21 Sept., 1993, p. 7). Eighteen percent
of this number were said to be children under the age of four (The Economist Intelligence Unit, Country Report No. 2, 1992 : 11).

The MHCW estimated it needed USS10.5 million for its 1992 - 93 National AIDS Control Programme, an indication that the seriousness of the epidemic had become evident (The Economist Intelligence Unit, Country Report No. 1, 1992 : 12). The incidence of HIV infection at that time stood at 5.6 percent of the sexually active population. The largest medical aid society in Zimbabwe (CIMAS) has estimated that “on current projections AIDS will cost it ZS372mn by the year 2000, on its present membership alone” (The Economist Intelligence Unit, Country Report No. 1, 1992 : 12).

2. 5 WOMEN

The majority of health care providers in the MHCW are women. It is, therefore, of paramount importance that women’s historical position in society be considered. This will allow us to understand the impact of organisational experience on women’s quality of working life and status in society.

2. 5. 1 The Historical Status of Women

During colonialism a number of draconian measures were taken by the state in order to push natives into wage employment. There was the expropriation of African territory, racial reservation of land (Jacobs, 1992), and the reduction of African land holdings (Palmer, 1977). There were also more direct methods, such as hut and poll taxes, which were meant to force Africans to seek wage employment. The chief objective was “the transformation of a population of independent agricultural producers ... into labourers... (Ladley and Lan, 1985 : 96).
The exclusion of women from the wage economy relegated them to farming, and reproducing wage earners for the labour market. Also, because of poor wages for Africans the "reproduction of the work force was subordinated to the rural subsistence sub-economy" (Robinson, 1989: 350) where we are told "...peasant farmer housewives [experienced profound difficulties] in maintaining even subsistence level production and guaranteeing reproduction in the absence of their menfolk..." (Simon, 1985: 84). Thus, women had to work hard on the poor and deteriorating land. They experienced enforced change from shifting cultivation to sedentary agriculture brought about what Jacobs (1992) calls the 'feminisation' of subsistence agriculture. Sedentary agriculture "reduced men's work of clearing land but increased women's labour in the struggle to produce crops from soils of declining fertility" (Jacobs, 1992: 35). The absence of men also meant women had to look after cattle.

It is generally agreed that before colonialism women enjoyed a range of rights such as access to land (as a dependent), ability to dispose of income from their own crops and other activities like traditional midwifery. Colonial rule eroded these limited rights (Stoneman and Cliffe, 1989; Jacobs, 1992). According to Stoneman and Cliffe (1989: 72), the settler state did "...prop up the power of elders and chiefs over women, young men and land". It is argued that the statutory legal system was developed to subordinate customary law and that such "manipulation, as a by product, affected the capacity for property ownership among black women perhaps most detrimentally of all" (Cheater, 1987: 174). Colonialism also had the following effect: customary procedures were codified and deemed 'Customary Law', so that practices which had some degree of flexibility and which were subject to community (and elders') opinion became more rigidly imposed.... [possibly] .... reduce[ing] the leeway that some women were able to enjoy [Jacob, 1992: 9].
For example, the confirmation of customary land tenure practices resulted in the perpetuation of women’s exclusion from direct access to land (Jacobs, 1992). Although women had been ‘minors’ or dependents before settler colonialism (Stoneman and Cliffe, 1989), under colonial law they were reduced to a legal minority and could not make contracts or stand in court “without the permission of, and representation by a male guardian” (Jacobs, 1989; 1992).

Another issue that has been governed by ‘customary law’ is that of land use rights which married women have not had in their individual capacity but only by virtue of their subordinate relation to men (Jacobs, 1983; Kazembe, 1986). The result has, therefore, been the loss of access to the household land following the death of a husband or following divorce (Kazembe, 1986; Cheater, 1987; Jacobs, 1992). Hence a number of studies have established that the lowest or most impoverished stratum in communal/rural areas consists of widows.

In general, during the pre-colonial and colonial periods, Zimbabwean ‘women were subordinate in political and social organisation’. Some have pinpointed one of the supposedly root causes as ‘roora’ (bride price). This is “the transaction entered into between the members of the bride-giving family and bride-receiving family...” (Kazembe, 1986: 379). Kazembe states that this transaction transferred the labour services of the bride to the groom’s family, ....[and it became]....right for the husband to expect total submission from the wife.....[t]he productions of her labour and the children born of the union were his and his family’s...[Kazembe, 1986: 380].

In addition, the emergence of the cash economy also “led to the abuse and commercialisation of the custom, which is today seen as a way of recovering costs expended on the daughters” (Kazembe, 1986: 380).
From the initial stages of colonialism until the early 1960s it was government policy not to allow unemployed people in towns. They were regarded as dependents, not workers. This group included wives and children, who had to continue to live in the rural areas. This was reinforced by the housing policy which provided accommodation for ‘single’ men.¹⁷ Most jobs in towns and mines were reserved for men.

There also existed a bias against educating women (Kazembe, 1986). This has been the case in most African countries (cf. Meena, 1984; Robinson, 1988; Dennis, 1988). According to Kazembe, this practice dated back to early missionary days, when mission schools were mainly for boys. Later discrimination arose from parental attitudes. Meena (1984) states this was an overall colonial strategy of ‘divide and rule’ on the basis of such factors as, class, tribe, and gender. She uses this to explain why separate curriculums were developed for boys and girls ¹⁸: if equal numbers of women were given equal learning opportunities it would create a stronger political awareness (Meena, 1984). At the present time, “the overwhelming majority of illiterate and semi-literate people are female” (WUSC, 198 : 19), with literacy rates of 74 percent for men and 60 percent for women in 1990 (The Sunday Times, 10 January, 1993, p. 19).

Over the years, more and more women entered formal and informal employment, with “females of any age and males [between 16 and 19] getting three-quarters of the minimum wage given to men doing the same work” even in the public sector (Kazembe, 1986 : 385). Kazembe says this was because of the ‘breadwinner concept’. Labour practices were governed by the highly discriminatory (by race and sex) legislation, the Industrial Conciliation Act of 1934. Falling pregnant meant that one had to resign and then reapply after delivery. When one returned, one had to start at the bottom of the pay scale (Kazembe, 1986). Getting married meant being hired as temporary staff. In addition, women were heavily taxed because their incomes were considered as additional
income to of the husband (Kazembe, 1986). Kazembe further states that most women with formal jobs were employed in teaching, nursing or were agricultural labourers. "... areas that were really an extension of their domestic duties and were therefore considered as traditionally female occupations" (1986: 385).

2.5.2 The Present Status of Women

During the war of liberation, women fought on an equal footing with men. In fact, this has been one of the basis for arguing for more equal treatment and for a change in the status of women (Kazembe, 1986; Stoneman and Cliffe, 1989). At the time of independence, a Ministry of Community Development and Women's Affairs was established. This body has directly challenged the government to legislate in favour of equality between men and women (Jacobs, 1983; Kazembe, 1986).

Since independence, the government has enacted some legislation that is favourable to women. The Legal Age of Majority Act (1982) gives all Zimbabweans the right to vote at the age of eighteen. It also enables women to enter into full contractual capacity and to shed their minority status (Kazembe, 1986; Jacobs, 1992; WUSC, 1987). One acts which has a direct benefit for women is the Matrimonial Causes Act (1985). This act provides for the equal distribution of assets between spouses should they divorce (regardless of the type of marriage). In addition, there is the Succession Bill, which "gives widows due rights to inherit husbands' estates in intestacy" (Jacobs, 1992: 12). The Minimum Wages Act (1982), which stipulated minimum scales of remuneration for unskilled workers, benefited women in particular because a large proportion of the female labour force falls into this category (Kazembe, 1986). Today, men and women with the same qualifications who are doing the same types of job now receive the same pay. The new Labour Relations Act also gives women ninety days of paid maternity leave. They
return to the same positions that they held before going for maternity (Kazembe, 1986). The *Workman’s Compensation Act* makes provision for widows.

Despite all these changes in legislation, a 1986-87 labour force survey found only 22 percent of women either self-employed or working for wages, compared to 52 percent of men (Kanji and Jazdowska, 1993). Kanji and Jazdowska (1993) argue that the lack of employment opportunities for women in the formal sector results from a constellation of high unemployment rates for men, the colonial legacy of male, migrant labour and the dominant gender ideology. Women were found to be underpaid and concentrated in sales and clerical work, the health professions, and teaching. Kazembe argues that “there is still a lot of tacit sex discrimination in appointing, promoting and electing incumbents into high status positions” (1986: 393). She further argues that even in the ministries of health and education, where “female jobs” predominate there are very few women holding high-status posts. From a different angle, Jacobs (1992) has expressed her doubts with regard to the usefulness of this body of legislation especially to the rural women. For women in the countryside, the situation is largely unchanged. This situation is disturbing because “...[m]ost (80 percent) women in Zimbabwe live in rural areas; and it has been estimated that they are responsible for 70 percent of total agricultural labour” (Zimbabwe Government, 1991: 7).

During the “colonial era male domestic workers were the major victims of oppression” in the domestic sector [but] changes in the political economy...” has reversed the trend (Pape, 1993: 401). Domestic workers have become increasingly female after independence, not because males have been displaced, but because of the increased need for child-care with the employment of women. Pape (1993) found that most (85 percent) of these female baby-sitters are under 16 and that they are paid less than two-thirds of the legal minimum wage. Continuous shifts of ten to fifteen hours are not
uncommon. Further, "... these girls [are] the most frequent targets either of sexual harassment on the job or had been enticed into sexual relations with promises of domestic employment" (Pape, 1993 : 402).

Therefore, gender equality does not yet exist in Zimbabwe. Not only are the women subordinated to men, with fewer resources and educational skills, but they are also the least socially organised and the least able able to make themselves heard.

2.6 SUMMARY AND CONCLUSION

This chapter gave a brief outline of the geographical position of Zimbabwe and some of its socio-economic structures. It discussed the advancement of western medicine into the Zimbabwean frontier as a supportive arm of the colonial administration, whose provision of medical services was...ted by racial and urban biases. Thereafter, a brief overview of the post-independence health-care structure was given, with a particular emphasis on the planning structures and the current pertinent health problems the health-care system is dealing with; after which a related issue, the historical and current position of women, was discussed. This was done in order to provide a meso and macro socioeconocultural background that affectes the lives of the majority of respondents in this study, women health providers.
ENDNOTES

1 This is the same strategy that was followed by colonists all over the world (cf. Doyal and Pennel 1976; Doyal, 1979; Johnson, 1973; Manderson, 1987; Navarro, 1981).

2 It is said that “control of epidemic and infectious diseases led to the provision of fever hospitals in the towns, and the need for a healthy labour force to the establishment of mine hospitals throughout the country” (Gilmurray et al., 1979: 33).

3 Apart from providing hospital services, missions also started training nursing assistants who went to fill positions in other rural hospitals and clinics (dispensaries).

4 It is argued that in many colonies/territories “missionary hospitals and dispensaries were in place several decades before colonial governments accepted any general responsibility for African health care” (Good, 1991: 1). This role played by medical missions prompts Good to call them “frontier agencies of imperialism”, as well as “the vanguard of Western medicine and new cultural ideas”.

5 This was actually a very small percentage of the African population.

6 Sanders and Davies (1988) also point out the disparities concealed by the latter figure. This is because only the districts closer to urban areas were relatively well served. It should also be pointed out that this is one of the reasons why a district further away from a city was chosen for the study.

7 The WHO defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Eaudo, 1985: 1345).

8 Nyazema says that patients will “ask of their illness not ‘what is it, but why is it?’ and they will consult those who they believe can answer not one but both questions” (1984: 553). At the moment, it is traditional healers who try to answer those questions.

9 A more comprehensive analysis of the PHC policy was made in Chapter 1.

10 These comprise the central government, municipalities and local authorities, church missions and other NGOs, industries and mines, private practitioners and traditional healers (Hecht et al., 1993).

11 Hecht and associates report that there are 56 rural hospitals and 927 health centres - about 132 MHCWs, 510 local government, 70 mission, 55 urban and 160 industry-owned facilities (Hecht et al., 1993). Maybin (1988), however, puts the number of health centres at over 1000.

12 There are about 700 environmental health officers and technicians. About 6 000 VCWs that have been trained so far (Hecht et al., 1993). Again, Maybin (1988) gives the number of VCWs trained so far as about 7 000.

13 Hecht and associates (1993) state that only 26 of these currently meet the requirements for a first line of referral.

14 The infant mortality rate in Zimbabwe was 55/1000 live births in 1990, down from 74/1000 in 1980 (The Sunday Times, 10 January, 1993, p. 19).

15 Lack of documentary material precludes me from going beyond this period.

16 The early wage labour force in colonial African societies was composed almost entirely of male workers (Dennis, 1988; Meena, 1984; Robertson, 1988) and “the wage
earned was just enough to enable the individual to meet his taxation obligations and to subsist” (Meena, 1988: 2).

17 The colonial government only provided services for a settled urban population.

18 Girls are offered domestic science and homercraft, nursing and teaching, training them to be better 'wives' and carers. Dennis (1988) argues that these 'women's jobs' or 'female' jobs are only sought by men with limited educational qualifications.

19 This was largely so because it was mostly men who were allowed to migrate into urban areas to seek jobs.
Chapter Three

RESEARCH PROCEDURES

3.1. INTRODUCTION

The primary objective of this study is to investigate the combined effects of degree of autonomy and of resource allocation on the district primary health care (PHC) programme managers, field health workers and health personnel based at Mutoko district hospital [Zimbabwe] and at the district health centers, and the effect that these have had on the quality of care provided and the effectiveness of the PHC strategy. In order to collect accurate and reliable information about the work satisfacton of health personnel and their views regarding the quality of care they are providing, consumers’ levels of satisfaction with the available health services, a number of conceptual and methodological issues have to be considered. They included: obtaining representative samples of each category of people studied (health personnel and users), asking the right questions in an appropriate manner, and understanding and interpreting the data correctly. Below, the research site, study population and techniques for sampling are initially presented. Following this, the data collection techniques employed, then ethical issues and problems encountered are discussed. Finally, the key concepts guiding the research are identified and defined.
3.2. RESEARCH SITES AND STUDY POPULATION

Research to answer the main concerns of my study was undertaken in Mutoko district, in Mashonaland East province (Zimbabwe) (see Appendix III.II). The main site was Mutoko district hospital, which provides support, both managerial and administrative, to all district health facilities in the PHC strategy. In order to have a general overview of the state of health-care provision by the district health-care system, some of the health centres in the district were included in the investigation, and two villages within a 40 kilometer radius from the district hospital (in two opposite directions) were selected as sites from which users (non-patients) could be drawn (see Appendix III.II).

My sample consists of 47 health workers based at Mutoko district hospital (MDH) and affiliate health centers: 10 support staff based at MDH; 1 senior Ministry of Health and Child Welfare (MHCW) official; the district education officer; the district social welfare officer; the district administrator (Local Government); 2 heads of local development agencies, the Agricultural and Rural Development Authority (ARDA) - a parastatal organisation -, and the Agricultural Technical and Extension Services (AGRITEX) - a government department. I also surveyed 47 outpatients at MDH, 54 inpatients at MDH, and 40 households in Mutoko District (as shown in Table 3.1).

Table 3.1 also shows that the study population is composed of 12 program officers/department heads: the District Medical Officer, the MDH matron, the Community Nurse (District Nursing Officer's deputy), the District Environmental Health Officer, the Principal Environmental Health Technician, the District Rehabilitation Officer, the District Pharmacist, the District Laboratory Technologist, and the District Health Information Officer and the District Health Services Administrator.
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<td></td>
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<td></td>
</tr>
<tr>
<td>Nurses¹ MDH</td>
<td>44</td>
<td>20</td>
<td>46</td>
</tr>
<tr>
<td>Nurse-Aides MDH</td>
<td>6</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>Nurse-Aides (all) Health Centres</td>
<td>14</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Village Health Workers</td>
<td>148</td>
<td>5</td>
<td>7.4</td>
</tr>
<tr>
<td>Traditional Birth Attendants</td>
<td>🔹</td>
<td>🔹</td>
<td>🔹</td>
</tr>
<tr>
<td>Nurses - (all) Health Centres</td>
<td>28</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>District Medical Officer*</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Hospital Matron* MDH</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>District Pharmacist*</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>District Laboratory Technologist*</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>District Rehabilitation Officer*</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>District Environmental Officer*</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Principal Environmental Officer*</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Community Nurse*</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Sister-In-Charge* MDH</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Programme Officers/Department Heads</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>District Health Services Administrator</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>District Information Officer</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td><strong>Support Staff</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Clerk*</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Clerk</td>
<td>5</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>X-Ray Operator</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>CSS D Par*-er</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Ambulance Drivers</td>
<td>5</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td><strong>Officers From Other Depts./Ministries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>District Administrator [Min. of Local Govt.]</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>District Education Officer</td>
<td>2</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td>District Social Welfare Officer</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>ARDA (senior) Officer</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>AGRITEX (senior) Officer</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
</tbody>
</table>

¹ Includes State Registered & State Certified Nurses.
* Are also Department heads.
🔹 The number in the district is not known.
In this category, only the last two are not categorized as health-care personnel. The other health-care personnel include 26 nurses (State Registered and State Certified); 6 nurse-aides, 5 village community workers (VCWs) and 1 traditional birth attendant (TBA).

3.3 SAMPLING PROCEDURE

The theoretical perspective underlying this study stipulates that health and health-care outcomes have a social cause. It also takes work behaviour and other work processes and outcomes as a result of an interaction between organisational participants, organisational structures and external macro-structural variables. These factors and other considerations, such as sex, status, role or function in the district health organisation, and the stated PHC philosophy, have all contributed to my choice of selective multi-stage sampling in the investigation.

3.3.1 The District Hospital, Health Centers and Villages

Initially, the study sought to focus on two big rural mission hospitals. Random sampling of the 8 mission hospitals with 150 beds or more favoured Bonda Mission Hospital, in Manicaland Province, and Nyadiri Mission Hospital, in Mashonaland East Province. The problem of getting consent from missionary authorities as well as time, financial, and other constraints caused the focus to change to one big rural government hospital. And, this new focus was also considered to offer an opportunity to explore in greater depth and to have longer and more probing interviews. However, since the District Medical Officer (DMO) for Mutoko District Mashonaland East Province, and in whose jurisdiction Nyadiri Mission Hospital falls had already given his consent, his district hospital was chosen to be the primary site. Since the original hospital fell in the same
district no further sampling was deemed necessary. Its modern status as one of the several upgraded, rebuilt, and newly furnished, district hospitals in the country makes it representative in terms of structural, staffing, administrative, and other aspects of rural district hospitals in the country, thereby making it reasonably possible to make valid inferences. This would not be possible with mission hospitals since they fall under many different denominations, and therefore do not have fairly uniform structures and processes.

Random sampling was used in selecting health centres for inclusion in the study. As for the two villages, purposive sampling was utilised. The co-existence of the traditional/conventional villages and a number of resettlement villages (in two resettlement schemes) in the district made it imperative that each kind of village be represented. Another consideration was the relative proximity of villages to the two mission hospitals in the district, as well as the accessibility of the district hospital. It was hoped the relative closeness to a mission hospital, a health centre, and the district hospital would elicit useful comments from these respondents about which facility is meeting their needs best. So one village (village No. 10) from a resettlement scheme, with about 10 villages, situated closer to Nyadiri Mission Hospital and MDH was selected. The other village - a conventional one - (in the opposite direction and fairly close to All Souls Mission Hospital) was chosen because the researcher knew a fellow student (at McMaster) who comes from that area. The parents of this student provided an introduction to the village chairman and to the counsellor of the ward greatly. These introductions greatly facilitated the acceptance of the researcher and his assistants into the community. Considering the time available to conduct the study, this was a worthwhile strategy. It should be pointed out that choosing this village does not mean it was unique or special in other respects.
3.3.2 Officials, Programme Officers/Heads of Departments

The ministry of health (MHCW) official selected is the one responsible for directing the various PHC programmes, the Director of Maternal and Child Health and Family Planning. The purpose of the interview was to get a clear picture of the MHCW's expectations with regard to the setting and the achievement of the national PHC objectives. Similarly for other officials outside the MHCW that were included in the study. These are the District Administrator (head of local government) who coordinates the development efforts in the district; the District Social Welfare Officer who, apart from other functions issues letters for free health care to those deemed eligible; the District Education Officer and the two senior officers from the two major development agencies in the district, ARDA and AGRITEX. It was important that the extent of the intersectoral coordination between the MHCW (at district level) and other sectors be checked in order to find the extent of the emphasis being placed on the socio-economic aspects of health in the district health-care system.

Likewise, no sampling procedure was necessary when choosing programme managers of PHC programmes and department heads. These are the local programme implementers and their views on resource allocation, autonomy and other issues are bound to be crucial, hence their inclusion in the study was considered of paramount importance.

3.3.3 Health Personnel

3.3.3.1 Nurses

A stratified random sampling procedure was used in the selection of nurses at MDH. Respondents were drawn from, and the total number of staff in the seven wards is
44. A sample of 20 was decided on, which represents 48 percent coverage, stratified according to sex and hospital ward in which they worked. To arrive at the number of respondents to be sampled in each ward, the total number of nurses in each ward was divided by the total number of nurses at the hospital and multiplied by 20 (the total sample decided on, excluding the sister in charge). For example: Psychiatric Unit \( \frac{744}{7} \times 20 = 3.1 \), therefore 3 were required.

Table 3.2 gives the composition of each ward. The table further indicates that from the Male Ward, a sample of 3 was taken, with 2 females and 1 male. From the Female

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Total # Available</th>
<th>Sample</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Male Ward</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>Female Ward</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Maternity Ward</td>
<td>1</td>
<td>10</td>
<td>1</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Children's Ward</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>100</td>
</tr>
<tr>
<td>Theatre</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>50</td>
</tr>
<tr>
<td>Psychiatric Unit</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Out-Patient Dept.</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>33.3</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>29</td>
<td>8</td>
<td>12</td>
<td>53</td>
</tr>
</tbody>
</table>

Ward a sample of 2 was chosen, composed of 1 female and 1 male. From the Maternity Ward a sample of 5 was chosen, with 4 females and 1 male. The table gives this breakdown for the 7 wards as well as the percentage contribution of each ward to the overall sample. Having decided on the numbers for each ward, use was made of random sampling. When it came to the wards where either females or males were under-represented, cards were shuffled and picked until a proportionately representative number
of each category had been drawn. The final sample comprised 12 females (41 percent) and 8 males (53 percent).

When it came to nurses at the four health centres in the study no systematic sampling was done because of time and financial constraints. Each has about four health personnel, with two of them on duty at any particular time during normal working hours. Each health centre was visited only once and, the nurses that were found on duty are the ones that were included in the study. Fortunately, all of them agreed to take part.

3.3.3.2 Village Community Workers (VCWs), Environmental Health Technicians (EHTs), Traditional Birth Attendants (TBAs) and Nurse-Aides

Time and financial constraints initially dictated that only VCWs, EHTs and TBAs working in the selected villages would be interviewed. However, a group interview arose spontaneously during one of the visits to a resettlement village (village 10) where all village community workers in the Resettlement scheme were having their monthly meeting at the local health centre. Four of them were available when the researcher arrived and they all agreed to take part in the study, including the local VCW. EHTs in both villages were unavailable for inclusion as well as the TBA from Sasa village.

3.3.3.3 In-patients

A stratified probability random sampling procedure (using ward registers) was used to get the required sample of in-patients. All wards except the Psychiatric Ward were represented in the sample. It was felt that these patients might require a different approach and strategies, maybe even more time to conduct interviews with them. The overall sample was stratified largely according to sex and age and, a 50 percent
representation of each ward was decided upon. Each ward has 6 bays for different types of diseases, with about 8 beds each. Therefore, the sampling was done from bay to bay, until the total number of patients (50 percent) from that ward had been ascertained. The Male and Female Wards are for those aged 11+, hence representation of the entire age range (11-70') in the sample was deemed of great importance. The male ward had 27 patients, therefore a total of 13 was sampled and, the female ward had 25 patients and a total of 13 was sampled.

The Children’s Ward contained both boys and girls. At the time of research there were eighteen male and five female children. Therefore, each sex category had to be represented in the sample, with sub-samples of 9 males and 3 females. Because at that age children are distressed by any separation from parents or normal home life and have little understanding of what is happening to them and in the hospital, they stay with their mothers in the ward. And for the same reason it was felt more convenient to interview the mothers accompanying them. In the case of one child (in bay 2) who was selected and whose mother could not be located, another name had to be drawn. The last group of 'in-patients' to be included in the study population is that of what are called 'waiting mothers'. At the time of the study, no special arrangements had been made for them in terms of accommodation and food. These are expecting mothers who come from all over the district, to deliver at the district hospital. Their precarious living conditions made it imperative that they be included in the study population. A random sampling procedure was also used here. Out of a total of 38, only 16 were sampled in order to have a number relatively closer to the sub-samples from the other wards. Table 3.3. shows the contribution of each ward to the sample. A total of 54 in-patients were included in the sample from a 200 bed hospital (25 percent).
TABLE 3.3 : Ward Breakdown Of In-Patients In The Study Population at MDH.

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Total Available</th>
<th>Total # Respondents</th>
<th>Contribution %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Ward</td>
<td>27</td>
<td>13</td>
<td>48</td>
</tr>
<tr>
<td>Female Ward</td>
<td>25</td>
<td>13</td>
<td>52</td>
</tr>
<tr>
<td>Children’s Ward</td>
<td>23</td>
<td>12</td>
<td>52</td>
</tr>
<tr>
<td>Waiting Mothers</td>
<td>38</td>
<td>16</td>
<td>42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>113</td>
<td>54</td>
<td></td>
</tr>
</tbody>
</table>

1 = 18 Males & 5 Females
2 = 9 Males & 3 Females

### 3.3.3.4 Out-patients and ‘Non-patients’

A kind of probability sampling was used in the selection of out-patients to take part in the study. Almost all out-patients, after visiting various wards/departments for treatments, or other concerns, have to pass through the Pharmacy department. They do so either to collect prescribed medications or, if they are fee-paying patients to pay for treatments and drugs. An arrangement was made for the pharmacist to send every fifth person to the interviewer, who explained the objectives of the research and sought consent. The time interval between interviewees, say the fifth and tenth, was deemed adequate to allow an informed discussion. Only about one-fifth of the respondents had to wait a couple of minutes for the previous interview to finish. Unfortunately, it was difficult to stratify this sub-sample by sex. Conducting the interviews at different times of the day and over four different days, including a Saturday, was considered relatively adequate to further allow the inclusion of proportionate categories of either sex who might
be busy and therefore unable to come during weekdays. In the end, 36 females were sampled as opposed to 14 males.

By 'non-patients' we mean householders in the two selected villages (Sasa and Nyadire Resettlement Village 10). These are people who are likely to have visited a health facility in the district either recently or in the near past. For those who have never visited a health facility, or have not done so during the last several years, which was true for quite a number of middle and old-age respondents, it was also considered important to find out if that might be due to the nature of the health-care provision or limitations in the health-care structure.

Village 10 had 43 plot holders and each plot holder has a number. Since this resettlement village is made up of residents who were former farm workers, residents originally from other parts of the district and those from other districts, it was considered necessary to include a balanced view of these sub-groups. The household to start with was selected randomly by spinning a bottle. It pointed towards household number 3. From there on, every other household of residents from each of the subgroups mentioned above was selected and, due to time constraints for repeat visits by appointment, where there was nobody home the next (third) house in the sequence was selected - this was only done in two of the cases. This procedure was followed until 20 households had been selected for inclusion in the sample. This represented 47 percent of the households in the village.

Sasa village on the other hand had 85 households. The first household was chosen by picking the closest one to the local guide's household soon after permission had been granted by the local authorities and a guide was identified. The starting point was not at the beginning or end of the village. From the starting point every fourth household was included in the sample in order to get a total sample of about 20 households, a number equal to the one obtained from Village 10. More householders were found absent from
their houses in this village than in Village 10. So each time a prospective respondent was found absent, the fifth householder would be sought, if absent, then the sixth; but then the next one would be the second after the sixth and so on. Due to the number of absences and inadequate time for revisits, the last 5 households had to be taken one after the other in order to complete the required sample of 20.

3.4 DATA COLLECTION, ETHICAL ISSUES, CONSENT AND TECHNIQUES

This section discusses issues relating to access, ethical concerns and informed consent. I consider how they were dealt with in the investigation, and also the variety of data collection techniques that were utilized in order to best answer the research questions. The anticipated time frame for the study was June 1993 through September 1993, a timeline dictated by lack of funds. In effect, the permit from the Medical Research Council of Zimbabwe to allow the carrying out of the study was obtained 2 August 1993. Prior to that time, only some documentary material had been obtained from the MHCW and a couple of discussions conducted with MHCW officials based at the head office. The investigation was carried out in the months of August and September. I used research techniques such as informal and formal semi-structured interviews, non-participatory observation and use of government documentary material.

3.4.1 Access, Ethical Issues and Informed Consent

When I presented a copy of the research proposal to the Deputy Secretary for Health I received a quick approval. I was then referred to the Medical Research Council of Zimbabwe which has a final say in the issuing of research permits in the health field. The council also expects that a research proposal contains a section that deals with ethical
issues in the study as well as maintenance of confidentiality. This requirement was met, however, the council did not approve the research. The reason given was the structure of the proposal itself. However, when the authorities learned that the researcher was affiliated with the University of Zimbabwe, and that the results would not 'just be whisked back to Canada', a permit was granted.

The prior condition for receiving that permit was the approval of the District Medical Officer. He had been contacted, shown the proposal and had the research objectives explained to him. After this, he consulted with the Provincial Medical Officer and permission was granted. When the investigation started, the point of entry into the wards and other departments was the hospital matron who cooperated.

A letter of authorization from the District Health Services Administrator, who was based at the district hospital, was also necessary. I had to ask for the cooperation of health personnel based at district health centres. The need to include some villages in the district in the study necessitated a formal request to the Ministry of Local Government. The research objectives were explained to an Under Secretary in that ministry. His stamped letter of approval then had to be taken to the local District Administrator, who, in turn, placed his department's stamp on that letter. This letter was vital in getting the cooperation of the Resettlement Officer in Village 10 and the Councillor of the Ward in which Sasa Village is situated.

Despite the relatively easy entry into Mutoko District Hospital, it was not easy to dissuade health personnel from thinking this was a government sponsored research project geared towards retrenchment. It was unfortunate that the study coincided with the government's Economic Structural Adjustment Programme (ESAP) started in 1990 which, among other things, aims at downsizing the number of public servants. A nonchalant approach and informal discussions with staff after working hours eventual
helped to allay these fears. It also helped to establish a relationship of mutual trust. Moreover, and most importantly, the unanimous agreement of responsible authorities (hospital, local or otherwise) in giving consent to the researcher did not preempt the need to seek individual consent from health personnel, in- and out-patients as well as householders. After the research objectives were explained to each respondent, their consent was sought. The fact that they were not obliged to participate if they did not wish to do so was made clear. Fortunately, not a single respondent who was sampled refused to take part in the study. In addition, respondents were assured of the confidentiality of their identities and, this was reinforced by the fact that no names were asked during interviews.

3.4.2 Qualitative Methods

Qualitative research includes "...observations, interviews, and documents drawn from multiple sources" (Strauss 1983 : 274) and, "...involve the collection and analysis of narrative information" (McIver 1991 : 52). There are a number of reasons why qualitative research was an important component of this project. It has been argued by Strauss that "[q]ualitative researchers lay considerable emphasis on situational and often structural contents..." (1983 : 2). This is consistent with my perspective that seeks to put societal interaction, situational contexts, the district health-care system's organisational and wider societal structures under scrutiny. According to McIver, "[q]ualitative methods collect information which is likely to be more valid because analysis is 'bottom up' rather than 'top down'" (1991 : 70). Furthermore, other scholars assert that "...more detailed perceptions of health care can only really be obtained through qualitative, interactive processes" (Judge and Solomon, 1993 : 325).
Therefore, the choice of techniques discussed below as well as the sampling of various categories of personnel at different hierarchical levels in the Mutoko District Health-care System were guided by what Strauss and Schatzman call a sociologically axiomatic base: that in any human organisation, people stand in different relationships to the whole of that organisation, in some respects probably viewing and using it [as well as affected by it] differently; and that these differences can be gleaned from what people say and how they act [1973: 41].

3.4.2.1 Non-Participant Observation

Non-participant observation had originally been planned to be one of the principal data collection techniques, at par with interviews. Time constraints, however, forced the reduction of the emphasis placed on systematic observation of the structural features of, and social processes within the district hospital, the health centres and villages visited. It has, however, been noted that “[a]fter all, when one measures the cost of effectiveness of interviewing against observation, the former is more economical” (Strauss, 1973: 44).

While observations were guided by the study’s research questions, they were also done to test what was heard from respondents during interviews as well as from respondents and other organisational members through informal interviews and situational conversations. In this case observation of organisational events was done to ensure the validity of remarks made by respondents and non-respondents.

Observation started at the district hospital soon after a permit had been granted. The first two weeks were devoted to the collection of documentary materials and observation. At the same time, it was important to develop cordial relationships with personnel before conducting interviews. During this time, observation was supplemented
with situational or ‘incidental’ questioning or conversation in connection with the district health indices that were being gathered from hospital records. We also talked during tea and lunch breaks and after work about work processes and about their day-to-day interaction with other workers. I also observed and had casual conversations with outpatients waiting in queues, with in-patients basking in the sun outside their wards, and with relatives waiting for outpatients to undergo treatments. Time constraints did not allow systematic observation of health-care personnel doing their work in the hospital wards as well as the doctors and matron making their daily rounds.

Visits to health centres lasted about two and a half hours. During this time interviews were conducted with two health-care personnel. Observations had to be limited to checking the location of health centres in relation to the nearby villages, bus routes, and the facilities available. I also observed how health-care personnel dealt with any patients who came during that period of time. When we visited the two selected villages, I observed the infrastructure, including features such as toilets, water wells, proximity to health facilities and transport system as well as the general living conditions.

3.4.2.2 Formal In-depth Semi-Structured Interviews

Strauss (1973: 77) defines an interview as “... a mode of inquiry ... quite necessary where the actions of people are either unfamiliar or very complex”. I consider this to be the case in my research since I am dealing with a complex organisation and personnel with divergent tasks. Strauss further argues that “while direct observation is the heart of field research, the interview must be used to provide context or meaning” (1973: 77). Apart from being a primary source of data in their own right, interviews were also used to enable respondents to talk about their actions, identities and roles.
An explanation of the research objectives as well as an assurance of the confidentiality of the information sought preaced each and every interview. It was recognized that for the information supplied to be valid it had to be freely given, hence the importance of the voluntary character of the interviews as a relationship freely entered into by respondents was stressed. Anonymity of respondents’ identities was assured by not asking for their names during interviews. This initial conversation helped to set the stage for the ensuing interaction and create rapport. It was during these opening moments that each respondent was asked for permission to record the interview. Fortunately, only one respondent, an official responsible for the district AIDS programme, declined to have the interview recorded. Notes were written by hand. Recording was deemed essential in order to enhance descriptive validity by getting the respondents’ comments verbatim.

In these semi-structured interviews, some questions were set and some were left open. Each interview was treated as a somewhat lengthy conversation, during which the interviewer probed for detail, clarity or explanation. Although there was a list of guiding questions, there remained a flexibility in ordering it in a way that suited the respondent or the interview situation as long as the discussion remained within the realm of the pertinent issues. For example, when an interviewee fully answered the fourth and sixth questions while answering the second, an adjustment was made by the interviewer in order to build upon that in order to avoid repetition, maintain the tempo of the conversational approach and avoid distracting the attention and interest of the interviewee. The interviewer also tried as much as possible to obtain relatively comparable coverage and content for all interviewees from each homogeneous group of respondents.

While group interviews, prior to individual interviews, had been planned for nurses, nurse aides, VCWs, and EHTs as a means for distinguishing between shared and variable perspectives (among each group), it proved difficult to be able to get a sizable
number at any one time. In the case of VCWs and TBAs, the data collection depended on the time and resources available to reach them in their respective villages and to organize a 'meeting'. Because of the tight work schedules of nurses, it was extremely difficult to find four or five 'free' at any particular time.

A top-down approach was used in conducting these interviews, starting with MHCW officials in central offices, the district officials, department heads at the hospital and then other personnel. Interviews with other health-care personnel at MDH were carried out concurrently with those of in-patients and out-patients, interviewing patients whenever there was no free staff members available for an interview and, about eight interviews with the latter had to be scheduled after working hours. The major reason for starting with the policy makers and local administrators was to get a special overview of the MHCW’s PHC objectives and to find out what they think is happening at the local level, about the PHC achievements to date, about the rationale for the various PHC programmes and about current constraints.

Organizational life, even its formally stated written tradition, is subject to differential perception and interpretation by organizational members at different levels. Respondents at different levels are going to have different vocabularies, different patterns of language usage and different 'class origins'. Therefore, they are not likely to place the same interpretation on the meaning of questions asked. Because of this, different sets of guiding questions, but all pointing towards the main issues, were prepared for each homogenous group of respondents.

The interviews with programme managers and department heads covered such issues as perceived involvement in decision making and allocation of district health-care resources, work satisfaction, adequacy of resources at the district hospital and district wide (See Appendix III.III and III.IV).
When interviewing health-care workers, questions focused on their knowledge of PHC objectives, existence of any latitude for decision making in their positions, what factors make for satisfaction and dissatisfaction in their work environment, and how they cope with such situations, the adequacy of health resources and effects of fewer resources and manpower on health services. Respondents were encouraged to elaborate on their answers to questions on these topics. Questions directed at patients were centered around basic demographic data, time spent on travelling to the hospital, time spent waiting for treatment and that spent during treatment, the other medical units they have visited (traditional or otherwise), what other medicines (if any) they have used, duration of the complaint, the diagnosis, their relative rating of the hospital in terms of the caring nature of personnel and 'efficiency' according to their own definition, etc. The same questions (modified to suit non-patients) were used with respondents from selected villages. In addition were some questions on whether they have ever visited any of the nearest health centers or the hospital for treatments, and their satisfaction/dissatisfaction with the services as well as those provided by TBAs, VCWs, and EHTs. If they have never visited the hospital we also wanted to find out why not.

The main objective of interviewing non-patients was to balance the views of the people in the district because patients were going to respond within the organization that is taking care of them, so it was thought necessary to be cautious in granting validity to the information they provided on what they think and feel about the type of care they had or were receiving.

Interviews with district programme managers and department heads were generally longer, averaging about 120 minutes. Those with health personnel averaged 75 minutes, those with in-patients and out-patients, about 38 minutes. The fact that householders were interviewed in their homes, and were therefore more relaxed, helps to account for an
interview that was on average longer than that for in and out-patients. It stood at 30 minutes.

3.4.2.3. Documentary Materials

Data from these sources were intended to supplement that obtained using the other techniques. Access was provided at various levels. At the MHCW head office various pamphlets provided detailed information about the PHC policy and its philosophy, the various PHC programmes and their objectives, past evaluations of the national health-care system and the 1993-1997 health human resource master plan. Also collected from the head office were national statistics pertaining to the turnover of nurses, doctors and specialists within the public sector. At the district hospital (District information office) unlimited accessibility was provided to disease-specific morbidity data (1990-1993) sent from all hospitals and health centres in the district, from which could be gleaned the leading causes of in-patient and outpatient morbidity in different age groups as well as the estimate cost of ‘patient days’ due to those common diseases in the case of health facilities with in-patients. These data, however, will be used sparingly because it is well-known that because of ‘...underreporting of health problems, inaccurate diagnosis by health staff, and failure to include serious cases that bypassed the health centre for the hospital [or district hospital for the central hospital]’ (Faruque, 1982: 14), morbidity and mortality data ‘...do not represent the total population and are of dubious quality. Therefore, they can not be expected to provide more than a general and crude indication of the disease pattern in the population’ (Lee, 1992: 30).

From the hospital matron’s office I also obtained the hospital organisational charts that incorporated other district health-care personnel. The District Social Welfare Officer also made available data on public assistance to the aged, disabled and the chronically ill,
and, most importantly, requests for letters to take to health facilities for free health services. These data cover the period January 1990 to July 1993. The District Administrator was also able to provide the 1992 census statistics for the district. These were important in providing the number of villages and households in the district. They were also important in calculating the ratios of health personnel to the district population.

3.5 DEFINITION OF KEY CONCEPTS IN THE STUDY

The fundamental theoretical framework underlying this study posits that there is a relationship between job autonomy/participation in decision making and resources, and outcomes, such as quality of health care and effectiveness of primary health care strategies mediated by stressors like role overload and outcomes such as job satisfaction/dissatisfaction. The predominance of the qualitative methods of data collection and analysis in this study has precluded the attempt to use measures with a quantitative bias. An attempt was made, however, to ensure that the measures captured the intrinsic nature of the variables. This section, therefore, presents the definitions of the key concepts in the study.

3.5.1 Independent Variables

3.5.1.1 Job Autonomy/Participation in Decision Making

The Alma-Ata 1978 conference which promoted the notion of “Health for All by the Year 2000” recommended that appropriate responsibility and authority be delegated to intermediate and community levels (WHO 1978: 24). The WHO has asserted that
reorientation of health systems to PHC...involves redefinition of the objectives of the principal health institutions, the re-allocation of responsibilities, and even the revision of the power structure [WHO, 1988 : 109, emphasis added].

Thus, the "need for greater flexibility and autonomy in dealing with local problems is...seen as a necessary condition for improving the quality of the managerial process for national health development" (Lee, 1992 : 30).

The concept of autonomy is closely related to two other concepts - alienation and power. In its classic Marxian sense, alienation refers to the separation of workers from the work process, the products of work, fellow workers and creativity. According to Adler (1993), work that is not alienating is that which is controlled by the worker. Hence, control over various aspects of work enhances the reduction of alienation as well as the empowerment of workers. Power, in its Weberian probabilistic sense, is defined by Kanter as ".....associated with the exercise of discretion, the chance to demonstrate out-of-the-ordinary capacities in the job, handling uncertainties rather than routine events; ....and with the relevance of the job to current organisational problems" (1977 : 275-276). It is also said to be the ability to set and execute projects and denial of this results in alienation (Adler, 1993). Thus, work power defined in this manner is only semantically different from job autonomy, which is said to involve "control over scheduling, work pace, and conceptual initiative at work" (Adler, 1993 : 450).

Adler (1993) goes further to suggest that job autonomy can be regarded as a work-related reward. He equates it to wages, authority, and status, because it entails independence and control for workers, or the ability to use their initiative in carrying out work tasks. In defining job autonomy, Parmelee argues that it is the "probability of an individual’s exercise of discretion in his or her work role" (Adler, 1993 : 452). Wright has added two other dimensions to the conceptualisation of job autonomy. These are conceptual and time-related job autonomy. By conceptual autonomy she means 'cognitive
input’ or the extent to which an individual controls the conceptual aspects of work (Adler, 1993). The time-related dimension involves the ability to influence scheduling and free time at work.

As a professional attribute, job autonomy “consists of the practitioners’ desire to be free to make decisions about their work” (Snizek in Rhodes, 1985: 241). Hence, in reference to the nursing process, its proponents claim that autonomy will improve patient care. This may also serve as a strategy of professionalisation (Rhodes, 1985: 241).

For the purpose of the present study, I take Adler’s definition which states that “job autonomy refers to the worker’s ability: (a) to design aspects of work, implement ideas, and introduce new tasks; (b) to decide on work hours and time off; (c) to decide on the work pace” (1993: 452). Assuming that Wright’s ‘conceptual autonomy’ is subsumed in ‘a’, it is argued that placing more responsibility in health providers’ hands in terms of conceptual autonomy can lead to a reduced need for middle management, in this case the provincial office, as well as equitable distribution of health resources at district level and optimal use of health care resources. It is Morlock’s contention that “the nursing profession desires more participatory management, greater equity in power relationships and more participation by nurses in hospital decision making with respect to programmes and policies” (1987: 287).

To measure this variable, every health worker, member of support staff, and programme manager was asked about their responsibilities within the district health-care system. They were asked whether they thought there had been enough decentralisation of authority and power to allocate resources (for programme managers and department heads) or delegation of authority (for other health personnel and support staff). They were also asked if they could change or introduce new aspects to their work without consulting their superiors, deciding what to do, and when and how often to do it. It was thought
that such measures would give a sense of immediacy and decisiveness as compared to predetermined categories from which respondents would have to choose without room for elaboration.

3.5.1.2 Resources

As conceptualized in this study, resources refer to the "means of supplying what is needed" (Oxford Dictionary 1982: 887), in terms of personnel and other stock that can be utilized to effect health care. The PHC strategy embodies the concept of equity in health and that, too, entails providing health care according to need. Apart from personnel, the other essential resources are essential drugs and transportation.

It is argued that "adequate support for PHC demands efficient handling of drugs and supplies, including procurement" (Tarimo, 1991: 87) and that "improved management of existing resources will lead to higher efficiency... [and] limitation of resources tends to diminish the quality of services provided" (WHO, 1988: 121, 99).

The effect of resources on quality and effectiveness is conceptualised as being twofold. The first effect is indirect. For example, the shortage of drugs and staff is expected to affect the quality of health services directly by failing to meet demand. It is also hypothesized to have an impact, just like job autonomy, on the two outcome variables via negative outcome variables like role overload, burnout and job dissatisfaction. It is clear that shortages of staff leads to role overload, or heavy workloads, for the few available staff. Working with severely limited resources is hypothesized to lead to staff burnout and job dissatisfaction.

Therefore, health personnel, support staff and programme managers/department heads were asked if they ever experience any shortages of drugs, personnel, equipment,
supplies. They were also asked how they think this affects the quality and effectiveness of health care services.

3.5.2. Mediating Variables

3.5.2.1. Burnout

This research investigates the organisational job stressors and some psychological research on job stress and burnout would be one logical starting point in bridging the gap between organisational experiences and the objective working conditions directly affected by our major independent variables (autonomy and resources). An understanding of these relationships is facilitated by the work of these scholars who have related in various ways, experienced burnout in social services workers to organisational structures.

Research on job stress and work satisfaction (Maslach, 1982; Cherniss, 1980; Burke and Greenglass, 1989; Karasek and Theorell, 1990, Ford, 1988) has strongly pointed towards the arousal of feelings of dissatisfaction and burnout in (over-centralized) organizations where there is lack of autonomy to influence decisions and policy formation. Maslach (1982) and Cherniss (1980) have asserted the significance of the negative effect of stress and burnout on the quality of service in social service organizations/programmes.

What is most important for this research is, however, the investigation of the reactions and the effects of such reactions on health-care provision. Maslach (1982) has argued that when one is caring for so many people, especially in understaffed institutions, one suffers from emotional overload. The usual response is to cut back on one's involvement with others. Caregivers begin to focus on people's specific problems only, because they do not have time for complete and adequate service. Maslach (1982) posits that the situation is made worse when there are limited resources with which to care for patients.
This study does not attempt to make any direct measures of burnout levels among health personnel. Any inference about its existence is made on the basis of the observation of the objective working conditions or job stressors that cause burnout, as well as the workers' levels of job satisfaction: dissatisfaction. The patients' and community's views about the health workers' attitudes towards them, as judged from their interpersonal skills or bedside manners, will also be of great value in this regard. As a mediating variable, burnout is important in the way it is likely to translate or relay the effect of the two independent variables on to the quality of health care provided.

My working definition of burnout is taken from Maslach (1982). She defines it as "...a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (Maslach, 1982: 3).

3.5.2.2  Job Satisfaction/dissatisfaction

Drawing on theoretical and empirical research, there appears to be ample reason to assume that stressful work conditions, such as role overload, will produce job dissatisfaction. Organisational studies have typically not been conducted in relation to work experiences in PHC organisational settings, particularly those located in Zimbabwe.

While work/job satisfaction is conceptualized to affect performance (Duxbury et al., 1984) and well-being, it is also said to affect the quality of patient care as well in nursing (Landweerd and Boumans, 1988). So, "identifying which job-related factors are related to nurses' satisfaction is a necessary condition for quality patient care" (Zuraikat and McCloskey, 1986: 143). ²
The range of definitions of job satisfaction that have been given depict the range of theoretical conceptualisations in the field. For example, Landweerd and Boumans (1988: 225) define it as "an individual employee’s evaluation of the work environment." Gillies defines it as "one’s effective response to one’s job" (Bartholomeyczik, 1992: 27). Two similar definitions to this are given by Price (1977) who sees it "as the degree to which there is a positive affective orientation towards membership in a system" (cf. Zuraikat and McCloskey, 1986: 143) and Kalleberg, who sees it as the "...overall affective orientation on the part of individuals toward work roles which they are presently occupying" (Hurlbert, 1991: 416).

A completely different definition is provided by Mumford (1976). He defines job satisfaction as "the fit between what an employee was seeking from work and what he was receiving ....in other words, the 'fit' between job needs and expectation and the requirements of the job" (see Metcalf, 1986: 287). In this study, I am using this definition, together with the one offered by Krahn and Lowe (1993) who define job satisfaction as "specific subjective reactions of individual workers to the set of rewards, intrinsic or extrinsic, provided by their job" (Krahn and Lowe, 1993: 340).

It should also be noted that Hurlbert’s (1991: 415) qualification is of significance here, that job satisfaction "... is an intangible reward affected not only by structural job conditions but by perceptions; [and that those] who experience the same objective job conditions may report different levels of satisfaction." It is "....directly related to the amount of autonomy, responsibility, recognition, and achievement afforded by the job" (Bartholomeyczik, 1992: 27).

While job satisfaction/dissatisfaction is expected to be affected by lack of autonomy and inadequate resources, it, in turn, is expected to affect the quality and effectiveness outcome variables. Absenteeism and turnover are commonly used as
measures of job satisfaction. Some studies have traditionally measured these by asking people to rate their jobs or facets of it on a predetermined satisfaction scale. In this study, the job satisfaction measure asked respondents how satisfied they were with their jobs overall, to give the factors that make for satisfaction and dissatisfaction in their work environment, as well as conditions that affect staff morale and motivation.

3.5.3 **Outcome/ Dependent Variable**

3.5.3.1 **Quality of care**

Quality of care is a critical component of health services (Ali and Mahmoud, 1993). Considerable progress has been made in its conceptualisation and measurement although it is argued that more research is devoted to costs of hospital care (Scott and Flood, 1984). What we call ‘good quality’ is determined, however, by value judgments that can vary with time and among different groups (Ali and Mahmoud, 1993).

Outcome measures are said to be best for indicating the impact of services (Faruquee, 1982). The evaluation of the quality of health services rests on the assumption that quality has a positive relationship to effectiveness (Ali and Mahmoud, 1993: 51). In fact, the quality of the services that are delivered is regarded as an important dimension of effectiveness for health-care organisations (Scott and Shortell, 1987: 439). The collection of valid outcome measures may present difficulties. It is difficult to control for non-project influences, because the project, be it in health or education, operates in an environment that is affected by many factors outside the health care/medical field (Faruquee, 1982, Ali and Mahmoud, 1993). This is even more of a
problem when one considers patient satisfaction measures, which are considered to be highly subjective and hard to measure.

Roemer and Montoya have defined quality of health care as “the degree to which the resources for health care, or the services included in health care, meet specified standards” (Tarimo, 1991: 56). Whilst this may be true, it is clear that this is a ‘top-down’ definition. Who specifies the standards? Obviously health professionals and specialists. Tarimo (1991) goes further to say that quality is assessed on the basis of a review of charts and case notes relating to various services, for example, antenatal or family planning. The fact that “most studies pinpoint that quality of care is a significant factor influencing demand” (Litvack and Bodart, 1993: 370), and that “utilization of rural health services may be increased if their quality can be upgraded” (Kloss, 1990: 113) (because the rate of utilization is itself a reflection of the quality of care [Bindari-Hammad and Smith, 1992: 141]) tells us there is a missing element in Roemer and Montoya’s definition of quality, the service users. Hence, researchers like Donabedian have differentiated between the ‘technical’ and the ‘interpersonal’ aspects of quality. (Donabedian 1983, cf. Long and Harrison 1985; Long 1985). The second aspect relates to the need for the quality of services to meet socially defined norms and values, reinforced by the ethics of health providers and the expectations of patients. The first involves the application of medical science and technology to maximise benefits. Both Vuori (1982) and Donabedian (1980) concur in believing that the definition of quality of care should take into account a broader definition of health. In particular, it should take into account the perspectives of the lay person/service users (Long, 1985). In the final analysis, “...it is the community’s valuation of states of health, of indicators of provision that are important, and must then be addressed in identifying need, measuring health outcome, and in expressing the effectiveness of a health programme” (Long, 1985: 22).
The public’s perceptions of quality differ from those of physicians and other health personnel. Scott and Shortell (1987: 440) state that “[t]he public may give weight to access, convenience, comfort, and interpersonal relationships while the professionals...place greater emphasis on technical skill.” In order to strike a balance, however, Mclver asserts that

the information obtained must reflect the views, experiences and opinions of service users, but it must also be information which relates to issues considered important by service providers, and must be collected in a way which enables them to improve service quality [Mclver, 1991: 2].

Therefore, a study of consumer evaluation of quality of care needs to identify and employ the criteria, and the standards used by consumers themselves instead of using consumers as sources of data about aspects of care that have been already predetermined by professionals or researchers as relevant for study (Locker and Dunt, 1978). In this study, quality of care is defined as the degree to which the resources for health care, or the services included in health care meet the health system’s objectives of care as well as the expectations and perceived needs of consumers.

Since client satisfaction is, in one sense, an outcome of care and the client’s judgment on the quality of care (Donabedian, 1983), the measure of quality of care used in this study is two-fold. First, health workers were asked to comment on the effect the independent variables have on the quality of care, taking into consideration the national PHC objectives and the district PHC programmes’ targets. In an investigation of the quality of care of a programme (PHC) that aims at empowering health care recipients, reorienting health care resources and focus towards rural communities it is imperative that client satisfaction be used as the primary measure of quality care.

The WHO acknowledges that people have both the right and the duty to participate in the “...process for the improvement and maintenance of their health” (1978: 23), and “the Alma-Ata [conference] considered it a cornerstone for determining quality of
care" (Mansour and Al-Osimy, 1993 : 164). Locker and Dunt (1978 : 283) argue that "...studies of consumer satisfaction, to the extent that they are taken into account in policy formulation, are an indirect form of consumer participation." Patient satisfaction is "seen as a measure of the degree to which health care providers have been successful in meeting patient-defined needs and expectations" (Doering, 1983 : 291). It is a measure that has the advantage of including the patients' perspective (Scott and Flood, 1984). It is also "considered an indicator of efficient utilization of health services received and the extent to which these services meet the [consumer's] wants and needs." (Ali and Mahmoud, 1993).

An assessment of the quality of care, from the standpoint of this study, is inseparable from an assessment of patient/client satisfaction. The latter is dependent on, and feeds into the former. Omitting the latter would result in our taking the viewpoint of experts and bureaucrats, or in using an overly quantitative approach based on cost-effectiveness, efficiency or epidemiological data. Such an approach would not be concomitant with the theoretical perspective of this study.

Service users were asked to comment on their satisfaction with health-care services received in their community. They were also asked to comment on their perceived health needs and unmet health needs. In my investigation of health needs and services received, I am concentrating on some particular dimensions of quality of care. These are given by Scott and Flood (1984 : 237) as accessibility (physical, economic and psychological), appropriateness, sufficiency, timeliness and efficacy in producing the desired results. Other components of service, such as waiting time, nurses' interpersonal skill (Melver, 199:4) and utilization of services, are also considered.
3.6 CONCLUSION

As stated at the outset, the assumptions to be investigated in this study are that the degree of job autonomy and pattern of resource allocation would have an impact on health care providers and the quality of care provided in the district. In this chapter I first discussed the study population, research sites, and sampling procedures. I then went on to discuss our methods of data collection. The fact that my study has a qualitative bias has consequently led us to use semi-structured interviews as well as non-participant observation as our chief methods of data collection. Government records have also been used.

I also discussed the main concepts guiding this study: job autonomy/ participation in decision making and resources, burnout and job satisfaction/ dissatisfaction, and quality of care. The order in which we have defined these variables is the order in which they will be utilised and discussed in the chapters that follow.
ENDNOTES

1 This included families of some key figures in the village, like the village chairman, the village community worker and traditional birth attendant.

2 Maslow’s work in the early 1950’s had a tremendous influence on the study of job satisfaction (cf. Zuraikat and McCloskey, 1986: 143). His theory of human motivation posits that our needs are never satisfied because once one need is satisfied, another takes its place. Herzberg (1966) then developed a theory of job satisfaction based on Maslow’s hierarchy of needs by making a distinction between factors that are satisfiers and those that are dissatisfiers (cf. Zuraikat and McCloskey, 1986). All factors related to the job environment (including salary and work conditions) were considered as important because their absence caused dissatisfaction. On the other hand, factors relating to the work itself (such as peer recognition and increased responsibility) were regarded to improve motivation and therefore necessary for satisfaction (Zuraikat and McCloskey, 1986).
Chapter Four

JOB AUTONOMY IN THE DISTRICT HEALTH-CARE SYSTEM OF MUTOKO

4.1 INTRODUCTION

Work is a central human activity (Seeman, 1987; Coburn, 1981; Reinhart, 1987; Watson, 1987) which is said to "...offer [either] a sense of accomplishment or meaningless; ... be a source of pride or shame" (Reinhart, 1987: 1). A number of factors that can cause one to feel this way come to mind, but here I am concerned with only one of them: job autonomy.

It is common knowledge that, when individuals take up employment, they surrender some (general) autonomy (Watson, 1987). This is largely because somebody else is in charge of, or owns the place of employment. That means when a person joins an organisation

he accepts an authority relation; i.e., he agrees that within some limits (defined both explicitly and implicitly by the terms of the employment contract) he will accept as the premises of his behaviour orders and instructions supplied to him by the organisation ... [and:] acceptance of authority by the employee gives the organisation a powerful means for influencing him - more powerful than persuasion ... [March and Simon, 1958: 90].

On the other hand, it is said that "[a]n increasing number of workers want more autonomy in tackling their tasks...and greater participation in the design of work and the formulation of tasks" (Rinehart, 1987: 10 - 11). Research has shown that most Canadian workers find fulfillment in jobs that provide considerable autonomy, complexity and variety (Krahn and Lowe, 1993). Allowing for cultural differences, I believe this also

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applies to workers in other countries. Basing their position on longitudinal data from studies in United States, Kohn and his associates argue that

work that is free from close supervision, that involves considerable complexity and independent judgment, and that is non routine will have a lasting positive effect on one's personality and psychological functioning [and that] jobs allowing little self-direction are more likely to lead to psychological distress [in Krahn and Lowe, 1993: 365].

The centrality and importance of job autonomy since about mid-twentieth century is thus evidenced by the increasing amount of attention it has been given by numerous researchers from various disciplines.¹ Social scientists from these various fields have all pitched in, and as a result we have a plethora of terms which have been used in place of, or as synonymous with, job autonomy as I have defined it in Chapter Three. The most common and widely used ones are the following: participation, worker participation, participative management, organisational democracy, decision making, decentralisation, staff control, and power as defined by Adler, (1993) and Kanter (1977) (see Chapter Three). For example, Chernomas and Chernomas (1989) use workers' decision making power, participation and (job) autonomy interchangeably. Krahn and Lowe (1993) use decision making and autonomy as synonyms. Ejiofor views participative management "as an organisational intervention strategy that allows workers to take part in making decisions that ...affect their work environment" (1983: 239). And Blunt (1984), who takes a broad meaning of decentralisation², says it is analogous to the idea of participation in decision making. He also uses worker participation, decentralisation and organisation democracy synonymously; taking them as all having as their core the devolution of power, in contrast to pseudo or partial participation in which the right to decide still rests with management alone (Blunt, 1984). Morlock and associates (1987: 239) also take this broad view of decentralisation and, equate it with "the idea of high levels of staff control."

Despite the variety in the terms that are used, the critical issue in job autonomy is
power (as defined in Chapter Three). Adler (1994), who defines power as the control over subordinates or organisational resources, sees it as an essential component of work stratification. Organisations "... are significant concentrations of power" (Cockburn, 1991 : 17) and, "in the majority of health care organisations, power is derived from multiple sources - formal authority, control over critical resources [and], expertise..." (Morlock et al., 1987 : 293). Furthermore, Watson argues that "social organisation of work will reflect the basic power relationships of any particular society" (1987 : 87). More disconcerting is the fact that many studies continue to show that men generally have more power at work than women (Adler, 1994). "Men are more frequently found in jobs that offer high autonomy, that is, self-direction and freedom from close supervision" (Marsden et al., 1993 : 371). This is a particularly important, because in this study, the majority of personnel in the Mutoko district health-care system, and throughout Zimbabwe, are women. According to Hall (1975 :54),

a powerless person is an object controlled and manipulated by others or by an impersonal system ... He [/she] cannot assert himself [/herself] as an agent of change or modify the conditions of his [/her] domination. He [/she] reacts rather than acts.

Because he takes powerlessness as the most important aspect of alienation. Hall (1975) contends that the more freedom a person has, the less the alienation he or she experiences.

The crucial significance of job autonomy to both workers and management has spawned various research efforts that link its presence or absence to such factors as worker attitudes, the health status of workers, work performance, and productivity levels.

Little or no participation in decision making has been said to cause job stress (Cherniss, 1980; Coburn, 1983; Ford, 1988), emotional strain (Maslach, 1982) and consequently burnout (Maslach, 1982; Cherniss, 1980). Karasek and Theorell (1990) assert that heart disease symptoms are most common among those whose work is low in
latitude to make decisions.

Hierarchical power structures (Cherniss, 1980), authoritarian work milieux (Rinehart, 1993) or rigid hierarchical organisational systems (Karasek and Theorell, 1990) are known to reduce worker autonomy and control (Cherniss, 1980; Rinehart, 1993). They are also known to "...impede work performance by breeding discontent and resistance" (Rinehart, 1993: 298) as well as lead to job dissatisfaction (Morlock et al. 1987; Cherniss, 1980; Karasek and Theorell, 1990) and work alienation (Cherniss, 1980; Coburn, 1983; Rinehart, 1987; Hall, 1975; Morlock et al., 1987). A study by Aitken and Hage in 1966 found that relatively high levels of alienation are present among a professional group when the organisational environment in which they work is characterized by high levels of centralisation and formalisation (Cherniss, 1980; Morlock et al., 1987). High levels of centralisation and formalisation lead to lack of participation in decision making and an absence of discretionary power on the part of persons involved. Other studies conducted in the United States in health and other types of organisations have indicated that "decentralisation... defined as member participation in important organisational decision making tends to generate less alienation and dissatisfaction with work" (Morlock et al., 1987: 291).

The converse has also been found. Higher levels of job autonomy or control over making decisions about how a job should be done "...can increase a worker's feelings of satisfaction" (Krahn and Lowe, 1993: 347; cf. Coburn, 1983; Chernomas and Chernomas, 1989). This relationship was reported as early as the 1950s by one of the classical organisational theorists, Blau. He notes that "there is a fair amount of evidence that the exercise of discretion and responsibility increases satisfaction at work" (Blau, 1967, 61).

Some scholars have looked at the issue of participative decision making in terms of advantages and disadvantages. Some of the advantages as given by Yukl (see Landy,
are that: workers will identify with their decisions and therefore work hard to make the solution work; it is a normal mature behaviour that satisfies needs for autonomy and achievement; it improves communications and provides opportunities for conflict resolution between manager and subordinate; and, better decisions are rendered to the extent that the talent and skills of the workers are tapped. Some of the disadvantages given by Yukl are that: where participants lack skill or knowledge to make correct decisions, low quality decisions will be rendered; if the leader is not skilled, the process becomes frustrating, and the decision suboptimal (see Landy, 1985: 449-50).

This is a contribution in the right direction. The serious drawback of this approach to job autonomy is that it is limited in scope. It is based on the Vroom-Yetton (see Landy, 1985) contingency theory model of leadership and, in this model, there are occasions when subordinates are not supposed to make decisions, or when participation is inappropriate. For example, one of the disadvantages given by Yukl (see Landy, 1985: 449) is that “participation in some decisions makes employees think that they should be involved in all decisions”. Yet, according to my definition of job autonomy, workers should be involved in all decisions that affect the various aspects of their work as well as those that influence policy making. They should be involved, not intermittently, but as a continuous organisational process as long as they remain part of the organisation. This is the ideal situation to strive for.

Having outlined the concept of job autonomy, this chapter is going to review some key organisational perspectives on autonomy. It will then explore the nature of professional autonomy, an ideological pressure that normally affects professionals and semi professionals (in this case doctors, nurses and other health occupations) before reviewing the kind of autonomy implied in the PHC concept. The next section takes a critical look at issues that threaten the realisation of job autonomy for health-care
professionals as a result of cost-cutting on health-care spending; and in Third World organisations in particular because of bureaucratic inertia and the existence of centralized organisational structures. After this, the chapter critically analyses the respondents' (Mutoko District health personnel) perceptions of job autonomy, as well as the objective existence of job autonomy within the district health-care system.

4.2. THE DOMINANT ORGANISATIONAL PERSPECTIVES

In this section, I discuss contributions that analyze organisational structures that inhibit or facilitate the realisation of job autonomy, and those that have attempted to formulate strategies to help organisational participants attain job autonomy.

It is generally agreed that Max Weber (1864 - 1920) was the first scholar to make a systematic analysis of organisations (March and Simon, 1958; Scott, 1992). His bureaucratic theory (Weber, 1946; 1947) is of paramount importance to a theory of organisations (Perrow, 1986; Grusky and Miller, 1981). Weber viewed society as a power struggle and, as a result “focused attention on the concrete forms of dominating power relationships that developed in historically unique settings” (McNeil, 1981: 51). This caused him to study the three types of authority: traditional, charismatic, and bureaucratic or rational-legal and, the sources and kinds of domination. He took “authority as the means by which dominance is cloaked with legitimacy and the dominated accepted their fate” (Aldrich, 1979: 6). Among the three forms of authority, Weber saw the legal-bureaucratic authority as becoming dominant in modern society and, suggested that to be effective and efficient as an organisational instrument, a modern organisational structure requires bureaucratic authority. The realisation that bureaucracy was a 'power instrument [based on domination] of the first order' (Weber, 1947), and that it was a threat to
individual freedom scared Weber (Hunter, 1981; Perrow, 1986; Watson, 1987). He also argues that "[t]he bureaucratic structure goes hand in hand with the concentration of the master [and that] a corresponding process occurs in public organisations" (Weber, 1981). This kind of scenario leaves little or no room for job autonomy for subordinates.

Recent students of bureaucracy, notably Merton, Selznick and Gouldner, have had their research and analyses suggesting important dysfunctional consequences of bureaucratic hierarchy. They found it to be 'dysfunctionally rigid', (Karasek and Theorell, 1990). Merton (1968) proposes that there exists a demand for control made on the organisation by the top of the hierarchy, taking the form of an increased emphasis on the reliability of behaviour within the organisation. The need for accountability and predictability of behaviour is secured by the use of techniques which draw from the principles of the "machine" model 6 of human behaviour whereby standard operating procedures are instituted. Two of the three consequences are: an increase in the internalisation of the rules of the organisation by participants and, an increased use of categorisation as a decision-making technique which decreases the need to search for alternatives. The three consequences ultimately combine to make the behaviour of members of the organisation highly predictable; i.e., they result in an increase in the rigidity of behaviour of participants and the application of internalised rules in inappropriate situations (Merton, 1968). In this kind of situation it is difficult for one to use initiative as well as to innovate, which are some of the characteristics of job autonomy.

Like Merton, Gouldner (1954) considers the dysfunctions of rules and formal structure. He argues that the use of general and impersonal rules regulating work procedures is part of the response to the demand for control from the top, and that such rules decrease the visibility of power relations. He thus looks at the dysfunctions as limitations on the successful exercise of power within an organisation.
More contemporary scholars have also pointed out the negative features of bureaucracies. Ramsay and Parker posit that taking Weber's 'ideal type' as a prescription for organisational excellence and the 'one best way' to construct an organisation means "a prescription that specifies a rigid hierarchy, top-down communication, [and] specific role definition ..." (1992: 253). The hierarchical pyramid characterising "highly bureaucratic organisations necessitates a wide gap between leaders and followers and decreases the power of the unskilled...employees to affect decisions made at the top" (Ritzer, 1977: 268). The formal system of rules further reduces these workers' ability to affect decision making and workers are said to respond to this high degree of bureaucratic authority with feelings of powerlessness, anomie, self-estrangement, normlessness and general alienation (Ritzer, 1977). Ferguson goes even further to argue that

bureaucracy, as the 'scientific organisation of inequality', serves as a filter for ... other [societal] forms of domination [viz. class, race, sex], projecting them into an institutionalised arena that both nationalizes and maintains them [Ferguson, 1984:7].

And a good example, more relevant for my study, is that of women who are dominated in society as well as in work organisations.

Many scholars have indicated that rigid rules and procedures hamper an organisation's ability to deal with new or uncertain situations (Ford, 1988) and. organisational research suggest the need for the 'de-bureaucratisation' of some organisational structures (Hall, 1975). These kinds of thoughts have led to the development of contingency theory, whose well known proponents are Burns and Stalker (1961); Perrow (1986) and Woodward (1965). This theory (in all its variations) calls for an exceptionally flexible style of leadership ready to cope with many uncertainties (organisational and environmental) (Ford, 1988). Managements are expected to seek the most appropriate shape of organisation to achieve their purposes given prevailing
situational contingencies. Burns and Stalker (1961) call such adaptive organisational structures the ‘organic model’. There is more lateral than vertical interaction and communication resembles consultation rather than command. This is in contrast to what they call the ‘mechanistic model’ which corresponds to Weber’s ‘ideal type’ bureaucracy. According to Shortell and Kaluzny

the more organic organisational form involved decentralized decision making, more participative decision making, a greater reliance on lateral communication and coordination mechanisms to link people and work units [1987: 22 - 23].

On a relatively more practical and/or physical level, the work world and organisation theory have also been influenced by scientific management and administrative management theories. The first theory, also called “physiological organisation theory” by March and Simon (1958), can be traced back to F.W. Taylor while the second is related largely to the works of Gulick, Urwick and Fayol.7

According to Perrow, scientific management came to the fore in the 1920s as (except for Weber) “... the first efforts to analyze management practices and to try to generalize them ...” (1970: 15). Weber’s writings on bureaucracy only became widely read in the English-speaking world following their translation from German in the 1940s (Perrow, 1986).

Scientific management came at an opportune time for entrepreneurs and management. This was a time when managers were attempting to rationalise production to suit the new mass production techniques (Perrow, 1986; Watson, 1987; Rinehart. 1987). With increasing mechanisation, management had to be able to adapt jobs to the new technology, to motivate workers to perform these jobs efficiently as well as to establish lasting control (Stone, 1981). Use of this new technology and/or the rationalisation of production reduced skilled workers into unskilled workers (Braverman,
1974; Blauner, 1964; Stone, 1981; Rinehart, 1987), thereby homogenising them into a class (Stone, 1981; Perrow, 1986) with common interests to defend. This created the problem of labour discipline and, management had to find ways to motivate workers as well as to prevent a unified opposition. Taylor came to the rescue by developing methods of wage payments and new advancement policies relying on stimulating individual ambition. This resulted in the redivision of labour - shop floor bureaucratization, according to Littler (1982) - because conception and execution of work were separated. It also lent scientific respectability to management’s exploitation of labour (Clegg and Dunkerly, 1980; Stone, 1981).

The psychologicist nature of Taylorism is embodied in his concept of ‘soldiering’ (Taylor, 1992), which means “the natural instinct and tendency of men to take it easy” (Watson, 1987: 33). He believed workers “were all too prone to work and play, to consciously restrict output, and to work far below their capacity” (Rinehart, 1987: 47), and that these evils of soldiering could be remedied by the application of scientific management (Taylor, 1981; 1992). Even more serious was ‘systematic soldiering’, which Taylor believed came from the thought and reasoning caused by workers’ relations with other men (Braverman, 1974).

This belief led Taylor to recommend the phasing out of management of ‘initiative’ and incentive for scientific management/task management which he thought to be superior (Taylor, 1981). In the former type of management it was necessary for each workman to bear almost the entire responsibility for the general plan as well as for each detail of his work (and the physical labor), and in many cases for his implements as well (Taylor, 1981: 59).

Thus, under Taylorism the workers’ initiative is obtained by making managers assume new duties and responsibilities by removing all brain work from the shop floor and putting it in
the planning department. Therefore, the first step (to counter ‘soldiering’) as well as first of the great principles of scientific management is

the deliberate gathering together of the great mass of traditional knowledge which, in the past, has been in the heads of the workmen, recording it, tabulating it, reducing it in most cases to rules, laws, and... mathematical formulae [Taylor, 1992 : 73].

It can therefore be said that “under Taylorism workers were paid to work, not to think” (Rinehart, 1987 : 49), and received narrow economic incentives for their efforts (Grusky and Miller, 1981; Watson, 1987). In addition to planning tasks, scientific management encouraged close supervisory control of workers, worker discipline and obedience in order to boost productivity (Grusky and Miller, 1981; Rinehart, 1987). Hence Perrow (1986) calls it a ‘management ideology’, in the name of science.

According to McGregor (1992 : 174), “conventional organisation structures and managerial policies, and programs [still] reflect [the scientific management] assumptions”. Braverman (1974) also thinks that scientific management (with its attendant deskilling) is becoming more dominant in this later part of the twentieth century. Direct attacks on Taylorism started, however, in the late 1940s (Perrow, 1970).

Another influential school of thought has been the Human Relations movement. Coming into existence in the 1930s through the writings of Elton Mayo 11 and Chester Barnard (Perrow, 1970; Watson, 1987), the human relations approach “sought to counter scientific management’s focus on formal requirements and simple economic rewards as crucial motivational elements” (Grusky and Miller, 1981). In fact its emergence is said to be the result of the failure by Taylorism to deal with the ‘labour problem’ (Rinehart, 1987).12 The psychological studies (Hawthorne experiments) conducted at Western Electric Company in Chicago from 1924 to the early 1930s by a group headed by Mayo
indicated the need to pay attention to other variables in work behaviour, especially informal relations (cf. Homans, 1951; Rinehart, 1987).

Two similarities emerge between Human Relations and Scientific Management, in terms of their broader objectives and historical context. Like Taylor, Mayo was also anxious to develop an effective managerial elite who would be able to elicit cooperation from workers (Rinehart, 1987; Watson, 1987). As more problems of labour control and motivation surfaced, compounded by the growing trade union challenge, the Human Relations Scholars (like Scientific Management Theorists) came to the aid of management. They believed that cooperation between employers and workers should be increased by recognising the importance of informal groups that shaped workers’ attitudes and feelings which, in turn, mediated workers’ response to material conditions of work (Homans, 1951; Bendix, 1956; Braverman, 1974; Rinehart, 1987).

The early work reform programmes, for example, employee counseling and foreman training, initiated in the 1930s and 1940s by the ‘Mayoites’ lacked much appeal, but those that came out in the 1950s and early 1960s, participative management and job redesign gained a lot of momentum (Rinehart, 1987; 1993; Krahne and Lowe, 1993). Participative management, consistent of schemes like: consultative supervision, works councils, management by objectives, joint committees, quality control circles, etc. and integral to all are “the relaxation of supervisory controls and the involvement of workers and local union leaders in decision making” (Rinehart, 1993: 299; cf. Rinehart, 1987; Ejiogu, 1983). According to Ejiogu, participative management is “espoused by management theorists and practitioners because of its assumed - and often demonstrated-relationships to organisational effectiveness, efficiency, productivity, and employee morale” (1983: 239). These ‘fruits’ can only be enjoyed after a successful transformation (by management) of recalcitrant workers into cooperative ones (Rinehart, 1993).
Job redesign, which comprises schemes like job enlargement, job enrichment, job rotation and autonomous work teams/groups\textsuperscript{15} restructures job content by expanding employees' tasks and responsibilities ... by increasing the task cycle and by assigning to workers, either singly or in groups, duties ordinarily performed by supervisors [Rinehart, 1993 : 299].

It is apparent that the Human Relations theorists have gone much further than scientific management theorists in advocating workplace changes, more so in ways that recognise workers' need for job autonomy. It is argued that most of the authority remains with management (Krahn and Lowe, 1993), because "participatory schemes grant employees (only) the right to be consulted, to influence or to make suggestions, but management always retains the right to veto workers' ideas or practices" (Rinehart, 1987 : 182-3). Instead of giving workers power, the unstated objective is to dilute their power, as individuals and as unions, by making them work towards management goals and adopting a management perspective through the use of all these strategies which Blunt (1978) has called 'humanitarian humbug'. As for job redesign programs, Rinehart (1987) argues that the basis of their adoption has little to do with improving workers' motivation but facilitate the achievement of management objectives by reducing worker resistance and intensifying labour. And job enrichment consultants are alleged to incorporate elements of scientific management into their programs (Rinehart, 1987).

Thus, contrary to popular belief that Taylorism has been superseded by the Human Relations movement, Braverman (1974 : 87) argues that, "Taylorism dominates the world of production; the practitioners of 'human relations' and 'industrial psychology' are the maintenance crew of the human machinery". According to Blunt (1978 : 439) the Human Relations school "is sometimes referred to as 'moo-cow sociology'...[because] most of the methods employed are manipulative devices aimed solely at increasing worker
productivity” without paying attention to the devolution of power and decision making in the organisation. 16

Most of the criticisms have, however, come from neo-Weberians, neo-Marxians and others who take a more critical approach to the distribution of power in work organisations. According to Krahn and Lowe, “the concentration of power in the hands of managers is a pervasive feature of organisational life ...” (1993 : 305) and, we know that “unequal power is at the root of alienation ...” (Rinehart, 1987 : 18).

Edwards (1979), for example, views the work setting as a ‘contested terrain’, with various parties vying for control and a greater share of what is created there. Workers seek to have control over the labour process, and employers also want to exercise maximum control over workers and the labour process. When “workers regulate the labour process their activities reflect their own interests and inclinations, not those of employers” (Rinehart, 1987 : 35) Where the capital at stake is great, there is greater “need for ‘clever’ people to keep yet other people, who are apt to do ‘stupid’ things, in line to stop the ‘system [from] running out of control”’ (Nichols and Beynon, 1977 : 203). According to Nichols and Beynon the system’s demands are increasingly contradictory because

it wants to engage people as a commodity, as labour power, to be managed, directed, controlled, it also wants them to be engaged, to be ‘involved’ but not to control...[or] manage for themselves [1977 : 203].

Another direct attack on scientific management that had great influence in the 1960s, was launched by theorists that come under the school of thought Watson (1987) calls the self actualisation school; what Ford (1988) calls process motivational theories or what Morse and Lorsch (1985) call the participative approach. This school of thought draws heavily from the work of the humanistic psychologist, Abraham Maslow, who put forward a ‘hierarchy of needs model’ for human beings, with self-actualisation being the
highest. Traditional managers are therefore seen as failing to get employee cooperation because their approaches do not provide the intrinsically and naturally sought rewards which employees ‘need’ once their basic needs are satisfied (Watson, 1987). The chief proponents are Herzberg and McGregor, whose position suggests that organisational efficiency can be achieved through participative approaches (where workers set objectives and get involved in decision making), enrichment of jobs, and the development of more open and authentic colleague relationships (cf. Watson, 1987; Morse and Lorsch, 1985).

Herzberg’s (1985) ‘Motivation - Hygiene’ or two factor theory of work motivation emphasizes the extrinsic and intrinsic rewards of work. Hygiene (or contextual) factors, when present, can reduce job dissatisfaction but can not lead to satisfaction if present. And content or motivation factors, which are said to have a much longer term effect on employees’ attitudes (Herzberg, 1985), “have to be present, in addition to hygiene factors, before satisfactions can be produced and people motivated to perform well” (Watson, 1987 : 35). Hence Herzberg advises that the time related and monetary efforts ‘currently devoted to hygiene’ should be given to job enrichment efforts in order for industry and society to reap large dividends in ‘human satisfaction and economic gain[s]’ (Herzberg, 1985 : 138). These motivators have to be built into jobs, as part of job enrichment (enlargement) while managerial controls over how they are performed are reduced. Workers are allowed to set targets, plan their work and, choose work methods to be used as far as possible. This is in direct contrast to what Scientific Management would have managers do, and gives workers some control, as part of job autonomy.

Complementing Herzberg’s efforts is McGregor’s (1992) ‘New Theory of Management’. Theory Y, which he says is based on more adequate assumptions about human nature and motivation. McGregor (1992) calls the scientific management approach
‘Theory X’, which “sees human beings as naturally disliking work...[and] the manager therefore controls and coerces people towards the meeting of organisational objectives” (Watson, 1987: 34). This leads to passive acceptance of the situation, leading to lack of creativity among workers; and, resentment, which is likely to lead to aggression and lack of cooperation (Watson, 1987).

In contrast, Theory Y emphasises people’s intrinsic interest in their work and their “desire to be self-directing and to seek responsibility, and [their] capacity to be creative in solving business problems” (Morse and Lorsch, 1985: 139). This would occur “if employees were allowed to contribute creatively to organisational problems in a way which enabled them to meet their need for self-actualisation” (Watson, 1987).

Therefore, McGregor’s (1992) *steps in the right direction* entail the institutionalisation (in work organisations) of: decentralisation and delegation, job enlargement, participative and consultative management, and performance appraisals, each of which is said to contribute to the satisfaction of workers’ ‘social and egoistic needs’. The first one is argued to free people from the ‘too-close’ control of conventional organisations, allowing a latitude for self-direction and assumption of responsibility. Job enlargement is said to encourage the acceptance of responsibility at the bottom of an organisation, while the third step is geared to encouraging people to direct energies toward organisational objectives as well as giving them some voice in decisions that affect them (McGregor, 1992). The last but not least step encourages the individual “to take a greater responsibility for planning and appraising his own contribution to organisational objectives” (McGregor, 1992: 179).

Although the motivational theories have gone significantly further than scientific management in prescribing management actions that enable workers to realise relative job autonomy, they have been labelled a ‘mirror image’ of the latter because, they base their
"...approach to human work behaviour on a theory of human nature", and this is 'reductionism' and 'psychologism' (Watson, 1987: 34, 36). Watson argues that the complexity of human nature leads people to act differently in different circumstances, "we have socially mediated wants [affected by structural and cultural factors], rather than built in needs" (1987: 36). This is an observation echoing one made by March and Simon (1958) in their critique of scientific management's 'machine model' of human behaviour. They posit that individual motivations or attitudes as well as organisational demands to produce are both "partly under the control of the organisation but partly also determined by extra-organisational factors" (March and Simon, 1958: 82). And,

the amount of organisational control, in turn, depends partly on the behaviour of the organisation (e.g., supervisory practices) and partly on factors largely outside its control (e.g., general economic [cultural and political] conditions) [March and Simon, 1958:82].

Moreover, the two theories I have just discussed, because of their extensive emphasis on organisational efficiency and organisational objectives could be charged with managerial bias.

Another influential theory which takes a different approach to job redesign, is socio-technical systems, the result of research carried out at London's Tavistock Institute (Davis and Cherns, 1975; Richardson, 1991). It relates the social relations that develop in the workplace to the technological character of work and changing the latter is likely to change the former (Perrow, 1970; Trist, 1977; Rinehart, 1987). Thus, "... industrial activity [is seen] as a sociotechnical system comprising social and technological subsystems that can interact positively and negatively" (Richardson, 1991: 336). Hence these subsystems should be developed simultaneously. Men become 'complementary to the machine' rather than 'an extension of the machine' (Trist, 1977). This theory also criticises the management-oriented human relations school for making scientific
management strategies more acceptable to workers (Richardson, 1991). Their solutions, according to Richardson (1991), are "... attractive to capitalists and workers alike."

The socio-technical systems school stresses the importance of expanding workers' tasks, autonomy and discretion, and the changes are implemented through work teams that are responsible for given tasks, as well as deciding "how fast to work, job assignments and rotation patterns, and work methods" (Rinehart, 1987: 186; Trist, 1977). It is also chiefly responsible for generating the core ideas of the Quality of Working Life (QWL) Movement [in the 1970s] (Krahn and Lowe, 1993; Davis, 1975; Davis and Cherns, 1975). "... which tries to implement sociotechnical concepts in practical situations" (Richardson, 1991: 337).

The QWL proponents have rallied to formulate a "... body of theory and practice [an important component of which is sociotechnical design] on how to create the conditions for a humane working life..." (Davis and Cherns, 1975: 8). A variety of approaches are used to enhance the quality of the following aspects of working life:

... what people do, how they can contribute their skills and knowledge to their work organisations, what control they have over their own work, how they can deal with difficulties and frustrations in the work process, what freedom and autonomy they can exercise, and how they can relate what they do to their future and to society at large [Davis, 1975: 4].

Achieving these objectives requires changes in the structure of organisations, jobs and work roles.

However, QWL strategies have had better success in Western Europe (particularly Sweden) than North America (Davis and Cherns, 1975; Davis, 1975; Richardson, 1991). In Sweden, QWL fit well with the local culture because they become part of the growing Swedish concept of industrial democracy. This
... 'industrial democracy movement' can be seen as a stage in the
evolution toward egalitarianism of a stratified society that is ...
committed to the democratic ethos [Davis, 1975: 8].

As a result, success of QWL is contingent upon union and management cooperation, and
the support of the dominant political party (Davis, 1975; Davis and Chernes, 1975).

The state of affairs is different though in North America, where both management
and unions have been reluctant to give up their power. All cases reviewed by Davis
(1975) were initiated by management without union or worker participation. According
to Davis (1975: 8)

Americans are split between adjusting people to meet the needs of
organisations or society and ‘doing one’s own thing’, that is, 
emphasizing individualism even in bureaucratic organisations.

Furthermore, the exclusion of unions leads them to attack management’s motive in
undertaking the QWL organisation and job designs. The general motives imputed are ‘... to increase workers’ autonomy and responsibility to avoid unionization or to undermine unions ...’ and management’s interest ‘... in improving life at the workplace only if it will
increase productivity’ (Davis, 1975: 5).

Davis (1975) charges that one problem with QWL projects is lack of definitive
criteria or standards to measure or evaluate changes undertaken in jobs and organisations.
A significant number of strategies involve job enrichment improvements. However, Davis
(1975: 13) argues that

... focusing on jobs as the area of study to the exclusion of the larger
organisation and the external environment shifts attempts at
comprehensive changes in relations between man and his work to the
more marginal possibilities.

Apart from being management initiated (in general), QWL is also charged with being
management-oriented. Hence it has a narrow goal, which, while focusing on the worker’s
individual needs, aspirations, and characteristics, it primarily does so to achieve the
organisation’s goals (Davis, 1975). Despite these pitfalls, QWL is said to lead to the
enhancement of the quality of life at the workplace (Davis, 1975). According to Richardson (1991: 338) the sociotechnical systems approach (which has become part and parcel of QWL) is promising and "... has the potential to combine a degree of workplace democracy with industrial efficiency".

Friedman has argued that employers can initiate work reforms which give workers what he calls 'responsible autonomy' (cf. Zey-Ferrel and Aiken, 1981; Krahn and Lowe 1993). It is a way of controlling workers (to obtain their cooperation) by giving them leeway (or scope for making some task-related decisions) and "encouraging them to adapt to changing situations in a manner that is beneficial to the organisation" (Zey-Ferrel and Aiken, 1981: 124). It is argued that responsible autonomy techniques - giving workers status, authority and responsibility - have been used in human relations approaches to work reform, like participative management, job redesign and QWL schemes (Zey-Ferrel and Aiken, 1981; Krahn and Lowe, 1993). Hence, despite all the talk about making work a meaningful experience through work reform programmes, most people are not engaged in meaningful jobs (Nichols and Beynon, 1977; Rinehart, 1987; Krahn and Lowe, 1993). Both the social psychological and structural perspectives on alienation which share an emphasis on workers' powerlessness conclude "that many jobs offer limited opportunities for personal growth, and self-fulfillment" (Krahn and Lowe, 1993: 357).

It is also interesting to note that "most professionals are said to be alienated from their work [because], as employees, they have no control over the goals, policies, and social purposes of their employing organisations" (Rinehart, 1987: 94). Moreover, "as part of the salariat, they are subject to varying degrees of organisational constraint" (Rinehart, 1987: 94). This observation should certainly be of interest to me since most of the health personnel in this study are (or consider themselves as) professionals, and, I shall discuss this issue more appropriately in the next section below.
4.3 Professional Autonomy

Some occupations are generally classified into professions. There are established ones, like medicine and law, and new ones, for example natural and social scientists, semi and/or paraprofessions and marginal professions (Ritzer, 1977; Freidson, 1988). Social theorists that take the power/critical approach see no qualitative differences between professions and any other occupations other than the former’s greater power (Johnson, 1972; McKinlay, 1973; Ritzer, 1977; Witz, 1992). Freidson (1988) contends that what distinguishes professions from other occupations is the control they have over the technical content of their work. According to Freidson (1984), the traditional view of professions is that they are relatively free of hierarchical forms of social control typifying other occupations, are independent of significant formal control by non professionals, and are subject only to informal collegial control as well as responsible to their professional associations. Thus, they have successfully struggled for the right to control their own work and have been granted legitimate organised autonomy (by the dominant elite or by the state) (Freidson, 1988).

Therefore “autonomy, as a professional attribute, consists of the practitioner’s decisions about his work” (Snizek in Rhodes, 1985 : 242; cf. Ritzer, 1977; Duran-Arenas et al., 1992), and, Kinston argues that professionals “requir[e] a high degree of autonomy in their work...” (1983 : 1164). On the other hand, there have been arguments to the effect that “professions have never been as autonomous as they would like us to believe, do not require this autonomy, and often use it to the detriment of clients and the public” (Ritzer, 1977 : 51). Freidson also states that it is “appropriate to place restrictions on the scope of professional autonomy, particularly when the work involved directly affects the public interest” (1988 : 344).
4.3.1 Professionalisation

The critical theory of professions takes the professionalisation process as
'professional projects', that is, "strategies of occupational closure which seek to establish
monopoly over the provision of skills and competencies in a market or services" (Witz,
1992 : 64; cf. Parkin, 1979; Murphy, 1988; Freidson, 1986). These projects are, however,
gendered, and influenced by patriarchal structures, because in a patriarchal society male
power is institutionalised. That means

gender makes a difference to both the form and the outcome of
professional projects...and...historically, men have organised and acted
to limit and control the terms on which women participate in paid work
[Witz, 1992 : 5, 36].

This is regarded as one of the major reasons why women occupy subordinate positions in
work organisations.

In the health-care field medical men, we are told, engaged in "gendered
exclusionary strategies to maintain a male monopoly of registered medical practice"
around the 1860s and 1870s (Witz, 1992 : 5). And, the "gender division of health care
[necessitates] draw[ing] upon an historical understanding of struggles to establish the
professions in health care ..." (Davies, 1992 : 241), which I shall attempt to do briefly.

Many theorists advise that we take professionalism as a historically specific
process (Johnson, 1972; Freidson, 1986; Abbot, 1988) in which professionals seek to
obtain occupational licensing. Licensing, according to Roth (1974), does not depend on
need, but the political power of those seeking it. Organised medicine has, therefore, used
its cultural authority (Starr, 1982) or professional power (Alford, 1975) to gain more
economic power, political influence and prestige, as well as control over other health-care
professionals (Brown, 1989). Among other things, dominance was also gained and
preserved through powerful institutions like universities (Ehrenreich and English, 1974;
Collins, 1979; Larson, 1977; Biggs, 1988) and colleges (Coburn et al. 1983, Berlant,
1975; Roberts, 1966), which imparted knowledge as well as credentialed and certificated the graduates and medical associations which protected markets for them (Wortherspoon. 1988; Fry, 1976; Conrad and Kern. 1990; Fisher. 1986; Alford. 1975).

The most important thing is that, in its rise to dominance, medicine suppressed and restricted the activities of other occupations. Medicine's quest for power and monopoly is responsible for relegating nursing into a 'sexual ghetto of lower paid occupation...' (Butch, 1988 : 313; cf. Ehrenreich and English. 1974). Prior to the professionalisation of medicine, the arts of healing were practiced by women, until the church, state and medical profession united to repress female medical practice (Ehrenreich and English. 1975; Reverby, 1989; Witz, 1992). In Europe this was done largely through witch-hunts between the 14th and 17th centuries (Ehrenreich and English, 1975; Witz, 1992). Because they were excluded from the modern university system, women had to seek their nurse training in the institutional location of the hospital and, in England, a separate university for women had to be opened (much later than the men’s) for those that wanted to receive medical education (Witz, 1992). Their own professional project in the nursing field spanned the period 1888 to 1919 (when the British Nurse Registration Act was passed). The project sought (among other things) to challenge: the hospital teaching schools’ authority over their standard and length of training as well as their pay and labour conditions; the ‘interoccupational relation of control between medicine and nurses’, and gender relations, in order to achieve autonomous organisation of women in the labour market (Witz, 1992). Registration, it was argued, would “form nursing into a distinct profession...” (Witz, 1992 : 133).

This female project was chiefly opposed by the Hospitals, matrons, physicians and Florence Nightingale. Nightingale’s conception of a nurse was that of a devoted, disciplined and selfless worker (Game and Pringle, 1983; Reverby, 1989; Witz, 1992).
And her reforms helped to enhance the power of matrons, and to set up an exclusively female chain of command (by-passing the administrative and medical staff) in the hospital hierarchy (Witz, 1992). In this hierarchy, nurses had two functions. They attended to hygiene, and they assisted the doctor (Game and Pringle, 1983) 21.

The leader of the pro-registrationists, Mrs. Bedford-Fenwick’s strategy was to seek registration but ensure that nurses of the future remain under the supervision of medical men (Witz, 1992). Thus, “the organisation of the nursing occupation was [also] crucial in the maintenance of the dominance of medical authority” (Game and Pringle, 1983 : 99). This kind of organisation expected that “its practitioners [nurses] would accept a duty to care rather than demand a right to determine how they would satisfy that duty” (Reverby, 1989). It is argued that this female professional project was not successful because state recognition did not translate into ‘practitioner autonomy’, “nursing work continue[s] to be controlled and regulated by the operation of the market place and the hospitals” (Witz, 1992 : 163). The internal contradiction in the nursing professional project was that of claiming professional status for nursing while it acted within the framework of another profession, medicine. Witz (1992) points out. Moreover, the incorporation of nursing into hospitals led to their institutionalised subordination to the physician and hospital administration (Chernomas and Chernomas, 1989), and, its failure to become a full profession renders it unable to insist on complete freedom from control by physicians, the public (clients) or administrative superiors (Ritzer, 1977). Hence we could say they are relatively powerless in their employing organisations.

Nursing is therefore called a semi-profession (Coburn, in Chernomas and Chernomas, 1989) or paraprofession (Freidson, 1988) because it has only gained occupational autonomy but lacks control over the nursing labour process which is still under the control of medicine. The source of physician power is the capacity to
legitimately control the content and social organisation of medical practice (Duran-Arenas et al., 1992; Freidson, 1988). So, like other health occupations/‘professions’, much of nursing history has been taken up with the effort to escape this subordination (Freidson, 1988, Chernomas and Chernomas, 1989; Halpern, 1993). And,

by claiming a unique theory of nursing, nurses hope to finally escape from medical domination by neutralizing medicine’s claim to a monopoly of scientific knowledge about health and illness [Chernomas and Chernomas, 1989: 285; cf. Reverby, 1989].

But according to Halpern (1993: 285), the fact of the matter is that

as long as medicine retains its authority to supervise ancillary professions, these occupations cannot become full-scale professions, no matter how well trained their members or how skillful their leadership.

The view that nurses assist rather than initiate the focal tasks of diagnosis and treatment, or that they perform tasks at the request of or under the supervision of the doctor has been challenged. Hughes (1988) says it is a traditional perspective which might not hold in all medical settings or for all doctors and nurses. Citing examples of studies of psychiatric hospitals, Hughes (1988) argues that the nurses and aides control many aspects of the everyday running of wards. His own study of a department in a British district general hospital yielded similar results. Nurses frequently moved close to areas of judgment that are normally a legal responsibility of doctors. Game and Pringle (1993: 98) concur by arguing that doctors have delegated more caring functions

so that, more than ever before, nurses are responsible for decisions about patients’ treatment, previously the province of the medical profession...[therefore]...[o]fficially, the rule about doctors’ diagnostic decisions still stands but unofficially nurses make them.

But, at the same time, the basic (unpleasant) nursing duties devolve to lesser qualified occupational categories (like nurse-aides).
However, the overwhelming majority of social scientists are of the view that there is no significant formal authority and job autonomy in nursing. Hence some argue that the nursing profession desires more participatory management, greater equity in power relationships, and more participation by nurses in hospital decision making with respect to programs and policies [Morlock et al., 1987: 287].

4.3.2 Socialisation

My position is that participatory management alone is not going to improve the situation of nurses, because their "...dilemma ...is too tied to society's broader problems of gender and class to be solved solely by the political or professional efforts [of] one occupational group", (Reverby, 1989: 482; cf. Davies, 1992). This forces me to consider wider structural features, the socialisation processes as well as that which takes place during the training of nurses, when they acquire or strengthen their work orientations. This socialisation process is closely tied to patriarchal and gender relations. 22

Contemporary feminist scholars use the word patriarchy more broadly to refer to gender relations, in which "men are dominant and women subordinate...therefore describ[ing] a societal-wide system of social relations of male dominance" 23 (Witz, 1992:3). Since work organisations are peopled with both men and women, we could say "patriarchy is a structure that gives some men power over other men, and all men power over women" (Game and Pringle, 1983: 22). It is therefore argued that the subordination of nursing to medicine was secured [among other things] through the construction of an ideological equivalence between two sets of relations, nurse-doctor [professional relations], female-male [patriarchal family] relations [Witz, 1992: 63].

The symbolism of the family, doctor/father, nurse/mother, patient/child “has been used more explicitly in the definition of jobs and authority relations [in the health field] than in
any other industry", argue Game and Pringle (1983 : 94). They go even further, to posit that Edward’s (1979) forms of control are patriarchal. They say

simple control is control by the ‘father’, often in a symbolic sense but frequently literally...[and] in nursing ....a simple form of control which is explicitly patriarchal has predominated throughout most of the twentieth century .... [t]he doctor and the matron have been set up as the father and mother of the household [Game and Pringle, 1983 : 21].

We are also told that “gender ...is not just about difference [between man and woman], but about power: the domination of men and the subordination of women”, a power which is “maintained by the creation of distinctions between male and female spheres...[of work]”, (Game and Pringle, 1983 : 16; cf. Davies, 1992). Sex typing in professions has caused semi professions like nursing and junior school teaching to be sex-labelled/typed as female domains/jobs (Hall, 1975; Ritzer, 1977; Rinehart, 1987). These jobs entail functions similar to the traditional role functions women perform in the family. Such tasks require nurturance, support, socialising and helping. These stereotypes of how women are supposed to behave have resulted in large numbers of women getting into semi-professions (causing them to be called ‘women’s jobs’). It is argued that women’s presence in large numbers has contributed to lowered autonomy and hence less professionalisation in these occupations (Hall, 1975; Kadandara, 1990; Witz, 1992).

Thus, gender socialisation underlines and endorses the division of labour by sex, reflecting and reinforcing gender ideology, thereby supporting the unequal distribution of resources and power (Davies, 1992). According to Game and Pringle (1983), an increase in the numbers of male nurses and female doctors has not changed the basic power relations. Gender socialisation therefore devalues women, which, according to Davies “reinforces and is itself reinforced by the devaluation of nursing work” (1992 : 246). In this regard, Davies (1992 : 246) makes a noteworthy comment, that
female gender stereotypes...emphasize service to others, a personal self-sacrifice rather than individual autonomy, freedom and achievement, and ... de-emphasizes organisational status, stressing shared goals, connection and communication rather than command and control.

This is a point that has also been expressed by Reverby (1989) but specifically concerning nursing.

Gender socialisation also helps foster work orientations or preferences (Krahn and Lowe, 1993) that people bring with them when they come to join an occupation, and these affect how they feel about their work. But gender stereotypes are also instilled in people during training, or on the job, and this helps modify or strengthen their original orientations (Watson, 1987; Krahn and Lowe, 1993). Professionalisation, we are told, "involves a symbolic, ideological, and psychological transformation" (Haas and Shaffir, 1987). Ritzer (1977) posits that there are many similarities between the training programmes of professionals and semi-professionals, although the latter's are not as complete. The socialisation of doctors and nurses, therefore, has many similarities. It involves the learning of the cultural content of the role and some self-identification in the required tasks, as well as group-identification by clothing and other paraphernalia (Ritzer, 1977; Haas and Shaffir, 1987).

In the training of nurses, Florence Nightingale emphasized the ideal of nursing as a dedicated, selfless calling, whereby the qualities of a good nurse were those of the good woman: sympathy, cheerfulness, self-control, usefulness, kindness, patience, trustworthiness, self-control, etc. (Witz, 1992). The effect of gender ideology is evident, the (good) nurse and the (good) woman are one and the same. Thus, the "Nightingale regime of training...instituted major themes in the discourse of nursing: gender, subservience, vocation, discipline, and morality" (Witz, 1992: 142; cf. Coburn, 1981, Schwartz, 1987). In this training, 'independence was to be sacrificed on the altar of altruism' because 'nursing rarely united altruism and autonomy' (Reverby, 1989: 477).
Reverby (1989 : 476) contends that “many nursing superintendents lived the Nightingale ideals as best they could and infused them into their schools”. These ideals were also infused in nursing schools worldwide, and their effects are still being felt today. Davies, for example, thinks “nursing…..reflects the gender relations of a Victorian age...because the gender relations of that age are written in the organisational forms of today”, (1992 : 248). As a result we have bureaucratic domination that is directly reinforced by sexual power structures (Game and Pringle, 1983).

While medicine developed an ethic of autonomy between the 1800s and the mid 1900s (Ritzer, 1977; Freidson, 1988), the nursing reformers like Mrs. Bedford-Fenwick (in late nineteenth century England) and those in the United States (in the twentieth century) “....were forced by the social conditions and ideology surrounding nursing to attempt to professionalize altruism without demanding autonomy” (Reverby, 1979 : 478). Contemporary feminism has, however, begun to put things into perspective. Challenging organisational structures, it argues that

superior domination through hierarchical patterns of authority is not essential to the achievement of important [organisational] goals but in fact is restrictive of the growth of the group and its individual members [Ferguson, 1984 : 5]

In the health care field, liberal feminism
give[s] nursing a political language that argues for equality and rights.....suggest[ing] a basis for caring that stresses individual discretion and values .... [and also] .... questions deeply held beliefs about gendered relations in the health care hierarchy, and the structure of the hierarchy itself” [Reverby, 1989 : 481].

It is such pressures, I believe, that are causing some hospitals to “experiment ....with numerous ways to organize the nursing service to provide the nurse with more responsibility and sense of control over the nursing care process” (Reverby, 1989 : 480).
Reverby (1989) documents that some nurses (in the United States) have rejected liberal feminism, largely because of their sense of fatalism, stemming from their "... understanding of the limited promise of equality and autonomy in a health care system they see as flawed and harmful" (1989: 481). While job autonomy is seen as a motive for choosing a professional career (Cherniss, 1980), I do not think that this would be the case with nursing. Some probably join because of prospects of a career in a tightening labour market. It is hoped that efforts to professionalise as well as the work of feminists will get the necessary cooperation from the respective societal structures in order to bring forth job autonomy into nursing. As for now, they occupy an ambiguous position in the health-care system, one that has potential for considerable role conflict (Rhodes, 1985; Chernomas and Chernomas, 1989). They are subject to three ideological pressures which define them as: a professional, a medical auxiliary/semi-professional and an organisational employee. As either employees or semi-professionals they are "expected to render obedience to physicians and hospital administrators, and to conform to rules and regulations not of their making" (Chernomas and Chernomas, 1989: 646; cf. Rhodes, 1985). Professionalisation would thus free nurses from others' dominance of their labour process. However, many of those in nursing already consider themselves professionals. A study by Rhodes (1985) indicates that a paramedical ideology is rejected by nurses. The main findings were that

nurses predominantly espouse a professional ideology, they perceive decision making to be part of their everyday work and contend that they ought to be able to make decisions in 22 out of 23 areas of patient care [Rhodes, 1985: 241].

But it is one thing to reject and another to actually live or experience the working conditions. In such an instance it would be crucial to look at the objective situation of the nurses and find out if they indeed have decision making power, and to what degree.
4.4 PHC AND JOB AUTONOMY

In contrast with professional socialisation which imparts an ideology of professional autonomy, PHC is an approach to health care whereby job autonomy is supposed to be embedded (implicitly) in the job description of the health-care personnel involved. It is an approach with strong implications for the devolution of decision-making power (and control of the labour process) to all local health-care managers and personnel. Countries that embrace the tenets of PHC are, therefore, expected to change their health-care organisational structures. The WHO (1988 : 109) states that

these changes go beyond physical design and may involve the redefinition of the objectives of the principal health institutions, the reallocation of responsibilities, and even the revision of the power structure.

The debates which led to the adoption of the PHC concept brought to my attention the fact that conventional health services (in the Third World) organised along Western or other centralised lines are not likely to meet the basic minimum needs of all people, especially rural people (cf. McPherson and Midgley, 1987).

The top-down approach to health care in many Third World countries is, in most cases (if not all) a legacy of the imposition of modern, ‘alien’ medical systems onto people under colonial control (Phillips, 1990). Colonial influences favoured curative as opposed to preventive medicine. This emphasis on cures “...reinforced the ‘facility orientation of health care, and this fostered the growth of ‘top-down’ hierarchical systems”. (Phillips, 1990 : 112). According to Werner

health care will only become equitable (socially just) when the skill pyramid of the conventional health care hierarchy is tipped on its side ... [and] ... more importantly, the psychological equality of community with health workers and professionals of all levels is more readily achieved when a rigid vertical hierarchy is removed and the equivalence of different functions stressed [Werner, in Phillips, 1990 : 115].
Therefore, PHC is not compatible with medical dominance. Also, within the national health framework, district health systems are supposed to have considerable managerial autonomy so that they can use local resources more efficiently to meet district needs. We would, therefore, expect to find a relatively considerable amount of job autonomy among health-care workers, especially those working in the periphery, employed in ministries that have implemented a PHC policy.

4.5 THREATS TO JOB AUTONOMY

It has been argued by Bacharach that creation of certainty through bureaucratic job structuring comes into conflict ... with the professional ethos which maintains that the control of uncertainty is the prerogative of the professional [1990:203].

It is not bureaucracy per-se that is a threat, but the level of bureaucratisation that can limit professional autonomy. When professionals have the administration setting terms of employment for them and defining the nature of their tasks or projects, the resulting 'professional alienation' "reduces the domain of freedom and creativity to problems of technique; it thus creates workers...who act as technicians...." (Derber, see Rinehart, 1987:95). Some theorists argue that "as more and more physicians are becoming employees of large hospitals and their work becomes standardized, their autonomy and authority will be undermined" (Stevens et al. 1992:295; Wahn, 1992). This is probably why we hear that "physicians are seeking increased participation in hospital management activities in order to avoid too much loss of their autonomy" (Stevens et al., 1992:295).

The debate on physicians' loss of autonomy or dominance started in the early 1970s. One debate, that started by Haug (1973, 1988), focuses on some societal forces that are eroding the power of the medical profession. Some of these forces are increased division of labour in which professionals become dependent on bureaucrats and the trend
toward group practices. Haug (1973, 1988) asserts that this results in the deprofessionalisation of medicine, which is their loss of monopoly over knowledge, job autonomy and authority over clients. The threat to autonomy brought about by bureaucratisation, however, has been noted even earlier than this, by Wilensky (1964), Goode (1957) and Johnson (1972).

A related hypothesis is the proletarianisation argument, which emphasises the circumstances of professional work in large organisations, especially the bureaucratisation being forced on medical practice due to capitalist expansion (Oppenheimer, 1973; McKinlay, 1973; Ritzer, 1977; McKinlay and Arches, 1985). Freidson (1984, 1985) has evaluated these two hypotheses and found them deficient due to what he thinks is their ambiguous conception of the professions. He agrees that the nature of professional control has changed, but it is still largely dominated by professionals themselves (as administrators).

New developments in the health-care field ought to have both physicians and nurses more worried about their job autonomy. These are innovations to reduce hospital or health-care costs. The World Health Organisation has stated that since the global recession about 1977

the health budgets of many countries have been severely reduced at a time when additional resources are required to build and sustain national health systems based on primary health care to meet the priority health needs of all people [WHO, 1988: 12].

It is argued that efforts by governments to control their budgets and the quality of care will eventually "...pull the hospitals towards bureaucratic rigidity" (Westley, 1984). Pressures for cost containment in health-care institutions and the "necessary" changes they 'have' to make are forcing them to challenge the conventional approaches to work
organisation (Morlock et al., 1987; Karasek and Theorell, 1990). In Canada’s health-care system cost containment became popular with the advent of medicare (Campbell, 1992).

Standardisation in health-care work and patient care is done to enhance efficiency as well as economic productivity, but these systems of patient classification for greater economic efficiency are said to be negatively affecting Canadian nursing (Edginton, 1989; Campbell, 1992). Efficiency is said to be facilitated because the care needed for each specific problem is pre-defined by objective decision making which, according to critics, does not allow for individual differences in patients. This “reduces the nurse’s ability to make on-the-spot decisions about care” (Edginton, 1989: 118), and replaces the “...nurses’ traditional methods of control over their practice...” (Campbell, 1992: 473). Moreover, apart from the removed control, the skill of the nurse in assessing patient needs (using their professional judgment and knowledge) decreases, since the nurse is no longer responsible for that task (Edginton, 1989; Campbell, 1992). Edginton (1989) goes further to say that nurses become stressed out because of pressures from three sources: the physician’s orders for patient care, the hospital administrator’s orders to reduce costs and be more efficient, and patients’ demands for care and attention. Furthermore, it is said that the major concerns for Canadian nurses, the majority of whom are women, are low pay, lack of prestige and autonomy: i.e. “their lack of control over their work in the male-dominated milieu of the hospital” (Cleland, in Edginton, 1989: 118). Hence Campbell rightly argues that “being required to absorb a disproportionately heavy burden of cost containment must be seen as a gender-specific form of oppression of nurses” (1991: 413).

Innovations that are intended to reduce hospital costs have also affected doctors to a great extent. Larson has argued that doctors will experience ‘economic alienation’ when they become salaried employees in hospitals. Wahn reports that “in contrast to
Britain and other European countries. North American physicians have successfully resisted becoming salaried hospital employees" (1992 : 426). But the situation in North America is said to be changing because of the government's involvement in the financing of hospitals. Efforts to minimise costs "have spurred efforts to ensure that members of their medical staff act as if they were hospital employees" (Wahn, 1992 : 426). Economic alienation can be brought about through other means. Provincial hospital commissions have, in many cases been known to force hospitals to adopt efficiency measures that are contrary to the interests of medical staff (Wahn, 1992). With these commissions as watchdogs "hospital administrators are no longer in a position to allow doctors to dictate the conditions under which patients will be treated" (Wahn, 1992 : 427). We are told that physicians are learning to accept these restrictions on their autonomy that result from hospital budget cuts.

Apart from reinforcing the trends towards salaried hospital practice, a growing oversupply of physicians in both Canada and the United States is said to be putting hospitals in a position to "withdraw privileges from doctors who practise uneconomically and to impose restrictions on those who remain" (Wahn, 1992 : 428).

Within hospitals, the need for efficiency "is altering internal...power structures and transforming relations among [hospital workers]" and this is argued to result in the decline in doctors' influence and autonomy (Wahn, 1992 : 428). Traditionally, doctors have been at the top of hospital hierarchical structures, but now have slipped down to the position of middle management. At the same time 'nurses and other....workers have begun to extricate themselves from doctors' authority' (Wahn, 1992). These trends are negative for doctors, because they are losing power, control, and freedom. And Wahn's conclusion is that
medical dominance is ... diminishing in the hospital setting, and ... the forces and factors robbing doctors of decision-making power bear a strong similarity to those which in the nineteenth century undermined the position of independent skilled craftsmen [Wahn, 1992 : 422].

Most Third World countries also face the dilemma of dwindling financial resources and are having to reduce health-care costs as well, perhaps at an even larger scale. There exists in many Third World countries pressures to raise standards of administration in conformity with international norms to satisfy aid conditions. According to Milne (1970) this results in increased formalism in work organisations. Although the threats of strategies like standardisation and patient classification (rationalisation), might seem remote at present and largely confined to Western nations, it must not be forgotten that most research findings used and administration practices prevailing in the Third World organisations originate from the West (Ejiogu, 1983; Milne, 1970). And, "many hospitals in developing countries are organized and staffed based on industrialized country models" (Barnum and Kutzin, 1993 : 31). What is likely to speed up the relay of these methods to achieve efficiency are the economic restructural programmes funded and supervised by the World Bank and the International Monetary Fund.

Zimbabwe instituted its economic structural adjustment programme (ESAP) in 1990, and since most of the strategies involve downsizing and cutting costs, the nursing director is already concerned about the "effects that restructuring will have...on the humane side...[of the health care organisation]" (Kandandara, 1992 : 9). The nursing directorate is already experiencing stress among health personnel with regard to this issue. She goes on to say that "although health care has always been "business" in many ways it is only now that 'cost containment' is the common pass word..." (Kandandara, 1992 : 12). At present, cost efficiency is being (among other things) largely sought through cost recovery mechanisms, especially by implementing 'user friendly' fee schedules. At the recommendation of the World Bank, a number of strategies for strengthening cost
recovery were initiated by the Ministry of Health in 1991 (Hecht et al., 1993). Hecht and associates also recommended the creation of additional posts for health administrators, economists, planners and financial analysts to formulate and monitor health financing policy (1993: 227). It is envisaged that the creation of these posts will provide the needed capacity for moulding a cost-efficient health-care system. At present I do not know to what depth and in precisely what manner this restructuring will affect the job autonomy of health-care personnel.

Another threat to job autonomy, a more general one, applies to most developing countries as well, and is closely related to the issue of bureaucracy that I have discussed above. Many Third World countries have adopted a rigid hierarchical system in health-care delivery (facilities) and administration (Phillips, 1990). It has been widely claimed that management and organisational practices in most developing countries are autocratic, authoritarian, mechanistic, paternalistic and hierarchical (Milne, 1970; Blunt, 1984; Kiggundu, 1986; Corwin, 1987), "and based on Theory X assumptions" (Kiggundu, 1986: 343). It is advanced that

little autonomy and decision-making power is delegated down the chain of leadership [and] employees are subjected to excessive division of labour and close supervision, partly because managers believe in the myth of worker indolence [Kiggundu, 1986: 343].

Some evidence suggests that these present management attitudes were copied from or cultivated by European managers who claimed racial superiority and believed in the myth of worker indolence (Kakar, 1971; Kiggundu, 1986). These modern work organisations owe their origin, form and inspiration wholly to periods of colonial rule since the nineteenth century (Corwin, 1987; Blunt, 1978; Kakar, 1971). It has been stated that self-management in Algeria was an attempt to break down the rigid forms of organisation inherited from the colonial period (Blunt, 1984).
According to Evans (1981), planning and management are centralised in most developing countries, without regard for the constraints caused at the operating level. Centralisation is an indication of the distribution of power in an organisation (Conaty et al., 1983). Overcentralisation, according to Perrow, occurs because of tradition, rather than necessity (Ford, 1988), and in developing countries “the absence of delegation does not imply that there is effective centralization, only that there is appearance of centralisation” (Milne, 1970 : 58).

Blunt states that

organisational systems that incorporate decentralised forms of decision making hold the most promise for facilitating development through widespread basic need satisfaction in Africa, and possibly other developing countries [1984 : 405]. He also argues that descending forms of participation are appropriate and necessary for work organisations in East Africa because of the remarkable similarities that exist in traditional systems of government (Blunt, 1978). This strategy involves the complete removal of close supervisory controls.

Common logic would encourage us to institute a combination of these two strategies, decentralisation and descending participation, in order to bring about job autonomy in work organisation in Africa. Kiggundu (1986) states that programmes promoting decentralisation and popular participation in a number of countries in the developing world, including Africa, fail largely because of a general widespread sense of powerlessness and helplessness outside work organisations. He says “a relationship exists between experienced powerlessness and the inability to manage strategic tasks” (Kiggundu, 1986 : 345). This general powerlessness comes from people’s experiences from contact with various societal structures.
The issue of job autonomy and its value is not only an empirical one - it is also a philosophical one (like the PHC concept) with a focus on social justice. For example, the democratic and socialist theoretical postures treat participation as a social phenomena or organisational intervention in which employees become economically liberated as they participate actively in the organisational control and production process [Ejiogu, 1983: 239]. Marxists and socialists, therefore, see it as a basic human right to control the productive process (Krahn and Lowe, 1993). And the socio-technical school asserts that QWL is a new organisational philosophy involving questions of basic values.

Many countries, particularly the Scandinavian countries, passed laws that require managers to share decision making with subordinates (Landy, 1985). "The feeling is that this is the right of the worker and that this right cannot be abridged for economic or administrative reasons, no matter how compelling these reasons are" (Landy, 1985: 450). On the other hand, although there are many important similarities, professional autonomy is largely thought of as a reward for attaining professional status, not something every worker deserves.

4.6 JOB AUTONOMY IN MUTOKO DISTRICT HEALTH-CARE SYSTEM

In his address soon after independence to a WHO delegate in 1980, the then Minister of Health indicated that the bottom-up system to be developed in the health services was a reflection of the wider democratisation of society and decentralisation to take place (Maybin, 1988; Kadandara, 1990). He said that the community participation I have been talking about is inseparable from the debureaucratisation of the service itself, from a wider involvement in discussion and decision making at all levels [Maybin, 1988: 13].
And the Director of nursing services states that

the decentralisation of health services to eight provincial sectors and fifty five administrative districts has given health managers at these levels an opportunity to exercise their expertise and bring into play many innovative strategies [Kadandara, 1990 : 25].

Quite recently, the government's Health Human Resource Master Plan spelled out one of its policy recommendations as the completion of "...decentralisation of responsibility to provinces..." (Zimbabwe Govt., 1993).

At this juncture I therefore need to assess the extent of this 'debureaucratisation', 'decentralisation' and 'decision-making' capacity.

4.6.1 Programme Officers and Department Heads/Supervisors

At the district level a significant number of posts have been created to fulfill the requirements of a PHC approach to health care. These are depicted by an 'a' in the organisational chart of the district. (see Diagram 4.1, page 119) As is shown in Appendix IV.I, senior posts in the same occupational categories have also been created at the provincial level, under the Provincial Medical Director's office. At central level, below the minister and permanent secretary for health are directors, deputies and assistants to which these provincial functionaries are also answerable.

Seven out of twelve (58 percent) of senior staff interviewed were supervisors, managers and programme officers, most of whom with posts specially created to facilitate the achievement of PHC objectives. They strongly feel that there is no adequate decentralisation in terms of decision making authority/power. According to one official there is that of jobs, but that of responsibility and authority is not yet done. Such that most of the tasks in actual fact are being done at the higher offices [AP 25].
Although planning is claimed to be done at all levels, one official states that the PMD’s office “... actually throw[s] away some of the issues we will have raised ... we are more or less in an advisory capacity .... we wish for recognition” (HP 24). The Environmental Health department seems to be relatively autonomous, involved in planning, probably because of the nature of their work 32. It is a new area with field tasks that have not been standardised yet. The officers state that they come up with their own plans (HD 28), that the department is “‘totally’ decentralised...[and] fully involved in planning” (HP 29). When asked if they are involved in resource allocation, one officer said that was not viable because the district budget is done ‘upstairs’. we are only told we have been allocated so much, we are not involved ... But at times they ask us to give our requirements, but that’s just a formality ... they won’t be honoured [HP 29].

The other programme officer with the opinion that there is adequate decentralisation because “[they] have a lot of freedom to do things according to [their] plans.” is the Rehabilitation Officer. And that might be explained by two things. First of all the department seems “......separate from the rest of the (district) hospital....[because]...for a long time....CIDA has been having a greater financial input into [its] programmes”. says the officer. Apart from external aid which ‘refurbished the department’, the officer herself is an expatriate. In her 1993/94 master plan she wrote, “there is no possible replacement for the physiotherapist if she goes...” (HD 33). I believe that the scarcity of her technical expertise might have played a role in obtaining power to influence decision making. She states that the authorities “... do ‘anything’ we request them to do” (HD 33).

If the environmental health department thinks being asked for their budget requirements is ‘just a formality’, the situation is a nightmare for the DMO who makes the district budget. It is
decided on at provincial level. We can only bid. They call for a meeting to hear the views and opinions from different districts. and then... it is just decided upon at provincial level. So I don't know how much of this is play or game and how much is decision making [AP 27].

**DIAGRAM 4.1: The District Health Care System Organisation Chart**

(x) = Fall under the ministry of National Affairs, Employment Creation and Cooperatives, Department of Community Affairs.

a = Posts created under PHC.

The district office, therefore, at the operational level is “charged with the implementation of what has been planned...” (AP 25). Allocations for various activities are done at a higher level and the district office is required to ‘expend within the budget constraints’ (AP 25). The administration department has ‘power’, however, to reallocate
financial resources, for example if they discover Provisions or Clinical has less money and Domestic has more. But the catch is, they have to "apply through [the] PMD to [central] Treasury for .....a virement..." (AP 25). And,
in most cases the financial year will elapse before the action has been taken, which means the money will actually be forfeited because we won't be paid back. It goes back to Treasury [AP 25].

So the district office is actually powerless in terms of shifting resources. They "require adequate control" "....so that [they] can put some resources where they are needed" (AP 24). This also applies to dealing with human resources. District officers or supervisors have no power to discipline staff, but can only "....make recommendations which sometimes takes a long time...." (AP 26), "...sometimes it takes a couple of months before you can anticipate a reply from the other end" (AP 27). There is "a very strict system of control....[and] formalities ...[even] when it comes to putting people in new posts and so on, it all comes from head office via the PMD, [and] it's difficult to run programmes efficiently due to this control system" (AP 27). Yet it has long been emphasised that "....most districts are dissatisfied with the existing system of hiring, firing and transfer of personnel" (Zimbabwe, 1986 : 14).

Because of this tight control from PMD and central offices, I hypothesise that it is inevitable that managers and programme officers fail to give decision making powers to juniors, i.e., supervisors. For example, the community nurse, who is the sister in charge responsible for supervising personnel in health centres 13 can decide where to visit for the day, but she cannot change anything there before she has consulted the DNO. She sums up her feelings by saying, "I am not very motivated because I am in a decision-making post, but I can't make decisions....I want to feel accountable, answerable for something". Another one, with even a higher position in the district health-care system says, "Concerning my job, I don't think I have that power [to make decisions] although I am
(PM 30). All that he can do is set targets and objectives. The means to achieve these goals, however, have to come from above. Hence, Kanter (1992: 49) argues that "more powerful leaders are also more likely to delegate...[and], powerlessness ... tends to create desultory management and ... rules-minded managerial styles."

Others actually feel the administration controls too many areas. This brings us into line - versus - staff conflict. For instance one argues that the work they do comes from doctors and nurses ..., so communicating to the ... [administration, where functionaries have no medical qualifications] might mean [their misinterpreting] some of the things I ask for, or as not necessary or without priority [HD 31].

He goes on to say that "you don't make final decisions...about finance, transport, rural covered mileage, etc. without consulting [them]" (HD31).

It is no wonder, then, that some members that occupy critical positions have to hold the organisation to ransom in order to get things done. During the time the research was under way the laboratory technologist told the hospital administration that he was suspending all tests until he got a general hand. In fact, at the time of the interview he was claiming he needed "at least three more assistants". Informal sources say the pharmacist used a very similar strategy to get a general hand not too long before this happened.

The district officials see the root cause of their powerlessness as the rigid hierarchical structure of the ministry of health. All respondents remarked that their work is hindered by bureaucratic control. "Decentralisation", according to an administration official, "is supposed to cut down some areas/channels which delay communication" (AP 24). In the structure there are still a lot of people to communicate with, get information or permission from. Hence eight out of the twelve (67 percent) supervisors and programme managers interviewed indicated that they found the procedures for communicating policy from the central level inadequate. One official who started working at the district hospital
in the mid 1980s says "the delays can still be felt" (AP 25). In fact they are having more complications

because we...[do some] things without being sure if we have the authority to do them. At times we do something that the central office [says] was supposed to be done by the provincial office, and they send it back again [AP 25].

Another one says

there is too much bureaucracy .....by the time the final decision is made, it will have had...some serious repercussions, [e.g.] a misconduct case...you make your charges, send them to PMD [who]...further analyses what we have done, submit it to head office where they scrutinise it before they send it to the final deciding board, Public Services, then it comes back through that same channel ... [AP 26].

Also, because of the numerous channels, important circulars take a long time to reach the district hospital level, let alone health centres. As far as vacancy notices are concerned, sometimes "the deadline comes before you get hold of the circular" (AP 25). "At times you see a circular now [September] with a January date stamp" (HD 36). The same applies to Travel and Subsistence (T & S) claims which have reimbursement procedures that are both time-consuming and cumbersome. They take three months or more to be honoured. Sometimes "by the end of that time you find that the funds have been exhausted ..." (HD 35).

It is apparent here that the district managers and supervisors have little, if any, conceptual (job) autonomy, as defined by Adler (1993). They are saddled more with routine, and some measure of adaptive decision making, while much of the adaptive and innovative decision making is done at the central level 34. Thus corroborating the "...often made remark about management in the health sector in developing countries, ...that local managers are too limited in the freedom they have to deal with local problems" (Lee, 1992 : 30). According to Kanter, the parameters of a manager's post should allow for non-routine action, discretion and exercise of judgment. Therefore.
managers need to know that they can assume innovative, risk-taking activities without having to go through the stifling multi-layered approval process [Kanter, 1992 : 450].

I therefore believe that true decentralisation would allow the Ministry of Health and Child Welfare to phase out its day-to-day management activities and increase its role as a regulatory and monitoring ministry. This kind of approach would place more responsibility in the hands of local managers and supervisors in terms of conceptual job autonomy.

4.6.2 Health Personnel

In this section I deal with personnel that is based at the district hospital. State Registered Nurses, either junior or senior sisters, are above the highest promotional position for SCNs (Principal State Certified Nurse) \(^{35}\) in the organisational hierarchy (see Diagram 4.1). At the district hospital there are both SRNs and SCNs, unlike health centres which have SCNs only. \(^{36}\)

Five out of six SRNs and nine out of eleven SCNs who were interviewed clearly stated that their roles and responsibilities were clearly defined. According to the hospital matron, nurses are guided by job descriptions. Job descriptions also guide the supervisors in their day to day work as they check how nurses are performing. It is my contention that jobs that require strict adherence to job descriptions do not involve innovative decision making because of the increased level of formalisation.

Only four out of eleven SCNs and one out of six SRNs thought there was enough delegation of decision-making responsibilities. The one SRN that said there was enough delegation of authority was asked if she could refer patients or solve any major problem without telling her supervisors first. She answered, “we always have a doctor on call, we are never left alone. At times I try to do something and when he comes he says I must
have done it the other way” (SRN 12). Another nurse, asked the same question, answered, “when it’s something [routine] to be done in the theatre, we can do [when the supervisor is not around], but with changes, we [have to] consult” (SRN 13). Similar comments were made by other SRNs:

Most of the time we have to consult the sister in charge then she can take the problem to the Matron [SRN 4].

I prefer going ahead then I can report later or just inform [the seniors], then go ahead with my work [SRN 3].

The chain of command is even longer for the SCN, who has to report to an SRN. Senior Sister, Sister in Charge, Matron, doctor, DNO and DMO. The differences between SRNs and SCNs are, a year’s difference in training, and the colour of the epaulettes they put on - a green borderline for SRNs, and red for SCNs. Thus, they are distinguishable. And apart from the difference in salaries, “the SRN is the one who is in charge” (SRN 5). Some SCNs contend that “some [seniors] tend not to work [hard], hoping that the junior [SCN] will do more work ...” (SCN 1). According to one SCN they only make decisions “if something is minor” (SCN 6), probably on issues that will not make SRNs feel threatened. Otherwise, instead of making decisions they put across an idea “…as a suggestion to the doctor” (SCN 10), “… if it’s good [suggestion] the doctor will accept it” (SCN 11). However, one SCN contends that “…as a junior, if you bring forward an idea, some always wish they were the source...so they do not implement them” (SCN 8). This scenario confirms what Hughes (1988) calls the ‘traditional approach’ to the doctor-nurse relationship that he tries to refute with his study.

So it is said most of the time they tell you “…we are not counted, only the green shoulders, the red ones are not counted” (SRN 4). And, sometimes when they meet outside “they [SRNs] remind you of your junior position at work” (SCN 8). One SRN says even if there is an SCN with 20 years experience (against her 11 years), and there are
areas she (SRN) does not know. still “in the ward I will be the judge ...but if you don’t get humiliated easily you can ask [for advice]” (SRN 4). An SCN talking about the same issue says there are conflicts

especially when you do things the right way. [something] your superior [SRN] doesn’t know. They talk of [being] accountable, credibility...and so on. but you have just done the right thing for the patient [SCN 11].

However, one says such conflicts are solved by the junior “swallow[ing] [their] pride” (SCN 2), while one SCN says by reporting “to the sister, senior sister, sister in charge, then matron, and if she fails.....it goes to the Hospital Executive” (SCN 8)\textsuperscript{37}. And, an SRN says they solve such intraprofessional conflicts “by resorting to job descriptions” (SRN 13). It is occurrences like this which serve to put the SCN into his/her place, by reminding them of their limited responsibilities and to whom they are answerable. The powerlessness and helplessness of SCNs is neatly summed up by one who says

most of the time we have to wait to be told what to do by our superiors...I can bring up an idea as to what can be done with a particular patient, and if they do nothing about it there is nothing I can do [SCN 6].

The fact that there are only two doctors at the district hospital (DMO and Government Medical Officer [GMO]) with seven departments would lead one to expect nurses to have more responsibilities, but it seems that the meager decision making responsibilities that trickle down to the nursing profession are usurped by supervisors and SRNs \textsuperscript{38}. This undoubtedly leaves the nurses unable to determine their own work schedules and priorities; with decision making concerning only the technical aspects of their traditional roles of personal care and prescribed treatments. In short, there is little room for initiative.

In contrast to the situation in the West where scholars have for almost two decades been debating the deprofessionalisation of medicine because of such developments as those in technology, and information systems, in Zimbabwe the medical
profession is still as dominant as ever. In the last decade or so, doctors employed by the
government have gone on several strikes to demand better working conditions. They have
achieved some relatively favourable outcomes. The shortage of doctors, resulting from
emigration of trained people makes their position even stronger. This also forces the
government to depend on expatriate doctors for most of the rural posts. For example, the
two doctors at MDH during the research period were both expatriates.

The work of nurses largely facilitates the practice of medicine in the district health-
care system. For example, the X-ray operator says, "the doctor is the one who decides
what should be done and how". Expatriate doctors are also seen to "impose what is
practiced in their own countries..." (AP 26). Doctors in general are said to make nurses
feel inferior because they studied medicine for more years than nurses. According to one
nurse,

with your little knowledge ... you may [even] manage a certain problem
better than him....but if it saves a person's life you can always deal with
the problem, without notifying the doctor that you have changed. lets
say ... certain drugs ... [SCN 1].

However, another nurse who has had a positive experience, enthusiastically told of this
incident whereby a patient

... had a dislocated jaw and the doctor tried to put it right but couldn't.
I get there and it only takes me a few seconds to do it. That was a
doctor's job but I had done it....I have got experience [SCN 11].

As in most health-care institutions, nurses here rate low on the time related dimension of
job autonomy i.e., the ability to influence scheduling and free time at work. They have set
times for such activities as prescribed treatments, for sending patients for X-rays 39
Emergencies can disrupt their set schedules and priorities. At MDH nurses do not choose
a department in which to work, based on their specialty areas or their interests. The
Matron rotates them once every three months in order that they might be motivated to
want to learn or train in some other areas they are deficient in. While this is a very positive strategy, it might also save to depress motivation, thus increase the nurse’s powerlessness. Here is why. A nurse working in the psychiatric department who had not studied psychiatry during his training said that he lacked the power to make decisions because, for most things, he has to wait for a qualified person. Another nurse in the same department said the following:

The problem I face is that of working here without enough knowledge. When those [qualified]...are away, a patient may become violent and you begin to wish they were here [SCN 6].

Apart from this rotation, nurses can also fail to influence free time at work as well as the pace of work because of work overload. For instance, one female nurse said the ‘system’ needs to be ‘flexible’. “I have got many problems at home, and those problems need me to be at home” (SCN 16). Others said:

Sometimes we overwork, but our salaries remain the same [SRN 5].

Say like now I have 48 patients, and I am the only one. Its a big problem [SCN 8].

There are those of us who are working long hours, using our spare time and no one recognises that [SCN 37].

At times we do ‘splits’, whereby we come on duty at seven, and break at 12, come back at 4:00 PM, and break at seven thirty. So we are overworking [SCN 14].

However, the effects of these two aspects, rotation and work overload, are aptly summed up by the plight of a nurse in maternity ward who says
In here people are crying, that woman is alone, and some patients are waiting to be discharged by me, and the nurse [No. 16] we have right now did not take a maternity course, she doesn’t know anything. You have to tell her what to do....In this department we need to do a lot of paperwork, so there is not much time even to answer the superiors when they ask “why didn’t you do this or that?”, because we are under pressure [SCN 18].

I shall return to the issue of time-related job autonomy in the next chapter when I discuss the causes of heavy workloads. For now, I need to look at another aspect of general working conditions over which nurses at the hospital have no influence. There is not enough institutional housing accommodation for the whole staff. Hence houses and apartments are allocated according to seniority and grade. This system of allocation is supposed to favour SRNs and those with higher posts rather than those with seniority in terms of service. This means that families are constantly moved round the hospital compound each time someone more senior joins the staff. This explicitly illustrates the ineffectiveness of workers’ grievances or their suggestions for changing government and hospital policies with regard to the provision of adequate staff accommodation and its allocation respectively.

When asked about the extent to which higher officials paid attention to workers’ morale and motivation, all district officials indicated it was far from adequate. When the same issue was discussed with nurses but relating to the local management’s attention to workers’ motivation, all but 3 out of 19 nurses, said it was adequate. One of the few nurses who said that it was not adequate stated her position as follows:

Normally when you talk of motivation, it’s just a matter of praising for what I have done, which is good. But if I have a problem or a request, that must be met [too]. If not, an explanation must be given...And they should even consider where I am coming from because at home I have got one, two or three problems. They don’t ....When a son of a staff member was ill she was still required to carry...out her duties ... That is very unfair [SRN 3].
Most of those who expressed positive opinions about motivation supported their opinions by indicating that their supervisors made frequent rounds to offer support. During these visits, they listened to their problems with a sympathetic ear and also gave encouragement. Besides being a limited view (compared to No. 3's), this could also be interpreted as the nurses' inability to conceptualise the frequent visits as a control strategy: a routine that further increases their dependency on superiors, thereby leaving little room for initiative.

The situation is different and a bit more problematic for nurse-aides/support workers, who have more seniors to report to (see Diagram 4.1). Because of the shortage of first level nurses at the advent of PHC, the nurse-aide position was created in order to meet increased demands for health care (Nondo, 1991). Realising that the nurse-aide's position is ill defined, the Zimbabwe Nurses' Association (ZNA) is emphasizing the need for training of nurse-aides that is contained in the law governing and regulating the education and practice of nursing (Nondo, 1991). Such training is to be carried out by Registered Nurses. And, the ZNA wants a clause in the law stipulating that nurse-aides "will always work under the direct supervision [and control] of the first-level professional nurse" [SCN] (Nondo, 1991 : 177). The then president of ZNA goes on to say

> the support worker has been awarded an 'associate membership' position within the association and hence he/she does not have the same rights as professional nurses [Nondo, 1991 : 177].

This is quite akin to the strategy of closure, used by medicine in protecting its territory. The situation of limited rights is quite apparent at MDH. Their duties include bed making, bathing and feeding patients, taking temperature and blood pressure readings, taking patients to the theatre, and dressing wounds. Duties are dictated most of the time and they work in an atmosphere where they are always reminded of their subordinate position. According to one nurse-aide,
you hear some [nurses] saying 'I am alone' and yet you are there and working hard and doing all your duties. And some...say that in front of patients, and patients might end up losing respect for us...they start realising 'Oh, this one is not a nurse'. So when you eventually tell that patient to say or do something they won't respond...they will have lost all respect for you [NA.B].

Because of the increasing number of patients "...at times the wards get full...and become so busy, and all the duties must be done on time before the next group comes" (NA.B). Amid these time constraints, "if you go to administration for something they can take 30 minutes before they attend to you; or ask you to wait because they have visitors" (NA.A).

One nurse (SCN 7) indicated that they are sometimes overworked. Sometimes the only nurse in the ward, apart from a nurse-aide. Asked what her recourse is, she just said "In the hospital ... you are supposed to work as a team, we help each other" (SCN 7). This means that, in addition to helping with the nurse's duties, the nurse-aide also has her/his own duties to complete. This complicates the tight schedule which the nurse-aide already has. The only 'power' (though marginal and does not affect the overall power relations) that some of them have comes from long tenure and, therefore, knowledge about the whereabouts of some organisational resources. For example, one aide states that their ideas are often rejected by seniors. She also said that "most of the time, because we have been here for a long time and know all the corners, ...some of our new SCNs actually come for help in terms of locating things" (A).

There is one case that exemplifies the inability of the nurse-aides to influence policy decisions relating to their working conditions at higher levels. She says she joined the service in 1982 after having undergone a short period of training. She was promised that she would go for a six months upgrading course. The upgrading programme was discontinued, and she says, "...We are actually being called 'unqualified nursing orderlies' (UNOs).... So we are still on standby for further training" (NA.B). One male nurse-aide
expressed a desire for an official title. He says, "As a worker, a married one... if you have a post that would be nice. Say you are... [department] supervisor... rather than just working without... [a] post" (NA.F). According to this worker, a man (head of household) with a family should ideally be in control of his life chances. However, he is not.

The marginal position of nurse-aides as well as their powerlessness at MDH is aptly portrayed in one aide's lament for the by-gone 'democratic' days. She says

what makes it impossible for us to be helped is that, we used to have monthly meetings... right from general hands to the doctor, where we used to raise our problems... and they would [take note] and consider how to solve them. But that has been stopped. No one discusses what is right and what is wrong. Each boss says whatever they want done [NA.A].

In this case, one can argue that the nurse-aides have very little job autonomy. Because most duties are dictated to them, they are left with only a few routine decisions to make about their work. Although this occupational category was supposedly created in order to meet health-care personnel needs, this must have been a most welcome move for the nursing profession. The move has allowed them to relegate most of their traditional monotonous duties to nurse-aides and it has allowed them to retain some of the limited problem-solving allowed to others by doctors for themselves.

4.6.3 Health Personnel in Health Centres

Apart from their health-care duties, health centre (HC) staff are required to do domiciliary visits and administrative duties as well. According to the community sister who supervises health centres and the matron at MDH, "they are managers". Therefore, in comparison with SCNs working in hospitals, those in HCs seem to be relatively less affected by the tight control prevailing in hospitals. But they do have to report to the
community sister, doctor, DNO and any other district official that visits the HC. However, they do not have to deal with SRNs as a senior rank. But, like those based in hospitals, their career opportunities are severely limited (see Diagram 4.1), unless they get the chance of going for an upgrading course to become an SRN.

HC personnel (SCNs) have to do monthly and quarterly returns and send them to MDH but the District information Officer states that most returns come a week or more late. This delays his compilation of the data and its submission to the provincial offices. He says HC personnel “complain that they are doing everything, such as administrative work, sweeping, therapeutic services, and have little time to do this and there is no compensation”. This sentiment was echoed by three out of the five HC SCNs interviewed. For example, one says “I hold the post of nurse in charge, there is a lot of responsibility and you get nothing [allowance] for it, but you get blamed a lot when things go wrong” (SCN.I). Because of tight time schedules, the information officer says that some frequently resort to reporting on two consecutive months using the same copy. This results in misleading morbidity and/or mortality data for the district. Some feel that there is not enough technical support from the district level because officials do not visit regularly. When they do there is not enough time for discussions to solve problems. Officials are mostly concerned with paperwork. As one put it, “when we see their car coming we get scared of the impending ‘war’, especially about reports, or duty rosters” (SCN.I). That means supervisors still see their task as administration, instead of programme development.

Four of them also feel there should be more delegation of authority from the district level because the communication channels to get approvals are too long. This is worsened by the absence of telephones (at some HCs) and vehicles. Feedback is also minimal when problems are sent to the district office (which in turn sends them to PMD if
necessary). They give up in the end, because "officials are resistant to change". (1). Moreover, like the managers at MDH, health centre staff or the nurse in charge have no powers to charge anyone causing hindrances or not pulling their weight. They can only make recommendations.

Nurse-aides based at HCs, it seems, make more than routine decisions in their daily duties, compared to those at MDH. For instance, one nurse-aide now based at MDH says "in [HCs], because of the shortage of qualified nurses we used to do more things, they always taught us to give medications, referring patients, doing emergency deliveries, etc." (NA. B). When one of the HCs was visited (Kapondoro, HC), one SCN was on leave and the second one was off sick, so the nurse-aide and another one 'borrowed' from another HC were performing the day to day duties normally performed by SCNs including giving health education. Asked if she had the authority to make decisions, one of them said "if it is things I am allowed to do I can. But normally there aren't things that I am barred from doing when they [superiors] are not here" (NA.E). And one nurse-aide from another HC actually talked as if she was a nurse. She said "patients don't understand [drugs given], so they need more health education so that they understand the nurse knows her job" (NA.C). So they switch between identities and role sets.

Even when SCNs are present nurse-aides can make suggestions as well. But it is my contention that, apart from the conducive environment, SCNs in HCs also delegate more responsibilities to nurse-aides so that they can fill in for them when absent or when workloads are heavy. The absence of the watchful eyes of supervisors makes the development of this patron-client relationship possible. Nevertheless, some seem unable to put aside their powerlessness, or rather their lack of authority to make any 'serious decisions'. The following dialogue is most telling:

Q. If you were to go for in-service training, which area would you want to specialise in? A. It's the authorities who choose for us.
Q. Yes, but what would you like to study yourself?
A. [long pause] But it’s not us who choose.
Q. Yes, we know that, but we need your choice.
A. With my rank? [with look of surprise] [N.A.D.]

Overall, it seems HC personnel have a certain amount of job autonomy (particularly in terms of the time-related dimension) as compared to those in their occupational category in hospitals.

4.6.4 Field Personnel

The category of field personnel includes environmental health technicians (EHTs) and village community workers (VCWs) 42. Sixteen EHTs in the district report to the senior EHT based at MDH, who, in turn, refers bigger issues to the PHT (see Diag. 4.1.). They make monthly reports. In these two occupational categories there is wide scope for job autonomy in terms of implementing ideas, introducing new tasks within the guidelines of district targets and deciding on work hours and where to work. This is possible because there is no close supervision, and their work tasks are not easy to monitor closely. They deal with villagers, providing health education, advising where and how to build latrines, water wells and rubbish pits. The way to approach villagers, presentation of health education material and to making decisions regarding where to build wells, etc. require initiative. The time to visit either village A or B, or either family A before family B, and when, are all determined by each EHT or VCW individually. Therefore, theoretically, their ranking on the time-related aspect of job autonomy must also be higher than that of nurse-aides, SCNs and SRNs. We will come back to this issue in the next chapter.

Presently, I need to discuss their very low ranking on the ability and power to influence their working conditions, particularly VCWs. VCWs were trained to go and
work in communities as part time workers but their work is extremely demanding. They are paid ZS70 per month, minimum wage is ZS150, and have not had an increment since the program started in the early 1980s. With such little income they are torn between their work schedules and household chores. As one of them says,

[but] you as the VCW ['mbuya utano']. it [the situation] just pushes you to go and 'rescue' those people you know are faced with contracting a disease. So for that time you have to forget about your fields. And the following day you get a note ['Katsamba’ - sarcastically] to say you are wanted at the ward meeting. And the day after, our superiors will come and say you are wanted at Mutoko [Nos. 2A and 3A echo ‘at Mutoko’]. That is the nature of our job, being pushed around [No. A4].

The four VCWs that took part in this group interview agreed it is difficult to pull out now, or to slacken, because they were selected by the community and are afraid of betraying them. “That in itself will make you go to work” says one (No. A4). One other VCW from Sasa Village says she leaves her fields unattended and sees to them on weekends, and, she cannot afford to hire anyone to help with household work. Since they are VCWs, officials from different ministries come and ask them to help with their projects too. Regarding this, one says “there is too much work and too little pay (No. A5). At present VCWs are tired and have almost given up trying to convince authorities to meet their grievances regarding pay/salary increments, increased responsibilities, bicycles to move around with. When they were aired “long back”, the superiors said that it was hard to meet these demands. Also, because there are no career opportunities, no internal labour market for VCWs, like nurse-aides, their condition puts them in the category of being in a ‘permanent’ secondary labour market in the health-care system.
4.7 DISCUSSION AND CONCLUSION

The fact that most of the workers either do not mention or downplay intrinsic work rewards, or what Herzberg (1985) calls motivators in this study indicates two things. Their powerlessness and/or preoccupation with job security at a time when the government is down sizing its labour force, and pay because of high inflation rates related to ESAP. One concerned department head who wants to be heard and have work conditions improved says “there should be an independent in-house journal/paper, which can help convey people’s messages and grievances” (DH 31). The DMO goes even further, to suggest the need to create a “workmen’s committee... which can express the feelings of all people working in the district health system”. This would operate at par with or replace the District Health Executive (DHE), which is a “professional board with rather extensive authority to decide on behalf of others”. The DMO expressed his vehement disapproval of “people sitting on top deciding on behalf of others”. There “should be made a system whereby people have the rights to express their views ...”.

It is hard to say whether this would result in district health personnel’s views affecting policy at PMD and central levels. Decentralisation of health-care facilities has happened, that of responsibilities, to a little extent, and that of power has hardly begun. The health sector is, contrary to rhetoric, operated top-down. The new strategy, based on PHC, is also top-down. We have the case of a bottom-up structure (PHC) that has been established over the old top-down structure. The district structures are still undermined by and subject to the bureaucratic, hierarchical and rigid control of provincial and central structures. In a decentralised system “the centre needs to be...strong...but the orientation required is one of technical services rather than hierarchical control” (Blunt, 1984: 415).

It could be that central and provincial managers fear losing their own place and special
privileges in the system, and they value predictability more than flexibility. Or, it could be that the new government with its political base among peasants from whom demands for provision of services emanate (Bloom, 1985) needs to keep a firm grasp on local public organisations through which to distribute patronage in order to maintain its legitimacy. But, according to Kanter (1992), delegation does not mean abdication.

As shown by my analysis above, this has led to a sense of powerlessness among district programme officers, department managers, first-line supervisors and other health-care workers. Powerlessness among most of the lower level workers, (SRNs down) manifests itself in routinised jobs where performance measures are closely related to job descriptions and rules. The PHC approach entails operating in a milieu where one makes some adaptive but mostly innovative decisions. One has to be a strategist. Effective strategic management, according to Kiggundu (1986 : 345) "requires ....the capacity to manipulate and exploit environmental symbols and cues to one's advantage...", but, ‘experienced powerlessness’ results in the inability to manage strategic tasks (Kiggundu, 1986). Watson (1987) has suggested that organisations needing to cope with environmental challenges which they face in a manner that balances predictability with innovative flexibility need to develop decentralised structures. Through these, “staff will be given a significant degree of discretion and be encouraged to take initiatives” (Watson, 1987 : 261). Rigid as it is, the health-care system does not allow for the ‘entrepreneurship’ which the nursing director (Kandandara, 1992) calls nurses to adopt. The structure does not allow for risk-taking and innovative decisions that partly characterise job autonomy.

My analysis has indicated that all categories of health personnel, from managers to VCWs, do not have the amount of job autonomy that is warranted by their
positions/duties and called for in a PHC strategy. With regard to the lower occupational
categories, the following observation has been made before, that

the lowest paid manpower who usually provide the primary care
services that have made the greatest contribution to equity have the least
say in health policy, or even in their conditions of employment
[Loewenson et al., 1991: 1088].

When considering the gender division of labour in the district health-care system, I
discover that the greater percentage of health-care providers are women. Their
powerlessness at work, that is, their inability to influence policy as well as matters relating
to their working conditions is a significant contribution to the reinforcement of the
oppression of Zimbabwean women. Moreover, it inevitably mutually reinforces the
stereotypical image of ‘women’s jobs’.

In this chapter, I have discussed a number of organisational perspectives on job
autonomy, from the classical to the contemporary. I have also discussed the issue of
professional autonomy and how it influences professionals to have particular expectations
concerning their jobs. The concept of PHC was also dealt with, not in its technical sense,
but the philosophical aspect that calls for initiative, or rather, job autonomy among health-
care providers, particularly the lower level personnel. After discussing some of the
possible constraints to job autonomy among health-care workers in the West and in the
Third World, I embarked on an analysis of job autonomy in the Mutoko District Health
Care System by occupational category before coming to the discussion and conclusion.
ENDNOTES

1 These include Psychology (Industrial and Personnel), Sociology (Industrial, of Occupations/Professions, Organisations, Health and Health Care, etc.); Political Science (Public Administration, etc.); Business Administration (Organisational Behaviour, Management, etc.); etc.

2 Blunt (1983) posits that when decentralisation is taken in its broad sense, it spreads decision making capability to areas of an organisation where it had not existed before.

3 In this study centralisation refers "to the degree to which members at lower levels participated in decision making" and formalisation refers to the "degree to which work was standardised and the amount of deviation from those standards that was allowed" (Cherniss, 1980 : 98). However, a more general and elaborate definition of formalisation is that it is

the established system of rules, regulations, and procedures utilised by
the organisation to ensure uniformity of operations and make possible
the co-ordination and control of the various organisational activities
[Conaty et al., 1983 : 117].

4 I regard ‘organisational structure’ as “the internal patterning in work organisations” (Watson, 1987: 126), or, more specifically as “the division of labour and means of coordination (integration) used to link the technology, tasks, and people in an organisation to achieve the desired goals” (Ford, 1988 : 353).

5 This is when his major works were published in the West, viz.: “From Max Weber: Essays in Sociology” by Gerth and Mills (1946), and “The Theory of Social and Economic Organisation” (1947).

6 This model will be explained shortly when I discuss the contributions of Scientific Management theory.

7 While Taylor focuses upon the basic physical activities involved in production, Gulick, Urwick and Fayol are more concerned with the problems of departmental division of work and coordination. Apart from any other similarities, to the effect that people like Perrow (1970) lumped all of them under scientific management, in the two theories, the most apparent is that both view employees as inert instruments performing assigned tasks which have to be broken down into simpler components (cf. March and Simon, 1958, Grusky and Miller, 1981).

8 By ‘initiative’ Taylor means the hard work, good-will and ingenuity of workers (Taylor, 1981).

9 Under the management of initiative and incentive managers obtained the initiative of their workmen by giving special incentives. These include such factors as

the hope of rapid promotion or advancement; higher wages, either in the form of generous piecework prices or of a premium or bonus of some kind for good and rapid work; shorter hours of labour; better surroundings and working conditions...[Taylor, 1981 : 57].

10 This is more akin to the old craft system and its guildsmen in which the craftsman/artisan who was a master of a body of knowledge and methods and
procedures had control over both his work process and product (Blauner, 1964; Braverman, 1974; Marglin, 1976; Stone, 1981; Edwards, 1981; Coburn, 1981; Littler, 1982; Rinehart, 1987).

It is Mayo (1880-1949) who eventually "came to be known as the leading spokesman of the Human Relations School of industrial sociology" (Watson, 1987).

By "labour problem" is meant workers' resistance to work place rigidities and subversion of managerial objectives through: absenteeism, turnover, work stoppages, sabotage, restriction of output, etc. (Rinehart, 1987).

It is, however, the means to the end that differed. According to Mayo, this could be done by making sure that workers' social needs were met at work by: allowing them to work together, and making them feel important in the organisation. He believed this approach would head off both social breakdown and industrial conflict (Watson, 1987).

This scheme was strengthened in the 1960s by the writings of McGregor (1992).

Job enlargement is meant to expand a job horizontally, to put more variety into a job. Job enrichment developed and popularised by Herzberg (Rinehart, 1987) is said to go "further by combining operations before and after a task to make a complex and unified job", and autonomous work teams comprise about twelve employees with the collective power/authority to decide on work methods, scheduling, inventory, and quality control (Krahn and Lowe, 1993: 215).

Differently expressed, "moo-cow-sociology" means: "just as contented cows were alleged to produce more milk, satisfied workers were expected to produce more output" (Scott, 1992: 61).

Hygiene factors are things like pay, supervisory style, physical surroundings, status, security, working conditions, etc. (Watson, 1987; Krahn and Lowe, 1993).

Motivation factors which relate to Maslow's "higher order needs" consist of achievement, advancement, recognition, growth, responsibility, opportunity to develop one's skills, chances to make decisions about one's own work, and the work itself (Watson, 1987).

Trist posits that "when job enrichment projects include participation they become congruent with autonomous work groups" (1977: 4).

Semi professions are professionalised to some extent but lack the power to gain recognition as full professions, and examples are school teachers, nurses, social workers, etc. Marginal professions, on the other hand, comprise of those that work hand in hand with professions but have no capacity to acquire professional status (Ritzer, 1977).

These developments in Europe, particularly England are quite significant for the large part of the world, including the United States (Reverby, 1989) and British colonies (Johnson, 1973) because professional projects there followed relatively the same pattern. In British colonies, however, it was the British that educated health professionals and paraprofessional there. As for Zimbabwe, the degrees for its School of Medicine were awarded by the University of Birmingham until 1971 (Hanna et al., 1975).

While gender relations refer to "the social relations between men and women", "gender refers to the social meaning of being a "man" or "woman"" (Game and Pringle, 1983: 150).

Formerly it was restricted to referring to the power of male household head (Witz, 1992).

Proletarianisation is defined as
the process by which an occupational category is [denied] control over certain prerogatives relating to the location, content and essentiality of its task activities and is thereby subordinated to the broader requirements of production under advanced capitalism [McKinlay and Arches, 1985 : 161].

25 Standardisation of patient illness “is a process of classifying certain types of illnesses in terms of how much and what types of care and treatment the patient needs” (Edginton, 1989 : 117).

26 This is called organisational alienation by Larsen, which comes about “when cost-conscious hospital managers create administrative mechanisms to improve the coordination of doctors and other workers and to increase physician productivity” (Wahn, 1992 : 426).

27 Hecht is a senior economist with the World Bank.

28 Just to give an example of how colonialists felt about natives, a Chief Native Commissioner (in colonial Zimbabwe) in 1918 advised:

The native should be trained not so much as a competitor with the white man in the business of life but as a useful auxiliary to help in the progress of the country [Zvobgo, 1986 : 322].

29 Where most decisions are made at the top of the authority hierarchy, the organisation is said to be centralised (Conaty et al., 1983).

30 The central premise of a basic needs approach is that the poor groups in the society should be made the focus of development.

31 According to Blunt (1978) descending participation entails taking over former managerial duties (by workers), and having a great say in the control of their own jobs and immediate work. And in ascending participation workers are only able to influence managerial functions and decisions.

32 The Environmental Health department is involved in working with communities in the provision of water and sanitation facilities, imparting health education in communities, water (drinking) sampling etc.

33 She also organises and coordinates health programmes and activities in the district, like World Health Day, health education campaigns and Extended Programme in Immunisation.

34 Gore defines routine decisions as those that deal with recurring tasks, adaptive decisions as those that deal with problems, and, innovative decisions as decisions that “deal with major changes in activities and operations that lead to changes in goals, purposes, or policies” (in Frank, 1981 : 11).

35 According to the Hospital matron there are very few posts like that. Mutoko District Hospital has only one.

36 This is a colonial legacy (the divide and rule technique) because SRNs were only whites who were deployed at large hospitals. Since blacks started training as SRNs (even before independence) they have been given posts in large hospitals. More than ten years after independence there still are no SRNs deployed at rural health centres. However, the training of SCNs has been phased out. Those that were in training in 1993 at various Mission Hospitals SRNs are trained in government general and central hospitals were the last intake. Those with SCN qualifications will be upgraded to SRN status after doing another year of training. This will eliminate the current occupational status differentials.
There is a Hospital Executive comprising of: the DMO, DNO, Pharmacist, DHSA, DEHO, and Senior Clerk (as the secretary).

However, I believe the situation is relatively better here compared to Provincial, General and Central hospitals with more doctors and specialists to make demands on nurses' time, as well as to report to.

Likewise, those working in the pharmacy, laboratory and X-ray departments have their duties centred on demands from other departments, wards, doctors, etc.

This is very much similar to the tactics used by professions that are considered dominant now, when they were mapping out their territories.

Such falsified reports were encountered by the researcher when collating morbidity data for the district.

Village Community Workers were formerly known as village health workers (VHWs) when they were still under the Ministry of Health. We have included them in the organisational chart (Diagram 4.1), connected with a dotted line, because they are still required to perform the functions they were performing under the MOH.

A DHE is made up of all heads of departments, representatives from all HCs, and representatives of EHTs, and it meets once every month.
Chapter Five

RESOURCE ALLOCATION AND DISTRIBUTION IN MUTOKO DISTRICT

5.1 INTRODUCTION

In the last chapter I indicated that all of the administrative and health-care personnel in this study do not have the job autonomy and/or power commensurate with their official roles in the district health-care system. In this chapter, I am concerned with the ineffective allocation of resources for the district health needs.¹

It has long been observed that the two major health problems facing the Third World are infectious diseases that are caused by inadequate water supplies and poor sanitation, and also the various diseases associated with malnutrition and undernutrition (Doyal, 1979; Jones and Moon, 1987). Scholars have described these as diseases of poverty (McPherson, 1982; Osei-Boateng, 1992), or diseases of underdevelopment (Doyal, 1979).

The situation is immensely aggravated by the availability of minimal resources that the governments can use to solve these health problems. Remedial advances are also hampered by "[i]nternational indebtedness and slow economic growth in [these] developing countries, due in part to an unjust international economic system....." (Chen, 1992 : 200). Hence, recurrent resource needs are continually underfunded. A common phenomenon is, therefore, one of absolute shortage of essential drugs, financial and manpower shortages, and unavailability of transportation for logistical support (McPherson, 1982; McPherson and Midgley, 1987; Phillips, 1990).
With regard to the Africa subregion, Osei-Boateng has observed that, "service conditions are generally unattractive [and, s]hortage of trained staff and inadequate supply of basic equipment and supplies make nursing care not only unsatisfactory but frustrating" (1992: 177). Such impediments to essential health care resulting from the chronic shortage of basic health resources have long been noted by scholars like King, way back in 1966 (MacPherson, 1982; Phillips, 1990). And the overwhelming rise of the Aids epidemic, particularly in Africa (Mhloyi, 1991; The Spectator, Nov. 26, 1994) is also placing remarkable pressure on these limited health resources. Within that African subregion Zimbabwe is no exception. It has been documented by various sources that, at both provincial and district levels, the major services delivery and management constraints are staff shortages, inadequate drugs, lack of transport, insufficient communication systems and other resources (Government of Zimbabwe, 1992; Manga, 1988; (The Daily Gazette, Sept. 8, 1993).

It would be naive however, to think that all populations in the Third World are equally disadvantaged and/or affected by this 'shortage syndrome'. In the Third World, more than three-quarters of the population live in rural areas. And a large percentage of these are women and children. It is in the rural areas where individuals are disproportionately afflicted by the diseases of poverty. Inadequate water supplies poor sanitation and poor nutrition underlie the conditions favourable for many diseases (Jones and Moon, 1987). Moreover, the majority of these rural people do not have stable sources of income. Agricultural activities are, more often than not, thwarted by the vagaries of nature. Droughts and floods are the common ones. Amidst such inequality of conditions between urban and rural areas, we are told there is "......unequal distribution of resources...." (Hexel and Wintersberger 1986; MacPherson and Midgley, 1987).
It has been argued that PHC "...necessitates changes in the allocation of health resources so that all citizens can benefit", (Muhondwa, 1986 : 1248). Therefore the goal of health for all through PHC is deemed achievable only in the context of social justice and equality (Hexel and Wintersberger, 1986), and equity in health (WHO, 1988) depends on the manner in which the health goal is incorporated into a country's overall development strategy which supposedly dictates the manner in which resources are allocated. Those that advocate the 'Basic Needs Approach' to development have argued that "...development policies and programmes must be directed towards the poorest sectors of the population, if necessary at the expense of the more efficient sectors" (Conyers, 1982 : 28). Barnum and Kutzin have poignantly asserted that

... in countries with low levels of per capita gross national product (GNP) and high rates of mortality, the most effective allocation of resources would result in a lower share of public resources committed to hospitals.... [1993 : 1].

As far back as the 1960s, we are told, "... the rhetoric emphasised preventive and rural priorities at the same time that expenditures were overwhelmingly curative and urban'. biased in favour of emerging elite and urban groups" (MacPherson and Midgley, 1987 : 153). There was much pious talk about health as a basic human right, but even in the most socialised countries the leaders and the elite continue to get the best health care. Now that the majority of Third World countries have been signatories to the 1978 Alma Ata declaration of 'Health for All by the Year 2000', about a decade later we hear that "[f]ew countries have been able to reallocate their existing health budgets preferentially to PHC", (WHO, 1988 : 12). Yet PHC "... services have the greatest effect on health status per unit of expenditure..." (Barnum and Kutzin, 1993 : 19). In spite of the alleged desire in many Third World health plans to shift resources and emphasis to rural provision,
...the change in emphasis from curative to preventive medicine - as measured in terms of distribution of health resources... is actually occurring very slowly, if at all, in most countries [Conyers, 1982 : 43; cf. Phillips, 1990].

As a result of higher per capita expenditure on health services in urban areas, the quality of urban services is much better (Conyers, 1982).

This kind of scenario has prompted scholars like McPherson and Midgley to argue that "... social policies in the Third World do not serve a 'first line' function, redistribute resources on the basis of need or cater for the whole population" (1987 : 121). Hence, others like Mburu observe that "[s]ocioeconomic inequality is not only in consumption styles, it begins with the way resources, goods and services are distributed" (1983 : 1153).

Therefore,

...social policy approaches in developing countries can best be conceptualised in terms of an incremental model in which existing provisions are expanded in an ad hoc, linear fashion and in which existing inequalities and inadequacies are perpetuated serving the interests of elite groups [McPherson and Midgley, 1987 : 122].

And,

...if structural capacities and distribution of resources within regions are not even across the entire country, then some regions will remain economically, socially, and medically disadvantaged [Andes, 1992 : 298].

In Zimbabwe, although even central hospitals sometimes experience "... an acute shortage of essential drugs ... vital equipment ...", and personnel (Daily Gazette, Sept. 8, 1993 : 8), the problem is more serious in rural health facilities (Manga, 1988). The stark differences in health status among various socio-economic and racial groups are paralleled by marked inequities in the distribution of health-care resources among them. According to Manga, the more serious imbalance concerns "... the heavy concentration of both physical and human resources in urban areas relative to rural populations" (1988 : 1132). Yet even before independence, before PHC became part of the health-care system, scholars like
Gilmurray and Riddel asserted that "a health system for the future should reinforce and accompany a basic needs approach to development" (1979 : 46). Despite 'equity' being a central concept in the (White Paper) health policy, the evidence above indicates otherwise. Hecht and associates have recently criticised the government for according free health care to several special groups at independence, indicating that "...there does not seem to be any equity basis for such special exemption" (1993 : 278).

So far, several contributions have been made towards the vital discussion on reasons for the misallocation and/or maldistribution of health-care resources in the Third World in contradiction to the PHC rationale and strategy for programming the limited resources available equitably or according to need. Phillips (1990) points to the persistence of hierarchical systems whereby referrals (of patients) up the system are equated with receipt of better care, and promotion structures for staff which are also linked with movement up the hierarchy. He therefore argues that these structures have been responsible for creating an image of 'bigger is better'. Hence,

----------many systems have tended to focus both higher levels of care and investment into the main urban areas...and budgetary allocations...[have] follow[ed] facilities and projects [Phillips, 1990 : 139].

Arguing in the same vein is Mosley (1989) who criticises the highly centralised control exercised by bureaucracies of developing countries. Most health bureaucracies "...are already locked into an urban-biased, hospital-biased, high technology system that is essentially self-perpetuating, administratively and politically" (Mosley, 1989 : 263) and Barnum and Kutzin (1993 : 22) concur with this assertion. Some, like Lipton (1977), with his concept of 'urban bias', have argued that urban dwellers are more politically vocal and therefore make demands politicians cannot refuse. The rich are concentrated in the towns, and that is where "...political power lies and, as a result they are favoured in service
provision” (Phillips, 1990 : 140). In addition, decisions by political leaders to allocate resources are also largely guided by economic considerations (Chen, 1992).

Because resources are limited, a significant expansion of preventive services can only be achieved by reducing the existing curative services which are mainly urban based, and for every decision to commit more resources to the health ministry or rural areas, a decision not to commit an equal amount of resources elsewhere is made. The volume of public resources to commit to health care, and where to put them geographically, are political decisions to be made by the state. And, “...the political will to extend realistic health services beyond urban elites often may not exist” (Phillips, 1990 : 134). According to Evans and colleagues, “political considerations may override all other priorities, and little progress can be expected unless there is a political commitment to apply resources where the need is greatest” (1981 : 1119). It has therefore been justifiably argued that the major obstacles to more just and efficient health delivery systems are not the usually cited ones of limited resources, poor communication, or lack of technical knowledge and data, but rather social systems that fail to place high value on the health care needs of rural peasants [Gish, 1977 : 129; cf. Phillips, 1990; MacPherson and Midgley, 1987].

In other words, the issue is not the sum of public resources available per se, but the decisions that are made about how they are used (Heller and Elliot, 1977). It is the power structures that influence the health-care systems that we should look at (Malcolm, 1964).

Yet the most powerful organisation advocating for PHC, the WHO

...remains largely silent on the fundamental political and economic structures within which health systems are situated and which, by virtue of affecting broader patterns of resource distribution, have profound health consequences [Baylies, 1986 : 68].

To sum up this argument, I refer to Navarro who sums up the position taken on this issue by a significant number of social scientists by saying that
...the major cause of death and disease in the poor parts of the world today...is not a scarcity of resources, nor the process of industrialization, nor ...population explosion but, ...a pattern of control over the resources of those countries in which the majority of the population has no control over their resources [Navarro. 1981 : 7].

To end on a positive note, I would like to refer to countries like China, Sri-Lanka, the state of Kerala in India, and Costa Rica, which have achieved relatively low infant mortality rates and attained a life expectancy close to the level in the industrialised world. They have done so through public priority given to innovative and encompassing PHC programmes plus investments in education and/or literacy, nutrition and/or food, clean water, health and sanitation (Evans et al. 1981; and Kutzin, 1993).

In this chapter, as in the other chapters, my discussion remains influenced by the structural perspective outlined in the first chapter. This enables me to look beyond the issue of health-care resources and services, because, as Heller and Elliot say, "systems of health do not exist in a vacuum" (1977 : 1). Hence we have to pay close attention to what Agu and Walker call "macrosociological determinants of health status" (1984 : 97), or what Andes calls "...structural underpinnings to regional disparities in health outcomes" (1992 : 296). They include social, economic, political, environmental, demographic and cultural elements of society, and they affect health either directly or indirectly through their impact on other variables. This is the kind of approach to health on which the PHC's principle of 'intersectoral approach' is based. From the organisational aspect, the structural perspective should enable me to analyse the impact other economic institutions or structures have on the district health-care system or health services in terms of resource allocation. The district hospital and the HCs are also regarded as part of each other's environment, the actions of which are mutually affective.

The chapter opens by discussing the national allocation of financial resources to the MHCW and the financial position of the district health-care system in question. We
then move on to discuss the shortage of equipment, essential drugs and other supplies through the eyes of health personnel and service users, and the extent of manpower shortage in the district health-care system. This is followed by a discussion of alternative human resources in the form of traditional healers (THs) and traditional birth attendants (TBAs), as well as health-care personnel and the community's social attitudes towards them; after which I discuss the impact of ineffective resource allocation on health education and counseling. Two other important issues are discussed after this, in respect to how they put an unnecessary strain on the available human and other resources. These are medicalisation of child birth and the commodification of health in the district. Then I move on to analyse the effect of inadequate health resources on accessibility and utilisation of health services, after which I analyse the possible and important contribution to health of other resources beyond health-care services in the district. The chapter closes with a discussion and conclusion.

5.2 FINANCIAL RESOURCES

There are no logical grounds on which one can stipulate the amount any particular country ought to be spending on health-care services. But, according to Conyers (1982), most developing countries have the obligation to increase expenditure on health services on both social and economic grounds. However, the critical limitation on achieving this goal (as well as 'Health for All by the Year 2000') for many governments is availability of funds. Although the financing of health services has for some time been of critical concern to governments of both developed and developing nations, the burden is heavier on the latter's coffers. The major reasons are the world economic crisis, difficulties
(Abel-Smith, 1985; Hardon, 1990) which have lowered rates of economic growth and international indebtedness (Chen, 1992; Phillips, 1990; Abel-Smith, 1985).

Faced with these formidable setbacks, most developing countries are forced to go to the World Bank (WB), the International Monetary Fund (IMF) and Western governments for loans to finance development projects. These loans are conditional on the acceptance and implementation of certain policies, including a reduction in public and social expenditure and health services are one of the targets of these economic recovery packages (Abel-Smith, 1985; McPherson and Midgley, 1987; Phillips, 1990; Kanji et al., 1991). However, the most notorious group of policies during the last two decades have been economic adjustment policies. Between the short period of 1980 to 1986, 75 percent of sub-Saharan African countries implemented IMF and WB-sponsored adjustment programmes (Kanji et al., 1991). With adjustment policies/programmes

... education, health and other social services which were considered basic needs and basic rights are increasingly seen as commodities for purchase [and], trickle down from economic growth is ...relied on to improve the standards of living of the majority... [Kanji et al., 1991: 989].

Apart from severely affecting the ability of governments to finance health programmes (Hardon, 1990), these adjustment programmes are said to affect high income groups the least because they can buy services in the private sector (Kanji et al., 1991). Their implementation, according to Kanji and associates, has not been successful in promoting growth and they "... are geared to maintaining the international status quo and thus continue the exploitation of the South by the North" (1991: 985).

In the case of Zimbabwe, like many other developing countries, world recession (in the mid 80s) forced the ministry of health to restrict its ability to finance its services. According to Sanders and Davies (1988), the government's funding of the health sector increased substantially after independence, but remained static since 1981/82. From 1980
to 1990, the country's foreign debt shot up from US $785 million to US $3.2 billion (Sunday Times, January 10, 1993 : 19). Throughout the 1980s

[In terms of overall cost of health care received per capita, for every $1 of benefit received by the rural population the urban population received $8 and the private sector beneficiaries received $36, despite the vastly inferior health status and correspondingly greater need of the rural population [Manga, 1988 : 1132].

Another indication of both a curative and an urban bias in health care financing in Zimbabwe is the disproportionately large amounts of resources devoted to hospital services. During the 1980/81 fiscal year

... 69 percent of total health expenditure was for hospital services alone ... of which 60 percent was devoted to 4 central hospitals ... which were easily accessible to ... th[ose] privately insured ... [Manga, 1988 : 1133].

And, as late as 1987, 7 years after independence, 45 percent of the ministry of health's recurrent hospital expenditure was for four central hospitals (Barnum and Kutzin, 1993) situated in the 2 largest cities. According to Barnum and Kutzin's (1993) recent review, Zimbabwe is one of two-thirds of 29 developing countries that spend 50 percent or more of their recurrent health budgets on hospitals. 9

The situation has however been worsened by the economic structural adjustment programme (ESAP) that was instituted in 1991. In a publication on how to cope with the negative consequences of ESAP on health services, the government of Zimbabwe states that "[f]unds for capital development will be limited and expansion of facilities to areas where they do not exist will be severely curtailed" (Zimbabwe, 1992 : 15). The health provider is called upon to be more resourceful and to plan and manage resources well. Considering the limited power and job autonomy I have discussed above I contend that this might be an unjustified call. When I look at financial resource allocations to districts I come face to face with the effects of an urban bias. A senior official at MDH says that "...in some instances
[they]...have to suspend some of the functions because of financial constraints” (AP25). The DMO makes bids (at the PMDs offices) every year for health services for the whole district. After bidding “...we are always getting a third of what we ask for”, a senior hospital official says (AP25). One nurse at the hospital corroborates this by saying that “if...say...the [District AIDS Committee] ...present[s] to the PMD a budget [bid] for S20 000, it may end up getting say S8 000” (SCN 38).

A curative or hospital bias in resource allocation is also evident here. According to the DMO, of all the district health activities, the medical and surgical “votes” get the largest allocation. However, he indicated that there was a reduction in that “vote” in 1992, hence “... there was a struggle to make ends meet ...”. The tight bureaucratic control within the MHCW also plays its part in the ineffective allocation of financial resources to district level facilities. Commenting on the district AIDS control programme the DMO says

...funds for AIDS work are supposed to be distributed from the NACP™ via PMD to the districts ...it’s been a problem to get these funds from the provincial office. [The] very strict system of control makes it impossible to run an efficient programme...I guess they expect us to cancel workshops and everything because they cannot give out the funds in time. So...our way out...has been to apply for funds to other donors...[AP27].

Hetch and associates (1993) have observed that the financial management practices in Zimbabwe’s MHCW include inappropriate use of centralised and decentralised authority. In their discussion on user fees, they assert that “a key step in the decentralization process would be to allow individual health facilities to retain a part or all of the revenues collected as fees ...” (Hetch et al., 1993 : 238). This is a strategy strongly recommended by the WB in order to increase autonomy in dealing with local problems (Lee, 1992).11 The government of Zimbabwe has recently encouraged health workers to “...appreciate the need for cost recovery and strengthen efforts currently under way to
collect user fees" in the face of ESAP (1992 : 16). However, as noted by Hetch et al. (1993), the determination of the patient’s eligibility for free or reduced-price care is completely decentralised to care sites. As I have already mentioned, before going to a health facility, those earning below ZS400 must get a letter of exemption from the Social Welfare office. Failing that, the hospital out-patients clerk or HC personnel will use their discretion but will most likely ask them to pay. Hetch et al. (1993 : 234) further note that after a decision has been made on whether

...a patient should pay, a highly centralized process takes over...[and] every dollar collected at [MHCW] facilities is supposed to be directly remitted to Harare [central offices].

That little decentralisation concerning the determination of a patient’s eligibility to pay opens the system to some abuse, and one possible reason for that might be the lack of incentives for those burdened with that decision. During the time this study was under way, it became known to the DHSA who had just been there for a couple of months, that the nursing personnel and hospital out-patient clerks were letting relatives and friends, who would otherwise have had to pay, receive free treatments at the hospital. Although the fee is nominal, and also considering the fact that the majority of rural people are poor, this might be the reason why the number of those receiving free care far outweighs the number of fee-paying patients. In January and February of 1993 alone, the number of out-patients who received free treatment at MDH was 3,284 versus 977 who paid. From January to August 1993, the number of free admissions at MDH was 2,126 versus 190 fee-paying admissions.

During an interview, one clerk indicated that "... [they] found the system in practice...and just continued with it" (HCI). To establish the extent of this informal organisation, the clerk was asked whether even the kitchen staff could also bring their
relatives. The answer was, "Yes, but we have to see how close the relationship is" (HCl).

An out-patient had this to say about the practice:

I have an aunt who works here... so when I came it never took me 10 minutes [to get treatments]. She gave an order for a card to be written and said do this and that for him. When I do not have money she says 'help him please'. The problem is that if the government says some must pay while others get free treatments it will not be able to control the situation, because the public servants (themselves) that work here, that help people, are the ones that teach us [how to beat the system] [OP14].

By the time this study ended, the matter was still under consideration and the administration, according to this clerk, said they could continue with the practice until a decision was made.

Such an informal organisation has its objectives and possible benefits to those involved. One possibility is that it serves to show up the otherwise inferior position of the hospital clerks vis-à-vis other hospital personnel who ask for such favours. In this reciprocal patron-client relationship the hospital clerks have fertile grounds for asking for favours from other hospital personnel. Considering the strategic position of the hospital at the growth point or township surrounded by villages, this gives both out-patient clerks and other personnel a chance to enhance their solidarity or social relations (through this practice) with relatives and friends in the vicinity, some of whom are likely to do favours for them at their own work places or pay in kind.

This phenomenon is akin to what Perrow (1986) calls particularism as opposed to universalism, in the sense that irrelevant criteria are used to determine who pays and who does not pay user fees. Hence Perrow rightly observes that "organisations are profoundly 'social' in character, in the sense that all kinds of social characteristics go into their operations by intent" (1986: 8). According to him, organisations must be seen as tools or resources that organisation participants often use to give them power that others do not have. Participants seek to control either the whole organisation or part thereof (Perrow,
1986). This is not surprising in this case due to the lack of job autonomy and power that I have indicated are lacking in the district health-care system, especially for lower participants. Apart from gaining this power, personnel might be engaged in an invisible vendetta or scheme just to get back at the whole government bureaucracy for things like perceived inadequate pay and other related reasons.

At this juncture, to end this section, I can only say that more money alone (though essential) will not produce the desired outcome of achieving the goal of ‘Health for All by the Year 2000’. Apart from doing away with the high degree of centralism, local health programmes could do with more political commitment towards those in greatest health need by political leaders. If “cost containment has meant a disintegrating, shabbier health service in most places and for most people” (Eyles and Donovan, 1990 : 11), in the United Kingdom’s long established National Health System, it is unimaginable how much overall negative impact it is going to have on the already underdeveloped Zimbabwe’s rural health services.

5.3 EQUIPMENT AND ESSENTIAL DRUGS

The availability of these resources depends very much on the existence of financial resources earmarked for health services. In 1993, it was reported that Zimbabwean “…government hospitals [were] experiencing an acute shortage of essential drugs and vital equipment, even at major hospitals in the capital Harare” (Daily Gazette, Sept.8. 1993 : 8). However, Zimbabwe is not alone in this. A recent study in Nigeria found that “…the local government dispensaries had on average less than 50 percent of desirable equipment and medical supplies” (Brieger, 1988 : 30), a finding that was supported by Kaluzny (1989) a year later. Considering the economic difficulties the majority of developing
countries are going through, it would not be far off the mark to assume that most of them are facing the same difficulties.

Since the emergence of PHC. hospitals, especially district hospitals, have been tasked with a new role: that of supporting activities like outreach programmes, community service, health education and providing out-patient care (Amonoo-Lartson et al., 1984; Brown and Kutzin, 1993). However, Barnum and Kutzin (1993: 277) express great concern over the fact that

...there may be some tendency for the [district] hospital to be favoured in the allocation of resources simply because of the presence of the administrators, who see the hospital’s problems on a daily basis.

This may very well be what is happening in Mutoko district where bids for the whole district are done by the DMO with the help of programme managers who are all based at MDH. Moreover, the district pharmacy which serves all the health centres and government hospitals in the district is part of the district hospital.

5.3.1 EQUIPMENT, TRANSPORT AND COMMUNICATION

Adequate transport is essential in a district health-care system. It is necessary for the distribution of supplies, for the transportation of supervisors and trainers from the district hospital to satellite facilities or workshops, for bringing field workers to the hospital for in-service training or work shops and for transporting patients from one level of provider to the other within the referral system. The difficulty faced by many developing countries (Barnum and Kutzin, 1993) is also a critical issue in Zimbabwe. That is, the viability of the transport system (especially concerning maintenance) is dependent on the cooperation between the ministry of health and another responsible ministry. In Zimbabwe all vehicles are maintained by the Central Mechanical Equipment Department
(CMED) a sub unit of the Ministry of National Supplies. A CMED local department is situated quite close to MDH, about 1 kilometer away. Government facilities as well as houses for personnel are built by the Ministry of Public Construction. In such a set up it is easy for that department’s problems to affect all other government departments in different ministries that are dependent on it.

For example, an ambulance driver at MDH says, “...Because of shortage of spare parts, when ambulances go for repair they take long to come back...” (AC). In fact they experience “...so many breakdowns” (AP24). When another driver was asked if there were enough vehicles for the district’s needs he said: “We have a fleet of about nine, but only three are functional. The others are at the CMED. It takes them so long to repair” (AD). Therefore, the issue here is not necessarily shortage of transport. It could be a combination of a number of possibilities, including shortage of spare parts, inadequate funds allocated to the CMED and lack of priorities within the CMED when it comes to repairs.

Another critical resource that is lacking in a good number of HCs are telephones. The district information officer showed great concern over this issue because he cited it is as one of the major reasons why HCs are unable to get their monthly morbidity data to him. Since they have no vehicles, telephones would enable them to provide this information easily, as well as ask for help in completing the forms. A telephone is also crucial in seeking immediate help from the district hospital. “So [the personnel in these HCs have to] ... look for a phone elsewhere or they send someone here by bus [to convey the critical message]”, says the senior clerk at MDH. And since ambulances are “...sometimes few...a HC might call [or send] for one when there is none available”, he goes on to say. Faced by such a quandary “...quite often people ...come...late and sometimes too late, either by ox-drawn scotch carts or on foot... and there is a lot of delay...
before they reach the hospital”, said the concerned DMO. This is, therefore, a clear indication of a referral system in jeopardy.

The issue of transport also critically hampers the supervision of HCs by senior officers. For example, the community sister is supposed to visit HCs once every week and, because of lack of transport, she has “…to join other senior members who are also going out but looking after other health programmes”. The rehabilitation officer says “…we do not see enough clients in the rural areas because we do not have adequate transport, but we do have the time” and the department’s target is “to have transport for home visits at least once a month”.

With this shortage of vehicles, programme managers and supervisors could be using their personal vehicles and then claim for the reimbursement of the incurred expenses. However, the bureaucratic channel through which the travel and subsistence (T & S) allowance claims have to go is so cumbersome that a considerable number do not get processed and “…you don’t get paid back” says one senior officer (SRN 36).

Lower level personnel’s duties are also affected by lack of transport. For example, a nurse at a health centre says

> We are supposed to be giving health information during outreach work but now we do not have bicycles to go into the villages. Some of the villages are quite far, some are 10 to 11 kilometres away, so those people walk to the clinic. …we encourage them to…We are not doing any outreach at all… [SRN 1].

Field workers (VCWs and EHTs) are also under the same predicament. Senior environmental officers showed great concern over the fact that their staff (EHTs) do not have enough or appropriate transport because they cover large areas on bicycles. According to one officer, “…Some EHTs cover up to three wards, while the ideal number is about one EHT per ward…They are not motorised, and, looking at the areas they have
to cover. a push bike is not ideal...” (HP 32). As far as VCWs are concerned, they have bicycles but are not provided with money for repairs. One VCW says
...this would enable us to go around doing our work. Because many a time you end up footing because you do not have money to repair the bicycle...and the villages in this resettlement area are very far apart...[H.1]

As far as equipment is concerned, shortages are not as drastic but nevertheless place a constraint on the provision of adequate health services. The district laboratory technologist expressed the need to have improved machinery in the haematology section so that they can do all parameters required by the patients and doctors in the district. The district information officer said “in Information and Records [department] there is need for a computer as well as a typewriter and a duplicating machine”. A typewriter and a duplicating machine would help the department to type and print all the numerous types of forms they use on a daily basis instead of using inappropriate forms that were printed many years ago. It also takes a long time for new orders to come in. The officer indicated that a computer would be crucial in saving space and time, especially when retrieving stored information.17

At the health centre level there were not many complaints about equipment shortages. However, those few were quite disturbing. One nurse said that they did not have a single item one of the important pieces of equipment, such as dispenser machines and speculums.18 At another HC, a nurse said. “We do not have certain forceps that we need for deliveries, as well as scissors, suction tubes, oxygen equipment and material like wool.” (SCN.H)

With regard to equipment at the district hospital, a senior official has this to say:
The hospital has a lot of it but no workshop for servicing it. Almost everyday you hear reports about breakdowns...Remember we are servicing the whole district, so with such breakages I think we need our own pool so that these things are attended to immediately [AP24].
This further strengthens the argument that was made above, that reliance on other government departments is likely to slow things down. Commenting on the effect of CMED, public construction and posts and telecommunication on the district health care services, the same official says that "...when those services involve other ministries, you see that some of our activities are being jeopardised...that ministry may not see things from our point of view" (AP24).19

Evidence here has shown the importance of transport, equipment and communications for the achievement of the district health system's objectives. Lack of logistical support, especially transportation, hinders the execution of essential duties. These include follow-up activities, outreach work and also supervision and communication with field staff. Although I cannot definitively say the reason is just lack of transport, APPENDIX V.1 shows erratic supervisory visits to HCs by district health officials during 1992 and 1993. For example, between January and September of 1993 Nyadiri Resettlement HC was never visited by the DMO, the DNO, or the DHSA, the most senior officials in the district.

5.4 SUPPLIES AND ESSENTIAL DRUGS

As I have indicated above, most Third World countries are currently facing financial difficulties, some of which involve high rates of inflation and WB and IMF directed devaluation of local currencies. Devaluation of local currencies has a direct effect on the purchase price of drugs, because drugs "... are largely acquired in international markets with foreign exchange and at internationally determined prices" (Barnum and Kutzin, 1993 : 27). Because of this and other reasons that I do not have time and space to discuss, "[a]bsolute shortage of essential, basic medicines (curative and prophylactic) is a common phenomenon..." in the Third World (Phillips, 1990 : 262). Yet, "...the supply of
essential drugs is "one of the eight elements of PHC" (Hordon, 1990: 29). When asked about the existence of this problem, the DMO said the following:

I think it's a national problem more than a local problem. They [the government] have not been able to get foreign currency to buy the raw materials from outside to make the drugs. So it's a chronic problem ... as it was experienced last year [AP27].

The types of general supplies that were found to be in short supply at both HCs and MDH included such items as dressings, gloves, syringes, bandages and chemicals and films for the X-ray department. A nurse working in the female ward at MDH addressed these issues by saying

... yes especially gloves, some lotions and dressing. Like now, we are given a 375ml bottle [of lotion] for the whole week, we have big wounds, and burns that we have to tend, and with that one bottle we cannot manage. We do not have cotton wool and sanitary pads that we need for threatening abortions... right now we do not have even one in the ward and, about gloves, we get about 2 or 3 packets for the whole week and this is nothing with the diarrhea cases we have these days ... [SRN 4].

All the health personnel who were interviewed at HCs indicated that they had shortages of drugs. Out of the eight, only one said that they did not experience this for long periods of time. However, the other health personnel at the same HC indicated that 1993 was the year they had been hit hardest by the problem.

At MDH only two nurses out of the health-care personnel, nurse-aides, nurses and senior officers who deal with medicines, including the district pharmacist, indicated that the hospital experienced shortage of drugs. One senior member (AP 26), supposedly wishing to be modest, said that the hospital was not seriously affected, and that they had the essential drugs. Perhaps this was the case, relative to the situation of other health centres. One nurse-aide said that they leave some for emergencies, while one other nurse indicated that they normally have alternative drugs. Again, it could be that ... particular hospital is favoured (over HCs) in the allocation of drugs.
The types of drugs that were frequently mentioned were antibiotics. One nurse (SCN 1) stated that the pharmacy could not cope because of the increased number of sexually transmitted diseases. Other drugs in short supply are: the drug for T.B. patients; drugs for pregnancy-induced hypertension; and those for other chronic diseases. We think the plight of this nurse (working in the paediatric ward) brilliantly portrays the situation under which the district health personnel are doing their work. She says...

...since January we have had to improve...We do not have enough syrups...[so]...in most cases we get tablets, but they are bitter, and if you crush them most of the children do not get enough doses...and they won’t swallow it all. We are also running short of very essential drugs, ...such as paracetamol syrup, something we need every day; bicarbonate of soda, but when we are resuscitating it is one of the major drugs used. And sometimes we run short of oxygen, it is needed so much in the...ward because sometimes children collapse and that is the method of resuscitation which should be readily available [SRN 17].

The district pharmacist, who acknowledges that there is a problem, says “...we continue to encourage our staff to use the little they have as economically as possible, that is, to prescribe rationally” (AP 30). This is corroborated by one nurse, who talked about the shortage of paracetamol, eye ointment and antibiotics in the out-patients department. She said,

We are really straining, so much that when you prescribe you actually cut the duration [of intake] because there are no drugs. The intravenous fluids are not there. Like at present we don’t have gloves, a real AIDS menace [SRN 3].

The encouragement to prescribe rationally that the pharmacist is talking about is actually the result of a call from central offices. In a government publication on how to deal with the negative effects of ESAP it is said that

there should be a conscious effort on the part of the health providers to reduce the cost per patient per day by reducing patients’ length of stay and rational use of drugs [Zimbabwe, 1992 : 16].
At this juncture, I can only point out the fact that the shortage of drugs and supplies is a severe constraint to the implementation of PHC. I shall discuss its implications for the utilisation of services below, and leave the full discussion of its impact until Chapter Seven.

5.3.2.1 Users' Attitudes And Reaction To Drug Shortage

Users of health services are members of the Mutoko district community. In this study they are represented by in-patients and out-patients that were interviewed at MDH and, the householders who were interviewed in their homes. Of the 24 in-patients excluding waiting mothers who indicated they had come to MDH through referrals from HCs, 10 said the reason was lack of drugs at their local facilities. This number could be larger than ten, because it is possible health personnel might refer people without specifically telling them the reason is shortage of drugs. Most of the out-patients (totaling 47) came from the district hospital’s catchment area and, of the 16 that were referred, 5 indicated that the basis for those referrals was shortage of drugs. At Village 10 in Nyadiri Resettlement Area, of the 28 individuals from 20 different households that were interviewed, 14 expressed deep concern over drug shortages at their local HC as opposed to 5 (of interviewees) from Sasa Village. One possible reason for such a large discrepancy is that Village 10 is more than 20 kilometres away from the nearest Nyadiri Mission hospital and only half a kilometre from the local HC, hence they are heavily reliant on the HC. On the other hand, Sasa Village is closer less than 10 kilometres to All Souls Mission hospital which is likely to be relatively better stocked compared the nearest HC.

Among all the in-patients and out-patients, only one made a comment about shortage of drugs at the hospital (MDH). This is a mother who was with her child in the children's ward. Although the child had a boil and a cough, the hospital personnel were only treating the boil because they did not have medication for the cough (IP 2).
Most of the comments about drug shortage were directed at health centres. Here are a few of them:

1. "...here there are more drugs, at our clinic they do not have drugs [IP 7]."
2. "... we choose to go to hospitals...there are more drugs [OP 40]."
3. "I think here things are better than at the clinics ... [so] ... they encourage people to come here. They say that do not have some of the drugs and we must come here [OP 25]."
4. "Nyamuzuwe clinic is close to us, but it is closed now. Drugs are a problem so it has been closed for 5 months [IP 21]."
5. "Nyamuzuwe clinic ... they handle people well but drugs are a problem [IP 12]."
6. "... when you go to the clinic they...say they have no drugs for it [cough], or even a headache ... [NP 2a]."
7. "There is a clinic close to our home, but they have problems of drug shortage ... After the child got burnt (at night), I passed through there and they told me they didn’t have medications and that I should come here [IP 9]."

However, the more poignant remarks are those that expressed the respondents’ helplessness and powerlessness in this matter. One in-patient said

The clinic close to us is always out of medicines, so they refer most serious cases to this hospital. So many people just stay at home with their illnesses, and some with money just come straight to the hospital [IP 3].

There are extra expenses are involved in going to the district hospital. One needs money for bus fare, for the treatments (if applicable) and possibly for lunch. Treatments might take long and buses are not conveniently frequent enough. Hence, one in-patient makes this plea: "...We urge them [officials] to supply clinics with more drugs, because everybody can reach them easily, including those without bus fare to come here" (IP 9).

The problem, according to one respondent, is that "... we just have buildings without drugs ... and, after you have walked all that distance you have to come back home in pain."
untreated ..." (NP26). The whole essence of social justice and equity in health services provision is invoked by the plight of a woman with asthma who says the following:

Some of us have illnesses that require tablets daily. But we sometimes go there and get told there are no tablets. And yet we are told not to default, which ends up happening because the medication is not available. And when that happens sometimes I have no money to go to the hospital [NP3a].

The scenario that has been painted here is that there is a general drug shortage in the country, in the district of Mutoko and even more so in the health centres. Because of this, more people are referred to the district hospital. Those that are more disadvantaged are those that cannot afford that long trip to MDH but nevertheless have great health needs.

5.4 HUMAN RESOURCES

The magnitude of rural health needs in the Third World makes it necessary that the health services provision be both capital and labour-intensive. However, in reality labour continues to be maldistributed, paralleling that of other health resources (Heller and Elliot, 1977). Navarro (1977) contends that the city-based elite has an economic and political influence on the distribution of resources, resulting in most of the human resources being centred on the country's "enclave". In Zimbabwe,

... thirteen years after independence, there still exists a maldistribution of health personnel between urban and rural health institutions ... both a legacy of the past and because rural life is sometimes perceived to be less appealing than urban life [Zimbabwe, 1993 : 2].

Worsening the problem is the continued brain drain from the MHCW. 24 Personnel are leaving public service for greener pastures in the neighbouring countries or Western countries (Daily Gazette, Sept. 8, 1993 : 8), as well as the Zimbabwean Army. An EIU
report states that "in the first seven months of 1991 110 doctors, mostly lecturers at the medical school resigned to work in neighbouring countries where pay was about double". (1992 : 12). Actual figures for all physicians could be higher than this because Appendix V.II shows that in 1991 only, the government lost 118 physicians, specialists and consultants combined and 83 in 1992. The reduction in wastage as we move from 1991 to 1993 could possibly be explained more by saturated outside job markets than an improvement in working conditions in the public service. The loss of specialists (to brain drain) is claimed to have reduced qualified pathologists in the public health sector to four (Daily Gazette, Sep. 8, 1993 : 8). By 1992, staff shortage was claimed to have brought the tuberculosis control programme to a halt, causing the reported cases to rise from 2000 in 1989 to 9600 in 1990 (EIU No. 1, 1992 : 12).

Appendix V.III shows the establishment of MDH. Apparently, only key posts have been included because of limited space. The minimum nursing posts required for smooth operation is 80, yet the approved and actual posts filled are only 44. Approved Government Medical Officer (GMO) posts are 3, and only one post is filled. As of 1993, both the DMO and GMO were expatriates. It is not, therefore, very surprising to hear a senior member of the hospital saying

... this is a very new and big hospital, but I think we are the most understaffed health centre in the province. Almost every department/ward is understaffed...because (almost) each day [nobody] ...work[s] 8 hours in one department, we are always shifting people [AP26].

Throughout the district there are, in fact

... continuous complaints of lack of nurses ... [but] the worst place is the district hospital. It has been upgraded ... [yet] we are still with more or less the same establishment as when it was smaller [AP27]

Apparently, these staffing levels have been severely affected by cost containment policies inherent in ESAP. According to the government of Zimbabwe, "the economic capacity to
employ has become a strong force to determine the levels of staff requirements (1993: 11). Hence,

there will be no increases in the establishment and there may well be a reduction of certain categories of employees in line with the policy of reducing the size of the civil service [Zimbabwe, 1992 : 15]

Consequently, by 1992, 790 health workers had been dismissed and 400 nursing posts had been abolished (EIU No. 4, 1992), a development that makes one to doubt that the government will be able to reach the minimum staffing levels (depicted in APPENDIX V.III) that it is aiming to fulfill (Zimbabwe, 1993: 27)

One concerned nurse at MDH said the following, “the number of nurses is decreasing instead of increasing, because if I resign or die today no one will replace me, so there is a big gap now” (SCN 11). According to another nurse in the maternity ward, about eight people had left the hospital and they had not been replaced by the time this study was done (SCN 18). Both of these nurses [as well as everybody else] know quite well that this freezing of posts and the resultant shortage of staff they are experiencing first hand are largely the result of ESAP.

5.4.1 WORKERS’ VIEWS AND ATTITUDES TOWARDS STAFF SHORTAGE

Staff shortage was a persistent theme in the interviews with all categories of personnel. In fact, I was intrigued by the frequency with which respondents in the study unexpectedly and deftly brought up this issue when called upon to discuss other, seemingly unrelated, aspects of their jobs. Hence, directly and/or indirectly, 42 out of 45 facility based health and administrative personnel and field staff supervisors indicated that there is a serious shortage of staff in the district.
One of PHC principles is equitable distribution of resources. When asked if health personnel were deployed according to need, a senior officer at MDH replied: "With ESAP it is very difficult to do that now because it seems they [authorities/government] are not interested in creating new posts for stations ..." (AP26). A supervisor in charge of health centres answered the same question by saying that "... all government health centres have two SCNs, a nurse-aide and a general hand, regardless of the size of the health centre's catchment area" (AP36). Besides the nationwide urban bias in human resource distribution there are chances that a number of HCs are covering large catchment areas with the same standard staff complement, possibly causing others to manage more cases than others. With regard to EHTs, ideally, one EHT should cover one ward, but at present one is covering about 3 wards (AP32). The hospital (MDH) is also "...shortstaffed", as one cook put it. "...because once I get in it's work non-stop" (AA) she says. The same goes for ambulance drivers. One driver said that "there are so many departments that need drivers/transport [so] there is pressure of work...if manpower could be increased our workload might become lighter" (AD). Given such a scenario whereby every department is short staffed, it is understandable why respondents would mention it at every opportunity. It has become a syndrome (the 'shortage syndrome'), affecting them directly, apart from its other consequences.

There is a general consensus and profound concern that roles and responsibilities of facility based personnel are no longer clear. In other words, people are no longer performing their tasks according to job descriptions. These are some of the typical comments respondents made regarding this issue:

A (nurse-aide): With this shortage of staff we end up doing duties not on our job description.

AP26: ... with the staff shortage ... a person is not sticking to what he/she should be doing at that time.

SCN6: ... sometimes we have more responsibilities because of staff shortage.
SRN17: I can't do what I am supposed to be doing because of the staff shortage.
SRN3: It is confusing ... you find that you are the nurse and doctor, could be the nurse-aide as well ... [or] the general hand ... because of the shortage.

In response to the question, "Do you think there is adequate delegation of authority and responsibilities in your workplace?" a number of senior nurses, mostly SRNs, expressed concern over 'who to delegate to', rather than over whether their supervisors delegate to them. Hence, I got answers like "No, there isn't because of shortage of staff...due to ESAP" (SRN 5; SRN 12). Another expressed his strong feelings as follows: "...I hereby repeat the issue of staff shortage, because there is nobody to delegate duties to. You have to do everything yourself..." (SRN 4). So, put in such a bind it is logical that one would not consider more responsibilities and authority.

The DMO and other supervisors are not exempt from the 'shortage syndrome'. The matron of MDH intimated that personnel are not sticking to what they should be doing at any particular time. She gives the example of her own situation by saying, "Like this morning, I was stuck in the maternity department doing deliveries instead of attending administrative issues...". The same applies to the DMO, who stated that he has no time to concentrate on all his formal duties. He said:

There is need for at least half the time as a DMO to do official administrative duties, preventive health programmes, statistics administration and management of district health services. But, as long as the patients are queuing outside your door the whole day somehow its impossible to run away from clinical problems, and the other side suffers.29

It seems useful at this juncture to discuss these two cases in light of research that has been done into role theory. This research has gained momentous impetus from the path-breaking work of Kahn et al. (1964). One of the basic needs of any organisation, according to Kahn et al. (1964 : 5), "... is dependability of role performance" by
organisational participants. The organisation, however, has unintended effects upon those who work in it, for example, in the form of demands/stressors.

It is my contention that staff shortage has created objective conditions sufficiently fertile for the development of role conflict for the DMO and matron positions. Role conflict has been "...defined as the simultaneous occurrence of two (or more) sets of pressures such that compliance with one would make more difficult compliance with the other" (Kahn et al., 1964: 1964; Katz and Kahn, 1978). Therefore, a "...person's occupancy of alternative roles...may result in conflicting expectations concerning his behaviour" (Warr and Wall, 1975: 148). One of the examples of this 'sent role' (Kahn et al., 1964) or 'inter-role conflict' (Warr and Wall, 1975) that is given is that of a foreman who is also a shop/union steward. Problems of conflict are also said to be varied as well as specific to each individual (Kahn et al., 1964).

Going back to the 'focal persons', we find that the matron is faced with contradictory demands, with two different demands competing for her time, one of which (clinical duties) is performed primarily because of staff shortage. The doctor (DMO), on the other hand, has multiple roles, one of which (clinical duties) is performed at MDH where he is based. Due to this proximity (combined with a moral obligation because the queues are staring him in the face) it is hard to neglect this role, of course, at the expense of other roles that should benefit the other hospitals and HCs in the district.

When demands of one's job or roles (environmental pressures) conflict with one's needs and values, we have what Kahn and associates (1964) call 'person-role conflict'. We have this in the nature of a significant number of health personnel who have a strong urge to go for in-service and/or post basic training courses. Where SCNs are concerned, this also involves training to qualify to be SRNs so that they are at par (on several parameters, including salary scales and promotional chances) with some of their
workmates. They can not be released to go for these courses because of staff shortage. Interviews are replete with comments like:

SRN3: ... staff shortage is so much that you can’t go further with your education if you want to ... So ... I can say my aspirations are shattered.

SRNS: ... we are supposed to go for in-service training, and because of staff shortage we can’t go, we can’t leave the hospital.

SRN 13: With regard to post-basic training, even the family planning programme that is offered here, we cannot do it because of staff shortage.

To the effect that health personnel are impeded from effective performance of their daily duties by lack of information that they would otherwise acquire from such further education/courses, we can talk of the possible existence of ‘role ambiguity’. This concept is defined as lack of specificity regarding job responsibilities (Kahn et al., 1964), or as ‘...lack of clarity, or predictability, about the expectations associated with a given role’ (Warr and Wall, 1975 : 148), including not knowing what opportunities for advancement or promotion exist for you. Lack of clarity can stem from lack of information, inadequate communication or other variables. The following discussion with a nurse serves to explain this issue.

Q: If we look at the qualifications that you have at present, would you say they are adequate for you to deal with the prevailing health problems?
A: I think they are.

Q: There are no illnesses you cannot deal with?
A: Uh ... there are certain diseases yes. Not that we cannot deal with them, but we need more information on them.

Q: And what do you think should be done about this?
A: I think there is need for refresher courses [SCN1].

Refresher courses are sometimes offered in workshops, and according to one nurse “...most nurses cannot attend [workshops]...so we are not up to date with current information because of shortage of staff due to ESAP” (SCN 18). Many nurses that expressed similar concerns wanted either to learn more about diseases like AIDS, or to learn other areas which they did not specialise in at college, considering the fact that they are rotated from ward to ward at certain intervals. A good example of the latter case is
that of a nurse in the psychiatric ward who said, "The problem I face is that of working here without enough knowledge" (SCN 6). Or another one in the same department who said with regard to some procedures he "... need[s] a qualified psychiatric nurse" to be around (SCN 9). Also, the fact that "...each day [the supervisors] can't make a person work eight hours in one department, [they] are always shifting people" (AP26), can cause role ambiguity. Another example of role ambiguity is that of the problem suffered by many health personnel, of having to do duties outside of one’s purview. For example one senior nurse who normally knows what she is supposed to be doing can not do that which she is supposed to "...because of staff shortage. As a result...you can go astray and start not knowing your job description" (SNR 17).

The job stressor that was most evident and which affected almost all categories of workers is role overload. Warr and Wall (1975 : 155) define it as "...having work to complete which is either too difficult, or of which there is too much, to carry out in the time available".34 We think that the quantity and time based incompatibilities are key dimensions in my study, but we also require the quality aspect. Therefore we require Kahn’s (1980) conceptualisation, which defines role overload as...the amount of pressure felt to do more work, the feeling of not being able to finish an ordinary day’s work in one day, and the feeling that quantity of work interferes with its quality [Bacharach, 1990 : 202].

While the theme of staff shortage was central in interviews with respondents, its effect, as well as their feelings of powerlessness, manifested itself in the prevalent use of the word ‘overload’. At MDH, nurses expressed concern over having to be the only or one of two health personnel in a ward most of the time. Each ward has a capacity of about forty and, "because you are working with forty patients, it is difficult to attend to them all" (SRN4). Expressing the quantity and time incompatibilities (of role overload) in her own words, nurse SCN7 in the male ward said, "...most of the time we do not finish what we are
supposed to. At times, you can be the only trained nurse to cover bays one to six, with
the ward being full”. Similarly, another one said, “Other times you go home before you
accomplish what you were supposed to, just because it is time up” (SCN 11). In the
female ward we met a male nurse who had 48 patients, alone. He said, “it’s a big
problem” (SCN8). In every ward we came across similar concerns. In the paediatrics
ward a senior nurse put her situation across as follows:

We are short staffed. As you noticed this morning we are only two.
There is no nurse-aide, no junior nurse to help [us], so even if you are the
one in charge you have no time to do administrative work you are
supposed to...And sometimes we ask the mothers [of patients] to help us
because of the shortage [SRN17].

Similarly, in the maternity department another said, “We are very few in this
department, ...and we do a lot of things at the same time, [including]...a lot of paper
work...[we are] ...under a lot of pressure” (SCN18). The same pressure (if not more) is
also felt by HC personnel, whom the community sister said “... always complain that they
have so many different programmes to implement, and so many things to report on but
there is only one or two people ...”. According to the matron at MDH, HC nurses
... do domiciliary services. They have to visit the chronically ill patients
within their catchment area, and also go into the community to do some
health educating .... So if one goes it means that the one remaining at the
clinic might not ... cope.

On top of this they have to do a lot of paper work, including morbidity, mortality and
immunisation reports. And prenatal and postnatal visits. These are not always done and
sent to the district in good time, according to the district information officer. Surprisingly,
the three (2 SCNs and 1 nurse-aide) health personnel that indicated their health facility
was not short staffed are based at (three different) HCs, and their partners indicated
otherwise.35
The feeling that the quantity of work interferes with its quality was also expressed by many health personnel. Since this is the subject of Chapter Seven we shall only briefly illustrate this phenomenon in order to complete my discussion of role overload. Asked what sort of problems she experienced when dealing with patients, SCN7 said that “they expect to heal quickly and be out of hospital. They feel you are not giving enough treatment or nursing care, which is of course a result of that shortage which I have talked about. So it’s not the patient’s imagination”. Some showed deep concern that the little time they have to perform their pressing roles does not give them enough time to perform a necessary component of health services, health education. A nurse in the paediatrics ward said, “...sometimes you don’t get enough time to give health education to the parents of the patients we are treating” (SRN17).

The next example indicates the existence of person-role conflict and the quality dimension of role overload. A nurse who indicated a desire to go for in-service training in child care was asked why she chose that area. Her answer was as follows:

I suffer inwardly, ... because I see that we are not doing enough to educate mothers. You find a child is born here healthy, and some months after that child has been taken home, you find them coming back with severe malnutrition. So I think we are not giving enough health education to mothers...We do [educate them on the importance of breastfeeding],... but we are failing [to do enough] because ... of staff shortage, we are very few [and] myself I am not happy about it [SRN 4].

The whole concept of overworking is captured in this sarcastic comment: “When they talk of ESAP, they probably mean 5 nurses are supposed to accomplish the duties of 25 nurses” (SRN 3).

In order to obtain information independent of the respondent’s own perceptions, we supplemented the interviews (and government statistics on staffing levels - Appendix V.III) with observations. Visits to the wards enabled me to see at first hand how staff on duty cope with the issue of staff shortage. Many interviews had to be postponed, some of
them several times, because the interviewee had no one with whom to leave patients. In some cases, where an interview was started with someone on duty, he or she would attend to something, either because the worker was alone or because the only other person on duty was also busy.

The waiting area for out-patients proved to be another strategic place to gather valuable information. Out-patients also showed concern over staff shortages, particularly shortages of doctors. The reason is that the doctor sees in-patients in the morning and attends to out-patients in the afternoon (if their problems are beyond the scope of the nurses). And some will have arrived early in the morning to be at the head of the queue. Also, there are times when some out-patients do not get attended to. For example, on 13 September 1993, 20 people had not been attended to by closing time. Most complained because they had come in the morning. Some had been attended to but had only visited some of the requisite points/departments but not all, by closing time. A few with whom we talked suggested those problem areas, including the out-patients clerk’s desk, be manned by more people in order to speed things up.

In closing this section, I would like to reiterate my concern with gender inequalities in society. I have already indicated that the overwhelming majority of health personnel are women. I have also pointed out the subordinate nature of women’s overall position in Zimbabwe. Hence, they are bound to have especially demanding roles to play in the family. Our health personnel are part of this society. They are at risk of overworking at home as well as at work. In other words, the job stressors which I have discussed are presently affecting women more than men. These will not change in the near future, given the low representation of women in the top hierarchy of the MHCW.
5.4.2 AVAILABLE BUT UNDERUTILISED HUMAN RESOURCES

In African countries, as is true of most other developing nations, "... the number of Western trained medical personnel, the number of clinics and hospitals in the rural areas, and the amount of money available to ministries of health are all inadequate to meet existing needs" (Green, 1988: 1128). It is imperative that viable solutions be sought so that these health needs are satisfied. The abundance of people with traditional healing knowledge and skills in this region begs that more than a cursory and partial view of this scenario be taken if the existing contours on the health fabric are to be smoothed out.

In the late 1970s when PHC was institutionalised, the WHO asserted that this strategy "...has to make use of all available resources, and therefore has to mobilise the human potential of the entire community" (1979: 61). It then passed a resolution that promoted training and research in traditional systems of medicine around the same time (Haram, 1991). Furthermore,

the WHO has [since that time] been prompting the biomedical establishment ... to adopt a ... more open mind about the contribution and efficacy ... of traditional-based systems... [Phillips, 1990: 83].

These propitious efforts come in the wake of more than a century of a process called 'structural iatrogenesis', which "...refers to the destruction of indigenous and folk medical cultures...leading...to...the expropriation of [the] health" (Gerhardt, 1989: 310) of the indigenous people. The process of the 'underdevelopment of traditional medicine' started with contact with the West (Igun, 1992). This contact had many fronts which include advances in modern medical science, Christianity, western education and colonialism (Chavunduka, 1986). For a number of reasons, colonial governments and missionaries discouraged the indigenous people from using traditional medicine (Phillips, 1990). Traditional healers were regarded as encouraging beliefs of witchcraft, as a major stumbling block in Christian missionary work, and the worshipping of ancestors instead of
God (Chavunduka, 1986; Agere, 1986). Ethnocentrism also played an important part, for early Europeans regarded those that acted contrary to the way they did as ignorant heathens.

According to Igun.

... indications are that [this underdevelopment] ... is continuing even under independent African governments. The ruling group, the academic and political authorities, tend to accept the values of the modern professions and give their support to them with concomitant neglect or even outright suppression of ... traditional professions [Igun, 1992 : 150].

As a result, the available traditional medicine "... may be of poor quality because of its general subordinate position and exclusion from an organised system" (Igun, 1992 : 152)

The current efforts to revive traditional medicine, apart from trying to regroup endangered cultural elements, is not simply a foray into the unknown. Numerous studies have revealed various positive things about traditional medicine. A good number of items in the traditional pharmacopoeia as well as medical techniques have been found to be effacacious (Chavunduka, 1986; Oyeneye, 1985; Igun, 1992; Freeman and Motsei, 1992). Indigenous medicine has been found to cure as well as heal (Subedi, 1992; Young, 1993). It has been found to be particularly effective in the treatment of health problems like psychiatric, orthopedic and maternal and child problems (Oyeneye, 1985). Since African healers make little distinction between body, mind and spirit, the whole person is treated (Chavunduka, 1986; Eudo, 1985; Green, 1988). This holistic approach has led to insight and success in treating illnesses with a psychosomatic component and, according to Green, "... most [modern] physicians lack both the training and the requisite familiarity with patients' social and family situations to deal effectively with patients' psychosocial problems" (1988 : 1128). In addition to performing a purgative and cathartic function in order to reintegrate patients into their society (Azevedo et al., 1991 : 1347), traditional
practitioners offer both social and mystical explanations for the causes of illness (Nyazema, 1984; Oyeneye, 1985). Hence even amongst people who generally use western medicine when they are sick, there are instances when the illness is seen to have African experiential causes, and can therefore not be treated by allopathic medicine [Freeman and Motsei, 1992 : 1186; Nyazema, 1984].

Equally important, is the fact that traditional practitioners are available, accessible, affordable, acceptable, and culturally appropriate to the indigenous population (Chavunduka, 1986; Green, 1988; Azevedo et al., 1991; Freeman and Motsei, 1992).

Once a government recognizes the importance of traditional medicine, there are a couple of possible ways in which the roles of traditional healers (THs) could be formalised. Some of these are incorporation/inclusion, cooperation/collaboration and, total integration.36 After gaining political independence, the government of Zimbabwe “...took the policy of registration and inclusion of [THs] into its national health service ...” (Freeman and Motsei, 1992 : 1187; Chavunduka, 1986). This policy has been implemented in Mozambique and Swaziland as well, but Freeman and Motsei (1992) contend that these policies have not resulted in the anticipated consequences. In Zimbabwe, despite official recognition of THs, there has been formal and informal resistance to the policy. Referrals are supposed to be mutual but are skewed in favour of the modern health sector (Freeman and Motsei, 1992). Apart from licensing THs, no other formal structures have been laid down to stipulate their role in the formal health system. According to Kikhela and associates, “simply licensing practitioners does nothing but announce publicly who the healers are ... [i]t does not indicate how the traditional healers are to be integrated into the health service system ...” (1981 : 97).

The country most cited as a success story in the implementation of one of these strategies is China. In China the integration of western and traditional medicine has been
quite successful. After the implementation of the policy in 1965 "... traditional practitioners [could] work in government hospitals and sit on committees responsible for hospital administration and common health services" (Ojanuga, 1981: 408; Li Wang, 1975; Igun, 1992). The resultant union of the two health systems is argued to have lowered the cost of a rapid expansion of medical services and facilities (to rural areas), and has allowed barefoot doctors, midwives, and health aides to share the responsibilities for health education, family planning, and mobilising the masses for a clean environment (Li Wang, 1975).

5.4.2.1 Aetiology of Disease and Traditional Medicine in Zimbabwe

According to Chavunduka (1986), there are many factors that determine one’s choice to consult a modern practitioner or a traditional healer. These include "...the cost of each type of treatment, and the definition given to that particular illness at that particular time by the individual and members of the social group" (Chavunduka, 1986: 32). Different societies have their own ways of defining and managing illness as well as their environment. It is Eaudo’s contention that "society [should] not negotiate sociocultural imperatives for a borrowed culture or rid itself of the traditional culture" (1985: 1345). Values, attitudes, behaviour, beliefs and perceptions of health, health problems, health needs and illness are developed within these socio-religious, cultural and environmental foundations (Ngubane, 1977; Nyazema, 1984; Mutambirwa, 1985: 1989; Eaudo, 1985).

Because of the presence of these socio-cultural imperatives, indigenous Zimbabweans have their own health values, views on aetiology, disease transmission and treatment that should be taken cognizance of by health planners.

Both traditional healers and their patients believe illnesses are caused by many things, ranging from witchcraft and spirits to bacteria and germs. Hence traditional healers
investigate all the environments physical, social and spiritual, for the causes of diseases (Chavunduka, 1986; Mutambirwa, 1985).

The first category consists of illnesses that people believe to be normal or natural (Chavunduka, 1978: 1986). These are illnesses such as coughs, colds, slight fevers, headaches, that occur from time to time and disappear. The problems associated with physiological changes and those arising from ecological changes are of a fleeting nature and are accepted as natural processes of life (Chavunduka, 1986; Mutambirwa, 1989). Ngubane (1977 : 123) calls them illnesses that ‘just happen’ and says they range “from common colds to serious epidemics such as smallpox and influenza”. According to Chavunduka (1986 : 32), “many people agree that normal illnesses are caused by such things as germs, bacteria, bad food, accidents and so on”.

Mutambirwa (1989) talks of the same illnesses but takes the issue from a slightly different standpoint. She states that traditional belief is that diseases are transmitted by ‘bad airs’ which are part of environmental air that contains good and bad elements. The first type is the bad air associated with diseases that affect the body and it is believed to originate from the physical environment. According to Mutambirwa (1989), no spiritual significance is linked to them because their source is considered entirely natural.

The second category of illness consists of the illnesses which people regard as abnormal or unnatural (Chavunduka, 1986), or those caused by the second type of ‘bad air’ (hence also viewed as unnatural) (Mutambirwa, 1989). According to traditional belief, if a headache or stomach-ache persists or fails to respond to medication, it then changes to abnormal or unnatural illness. Abnormal illnesses cause serious health problems that affect one’s physical, social/and spiritual existence. The unnaturalness of the air emanates from the belief that the just Creator does not permit ills to attack his
people. Hence such illnesses are thought to "originate from evil powers associated with physical or earthly aspects of life..." (Mutambirwa, 1989 : 929).

Traditional beliefs do not preclude the ultimate authority of the Creator, but in between are the ancestral spirits through which people's requests are channeled. Abnormal illnesses or 'bad air' that causes serious health problems are believed to attack those without spiritual protection from the ancestors and the Creator. Lack of protection from these powers lowers one's resistance against the above health problems. Ancestral spirits will not intercede for or protect their posterity from illnesses if they engage in irresponsible behaviour, fail to observe traditional rites or fail to concede to some of their requests (Mutambirwa, 1989; Chavunduka, 1986).

People's concepts of health are, therefore, inseparable from their concepts of life. Humankind is believed to be made up of three parts: the body/flesh, the mind/soul, viewed as immortal, and continuing to function during and after death to become the ancestor spirit, and the spirit, which lives in eternal health through its moral and just function, and directs the body to carry out healthy physical activities by engaging in moral, just conduct (Mutambirwa, 1989 : 928). There is no break of continuity between the world of the living and that of the dead.

All of the above conceptions, then, determine people's decisions on where to seek treatment. In the case of normal illnesses, many people use herbs or go to modern medical practitioners, but once the illness is defined as abnormal, people usually consult traditional practitioners alone since they are aware that modern doctors are unable to attack the[ir] ultimate cause ..., namely, jealous neighbours and co-workers, spirits or malignant kinsmen (Chavunduka, 1986 : 32).97

So, to the indigenous people, western treatments are for the body and traditional ones are for the body, mind and soul. Traditional ones heal as well as cure (Subedi,
Gessler has described the two functions of healing as the "...control or treatment of the problem, and providing a culturally defined meaning for ...[one's] experience of it". and whereas modern practitioners only perform the first one, indigenous practitioners perform both (Subedi, 1992 : 323). Unlike the biomedical science of curing that is based on universalistic claims and applications, Young (1983 : 1208, 1210) asserts that the process of healing "is predicated on the particularistic perceptions and expectations of sick people and the realities constructed by their medical cultures...[and]...their choice of medical options is strongly influenced by the meanings which they give to these sickness events and by the desire to limit or control their attendant anxieties.

Since official medical sectors are not organised to deal with these meanings and psychological needs (Young, 1983), people "... tend to accept, identify, seek and feel satisfied with indigenous health care because [it is] closer to them culturally and appeal[s] to them emotionally" (Subedi, 1992 : 323).

There are many types of traditional healers in Zimbabwe, and here I will discuss a few major categories. There are spirit mediums (or spirit diviners), who are believed to have the ability to communicate with ancestor or alien spirits while in a state of spirit possession (Chavunduka, 1986). They are mainly concerned with causes of illness, hence they specialise in diagnosis and (in most cases) refer patients elsewhere for medicines. The second category comprises herbalists, who are not concerned with the causes of illness but the treatment of physical symptoms. People with symptoms come directly or are referred by spirit mediums (Chavunduka, 1986). Next are spirit mediums who are also herbalists, who carry out a diagnosis while possessed and also treat patients. Then there are general diviners, who are also experts at carrying out a diagnosis by the use of bones (small pieces of wood, stones, shells, etc.) (Chavunduka, 1986). Then there are traditional midwives who are most likely to be well versed in traditional herbs that are relevant in their field of work. According to Chavunduka (1986) each category has its
own specialists; other specialists concentrate on children’s diseases, others on women’s illnesses, still others on mental disorders and so on.

The realisation that traditional medicine, versed in local psychology, is better oriented to deal with some of the social, physical and mental problems of the indigenous people prompts scholars like Chavunduka (1986), Mutambirwa (1985, 1989) and Nyazema (1984) to argue that traditional health care should be understood thoroughly so that it is made part of the national health system in order that the whole nation’s health needs are met adequately and appropriately. Writers like Subedi (1992) argue that developing countries with limited health resources which agree to make such positive changes should use modern medicine as a supplement to indigenous health care, and not vice versa.

5.4.3 HEALTH PERSONNEL’S SOCIAL ATTITUDES TO TRADITIONAL HEALERS

The history of biomedicine in the West “... has been one of consolidating a monopoly of power and stamping out competition ... from ... competing health care systems (Green, 1988). As it spread to other nations, to the South and East, it never lost its claims at universal validity. Haram argues that
the representatives of biomedicine cannot relinquish their claim [to universal validity] in the encounter with the folk medicine, unless traditional healers accept the fact that their own medicine is a culturally specific description of biological processes whose ‘literal’ description is to be found in modern medicine. If a medical doctor were to accept native medicine as an adequate alternative medical system, he would derogate from the very foundations of his discipline [Haram, 1991 : 173]

According to Phillips, negativism among officials is “... sometimes the result of attitudes inherited from colonial times and imbued in Western-trained doctors” (1990 : 77). Consequently, as noted by Vuori, many modern health professionals and authorities “believe, and would wish traditional medicine to be, ‘dead as the dodo’” (Phillips, 1990 :
83). In Igun's words, they "... close-mindedly dismiss traditional systems as a load of old rubbish" (1992: 155).

Table 5.1 presents health care workers' attitudes towards traditional medicine (TM)/THs. The relatively large number of respondents in the second category allows me to make an informed assessment of these workers' opinions regarding TM. Thirty-nine percent of the nurses showed a 'very positive' attitude towards TM/THs. Overall, there 55 percent health-care workers with positive attitudes and 30 percent with negative attitudes. 

**TABLE 5.1: Health Personnel's Attitudes Towards Traditional Medicine/THs**

<table>
<thead>
<tr>
<th>Category of Personnel</th>
<th>NUMBER AND PERCENTAGE OF RESPONDENTS</th>
<th>(\text{Very Positive} )</th>
<th>(\text{Positive} )</th>
<th>(\text{Ambivalent} )</th>
<th>(\text{Negative} )</th>
<th>(\text{Very Negative} )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Nurse - Aides</td>
<td></td>
<td>2</td>
<td>40</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
<td>5</td>
<td>22</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Heads of Depts.</td>
<td></td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>33</td>
<td>1</td>
</tr>
<tr>
<td>TOTALS</td>
<td></td>
<td>7</td>
<td>21</td>
<td>3</td>
<td>9</td>
<td>5</td>
</tr>
</tbody>
</table>

* Excludes the personnel department and includes only those that deal with patients directly.

This is quite unexpected because of largely negative results that have been obtained in other studies. Igun posits that

in Africa and most underdeveloped nations it is unfashionable in medical circles to talk positively about traditional medicine... [therefore]... the majority of Western type health personnel... close-mindedly dismiss traditional systems as a load of rubbish [Igun, 1992: 155].

In their study, Reissland and Burghart found that modern medical/agents distanced themselves from indigenous practitioners whom they viewed as 'ignorant' (see Subedi, 1992: 323). A 1977-8 study in Nigeria revealed that medical doctors were reluctant to have close professional contact with THs (Ojanuga, 1981). I can only speculate that differences in attitudes might partly be a function of the background (training) of
respondents. Doctors, who receive more intensive training would be generally expected to hold fast onto the tenets of their biomedical system.

The majority of respondents that showed negative feelings towards THs targeted the alleged toxicity of their drugs either due to lack of precise measurement of dosages or the inherent and ineffective nature of the drugs, which are quite legitimate and ethical concerns. For example, one SCN said she did not believe in TM and did not think it had anything to contribute towards the achievement of ‘Health for All by the Year 2000’ because of two reasons.

... one, they did not know the side effects of their drugs, because we are facing problems of ‘muti’ poisoning, two, the dosages are imprecise. They just give a patient a bottle full of drugs. You find that a patient... might come with diarrhea, or constipation or a descended abdomen. So these things just irritate me. I do not like it [SCN 14].

Another nurse in the paediatric department who said she had never witnessed anything positive about TM said that all she has noticed is that

... it is pulling us down, because we meet some of the patients who have been to traditional healers ... They are given herbs ... and when they are brought here their condition is very poor and the parents refuse to tell us that they have been getting treatments from herbalists. As a result, when we put these patients on our drugs ... their bodies react, and become acidotic ... sometimes to the extent of dying [SRN 17].

In the same realm of castigating prior visits to THs, one male ward nurse gave a short account of a patient whose

...relatives...asked for him so they could go and do their cultural practices at home. But he came back in a worse condition. We didn’t like it...This makes us not to believe in TM [SCN 7].

Traditional healers were also strongly upbraided for allegedly bringing witchcraft accusations into their treatment sessions. A nurse, who doesn’t believe they can give any help to the sick, describes his reservations as follows:
Because what they tell you is it's because of so and so who doesn't like you [witchcraft]. When you have a 'hot body', they tell you someone is [visiting] you during the night. Before I trained I used to live under such conditions, and my relatives ... too ... I suffered a lot from malaria, and only managed to survive by chance but these days I wouldn't like it. They always look for a cause. We treat the symptoms. [my emphasis] [SCN 11].

Most of these negative sentiments were echoed by the DMO who said:

I actually have more problems than good relations with these people. We see quite a number of people coming [here] because they sought help from traditional healers first. We see many people who want to be discharged from the wards to see traditional healers on the way, when we even know that they are on the way to recovery on our treatments ... We sometimes see them coming with 'muti' poisoning, and I think we have had a number of deaths in the wards to poisoning from traditional healers... lesions of the eyes, mutilations of female genital organs and so on ... They are a rather difficult group I think, in promoting health, because quite a bit of their business is really doing the opposite ... And a lot of this witchcraft business is there ... and ... I think these people are somehow bewitching people to death and then say it's a witchcraft thing ... [AP 27].

While there might be some elements of accuracy in these allegations or stereotypes of THs, we cannot discount the possibility that these negative attitudes are a result of whatever cases the THs were not successful in handling. All medical systems do not have a hundred percent success rate, however. There is also another explanation. Quite a substantial number of health personnel (in this negative category) prefaced their account by a sentence that distanced or exonerated them from possessing any knowledge about TM or having used it. One would either say: 'I do not have much knowledge...' (NA.B.), or 'I understand they are very good with psychiatric patients' (AP 26), or 'According to patients yes, it has positive contributions...' (SCN 7), or '...maybe it's helping them...' (SRN 17), or 'Myself I do not believe in...'' (SCN 6; SCN14; SCN 15). According to Phillips (1990 : 187), "some respondents may also be reluctant to admit openly to the use of certain traditional medicines because of fear of appearing ignorant or backward".
On the other hand, those with favourable attitudes about TM/THs, though critical enough as to mention some undesirable elements, emphasised the salutary aspects of TM, at times with an unequivocal pragmatism because of the current state of health and health resources in the district and nation. Thirty-eight percent of the health workers indicated that TM is particularly good at dealing with psychiatric problems. Two of these responses were placed in the negative category because the respondents said this was the only redeeming feature of TM, amidst a host of problems. Fifteen, 44 percent, believed THs, if given enough official support, might come up with a cure for AIDS. Six of these had previously indicated that they did not believe in TM. Perhaps we can only surmise that since there is no cure for AIDS/HIV, the complex nature of the disease, coupled with the mystical nature of TM, individuals develop such ‘conditional faith’. A nurse, who had apparently heard the widespread rumour that one or two THs had found an AIDS cure, said this:

If it is true, they could help a lot because many people are dying from it. Because we try to help these children with vaccinations and the like, but once AIDS comes in, there is nothing we can do [SCN 16].

Some happened to mention other strengths of TM, like this nurse at a HC who said: yes I think we can do with them, in areas like family planning. There are traditional drugs for family planning which I think the Ministry of Health should look into. Also AIDS prevention, the, are good with health education. And I feel there should be more cooperation between nurses and traditional healers [SCN. J].

Another mentioned ‘...snake bites, hallucinations and other ailments which need traditional ceremonies’ (SCN. G). This takes me into an area I have discussed above, the cultural aspect. One nurse based at a HC, made the following apt comment:

I think we need them because our culture is more attached to those people [THs]. People grow up knowing the existence of traditional healers and most consult them first before coming to the health centres, so we should just try to health educate the healers [SCN. H].
This ‘cultural connection’ is also expressed in the following comment:

A lot of our people, if not 90 percent of them, do consult traditional healers before they come to the hospital or after consulting the hospital, because of their holistic approach to medicine. So I think traditional medicine makes a positive contribution towards the goal of “Health for All by the Year 2000” [SCN 37].

The other issue that came about is that of the accessibility of THs as well as efficacy of treatments. One nurse said that THs

...are nearer the community, ...they can treat ... illness such as stomach problems...They really play a role you know. Psychologically they also reassure the patient, and it makes the patient to get better [SRN 5].

Just as the respondents with negative attitudes gave practical examples, those with positive attitudes also gave such examples. One said, “there is a young boy who used to come here [MDH] and had a fever. I met him later, well and walking and he told me he had been helped by a traditional healer. So, they do help” (SCN 16).

The issue of realism is also paramount regarding medical systems. One head of department at MDH who talked about people’s desperation in the face of diseases that hospitals cannot cure, concluded thus:

...so if we try using our microscope and we do not find anything, but the person is sick there is no [other] alternative. we have to try those who can see what we cannot [HD35].

What this officer is talking about are the causes of ‘abnormal’ or ‘unnatural’ illness whose causes biomedical practitioners are not equipped to deal with. The main reason that led me to tackle the issue of TM/THs is shortage of personnel. However, as evidenced by the above mentioned positive aspects of TM, the issue of the shortage of drugs has also been inadvertently brought into focus. And, none other than the district pharmacist brought this into perspective.
There is a lot traditional medicine can do, if we happen to identify all of them. Perhaps we will hear of somebody who will have found a cure for AIDS from traditional healers...So if we could manage to have a system whereby we have traditional herbs, not marketed by the traditional healers association but by themselves [for fear of exploitation], that could save us a lot of foreign currency...because we cannot afford most of these drugs which are being sold in the private sector [HP 30].

I therefore argue, following Iguna (1992), that a context needs to be created whereby all these positive aspects of TM are brought out, enhanced, and systematically utilised. This requires political will and action by policy makers in as much as it needs the participation of the front-line health workers themselves. It is these workers that are experiencing the shortages of manpower and drugs first hand. The attitudes of health personnel towards TM inevitably affects the way they deal with patients who have used it, in the manner of admonishments or otherwise, as well as how harmony between the two medical systems could be achieved.

In Swaziland, where there existed a long standing suspicion, fear and misunderstanding between nurses and THs because of the Western oriented training received by nurses as well as lack of communication between the two groups. "... joint training workshops have led to a marked improvement in attitudes and to the involvement of [THs] in efforts to promote good health practices and prevent disease" (Hoff and Maseko, 1986 : 412). Phillips, who argues that many stereotypes of THs lack flexibility and depth of appropriation encourages personnel to adopt "... a 'wider outlook' than the purely clinical or bureaucratic" (1990 : 158).

5.4.4 THE COMMUNITY'S SOCIAL ATTITUDES TOWARDS TRADITIONAL MEDICINE

Medical systems and health knowledge do not exist in a vacuum. They are an integral part of the social and cultural context of a particular society (Heller and Elliot.
Therefore, we think it is highly imperative and germane that the views of members of that culture be brought forth to illustrate more vividly the role TM plays in their lives. A decision to make TM part of a national health-care system or not to, because of deemed ineffectiveness, that does not take this into cognizance would be an imposition on health services users. Igun (1992) shows great concern over the general assumption that Western medicine is superior to TM because the former is more efficacious for most health problems, and poses the big question: whose or what criteria should be used to judge efficacy? His answer is "...utilizers themselves", not "...Western trained doctors" (Igun, 1992: 148).

<table>
<thead>
<tr>
<th>TABLE 5.2. : The Community’s Attitudes Towards TM/THs</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSITIVE</td>
</tr>
<tr>
<td>No. Female %</td>
</tr>
<tr>
<td>Village 10 *</td>
</tr>
<tr>
<td>Sasa Village **</td>
</tr>
<tr>
<td>TOTAL %</td>
</tr>
</tbody>
</table>

* Total respondents = 28 (19 Females, 9 Males) ** 25 (18 Females, 7 Males)

Table 5.2 shows the attitudes towards TM/THs that were shown by respondents interviewed in their homes in two separate villages in Mutoko district. Most respondents, both male and female, gave considerable credit to TM/THs. Out of 53 respondents, 37 showed positive attitudes towards TM/THs. The percentages also show that there is not much difference in these attitudes between men and women. For example, 68.4 percent of women in village 10, compared to 66.7 percent of men have positive attitudes.

Table 5.3 shows out-patients’ and in-patients’ use of traditional medicine for their current illnesses before coming to MDH as well as attitudes towards TM/THs. The table indicates that only 17 respondents acknowledged the use of TM before coming to the
TABLE 5.3: Hospital Patient’s Use and Attitudes Towards TM/THs

<table>
<thead>
<tr>
<th></th>
<th>USE OF TM BEFORE COMING TO HOSPITAL</th>
<th>POSITIVE</th>
<th>NEGATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female No. % Male No. %</td>
<td>Female No. % Male No. %</td>
<td>Female No. % Male No. %</td>
</tr>
<tr>
<td>In-patients *</td>
<td>3 11.5 1 8.3</td>
<td>3 11.5 4 33.3</td>
<td>6 23.1 4 33.3</td>
</tr>
<tr>
<td>Out-patients **</td>
<td>11 34.4 2 13.3</td>
<td>13 40.6 4 26.7</td>
<td>2 6.2 5 33.3</td>
</tr>
<tr>
<td>TOTAL PERCENT</td>
<td>20.0</td>
<td>28.2</td>
<td>20.0</td>
</tr>
</tbody>
</table>

**TOTAL RESPONDENTS = 47 (32 Females, 15 Males) * 58 (26 Females, 12 Males)

hospital for ‘modern’ treatments. **Both in-patients and out-patients were not as open as
the respondents that were interviewed in their homes with regard to their feelings about
TM/THs. This is indicated by the low percentages in the last four columns. Despite this
peculiarity, slightly more of the out-patients and in-patients showed positive attitudes,
28.2 percent, than negative attitudes, 20 percent, towards TM. As far as respondents
from Village 10 and Sasa Village are concerned it is relatively easier for me to discern the
little difference between females and males with regard to their attitudes towards
TM/THs, but the same can not be said about out-patients and in-patients. The raw scores
are not large enough to permit me to determine the effect of sex.

With regard to the seemingly low association with TM among both categories of
patients vis-à-vis the householders (in TABLE 5.2), we can only surmise as to the cause.
Firstly, patients were interviewed in a hospital (MDH) environment, and there is a strong
possibility there was a case of mistaken identity, whereby interviewers were regarded,
despite introductory comments and reassurances to the contrary, as hospital or MHCW
employees. This being the case, and also depending on their previous experiences and encounters with health personnel whereby they may have been reprehended for ‘delaying’ with an illness while consulting THs, they might have wanted to portray a politically ‘correct’ image. The situation might even be more daunting for in-patients who were interviewed inside their wards, where health personnel lurked in the background.

Secondly, for those who had tried TM, coming to the hospital was an indication of its failure with that particular illness (except for some who like to mix different remedies at the same time), therefore they did not have positive things to say about it.

Generally, the reason why some respondents might not even want to mention knowledge or use of TM is that they have ‘...to an extent been conditioned to believe in Western medicine or to conceal use of traditional medicine...’ (Phillips, 1990 : 73). Otherwise the real figures for consultations before coming to the hospital are probably higher.

The majority of respondents who showed negative attitudes towards THs indicated the current high costs of their services. The THs are probably, just like everybody else, affected by the current economic climate, particularly the high cost of living hence the raise in their charges. Despite the motive, this forces me to provisionally recant one of the qualities (of THs/TM) that we mentioned above, that they are ‘affordable’. According to one respondent, “these days traditional healers are lying, [t]hey just want money...[and] ...you can lose $50 or $100” (IP 18). Yet at the hospital and HCs the basic charge for fee paying patients is ZS1.50. Hence comments like this were common:

**IP 9** ... traditional healers just say ‘come to me’ because they want money
**IP 15** ...They want money first ... [and] just blame things on witchcraft
**OP 29** ... they ‘eat’ your money ... they just take your money for nothing.
I suspect that this despondency and concern for money only set in if the healing process has been inefficacious.

Most of the categories of illnesses given by respondents, as well as how to deal with them, correspond with those discussed above as given by Chavunduka (1986) and Mutambirwa (1989). For example, a cough that "...just comes... will go away" (IP 21) and there is no need to take it to the hospital, it is a natural illness. "With headaches, I wait like two three days to see what will take place" (IP 25). If it persists then it is defined not as natural and action will be taken. According to one patient "...if it is a physical illness, the hospital is better, but if the cause is bad spirits, it is only the faith healers or traditional healers who can deal with that" (OP 12).

Respondents indicated that all diseases emanating from such factors as envy, bad relationships, etc. should be taken to TM. For example,

"there are some illnesses when you have something in the stomach... an illness 'thrown in' by people/enemies... which can not be treated here. It has to be removed using traditional medicine...[IP 22]"

This is also illustrated in the following dialogue:

A: Relatives tried traditional medicine and were told that this is not a disease from God, it is coming from enemies because when the person goes into hospital he gets well, but when he comes home he gets sick again.
Q: So which diseases come from God?
A: Like coughs which last a week and you get well again, then you know it's God's illness.
Q: And these other ones, what causes them?
A: They are caused by hatred...[and are treated by] only consulting traditional healers...getting treatments...or by returning it to the sender [IP 23]

Numerous cases were also cited where people had visited HCs and hospitals with illnesses to no avail, and then were helped later by THs ⁴⁵ (and cases to the contrary were also cited). Some think it is better to approach the two medical systems at the same time. Like the respondent who says "I just alternate, getting injections from the hospital so that I get strength, and going for traditional medicine for them to explain [and remove] the
cause" (OP 27). Another one says "... it would be better to mix them...for example with psychiatric problems. So if you can start with traditional healers, and then come to the hospital or vice-versa ...” (IP 11).

Hence Azevedo et al. (1991 :1347) have commented that individuals seeking care for illness are usually pragmatic: they turn to different health care systems according to their subjective assessment of the problem and of the most suitable type of health.

My findings show that community members freely use both health systems according to which they perceive as most efficacious for a particular illness and they generally give credit to traditional as to Western medicine in terms of efficacy. Again, this depends on the particular illness and how it is defined. This concurs with Mutambirwa's findings (1989). In her study, 96.6 percent of women regarded modern and traditional health systems as complementary and only 3.05 percent said they trusted the modern health system more than the traditional system.

We have therefore demonstrated that TM is very much alive in the district of Mutoko. Stripped of all the stereotypes and shortcomings, it emerges as a viable and popular medical system with a skilled and varied human resource base. Better organisation and coordination, not alienation, is what it needs in order that the community's health needs be met.

5.5 FACILITY BASED AND FIELD PERSONNEL

The theoretical model underlying this dissertation highlights the importance of preventative health measures. In this section, I therefore would like to analyse and compare the emphasis being put on facility based personnel and field personnel, with an understanding that the former provide largely curative services while the latter provide
only preventive services respectively. In the first category we have all health personnel based in hospitals and health centres and, in the second we have EHTs and VCWs.

The kind of health planning in most developing countries has been based on international estimates of the number of human resources needed for an extensive coverage instead of the nature of prevailing local health problems and the most cost-effective method of dealing with them (Evans, 1981). Since the mid 1970s scholars have been reiterating the need for non-specialist primary health-care personnel (Doyal and Pennel, 1976) because "...doctors will never solve the primary care problems of the poor" (Taylor, 1976). In spite of these calls, there remains a considerable bias towards institutional curative services (McPherson and Midgley, 1987; Conyers, 1982). "Curing disease requires individual treatment of patients, while many preventive measures affect a relatively large number of people" (Conyers, 1982 : 43) particularly rural people whose major determinants of health are water, food and the environment, rather than the activities of modern health personnel (McPherson and Midgley, 1987). *47*

This is where the VCWs and EHTs come into the picture. According to Phillips (1990 : 114) with the use of VCWs "... 'health care' becomes part of improved living conditions and as a result, considerably 'deprofessionalized'" because "their jobs involve community improvements across the board, stop[ping] sickness before it starts and actively promoting health". *48* The same applies to EHTs, and to a slightly lesser extent to TBAs. All these categories of personnel come into the limelight largely with the emergence of PHC. Hence we can say PHC "...implies a departure from the simple equation of health care with the provision of medical techniques and Western educated medical personnel" (Baylies, 1986 : 69). Its development and success depends on, among other things, "...a health system that is designed to support and complement the front-line workers" (WHO, 1979 : 26), the majority of which are VCWs, EHTs and TBAs.
In Mutoko district there are only 13 EHTs, a number which, according to the supervisors is far from adequate, as we have indicated earlier. As far as VCWs are concerned, the government envisaged that one VCW would be responsible for 200 households. According to the DNO 148 (all female) village health workers (who later became known as VCWs) were trained at MDH until they ceased to fall under the health ministry. Training was stopped about 1988. Therefore, assuming all those that were trained are still performing active duties, one is covering on average 168 households, also assuming they are equitably distributed. I have already indicated (in Chapter Four - based on interviews with 5 VCWs) that they are overworked because they cover villages that are far apart. Both categories of workers, EHTs and VCWs, have to travel long distances on bicycles and on foot respectively, and are miserably remunerated. Also, the fact that field supervisors face a transport problem means there is inadequate logistical support for them. These are some of the reasons why we believe the preventive side of health care is not receiving the kind of support, financial or otherwise, that it should be receiving. In other words, the health-care system is still overwhelmingly curative in its approach, putting more focus on facility - based personnel.

To establish the importance of these workers to the health of the people in Mutoko district we went beyond these objective facts and objectives to establishing the perspectives of the community in this regard. Of the 107 out-patients and 'village respondents' that were asked to name the people in their community that are making significant contributions to their health only 2.8 percent mentioned HC personnel compared to 23 percent and 20 percent for VCWs and EHTs respectively. Here is what some of them actually said in their comparison.

IP3: VCWs...I think they are helping more to educate mothers about hygiene in the home...more than nurses in the clinics.

IP4: EHTs because EHTs tell us to build toilets in order to have a healthy life...
NP1: The people that are helping us here are these VCWs because they are the ones that know how people live in the community because they go from village to village checking toilets and how people live, etc. [also NP26]

NP8: VCWs ... because they spot the houses with AIDS patients, and go there to check that the person is bathed and given good nutritious food as well as clean clothes.

NP13: I would say EHTs because all the time they make sure things are being done properly ... [and] warn you before things get worse. Nurses and others can help us later but these are the ones who see the roots of our health problems.

Respondents were also asked if the hospital (MDH) or these field workers are helping them more with their health. Although the majority said that the hospital is more helpful, a significant number of respondents rated higher the contributions of field workers.

IP17: I think those in the community are helping us more because they come around often, educating people.

IP18: Those in our communities...because they give us many ideas so that we live in clean and healthy surroundings.

IP22: Things are different out there and in here [hospital]. But those in our community help us more because we live with them all the time. Here we only come and meet them when we get seriously ill.

OP16: ...if they [VCWs and TBAs] hear Mrs. so and so is sick they leave everything else to help you or take you to the clinic. If she doesn't come it's because she has had transport problems.

OP17: Because day in and day out they visit our homes, encouraging people, and with those that work in the hospital one might not have the time to come here and get explanations.

Thus VCWs and EHTs are immediately available, understand local problems and needs better than facility-based personnel. These are very rational and genuine responses which should be taken cognizance of by health-care planners. This is provided the lay rural people are given a chance to express their needs and preferences through their local political organisations that have proved to be ineffective thus far in order that the skill pyramid is revised, and working conditions of EHTs and VCWs be improved. The district needs more of them, and they deserve better logistical support.
5.6 MEDICALISATION OF CHILDBIRTH AND COMMODIFICATION OF HEALTH vs RESOURCES

While the general focus so far in this chapter has been the inadequacy as well as ineffective allocation of resources, it is imperative that we also briefly discuss these two factors that appear to be putting a strain on those available resources.

Medicalisation means "...defining behaviour as a medical problem or illness and mandating or licensing the medical profession to provide some type of treatment for it" (Conrad, 1987 : 122). According to Reissman (1989 : 195):

In order to gain cultural authority over definitions of health and disease and over the provision of health services, regular doctors had to transform general human skills into their exclusive craft.

Hence craft specialties like obstetrics are said to have "... been shaped by the needs and ideologies of pathologically oriented practitioners" (Pollock, 1988 : 176). Due to developments that started in the nineteenth century, many life events, including pregnancy and childbirth have fallen into the realm of allopathic medicine (Fisher, 1998; Trypuc, 1988, Pollock, 1988; Reisman, 1989; Conrad, 1987; Conrad and Kern, 1990; Oakley, n.d.), regardless of pathology (Conrad and Kern, 1990): a development Bolaria (1988 : 9) says "... perpetuates the addictive dependency of the populace on medicine and medical institutions." In the West, this has resulted in the usurping of the midwife’s traditionally exclusive role/place at the bedside of child bearing women (Ehrenreich and English, 1973; Reissman, 1989; Oakley, n.d.).

I tend to believe that women in Mutoko district are increasingly defining birth as an event requiring hospitalisation and physician attendance. This is in light of the many pregnant women, called ‘waiting mothers’, that I saw at MDH during the period of my investigation. According to the Matron, these are supposedly mothers at risk, either having their first pregnancy or those who have had many children and are likely to
'complicate'. They are always encouraged to deliver where there is a doctor, in case there is a complication. According to some nurses most mothers come too early, and some have no complications at all. Some that were interviewed had been there about three weeks. The matron could only hazard a guess as to why this is the case. Either they are 'pushed' by nurses in HCs or it is because when they go to the hospital they get pampered by their husbands.

Although MDH is a modern hospital, during my visit the waiting mothers were living in one of the oldest buildings. It has little ventilation, is crowded, and many women were sleeping on the floor. At one time there were 64 waiting mothers, and among the 16 interviewed 12 stated their main problem as overcrowding, such that "...some find no places to sleep" (IP45). "...there is not enough room for the many people, we have to sleep tightly squeezed together ...and now everyone is coughing" (IP46). Some said they slept in a sitting position for lack of space.

Waiting mothers add undue strain on an already burdened workforce at MDH. We observed and were told by senior personnel that the maternity ward is the busiest at MDH. Arranging for interview appointments was hardest with maternity ward personnel. The waiting mothers' living conditions also pose a threat to their health and their babies, creating potential patients that need treatment.

Before the introduction of Western medicine, birth was a process of caring by other women, traditional midwives or traditional birth attendants (TBA). These women trained by elders and equipped with herbal remedies. The purpose of the programme initiated in 1981 to upgrade their skills by improving the hygienic conditions under which they operate was to help such mothers. By the look of things official support for TBAs is dwindling and no new TBAs are being trained. The TBA that we spoke to said
... I no longer have the chance to deliver babies any more. Anybody that is expecting goes to the clinic or hospital. I used to go to meetings [at the HC and MDH] to discuss health issues ... and when I realised there was nothing for me anymore I stopped .... [NP4].

This is a TBA that was trained at one of the hospitals in the district. She only gets a token of appreciation, a chicken or ZS10 for her effort, but now she only helps those who cannot afford to get money for bus fare to go to MDH as well as buy other things needed there, like the child’s clothing (NP4). Her major problem also concerns the procurement of gloves and other basic things to use in her profession. The ministry of health does not provide them with these. This is another indication of the low priority given to community health ‘workers’, like the EHTs and VCWs we have discussed above. We can therefore argue that it is the system which is implicitly aiding the medicalisation of childbirth.

While the medicalisation of childbirth puts a strain on resources at MDH, that process is evidently countenanced by the maldistribution of resources. While Mutoko district has a district hospital and 3 other hospitals, its neighbouring district, Mudzi, has none. And, out of the 16 waiting mothers interviewed, 7 were from Mudzi District. According to the Matron at MDH, the other possible reasons why waiting mothers come there are the unavailability of electricity and running water in some HCs. So the mothers ‘do not feel quite safe’. So, following ‘the bigger the better approach’ all these amenities are centralised in district hospitals, luring the sick to the centres of ‘medical excellence’. Associated with the expansion of these large hospitals and emphasis on high - risk management is the lower priority placed upon HCs and primary prevention.

By primary prevention we mean improving environmental living conditions, including food and water to mitigate their effect on infant and maternal mortality. In a related argument, Oakley (n.d.) asserts that medicalisation of childbirth as evidenced by increasing hospital deliveries, and emphasis on antenatal checkups, puts stress on the
medical dangers of pregnancy rather than on the psychological and social ones. While intervention techniques are not necessarily bad, there is danger that they may create a sense of anxiety and helplessness in women (Oakley, n.d.) making them expect their labour to develop complications that biomedicine will solve (Pollock, 1988).

This issue is somewhat related to that of the ‘commodification of health’, a term with a variety of meanings but used by Nichter (1989: 236) to mean the ... tendency to treat health as a state which one can obtain through the consumption of commodities, medicine. This entails an objectification of the body, the decontextualization of sickness or diseases ...\(^5\)

Nichter (1989) discusses this concept in relation to the growing trend in India toward attempting, in the short term, to derive health through the consumption of medicines. Pharmaceuticals play a huge role in this process, as well as the medical system (Nichter, 1989). The public then respond to the ‘health concerns elaborated upon by marketing strategies [of pharmaceutical companies]...’, which attribute ‘powers’ to medicines beyond their active ingredients (Nichter, 1989: 237). Because of these factors, and that doctors are paid on the basis of distributing medicines, people have become accustomed to receiving medicines for all health problems (Nichter, 1989).

In this study, however, we are basically concerned with the public’s demand for prescriptions/drugs, especially injections when they visit the HCs or hospitals. This is of concern to me because of the current drug shortage in the country. Medical anthropologists have long known that people tend to prefer injection over oral, suppositories, and other forms of taking medicine (Subedi, 1992). Fosu’s (1992: 331) study included Ghana, Kenya, Uganda and Zimbabwe, all former British colonies, and this is what he has to say in relation to all four:
In an attempt to control epidemic diseases and to immunize against the deadly tropical diseases, therefore, a district legacy of the colonial health care system evolved. The syringe became the symbol of western medicine. The popularity of injections is legendary and has superseded other forms of taking medicines like pills and liquids.

This injection is the ultimate cure. In my study many respondents expressed concern over not receiving one when they visited a HC or a hospital, regardless of the type of illness. Some expressed concern over not getting drugs in general, like one respondent who said "...here I wouldn't say I was handled well because I haven't been given any drugs" (OP38). When CDWs were still VHWs in the ministry of health they used to keep some basic drugs with them. Now they do not, and they see this as a setback. Community members also see this as a setback, as evidenced by these remarks in response to a question asking them to compare hospital and field staff in terms of their contribution to the community's health:

NP26: ...because those that work here, like the VCWs no longer carry medicine...
NP25: ... we sometimes go to the VCWs and fail to get medicines. If they could stay with medicines all the time ...
OP20: ... All those connected to the hospital and use drugs are better/more helpful compared to field staff [also OP14].
OP14: ... field staff give no treatmnts, drugs. So we think the ones at the hospital are contributing more to our health because they have drugs, ... powerful drugs. So if they could move around with drugs ... [laughs heartily]. ...those women who move round on bicycles, giving condoms ... if they could get sufficient drugs I don't think anybody would be coming to the hospital.

In other words, all the other positive contributions by EHTs and VCWs are tainted by lack of drugs in their arsenal of health techniques. Muhondwa (1986) recognises this "...frustration of community members with the limited range of curative services which VHWs [are] able to provide" as a problem common in most countries where PHC has been implemented.

There is a category of respondents who always want the 'big one'. While lingering outside the out-patients department one day we overheard a patient (still wating in the
queue), asking another who had just completed her treatments (and coming to say goodbye) "...so you have been treated?" She replied, "...Ah, I have just been given tablets" dejectedly. She had wanted an injection. The three cases below illustrate people's preferences.

IP6: In our area nurses are more helpful [than EHTs, VCWs etc.] because they inject you ... and give you medications.

OP27: I just alternate, getting injections from the hospital so that I get strength, and at the faith healers for an explanation of the cause.

Q: Other diseases you treat at home?

A: ... I go to the hospital. We need the injection, so that blood vessels function properly. When the injection fails then you know Western medicine has failed, then you go to THs to get an explanation of the cause. [my emphasis]

Q: And if you go to the hospital/HC and don't get the injection?

A: ... Ugh ... [slight hesitation] ... we manage but it keeps worrying us.

NP2a: [about male nurse at HC]...he gives you an injection. If you go when the others are on duty, you won't get one, they give excuses and give you just tablets, so it is a big problem.... An injection loosens up the muscles [laughs heartily] [my emphasis].

[wife interjects] ... an illness needs an injection [emphatic] ... I took her [daughter] to this clinic the other day, she slept there and never got an injection until the following day. What kind of a thing is that? [genuine puzzlement]

The existence of such demands was corroborated by the matron at MDH who said:

We have the problem that patients want overloaded prescriptions. Sometimes things like analgesics are not even necessary but when a person comes with a headache and you tell them to smile, drink water and do some exercises, they don't understand. I think our people are drug oriented.

What I deduce from this is that people in this community have developed the misguided view that every visit to the hospital/HC with an illness should get a prescription. Doctor - patient or nurse - patient encounters [to use Nichter's (1989) words] are being reduced to an exchange of drugs as the measure of a meaningful transaction. Scarpaci's (1988) study in Chile came up with a similar finding. Prescription drugs were found to be a central feature in the help - seeking behaviour of respondents.
The implications of health commodification for PHC and for the community are significant. Utilisation patterns become skewed in favour of hospitals where "...there are more medicines..." (OP40). This affects the formal referral structure. There is an even greater demand for the few available drugs. But most importantly,

... the false security rendered by a proliferation of medicines for health as well as illness reduces the impetus of both the middle class and the poor to actively mobilise for environmental health, sanitation and hygiene ... [by offering] compartmentalized protection, quick fixes and a means toward health which does not rock the boat or deal with the muddied water [Nichter, 1989: 263]. 56

5.7 DISCUSSION AND CONCLUSION

In Zimbabwe’s new health policy,

there is a strong and clear intention to allocate (if not reallocate) resources in order to redress both the curative bias of health services in favour of preventive and promotive measures, and the urban bias in order to benefit rural populations [Manga, 1988: 1134].

This focus is in keeping with what Brooks (1985) calls the acceptations of equity, viz. distributive efficiency. According to Brooks (1985), it relates to what an observer considers to be distributive justice. He thereby gives an example of the health field, where a policy statement could be initiated that more resources ought to be devoted to caring for a specific group of people or that the existing geographical distribution of health care resources was unacceptable.

In this case, the 'observers' are the policy makers, and the government. And the distributive efficiency was to be effected through the PHC paradigm. This is a paradigm which, according to Malcolm (1994: 456), should

... be able to argue, on the grounds of equity, for a fairer share of the health resources for a defined population to be distributed to localities and groups in greatest need.
The ‘locality’ chosen for the study is a rural area, hence it consists of populations ‘in greatest need’.

The main purpose of this chapter has been to analyse the resource allocation patterns in Mutoko district. In my focus were three categories of resources: financial, human and equipment, and drugs and supplies. Whenever possible, I have tried to include the views and perspectives of the people that ought to benefit from these resources, as well as those that administer and/or use these resources to benefit the community. While this gave first hand knowledge and experience, it also helped to neutralise my ‘outsider perspective’.

I have established that an urban bias is still in place, with larger allocations of money going to central hospitals, and the HCs getting the least. District managers receive a fraction of their financial year bids. This affects other resources like drugs, equipment and supplies that they would need to buy with the allocated finances.

I have documented numerous complaints about shortage of transport and about the effects that this has on the logistical support of field staff, follow-up visits and referral of patients. Drug shortage, on the other hand, seems to be affecting HCs more than the district hospital, which goes to reveal some kind of maldistribution within the district inadvertently causing more people to come to MDH and thereby constrain the resources there as well as violate referral principles.

The analysis also revealed a pre-existing urban bias in human resource allocations. This has further been aggravated by the principles of ESAP. I have established that all categories of personnel in the district are overworking because of shortage of staff. This leads to what social scientists have called role overload. It is in this context that I have suggested the full utilisation and consideration of THs’ and TBAs’ skills and drugs in a
reorganised, and tolerant health system. The basis for this is their general acceptance among the community members interviewed.

With regard to resources I have discussed the nature of their distribution within the district, indicating that less emphasis is being put on field staff, which is a sign of a hospital and a curative orientation to health.

I have in the last section discussed some developments which are currently working towards straining the available resources. These are the 'medicalisation of childbirth' and 'health commodification'.

Overall, to the extent that rural people like those in Mutoko still receive health care inferior to that of the urban population despite their greater health needs, I can talk of the existence of what Hart (1977) calls the inverse care law. Hart (1977: 412) defines this as: "...the availability of good medical care tends to vary inversely with the need of the population served." In other words, in those areas with most sickness and death (like rural areas where there is the existence of more diseases of underdevelopment), hospitals carry heavier case loads with less staff and equipment (Hart, 1977). The poor are receiving too little in this case. Also, to the effect that the population composition in rural areas is largely female, because most able-bodied men are either working or seeking employment on farms or in towns, ineffective resource allocation is heavily affecting women and children more than men. This further perpetuates sexual inequalities, and has a long-term impact on women's life expectancy.

I have presented a similar argument with regard to personnel. The majority of nurses in Mutoko district are female. Hence, job stressors in the MHCW are affecting women more than men. This strengthens the existing gender based social inequalities.
ENDNOTES

1These two issues mutually affect each other, and I shall revisit this relationship towards the end of the chapter.

2This is an approach to development that is concerned with questions of equity and social justice (Conyers, 1982).

3These differences are the result of pervasive inequalities in wealth, income, opportunities for employment, land ownership, nutrition, working conditions, education, access to safe water, social and physical environment (Manga, 1988: 1131).

4These special groups include: members of the armed forces, police and prison services, government ministers, members of religious orders, clinical staff of the medical school (Hecht et al., 1993).

5These achievements have been made with income levels in the range of the least developed countries (Evans et al., 1981).

6In many African and Latin American countries this has resulted in falling gross national product per head or declining (in absolute terms) national product (Abel-Smith, 1985).

7According to Kanji et al. (1991: 988)

[The philosophy behind these policies is that African economies have various distortions in them which need to be ironed out by adjusting the economies to the 'free market', guided by supply and demand so that growth can be achieved...[and.] African governments [are seen as having] over subsidised state enterprises and overspent in social sectors such as health, housing, education, basic services and social welfare.

8Kanji and associates argue that in most sub-Saharan African countries there has been negligible to negative growth in GDP, exports and imports between 1982 and 1987. The region’s external debt is also said to have risen from around US $35 billion in 1979 to US $518 billion in 1983.

9Barnum and Kutzin (1993) have argued that a relatively low share of health resources going to hospitals suggests an emphasis on PHC and a concern with reaching rural populations. They further point out that hospitals are not the best way to deal with many services that caters for basic rural health needs.

10The NACP is the National AIDS Control Programme.

11Hecht et al. (1993) recommendation to the Zimbabwe government is therefore no coincidence, since Hecht is a senior officer with the WB.

12The basic outpatient charge for adults in ZS5 in a central hospital, ZS3 in a provincial general hospital, and ZS1.50 in district hospital and HC. Those earning below ZS400 are exempted from paying user fees. The government acknowledges that these fees "...are very nominal and are not in any way intended to offset the cost of the services provided" (1992: 16).

13Under normal circumstances this patient would be required to pay ZS1.50 for treatment per visit, plus the cost of drugs.
14 According to Perrow (1986: 8) particularism means that irrelevant criteria (e.g., only relatives of the boss have a chance at top positions), in contrast to universalistic criteria (competence is all that counts), are employed in choosing employees. And he contends that the former is quite common in both economic and non-economic organisations.

15 For example, asked about the possible existence of interdepartmental conflicts between them and superiors, one out-patients clerk said:

At times they want to come and challenge the way we do things or make decisions, both general nurses and their superiors. Things that you clearly see they shouldn’t be sticking their noses into, but they do... [HC 1]

16 Mutoko district has 29 Wards, each comprised of 10 or more villages. All wards except 4 have house holds ranging from 600 to 1 528. EHTs are expected to visit all these households.

17 The hospitals, as well as the district health-care system, does not have a single computer. An informal conversation with one senior officer revealed that the PMD’s office has quite a number of them. When NGOs donate computers that office takes them for its use.

18 This is an instrument for dilating cavities of human body for inspection.

19 In July 1994, during the presentation of the 1994/95 budget to the parliament, the minister of finance indicated that the Ministry of Home Affairs had been allocated Z$715 million, including Z$50 million to cover the 1995 General Elections as well as (largely) to maintain existing services including the new transport system for the Zimbabwe Republic Police, separate from the CMED (Budget Statement 1994). Such a political move for the MHCW is, I think, long overdue.

20 TB, asthma and other chronic illnesses are treated for free in all government facilities, regardless of income level, therefore their running out of them was no surprise to me. However, the other reason could be that there are an increasing number of cases in the district.

21 The WB and UNICEF encourage governments to institute a cost recovery system to solve the problem of drug shortage (Phillips, 1990).

22 Waiting mothers simply come to “wait” for their time of delivery and are not undergoing treatments.

23 This was information that just came spontaneously while respondents were in the process of answering other questions. Asking direct questions in that regard would imply that drug stocks are in the patients’ purview of knowledge.

24 There are a number of possible reasons for this. The government identifies the (“current”) unsatisfactory conditions of service in the public sector (Zimbabwe, 1993). In this broad category are included many things like increased workloads (due to shortage of staff), shortage of drugs and equipment (Daily Gazette, Sept. 8. 1993 : 8). We shall discuss some of them in the next chapter.

25 This is the Economic Intelligence Unit (EIU) country report.

26 Although no conclusive inference could be made about the existence of a causal relationship, it so happens that ESAP started in 1990.

27 Due to economic constraints, it has been decided that ideal staffing levels will not be striven for. Ideal/optimum staff levels are “...the number of posts required for normal service operations to be conducted smoothly” (Zimbabwe, 1993 : 32).
28 A field officer/supervisor contends that ‘...with ESAP...’ they won’t get any more (AP29). They need at least 17 more in order to cover the district adequately ‘...because [they] cater for communal and resettlement areas, plus small scale farming areas, which is quite a big coverage to be managed by 13 EHTs’ (AP29).

29 The DMO further stated that due to the shortage of doctors at MDH, most of his time is devoted to clinical work in the wards than in the theatre and HCs.

30 Katz and Kahn (1966) have defined roles in this manner:

In their pure or organisational form, roles are standardized patterns of behaviour required of all persons playing a part in a given ...functional relationship regardless of personal wishes or interpersonal obligations irrelevant to the ...functional relationship [in Warr and Wall, 1975 : 147].

31 Karasek defines stressors as job demands in the work environment (Lowe and Northcott, 1986). But more elaborately, Lowe and Northcott (1986 : 15) define “a stressor [as] an event or condition ...to which the individual reacts negatively...[and they] ...often take the form of pressures on the individual”. The commonly identified are: role conflict, role ambiguity, role overload, non-participation in decision making (cf. Kahn et al., 1964; Katz and Kahn, 1978; Lowe and Northcott, 1986; Ganster, 1989; Bacharach et al., 1990) and lack of job autonomy (cf. Ganster, 1989; Lowe and Northcott, 1986; Davis, 1979; Kahn, 1981).

32 There seems to be a general consensus as to the meaning of role conflict, because Warr and Wall (1975 : 148) state that “role conflict at work may be said to occur when a focal person receives contradictory demands from his role senders concerning what he is to do.” And ‘role senders’ are defined as “those people with whom the focal person interacts and through whom his role becomes specified” (Warr and Wall, 1975 : 147).

33 The two concepts of role conflict and role ambiguity are closely related in meaning because they both deal with uncertainty about one is expected to do in a job. But Warr and Wall (1975 : 148) have endeavored to explicate the two by saying that with role conflict “...it is uncertainty in relation to whose [or which] expectations are to be met and in the...case [of role ambiguity] it is uncertainty to the nature of those expectations”.

34 According to Bacharach (1990) there is less consensus on the exact conceptualisation of role overload. Miles and Perreault, Jr. (1982 : 138) define it as “the extent to which the various role expectations communicated to a role occupant exceed the amount of time and resources available for their accomplishment.” Sales’s 1969 study utilised the following indices: the amount of pressure felt to do more work, the feeling of not being able to finish one’s work in an ordinary day, and the feeling that the amount of work interferes with ‘how well it gets done’ (Kahn, 1982).

While in their initial study Kahn and associates (1964) concentrated on tasks to be completed within a time limit and the amount of work and how it interferes with ‘how well it gets done’; in later studies they concentrated on quantitative overload (a continuum from too little to too much to do) and qualitative overload (a continuum from too easy work to too difficult work) (Katz and Kahn, 1978; Kahn, 1982).

While some researchers see role overload as “another type of role conflict” (Kahn et al., 1964 : 59), others regard it separately (Bacharach, 1990).

35 We can only guess why these workers responded the way they did. One possible reason is the individual nature of responses to job stressors. Some people seem to take them in their stride and some get overwhelmed, depending on social and personality factors that influence how one copes. The other possible explanation concerns relative
autonomy (compared to hospital personnel) they experience due to lack of immediate and constant supervision. They are told (by superiors) that they are managers at that local level. Therefore admitting that they are short staffed would mean an increase in staff and having to share those pseudo managerial privileges.

36In the first option traditional healers become part of the health-care system as “first line” health providers, in the second, “both systems remain essentially autonomous and each retains its own methods of operation and explanation”, and, the third option entails “the evolution of a new health system through the blending of two system’s” (Freeman and Motsei, 1992 : 1184).

37According to Ngubane
treating the symptoms only would be ineffective if not done simultaneously with removing or correcting the source of illness. it would be like treating bilharzia symptoms while the patient continues to swim in an infested pool [1977 : 26].

38Young (1983) gives the example of the specific nature of the pathogen that is dealt with in curing infections regardless of one’s culture.

39The diviner throws the bones (on the floor) and “looks to see how they have fallen and then explains the meaning, in [relation] to the problem presented to her/him” (Chavunduka, 1986 : 34).

40After political independence the government of Zimbabwe sought to help mothers who lacked access to maternity care by utilising existing resources in the form of TBAs [as well as “household-level operatives” (Sanders & Davies, 1988)] by upgrading their skills, and drawing them into the health network after brief training sessions in local hospitals (Armstrong, 1989). The idea was piloted in Manicaland Province in 1981 and, the training aimed to change only those traditional practices that are considered harmful and to encourage those that are good.

41Those considered to have ‘very negative’ attitudes are those that showed a combination of the following: had categorically nothing positive to say about TM/THs; indicated they had never used it and showed apparent revulsion (at the mention of TM/THs); cited some nasty experiences with patients who had utilised TM (with negative consequences, and, could not contemplate ever working hand in hand with THs.

The opposite is true for those with ‘very positive’ feelings about TM/THs. Those with negative attitudes did not launch a vehement attack on TM/THs as did those in the first category, but did not think it had anything to offer in the achievement of the goal of ‘Health For All by the Year 2000’. The skeptical respondents who showed ambivalent feelings towards TM/THs had a combination of both mildly positive and mildly positive things to say, without leaning heavily on one side.

Perhaps I should mention that among those with positive and very positive attitudes there are some who pointed to a few shortcomings (of TM), but their positive leanings were unequivocal. The opposite is also true for those that showed negative and very negative attitudes.

42In a study done in Bikita, Zimbabwe, a doctor in the study “…maintained that in his hospital, malnutrition and African traditional medication are major contributory factors in children’s death” (Gilmurray et al., 1979 : 25).

43This kind of dichotomous distinction between the two medical systems is also made by another nurse who doubted there would ever be any mutual referrals between
the hospital and THPs. She said, "I don't think that would be practicable. They have their own beliefs and doctors theirs (SCN 7).

44By using TM I mean consulting any traditional practitioner. However, I realise use of traditional herbs also falls under traditional medicine but I tried to separate the two. But even considering the use of herbs, under lay care, among out-patients and in-patients combined there were only 13 (28 percent) who acknowledged using some kinds of herbs before coming to the hospital, compared to about 30 (57 percent) of respondents interviewed in their homes who acknowledged using herbs on a regular basis.

45One of the examples to catch my attention was that of a teenage boy [in-patient] who said

...long ago...I used to get possessed, and if I held onto someone or something I wouldn't let go, but it would eventually go away...I was taken to Parirennyatwa central hospital and they said they couldn't help me. Then we went to a traditional healer and that was the end of it [IP 36]

46Human resources planning is also influenced by medical education that is imparted from developed countries. This perpetuates a "...hospital-oriented, curative medical approach which strengthens the maldistribution of resources according to type of care by replicating the consumption of health resources prevalent in developed societies" (Navarro, 1977 : 72).

47At this point it might be useful to use Conrad and Kern's (1990) distinction between medical care/sick care and health care. Medical care "...deals with individuals who are sick or who think they may be sick" (Conrad and Kern, 1990 : 3) and, this can be called the curative approach. On the other hand health care "...deals with the promotion and protection of health, including environmental protection, the protection of the individual in the workplace, the provision of pure food and water..." (Conrad and Kern, 1990 : 3). This would then be called a preventative approach. In the first approach the objective is medicine. The second approach forms the basis of PHC. And according to Ayalew (1991 : 166), "In PHC the objective...is health, and medicine is only one of its elements - at least not its primary concern."

48In this regard Werner proposes that "...health care will only become equitable (socially just) when the skill pyramid of the conventional health care hierarchy is tipped on its side." (in Phillips, 1990 : 114). In the same vein Taylor (1976 : 221) argues that "rational manpower planning requires a truly pyramidal balance between doctors and auxiliaries to get the most cost-effective manpower mix."

49It is strongly recognised that the VHW (village health worker) programme made significant achievements in a short period of time whilst under the MHCW (Zimbabwe, 1993). However, the effectiveness of the community development workers (CDW) programme in health promotion is said to be debatable, hence the "...need for the Ministry of Health and Child Welfare to regain the direct control of the current CDW[VCW] programme if further achievement, especially in the prevention of diseases and promotion of good health, is to be made and maintained" (Zimbabwe, 1993 : 14).

50According to the 1992 census, there were 24 925 households in Mutoko district.

51Although increasing the number of doctors is a good thing to do, if it is done in the absence of other measures to increase the number of nurses and these front-line workers that I am talking about, then there is something health planners are missing. At present the government is planning "...to deploy 60% of all newly-graduated doctors to province and district hospitals..." (Zimbabwe, 1993), which is a laudable decision. But
the whole document (Health Human Resource Master plan for 1993-1997) addresses itself largely to higher ranking personnel.

In the middle of 1994 the Minister of Finance announced in his 1994/95 budget statement that ZS18 million had been set aside "...for the Medical Science Building at the University of Zimbabwe to facilitate the implementation of the double intake of medical students" (Zimbabwe, 1994 : 26). This is also a positive development, but will it benefit the rural folk? Time will tell, because up to now the government has provided only minimal services of doctors to the rural population.

Respondents were given options including Agricultural Extension workers, TBAs and THs as well.

Some of the life events now being seen as 'medical problems' are birth, sexuality, old age, anxiety, obesity, child development, alcoholism, addiction, homosexuality, etc. (Conrad and Kern, 1990).

With regard to pregnancy and childbirth, some writers like Fisher (1986) believe the rich and the male medical establishment were up to controlling women and their reproductive capacities, which is a feminist view (Conrad and Kern, 1990). However, some contend that middle class women reformers who wanted to alter the oppressive situation of women's life also contributed (Reissman, 1989). They desired to free women from painful and exhausting labour so that they could participate fully in other life events, hence the demand for anaesthesia in childbirth rose (Reissman, 1989).

Related concepts are 'drug culture', the culture of reaching out for a drug on the slightest pretext (Ghosh, in Nichter, 1989) 'pharmaceuticalisation of health' and, developing "...blind faith in the infallibility of modern medicine and the magical properties of prescribed pills..." (Greenhalgh, in Nichter, 1989 : 233).

Nichter (1989) puts across a valid and related point which might shed more light on why people get hooked onto injections. Most campaigns to eradicate epidemics like cholera, measles etc. have historically (since the colonial period - to stop their spread to colonial masters) relied on vaccinations "...to place one's faith in a fix for all seasons" (Nichter, 1989 : 263). Unfortunately, this is an approach incompatible with the disease patterns I have already discussed (diseases of underdevelopment) in the sense that it is just a temporary fix.

Although coming from a different angle concerning drugs, Hardon (1990 : 29) argues in the same vein, pointing out the same implications when he says:

Increasing the supply of drugs without due attention to promotive, preventive and rehabilitative care will not only undermine the implementation of comprehensive PHC, it will also have very little impact on the quality of life of people and will reinforce existing myths that drugs mean better health.
Chapter Six

BURNOUT AND JOB
SATISFACTION/DISSATISFACTION AMONG
DISTRICT HEALTH PERSONNEL

6.1 INTRODUCTION

In the last two chapters I discussed the two independent variables in this study: job autonomy and health resources. Most noteworthy, however, are the following findings: (i) district health-care personnel have little job autonomy and limited input to policy. (ii) there is a chronic shortage of health resources in the district of Mutoko, i.e., equipment, supplies and health-care personnel, and (iii) shortage of manpower has resulted in perceived role conflict as well as chronic high workloads among all district health-care personnel.

In this chapter, therefore, I add two intervening variables, i.e., burnout and job satisfaction/dissatisfaction, into the equation, as shown in Fig. 6.1. After reviewing some literature and studies on job satisfaction/dissatisfaction and burnout, the chapter will analyse the existence of burnout and perceived job satisfaction/dissatisfaction among the district health-care personnel in relation to variables 1 and 2 in Fig. 6.1. Our dependent variable, quality of care, is not shown in Fig. 6.1, but will be added to the diagram in the next chapter.

These intervening variables, burnout, job satisfaction/dissatisfaction, are workers' reactions to their objective job conditions as are such factors as alienation, stress, and job morale (Coburn, 1993a; 1993b). Hence, despite paid work being a central human
activity (cf. Warr and Wall, 1975; Hall, 1975; Seeman, 1987; Coburn, 1981; Rinehart, 1987; Watson, 1987) that "... frequently determines ... [one's] personal success or failure, as well as ...[their] status in the community" (Wiley, 1991: 500), it has its negative repercussions too.

Figure 6.1: Relationship Between Independent and Intermediate Variables
Since one’s job can affect one’s health, Kahn (1981: 15) argues that the study of people’s job satisfactions and dissatisfactions together with the social scientists’ findings and judgments go a long way towards measuring the quality of employment. It should also allow me to assess the impact these reactions have on job performance. Since this involves analysing workers’ attitudes and objective job conditions, I am to take “…both social structure and individual action into account …”, to use Krahn and Lowe’s (1993: 339) words. This is in keeping with my perspective that emphasizes the importance of organisational as well as the wider social structures in influencing work orientations and attitudes towards working conditions.

Scholars like Warr and Wall (1975: 10) noted two decades ago that “[t]he literature on job satisfaction is enormous both in quantity and scope… deal[ing] with the attitudes people have towards their jobs, and the causes and consequences of these attitudes”. However, it has been recently argued that “…[c]ontrary to the situation in industry, in nursing [there is] a lack of empirical investigation into the impact of work and working conditions on satisfaction, health and stress of the nurse…” (Landeweerd and Baumanns, 1988 : 225).

The situation is even more daunting with regard to empirical investigations in developing countries. Our position is more precarious when it comes to burnout, for Golembiewski and associates (1986:127) claim that “…no studies deal directly with the incidence of burnout in organisations”. We are, however, told the categories of people that experience it the most.

6.1.1 BURNOUT

There exists a strong relationship between burnout and stress. In fact, some scholars consider that burnout results from job stress (Klarreich, 1988); others see burnout
as a reaction to job stress and some consider burnout a type of job stress (Maslach, 1982; Krahn and Lowe, 1993). It is this precursory position of stress that forces me at this juncture to briefly discuss it and its causes before I dwell on burnout.

Despite the availability of copious amounts of literature on job stress, I have not been able to glean a succinct working definition of this term. Most writers concentrate on discussing the job stressors, their impact on workers, and stress management strategies.


The list is endless. But what all stressors have in common are the effects they have on workers. The effects, according to Lowe and Northcott (1986), are non-specific, depending on the individual, but include poorer work performance, industrial conflict, staff turnover, physical illness and/or emotional distress. I, therefore, agree with Beehr and Bhagat (in Jackson, 1989 : 31) who define stress as a function of the uncertainty of outcomes, because nothing in the causal relationship is definite or specific. Thus, Klarreich (1988 : 5) calls stress "...one of the toxic agents encountered on the workplace." As a result, it is what Lowe and Northcott (1986 : 111) regard it to be, "...an occupational health and safety issue."

Many studies have used job satisfaction as an outcome measure or indicator of work place stress (cf. Lowe and Northcott, 1986; Gray-Toft and Anderson, 1981; Krahn and Lowe, 1993; Cooper and Cartwright, 1994). According to Cooper and Cartwright (1994), there is a positive correlation between low job satisfaction and level of mental health.

Lowe and Northcott (1986) indicate that a few studies that compare men and women with identical jobs have found no difference in their stress reactions, however, their Canadian study informs them differently. They state that:

Even when men and women are exposed to the same work stressors, their distinct non-work social roles may contribute to different patterns of distress. Because being a spouse, parent, and homemaker are more demanding social roles for women than men, they provide higher levels of female distress [Lowe and Northcott, 1986 : 80].

Having discussed job stress and its causes, I can appreciate and understand Hare et al.'s (1988: 105) definition of burnout as "...a phenomenon in which the cumulative effects of a stressful work environment gradually overwhelm the defenses of staff members". This takes me into the discussion of the burnout phenomenon. Most scholars agree on a working definition of burnout, and, for my purposes I will use one by Maslach, a pioneer on the subject. She defines it as "...a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that occur among individuals who do 'people work'..." (1982 : 3).

Thus, this "...process or progressive emotional deterioration" (Klarreich, 1988 : 109) predominantly afflicts those working in human service organisations/settings (Cherniss, 1980). These people are helpers (Golembiewski, 1986, Maslach, 1982) like teachers, social workers, nurses and others. But, according to Hiscott and Cannop (1989 : 10) "[t]hose in the direct care nursing profession appear particularly vulnerable to stress and burnout problems". According to Macinik and Macinik (1990) the helping
professions have a high incidence of burnout because of low pay compared to other professions, lack of definite, measurable criteria for accomplishment and success, and limited chances for occupational mobility.

One's job characteristics (Maslach, 1982), occupational role and work setting (Hare et al., 1988), are what Krahn and Lowe (1993) call objective work situations that have been identified as "...factors which potentially influence burnout" (Hare et al., 1988: 106). These factors "...can either promote or reduce emotional stress. ...therefore they become an important factor in the burnout syndrome" (Maslach, 1982: 37).

The most commonly cited direct causes are lack of job autonomy/control, no direct input on policy decisions, hierarchical decision making structures and role overload. Among these, role overload is regarded as the common denominator in many work settings that are burnout prone (Maslach, 1982; Cherniss, 1980). According to Maslach (1982: 37), "[f]or the professional helper overload translates into too many people [i.e. clients] and too little time to adequately serve their needs - a situation ripe for burnout." Time constraints become particularly important "...especially when one must deal with large numbers of people or has limited resources with which to care for them" (Maslach, 1982: 50). The same concerns are central in my study.

Burnout is also reported to be high when people lack job autonomy or control over the care they are providing (Cherniss, 1980; Maslach, 1982). In this case, suffering from burnout is more akin to what Ford (1988: 294) calls "combat fatigue" which people like nurses suffer from. This is "...a constant, prolonged bombardment with stimuli while feeling unable to control the situation" (Ford, 1988: 294).

Since 'people helpers' or those that do 'people work' are predominantly female, it is safe to assume that more women than men suffer burnout in any given sample of human service organisations/settings. However, not many empirical studies have tackled the
effect of gender on burnout levels. A study done by Hiscott and Connop (1989) found job stressors to have more effect on burnout levels for males, relative to females. They attributed this to differences in role responsibilities in the psychiatric hospital studied.\(^1\) Another study by Burke and Greenglass (1989) indicates that male teachers reported greater burnout and less job satisfaction than did female teachers. Based on these results, the conclusion reached by Burke and Greenglass (1989 : 55) is that “...sex is an important psychosocial factor that interacts with stressors to affect an individual’s burnout”. However, I am left with no specific reason why female teachers are not similarly affected by the same work stressors.

The human costs of burnout are high. Apart from physiological effects which accompany high levels of strain (or burnout) (Golembiewski, 1986), there are also many self-reported measures of personal distress like psychosomatic symptoms (Burke and Greenglass, 1989), as well as psychological impairment and loss of self-esteem (Maslach, 1982). Some of the general symptoms are: “...apathy, hopelessness, fatigue, disillusionment, sadness, forgetfulness, irritability, minor physical complaints, time-pressuredness and social isolation” (Macinik and Macinik, 1990 : 247; Maslach, 1982, Cherniss, 1980; Klarreich, 1988). A burned out person gets “…completely fed up with work and life and [loses] the energy and enthusiasm to do anything about it” (Klarreich, 1988 : 96) because “…normal coping skills and attitudes do not suffice” in dealing with a collection of stressors that cause strain (Golembiewski, 1986 : 62). Over time, it is argued, the burned out person will withdraw physically from the job, i.e. absenteeism and turnover (Maslach, 1982; Cherniss, 1980; Macinik and Macinik, 1990). Alternatively, some seek reassignment (Golembiewski, 1986).\(^2\)

Social scientists have also found a positive correlation between burnout and growing dissatisfaction with the job (Maslach, 1982; Burke and Greenglass, 1989). This
is what probably leads one to withdraw physically. This logically, then, leads me to my next topic of discussion.

6.1.2 JOB SATISFACTION/DISSATISFACTION

Workers' job satisfaction/dissatisfaction is their attitude towards work, and physical withdrawal is one form of worker behaviour. So to understand job satisfaction/dissatisfaction fully I need to take a step back and discuss the concept of work orientation because it "...help[s] explain the factors both individual and structural, which influence people's attitudes and behaviour with regard to their work" (Watson, 1987 : 87). This concept "...refers to the meaning attached by individuals to their work which predisposes them to both think and act in particular ways with regard to that work" (Watson, 1987 : 86; Krahn and Lowe, 1993).³

It has been noted that people are motivated by different reasons to work (Kahn, 1981; Krahn and Lowe, 1993). We all adhere not to one but a number of interrelated work orientations, but one may be dominant (Krahn and Lowe, 1993). In his study, Khan (1981 : 3) found: "the regularity, the sense of obligation, the enjoyment of contact with others at work, and the exchange of effort for economic reward" to be common among three different respondents. Yet each was attached to work in ways somewhat different from the others. Hence, it is important to take the workers' own definition of the situation in order to recognise the variety of meaning that work has for them (Watson, 1987). This then forms a basis for explaining their attitudes and social behaviour.

Another development in the study of work orientations concerns their modification. One's work orientation "... once in ... [a] ... job, is constantly liable to change both as a result of factors operating within and factors located outside the workplace" (Watson, 1987 : 90; Hall, 1975; Krahn and Lowe, 1993), leading to a variety
of responses to the work situation (Hall, 1975). This line of thinking recognises that "... orientations or definitions of the situation are not necessarily fixed but are dynamic" (Watson, 1987: 90). Therefore, individuals shape the content of their job (to some extent), and vice versa (Kahn, 1981). Workers adjust to work situations that they cannot change, thereby generating new orientations or modifying old ones. For example,

"If a job offers few intrinsic rewards or little opportunity to develop a career, workers may adjust their values and priorities accordingly" [Krahn and Lowe, 1993: 319].

According to Ford, when people perceive their jobs to be low in opportunities for mobility or growth, they "... tend to limit their aspirations by not valuing more responsibility and participation, have lower self-esteem, seek satisfaction outside of work" (1988: 330).

Krahn and Lowe (1993) indicate that most studies on work orientation have focused only on men. Despite this shortcoming, some unsubstantiated conclusions on gender differences have been postulated. For example, the socialisation theory such as Ritzer's "... proposes that female gender role socialisation causes women to view the job as less central than do men" (see Mannheim, 1993: 4). Thus, women are considered to give primacy to family responsibilities. They are said to hold different work attitudes than men, to have lower work expectations than men (Lowe and Northcott, 1986). However, a number of writers have questioned this previously assumed gender differentiation in the importance of work and family.

Kanter (1977) has argued that the different structural conditions (in the form of opportunity structures) that men and women experience in the workplace contribute considerably to work value differences and behaviour at work. Hence, the widely observed tendency of women to be less committed, involved and aspiring than men in their work careers has less to do with their socialisation and upbringing than with their
opportunity structures. In other words, men would show the same characteristics under the same structure with the limitations women face. Krahn and Lowe (1993) bolster this argument by highlighting the importance of the different labour market locations men and women find themselves in. Women are said to be less likely to be in intrinsically and extrinsically rewarding jobs, therefore "... their somewhat different orientations and preferences might also be adaptations to the type of work they typically perform" (Krahn and Lowe, 1993: 321). They also regard domestic and child-care responsibilities many women face as an additional factor that forces them to readjust their work and career goals.

Two of the factors within this opportunity structure that influence job perceptions differently for men and women are job alternatives and prospects for advancement (Phelan et al., 1993). In their study, Phelan et al. (1993) found minimal gender differences in the factors associated with work attitudes. They "... found job attitudes to be much more strongly related to job-related factors" (Phelan et al., 1993: 82). Their results indicate that personal characteristics may be important factors shaping respondents' (both male and female) reactions to their jobs. They go further to argue [in the same vein as Kanter (1977)] that "... such personality' characteristics may ... be shaped by expectations and opportunities in the workplace rather than brought to the workplace by individuals" (Phelan et al., 1993: 82).

There is a general agreement about the correlation that exists between work orientations and job satisfaction (cf. Morris and Villemez, 1992; Krahn and Lowe, 1993; Mannheim, 1993). In fact, there is a mutual influence between the two variables. While "levels of satisfaction vary according to an individual's orientations ..." (Morris and Villemez, 1992: 55), "Job satisfaction [in turn] tends to increase work centrality by indicating possible feedback of work experiences ..." (Mannheim, 1993: 6). See Fig 6.2.
Indicative of the centrality of work in society are the numerous studies and literature on job satisfaction. This interest in workers' attitudes has also spawned a considerable number of definitions of the term. For my purposes, I shall use the one

![Diagram]

provided by Krahn and Lowe (1993). They define “...job satisfaction or dissatisfaction as...specific subjective reactions of individual workers to the particular set of rewards, intrinsic or extrinsic, provided by their job” (Krahn and Lowe, 1993 : 340). However, I need to buttress this with another definition by Mumford that establishes a link between these rewards and work orientations. She defines job satisfaction as “the fit between what an employee was seeking from work and what he was receiving ...” (in Metcalf, 1986 : 287). This component is important because one's response [satisfied or dissatisfied] is determined by one's experience and expectations (Khan, 1981).

There is general consensus among writers that job satisfaction/dissatisfaction is a complex and multi-dimensional response/variable (Warr and Wall, 1975; Breslau et al., 1978; Khan, 1981). It is affected by the work environment and/or structural job conditions (i.e. occupational role and level content of work; income/pay, etc.); workers' traits, perceptions, needs and experiences (cf. Breslau et al., 1978; Duxbury et al., 1984; Hurlbert, 1991; Krahn and Lowe, 1993; Khan, 1981). Hence, people working under the same objective job conditions may not be similarly affected by the prevailing job rewards and stressors and may report different levels of satisfaction (Lowe and Northcott, 1986; Hurlbert, 1991). However, several studies indicate that most people report that they are satisfied with their work (cf. Khan, 1981; Warr and Wall, 1975; Krahn and Lowe, 1993). The reason given by Warr and Wall (1975 : 14) is that

...strong dissatisfaction would in normal circumstances lead to a change in job, and ...habit and rationalisation over the years are likely to produce some kind of personal adjustment to a work situation.

Research on job satisfaction/dissatisfaction has traditionally followed a dichotomous approach. Researchers adopt either a need-based or a non-need based model of the process of determining job satisfaction (Hurlbert, 1991). Those that have rejected the conception of job satisfaction as need fulfillment, like Locke (1969), have stressed the role
of work values and rewards in job satisfaction, hence personality needs/trait are not deemed important (Hurlbert, 1991: 416).

Morris and Villemez (1992: 35) associated this dual approach with the metatheoretical orientations of Marx and Durkheim and they characterise the two approaches as ‘situational’ and ‘dispositional’ (or structural and individualistic). The former approach, deriving from a Marxian standpoint, for example, posits that experience at work is the key to explaining job satisfaction/dissatisfaction, regardless of education or background. Dispositional explanations on the other hand, predict varied levels of expectation and satisfaction based on socially induced value differences. Morris and Villemez (1992), however, do not regard the two positions as opposite ends of a continuum because both propose a relationship between values and rewards. The difference is therefore in explaining why this is the case, since one locates origins of values outside of the work environment and the other within the workplace. Morris and Villemez (1992: 36) therefore contend that both explanations are operative, because “...individuals carry dispositions into situations, and the interactions between dispositions and situations determine outcomes”. Perhaps, I should mention here that this is the position taken in this study. It is a position congruent with my theoretical framework that seeks to explain outcomes in the district health-care system as a result of a micro-macro interaction.

At this juncture, I will retrace my steps back to the need-based approach briefly mentioned above. The chief opponent is Herzberg, who draws from the work of Abraham Maslow on the human hierarchy of needs. It is the congruence between job structures and personality traits that is said to bring job satisfaction. Herzberg’s (1985) ‘Motivation - Hygiene’ or two factor theory of work motivation emphasises the extrinsic and intrinsic rewards of work. Hygiene (extrinsic or contextual factors - taking care of physiological, safety and social needs in Maslow’s hierarchy of needs), when present, can reduce job
dissatisfaction but cannot lead to satisfaction. Motivation (intrinsic or content) factors (taking care of self-esteem and actualisation needs) have to be present before satisfaction can be produced and people motivated to perform well. Many authors have therefore (following Herzberg) attempted to distinguish intrinsic from extrinsic determinants of job satisfaction (Hurlbert, 1991).

Kalleberg, for example, concluded from his studies that intrinsic rewards were more important in determining job satisfaction than were extrinsic rewards (Krahn and Lowe, 1993). This is an assertion that has subsequently been made by others (Breslau et al., 1978, Hurlbert, 1991). Others have gone further to link intrinsic and extrinsic satisfaction to occupational level. Firstly, it is argued that job satisfaction "...varies directly with a person's position in the occupational hierarchy" (Hall, 1975 : 42). The higher the status, the less the expressed dissatisfaction. And evidence has been presented that "...those in higher level work expect more by way of intrinsic satisfactions than do those in more routine manual work" (Watson, 1987 : 104). However, Gruenberg (1980) who tested this argument found little support for the position that lower-level workers have different needs (Hurlbert, 1991 : 416).

On the whole, Duxbury and associates have posited that "[t]his relatively simplistic model of job satisfaction [needs-based approach] has not coincided with reports of job satisfaction from nurses," (1984 : 98). Sennet and Cobb (1973) discussed American blue-collar workers who did not attach much significance to intrinsic work rewards, but emphasised pay and job security. Jinadu and Jaiyeoba's (1983) study of nurses in Nigeria has also obtained results that negate Herzberg's thesis. Although they found higher order needs (self-esteem and actualisation) satisfiers important
...lower-order needs, that is physiological and safety needs in the form of adequate financial rewards, figured so largely in the study that one cannot but conclude that they are powerful motivations and not simply satisfiers among nurses in Nigerian socio-cultural environment [Jinadu and Jaiyeoba, 1983 : 220].

Since Herzberg’s theory is based on observations in a developed country, it is Jinadu and Jaiyeoba’s (1983) contention that it should be modified if it has to be applied to developing countries where economic incentives can not be discounted as motivators.

Another issue that has been widely debated is that concerning gender and job satisfaction. Findings are contradictory. Some studies show that women are more satisfied than men, and some have reported no difference at all. Burke and Greenglass (1989) found female teachers to have greater job satisfaction than male teachers. The explanation given is that:

...may be...women in teaching, as in other female-dominated jobs, are more job satisfied because of the opportunity for camaraderie from similar women in their organisation or school [Burke and Greenglass, 1989 : 62].

Phelan and associates (1993 : 83) also contend that women tend to view their jobs in more favourable light than do men “...because their job alternatives and prospects for advancement are more limited”. This is a more plausible reason as compared to the more simplistic one given by Burke and Greenglass (1989). It is in sync with the one offered by other writers (viz. Kanter, 1977; de Vaus and McAllister, 1991; Lowe and Northcott, 1986; Krahm and Lowe, 1993) which puts more emphasis on the structural limitations women face, removal of which would lead to the disappearance of gender differences in work orientation.

On the other end of the spectrum we have, for example, data collected in nine Western European countries showing that men are more satisfied than women with their jobs (de Vaus and McAllister, 1991). However, it is stated that the difference is limited.
In the middle, we have results from studies like Lowe and Northcott’s (1986). In their study of postal workers, they found that males and females who do the same work have very similar perceptions of their job, encounter similar degrees of work pressure, and report similar levels of job dissatisfaction [Lowe and Northcott, 1986 : 95].

Krahn and Lowe (1993) are of the same opinion that no difference in job satisfaction exists between men and women, based on research evidence in the literature. They cite the 1989 General Social Survey results which “...showed virtually identical levels of job satisfaction among female and male employed Canadians” (Krahn and Lowe, 1993 : 342). But, because of the structural disadvantages women face, including limited work rewards, women are therefore said to more likely tolerate and even express satisfaction with menial jobs (Krahn and Lowe, 1993). 9

Sex has also been reported to affect one’s valuation of the type of job rewards offered. de Vaus and McAllister (1991) state that the data collected in nine Western European countries supports previous research that shows that men place greater value than women on both extrinsic and intrinsic work values. They see these results as refuting Kanter’s argument that the poorer job conditions of women produce a stronger extrinsic orientation (de Vaus and McAllister, 1993). However, they admit that the extent to which men and women differ on work values is limited.

Another variable that has been linked to job satisfaction is age. Research has consistently found older workers to be more satisfied with their jobs (Hall, 1975). Barthlomeyczik et al., and associates’ (1992 : 30) study found 20 - to - 24 - year - old night nurses to be less content than older nurses, and one possible reason they give is that “the dissatisfied (older) nurses have left the profession already”. In explaining the same phenomenon, Krahn and Lowe (1993 : 342) argue that: “Perhaps older workers have reduced their expectations, becoming more accepting of relatively unrewarding work. We
might call this an aging effect.’’ On the other hand, Hurrell and McLean’s (1989) study found no difference in job satisfaction based on age.

A considerable number of job stressors, intrinsic and extrinsic work rewards have been considered as affecting job satisfaction/dissatisfaction. Role conflict, role ambiguity and role overload are some of the job stressors that are said to reduce one’s general satisfaction with their job and work environment (Hurrell and McLanney, 1991; Khan et al., 1964). The commonly mentioned intrinsic job rewards that have a positive impact (when present) on job satisfaction are decision making latitude and job autonomy/control (cf. de Vaus and McAllister, 1991; Karasek, 1989; Chernomas and Chernomas, 1989; Krahm and Lowe, 1993). Professional autonomy, which is closely related to job autonomy is highly valued by professional workers. Stevens and associates (1992) state that professional autonomy is a key factor influencing the job satisfaction of physicians in their study. Breslau and associates (1978) found high level paramedical workers to be dissatisfied with their jobs. They indicate that this dissatisfaction

...may stem from the discrepancy between the professional orientations in which they were schooled [and taught the value of professional autonomy] and their subsequent subordination to physicians accompanied by routine menial tasks [Breslau et al., 1978: 860].

Control is almost synonymous with job autonomy. Karasek (1989) maintains that although the importance of control was realised in early studies, the emphasis was single - minded. There was little mention of workers’ demands and health outcomes (or worker well-being) were rarely addressed as a central concern but only a step towards productivity (Karasek, 1989).

Absenteeism, sabotage and turnover are the behavioural indicators of satisfaction/dissatisfaction commonly used by researchers (Hall, 1975; Zuraikat and McCloskey, 1986; Chernomas and Chernomas, 1989). Hence others have charged that
"hospitals with low job satisfaction scores have higher turnover and absenteeism rates" (Chernomas and Chernomas, 1989 : 644). This direct relationship between job satisfaction and these indicators is questionable. The decisions to leave a job are more determined by labour market conditions than by dissatisfaction alone (Krahn and Lowe, 1993; Cooper and Cartwright, 1994). Unless there are other jobs available, most workers can not afford to quit because of dissatisfaction, but "...it might ...encourage individuals to call in sick or come in late more frequently," (Krahn and Lowe, 1993 : 355). In their study of Canadian postal workers, Lowe and Northcott (1986 : 43) found that:

- Despite the high levels of dissatisfaction, relatively few postal workers had actually looked for another job during the past year. ...Aware of the bleak job prospects outside Canada Post, respondents could rationalize sticking with otherwise dissatisfying work...

Having covered the causes and nature of burnout and job satisfaction/dissatisfaction covered in the literature, I now turn to my study.

6.2 JOB SATISFACTION/DISSATISFACTION AMONG HEALTH PERSONNEL IN MUTOKO DISTRICT

A national survey in Jordan (another developing country) by Zuraikat and McCloskey (1986) to identify the major causes of satisfaction/dissatisfaction among registered nurses (77 percent of whom were female) found them to be more dissatisfied than satisfied. This dissatisfaction is normally expressed in the form of a brain drain to other countries, leading to an acute nursing shortage. The authors cite some of the major causes of this dissatisfaction as: lack of job autonomy and control; limited opportunities for career advancement and continuing education; limited participation in decision making - all of which are intrinsic rewards. A study done three years prior to this revealed 80 percent of nurses preferred to be in a different profession (Zuraikat and McCloskey, 1986).
When we move closer to home, Africa, we learn that conditions in nursing services are quite similar in most parts of the continent (Osei-Boateng, 1992). They are unattractive. Many nurses are said to lack job satisfaction due to: inadequate supply of drugs, basic equipment and supplies; low salaries; shortage of trained staff (Osei-Boateng, 1992). Osei-Boateng (1992) goes further to note that due to fewer job opportunities in the private sector, dissatisfied nurses from the government sector have only one outlet, to leave, thus contributing to brain drain.

The Zimbabwe Government (1993) acknowledges the unsatisfactory nature of the current conditions of service in the field of health. It identifies some of the main contributing factors to the brain drain from the Ministry of Health and Child Welfare (MHCW) as: inadequate staff accommodation, low salaries, inadequate equipment and supplies. The brain drain of qualified medical staff is to either neighbouring or Western countries (Daily Gazette, Wed., Sept. 8, 1993 : 8). This leads to shortage of staff, to role/job overload (for remaining staff) and job dissatisfaction and possibly more turnover. Thus, the Minister of Health notes that: "There is a strong temptation where there are shortages to respond to the so-called greener pastures" (Daily Gazette, Sept. 8, 1993 : 8).

The most popular question (with some variation) researchers on job satisfaction/dissatisfaction ask respondents is "All in all, how satisfied are you with your job?" (Krahn and Lowe, 1993; Lowe and Northcott, 1986). Since the majority of people typically report some degree of satisfaction (Khan, 1981; Krahn and Lowe, 1993), it is suggested that "...more specific and probing questions may be needed to uncover feelings " (Krahn and Lowe, 1993 : 340). In this study I tried to circumvent this problem by asking open-ended questions.

We asked "All in all, what factors make for satisfaction [and dissatisfaction-separately] in your job and work environment?" By asking respondents to give the factors
themselves, instead of giving them a list of possible factors to evaluate, I wanted to be able to highlight the factors which are important to the various workers themselves without inadvertently introducing interviewer bias.

The analysis of responses to the question on job satisfaction yielded a rather small number of satisfiers for the 37 facility based (MDH and HCs) workers interviewed. The largest response category of 10 was centred around contact with and/or helping patients as an important factor in the satisfaction of health-care personnel with their jobs, a finding that came up in Metcalf's (1986) study. This comprised of 5 male and 5 female health-care personnel. Some of these respondents went further to express what exactly they feel happy about. Some mentioned satisfaction obtained from managing difficult cases:

SRN. 13: ...especially managing a difficult case and you see someone going home again.

SCN. I: The fact that a person comes in a serious condition, I attend to them, and they come and thank me later on. That shows you are part of the community.

In this case, performance of work roles produces moral satisfaction for the individual worker. Torrence (1982) has argued that hospital workers commonly express a degree of commitment to service. Hughes (1958) mentions a related finding in a study of hospital nurses in New Orleans. The study showed that altruism motivated two thirds of them, and their most common source of satisfaction lay there. Three other health-care personnel, nurse-aides and a nurse also gave responses that could be put in this category. They mentioned "doing what I was trained to do..." (SCN.J), "work tasks..." (NA.F) and "...the work itself..." (NA.C) as sources of their satisfactions.

A similar response to this show of commitment to service is that of "helping [the] Ministry of Health...to achieve the goal of Health for All by the Year 2000" (HP34). There were only 2 responses in this category, given by male non-nursing personnel. The
other respondent said, "The idea of knowing I am doing a job that is contributing to the essential services of the Ministry of Health really satisfies me" (AP25).

The third common response again, given by only two workers, is satisfaction derived from the latitude they have to make decisions. The two (AP26; AP25) have administrative duties and for one, "...the recognition within the hospital, as an essential component in the hierarchy...[is satisfying]" (AP25). The respondent goes further to say, "...We talk of salaries and other benefits after getting this satisfaction I have talked about" (AP25). The other respondent apart from getting satisfaction from decision making authority, also mentions the initiative displayed by subordinates as well as appreciation of her ideas (AP26). These two responses are the closest that we get to intrinsic job rewards that I have discussed above.

The next response category posited by only 4 respondents concerns social relationships (or social interaction) with co-workers and superiors. These were given by 2 females (SCN6; SCN14); and 2 males (SCN10; SCN9), all nurses. Although my sample is not large, this might be an indication that women do not necessarily seek camaraderie (more than men) in work settings because they are in a female-dominated profession as suggested by Burke and Greenglass (1989).

Only 2 respondents mentioned an extrinsic reward as a source of satisfaction in their work. This is on-site accommodation provided by the district hospital and health centres. The fact that both are male might be a reflection of the cultural norm that males as breadwinners are responsible for the provision of shelter.

A particular outstanding response is given by the district laboratory technologist. He shows commitment to professional values when he answers: "...as a professional, I did the training because I like the job...Every professional likes their job...". He also gives concern for patients as a source of satisfaction.
What is most significant about the responses generated by my question is the number of respondents who indicated there was nothing satisfying about their job and work environment. About half the number of my respondents (16 = 43 percent) could not think of anything satisfying about their work. Of these 16, 12 are female (57 percent of females in the sample) and 4 are male (25 percent of male respondents). This indicates that women in my sample experience relatively fewer satisfiers than men. I cannot, however, say that women are less satisfied than men until I look at dissatisfiers.

Of the 13 nurses who indicate they experience no satisfiers, 6 are state registered nurses (SRNs) and 7 are state certified nurses (SCNs). All things being equal, one would expect more SCNs to give this response since they experience more structural disadvantages. I can only hazard an explanation here why this might be the case. SRNs are a higher category of paramedical workers than SCNs, and it is possible that they have higher expectations and therefore experience less satisfiers. On the other hand, SCNs might have adapted to the structural disadvantages they face and the prevailing working conditions which SRNs generally find unsatisfying. 13

The five field staff, village community workers (VCWs), that were interviewed indicated that they experienced no other satisfiers apart from helping their fellow villagers with their health problems. More probing would only get them to hypothetically state what the satisfiers would be under improved working conditions.

The facility-based personnel who said they experienced nothing satisfying about their work responded in two distinct ways. A few of these showed some surprise (as they repeated the word 'satisfaction?' as if to say "Are you kidding?") and then went blank for a considerably long time as if they were trying to fish out something minuscule and long forgotten from the recesses of their minds. On the other hand, I have those that instantly
said "there is no satisfaction..." and began pouring out the grounds of their opinion. In these outpourings, respondents went directly into describing dissatisfiers.

These are some of the typical responses.

SRN4: At present, it's very difficult to say [in a low dejected tone of voice] ... Since 2 or 3 years ago, it's not really satisfying [working here], and I repeat, because of staff shortage.

SRN17: [long pause, and light laughter] ... I joined nursing because I really wanted to. But now I am dissatisfied with most areas because of staff shortage. ... now ... you can't go on leave even though your time is due...but we need the rest.

SCN7: Satisfaction? [laughs] With the shortage of staff here, you never feel good because you are always overworked...

SRN3: It's difficult with all the constraints, it's really difficult, so much that people have the tendency to just show up for duty and then go home just like that.

SCN11: At work? I don't think anyone is satisfied...there are a lot of frustrations...

SCN15: Not really. Work is exciting if you are well staffed. ...we have to do a lot of things at the same time...we do a lot of paper work so there is not much time [for other things]...[we are] under a lot of pressure.

Here, I have deliberately chosen only those responses that divert from the discussion of satisfiers into giving dissatisfiers related to staff shortage. Almost a quarter of all facility-based respondents answered in this manner, which shows the extent to which health-care personnel have been affected by work overload. In the words of one female nurse, staff shortage "... affects most other areas ... without ... [it] most things ... run ... smoothly" (SRN17). Of the 40 respondents in the sample, only two (a nurse-aide and an SCN) indicated that they did not experience discontentment with any aspect of their job or work environment.

The most commonly cited factor that causes job dissatisfaction is staff shortage/work overload, as shown in Appendix VI.I. The next largest dissatisfier
shown in Appendix VI.I is the salary (at 50 percent) health-care personnel are receiving. Although VCWs are not included in this table, the dissatisfiers that all 5 mentioned are: salary, work overload, lack of transportation (bicycles) and uniforms.

I have noted a connection between these two dissatisfiers (work overload and income). Health personnel (at all levels) are fully aware that they are overworked, and they believe they should be either earning more or getting allowances, incentives or compensation for the extra effort. For example, one nurse says "...I feel very dissatisfied when I compare the salary and amount of work I do" (SRN17). Another SRN says "...sometimes we overwork, but our salaries just remain the same. We are not given enough" (SRN5). A nurse that periodically teaches a post-basic training course for the district also has a similar concern: "...[I] use my spare time to make preparations for the school. I think it calls for incentives in terms of money, but I am just getting basically the same as other nurses..." (SRN37). A 19 year veteran in the health field makes a more poignant remark concerning this issue. He says, "The medical field is not rewarding. We work quite a lot...but [are] not rewarded. You work up to retirement age without anything to show for it" (SCN11). Health centre personnel have a lot of responsibilities, including all necessary paperwork on top of caring and curing duties. Therefore, one of the nurses says

When my colleague is off duty I have to work for the whole week...we do not really specialise in anything, we do nearly everything. We are asked to be responsible and accountable for everything but there is no allowance [SCN.G].

A similar case is that of another male SCN at a HC who says, "the post I hold now [nurse in charge] has a lot of responsibilities and you get nothing for it...you put all that effort and there is no responsibility allowance...It really annoys me" [SCN.J].
Another reason for asking for compensation/incentives is the "risk" health-care personnel say they take. Some of the risks are the Tuberculosis (TB) and HIV/AIDS patients they deal with. One of the considerable number of health-care personnel that feels this is an occupational hazard is the laboratory technologist who handles 'dangerous TB and HIV specimens'. Given an allowance, he says, "We could then say well, it doesn't matter if we handle this - at least we are getting something at the end of the day". This problem of "... fear, real and unreal, of contagion ..." has been pointed out by Mhloyi (1991 : 8), who goes further to cite a study done in New York in which "... 63% of the medical staff at a New York teaching hospital in 1989 expressed doubt over the fact that health workers who observe safety guidelines are at a minimal risk of infection from patients". However, these workers' position is understandable, given the fact of shortage of gloves.

For us to understand this issue of incentives and salaries I have to go beyond these jobs, stressors and the district of Mutoko. The introduction of ESAP has meant devaluation of the currency, rising inflation, and a high cost of living. These macro-factors are bound to significantly affect workers' expectations and perceptions of their jobs and rewards. For example one nurse says: "Of course nowadays nobody would ever say they are satisfied with their salary...with this cost of living that is getting...high on a daily basis" [SCN1]. Helplessness regarding this issue was expressed by two nurses. While discussing the merits of a salary increase one says, "when we talk of a salary increment, inflation comes in..." (SRN 3) as if to say "why bother?" Another one expresses a similar opinion by saying

...I have never complained about money because I know it does not make any difference if I get it. Like now, they have just announced [last night] an increment for us, fair and fine...[but] when it comes, with this inflation, we are back to square one [AP26].
Another macro structure that I believe should be considered when considering how workers value their pay cheque is more cultural than economic. The extended family is still quite strong in Zimbabwe and that entails more responsibilities for the average wage earner. In one case, a nurse was expressing dissatisfaction with her salary when she said, "...we also have to look at someone's background...some of us come from extended families and with such 'problems', the salary is not enough" (SCN1). In such a case, satisfaction from wages is not from the pleasures that those wages afford a worker in the 'real world' like Hall (1975) says, but from meeting family responsibilities. More so in the face of the ever rising cost of living caused by ESAP, whereby nurses begin to feel that "...Our salary...is just enough for basic subsistence, but not enough to improve one's life in terms of other needs" (SCN1). In this regard, Khan (1981: 109) says, "when opportunities or rewards of a job are too meagre to meet the needs of the person, strain is the predictable consequence". He goes further to say the effects of pay generalise to affect satisfaction with the job as a whole. Thus, job satisfaction gets affected by perceptual and structural forces outside the work context.

I, therefore, strongly agree with Jinadu and Jaiyeoba's (1983) position that in developing countries economic incentives cannot be treated as solely. 'Hygienic' factors (according to Herzberg's theory). They are motivators as well. This position gets support from Nevis (1983: 250) who says the concept of a hierarchy of needs is valid only in terms of a specific culture, hence "...incentives and structures to further motivation can only succeed to the extent that they fit with basic values as reflected in that...culture."

Jinadu and Jaiyeoba (1983) argue that in countries with no governmental social security system to guarantee health workers a comfortable life after retirement income becomes an incentive to hard work (Jinadu and Jaiyeoba, 1983). (Recall the case above of the male nurse who is worried about working to retirement age without getting anything
to show for it.) Jinadu and Jaiyeoba (1983) go further to give another reason for their position. This concerns the numerous financial burdens heaped on nurses and other workers by the extended family.

Appendix VI.I further shows that other dissatisfiers with a considerable impact on workers are: inadequate accommodation from which workers can be shifted anytime (35 percent); inadequate communication channels (25 percent); inadequate travel and subsistence allowances which are frequently not honoured (20 percent), and shortage of equipment, drugs and supplies (18 percent).

What is discernible from this is that a considerable number of health-care personnel indicated (discussed in Chapter Four) that there is little: decentralisation of decision making, job autonomy, participation in policy making decisions, yet only three workers (a nurse-aide, a programme officer and department head) mentioned the lack of participation and policy decision making as dissatisfiers. We can only assume that workers are much more concerned with the more apparent factors; those disproportionately affecting them presently, e.g., work overload salaries and accommodation. Nevis (1983) has indicated that self-esteem needs act as a driving force in cultures that emphasize individualism. In his studies in the People's Republic of China (PRC), Nevis (1983) found (similar results) that people were most concerned over low wages and housing problems. This, he says is broad indication of severe problems at the level of physical, lower-order needs in China (Nevis, 1983). Hence "...Chinese workers cannot easily dismiss any failure to reward their effort by providing improvements in these areas" (Nevis, 1983: 257).

When the two measures are compared, as shown in Table 6.1, it becomes clear
TABLE 6.1: The Number of Respondents Reporting Satisfiers and Dissatisfiers

<table>
<thead>
<tr>
<th>Satisfiers</th>
<th>No Satisfiers</th>
<th>Dissatisfiers</th>
<th>No Dissatisfiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>16</td>
<td>38</td>
<td>2</td>
</tr>
<tr>
<td>57%</td>
<td>43%</td>
<td>95%</td>
<td>5%</td>
</tr>
</tbody>
</table>

*37 cases (8 missing cases) 40 cases (5 missing cases)

that health personnel in the district experience more dissatisfiers than satisfiers. Only 21 (57 percent) out of 37 respondents reported one or more satisfiers, while 38 (95 percent) out of 40 respondents reported one or more dissatisfiers. The table also shows that while 16 (43 percent) reported not a single satisfier, only 2 (5 percent) did not report any dissatisfier. Apart from asking direct questions about satisfaction(s)/dissatisfaction(s), many studies have gone further to ask some hypothetical questions (cf. Hughes, 1958; Kahn, 1981; Krahn and Lowe, 1993; Lowe and Northcott, 1986). The most popular (with minor variations) is: "Knowing what you do, if you had to make the choice again, would you choose the same type of work?" In a study by Sledge and Rohrer in New Orleans, 90 percent of the nurses said they would (Hughes, 1958). In the 1987 Environics survey in Canada, about 46 percent said they would stay in their occupation and 42 percent said they would change (Krahn and Lowe, 1993). In Lowe and Northcott's (1986: 43) study, over half of the letter sorters said no, and "in contrast, far more letter carriers said they would choose the same work again".

My hypothetical question was framed in the following manner: "Given your experience, if you were to start all over again would you choose the same profession?". To this 27 respondents (66 percent) said they would choose the same occupation, as
opposed to a large minority of 14 (34 percent) that said they would not. Table 6.2 also shows very little difference between SRNs and SCNs on this behavioural intention measure. In both groups, 38 and 39 percent (respectively) indicated they would not choose the same occupation.17 Table 6.2 further indicates that more males are willing to choose the same profession than women. In other words, more women would choose differently.

Therefore, these results contradict some findings which indicate that women are more satisfied with their jobs. Kahn (1981: 214) has indicated that “people in the high prestige occupations would choose them again [and those] in low-ranked occupations...would choose differently if they had a chance to do so”. So I might try to justify this finding by arguing that the sample of men had 9 (45 percent) programme managers and/or department heads, compared to 2 (10 percent) department heads in the female sample, therefore, the positive attitudes of these men in high positions might have skewed these responses.

**TABLE 6.2 : Desire to Change Profession if One Had to Make the Choice Again**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>YES No.</th>
<th>YES %</th>
<th>NO No.</th>
<th>NO %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Response</td>
<td>27</td>
<td>66</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td>Males</td>
<td>16</td>
<td>80</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Females</td>
<td>11</td>
<td>52</td>
<td>10</td>
<td>48</td>
</tr>
<tr>
<td>SRNs (only) *</td>
<td>5</td>
<td>62</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td>SCNs(only)</td>
<td>11</td>
<td>61</td>
<td>7</td>
<td>39</td>
</tr>
</tbody>
</table>

*All SRNs in the sample above are female
Total sample 41 (4 missing cases): 20 men, 21 women

This seems a plausible explanation until I take only nurses into consideration. When I split them according to sex, 41 percent of female nurses, compared to 33 percent of male nurses said they would choose a different job. This goes further to bolster my argument above, that women are more dissatisfied than men in my sample. However, I
cannot conclusively say gender is the only variable that is causing this relatively small but important difference. At this juncture, it is safer to say that the objective job conditions I have discussed are more responsible for the expressed job dissatisfaction.

Most of the respondents that indicated they would choose the same occupation put it in such a way that indicated that it was not the job attributes and working conditions per se that they were considering, but the culturally valued attributes of the profession (professional values). This highlights the importance of prior orientations to work. Some of the typical responses in this category are:

**SCN6:** Yes, I like the nursing profession very much.

**SCN3:** Yes. Nursing is the profession I grew up admiring.

**AP25:** I think I would, because personnel administration is a very interesting profession....

**HD31:** Yes. The profession is all right...I think it is a very good career.

Another noteworthy (but negative) response is that which set conditions for choosing the same profession. A few examples are:

**SRN13:** Yes, if they improve some of the conditions, including salary.

**HD29:** Without higher incentives I wouldn’t. Unless there are changes in salaries...Because if they asked me to continue working after retirement age I will tell them “thank you”.

However, the majority of those that gave a negative response either just gave a flat “No” or said no and gave some justification. We take such responses to mean respondents would not give the present profession any chance if they could help it. A few responses with such a bias are:

**SCN7:** No. I wouldn’t. I would prefer to be a teacher.

**SCNH:** Maybe I will put it as second or third choice.
SCN11: I would say thank you [cynical laughter], I have had it. It is good to be a nurse, because you will be helping people, but what you go through...Like these days...sometimes we do not have drugs. So when you go to a patient who is HIV positive, you really feel embarrassed about how you are going to tell them that.

Table 6.3 shows the percentage distribution between respondents’ mention of satisfiers (or lack thereof) and their need to change professions if they had to start all over again. A substantial number (69 percent) that reported no satisfiers indicated they would choose differently. However, a sizable number (31 percent) indicated no satisfiers, but indicated they would choose the same occupation. When we look at the external environment, we notice that the study was carried out during a period of economic hardships, high unemployment rates, because of ESAP. It is a possibility some workers, realising the effect of the economy on all segments of the population, might have rationalised and come to the conclusion that even if they changed occupations their situation would nonetheless be back.

<table>
<thead>
<tr>
<th>MENTION OF SATISFIERS</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>%</td>
<td>No. %</td>
</tr>
<tr>
<td>CHOOSE THE SAME PROFESSION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>19</td>
<td>86</td>
</tr>
<tr>
<td>6</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>10</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

(38 cases; 7 missing cases)
Many studies have indicated that the experience of dissatisfaction and intention to quit are moderated by external factors like the job market (cf. Lowe and Northcott, 1986; Krahn and Lowe, 1993; Fang and Baba, 1993). The effect of high unemployment rates or the job market on turnover is evident in the study. According to a senior staff, turnover ...[is] not significant at [MDH]...because people are training and they are not getting jobs [after that], so those that have a job tend to hang onto it. So that has sort of automatically controlled staff turnover. Because if you leave where do you go? [AP26]

In the words of one of the nurses, “There are some days when you feel like leaving the job, but there is nowhere to go” (SCN9). Another one says, “...sometimes you feel ‘if I had money I would just leave this profession and start a business of my own’” (SCN11). This example touches on the theme of the low salaries I have mentioned above, as well as the yearning for independence, control and/or self-direction that comes with having to direct one’s own enterprise.

Therefore, beyond the basic objective features such as shortage of: drugs, equipment, supplies, accommodation, and manpower and other things, I have shown evidence of the relatively dissatisfying nature of the district health personnel’s jobs that has come from their own negative evaluations.

6.3 BURNOUT AMONG HEALTH PERSONNEL

Some scholars regard job dissatisfaction as a causal factor when discussing burnout. For example, Cherniss defines burnout as “...psychological withdrawal from work in response to excessive stress or dissatisfaction” (1980: 16). Others, like Maslach (1982) indicate that burnout leads to job dissatisfaction. While this might suggest a
mutual (rather than a one way) relationship (that I do not disagree with), I choose to go by the second position, as depicted in Fig. 6.2. However, despite my subscribing to this logical sequence I have chosen to discuss burnout after job satisfaction because I did not measure burnout levels among the respondents. \textsuperscript{19} Hence it seemed safe and sensible to present job satisfaction/dissatisfaction levels first, so that I can make inferences about the existence of burnout based on the workers’ subjective feelings, attitudes to work, and behaviour.

Research indicates that those who experience greater overload report stronger job-related tensions (Warr and Wall, 1975), of which burnout is one. Maslach (1982) discusses an agency that was chronically understaffed and workers left without immediate replacement (as is the case in my study because of ESAP), leaving the remaining social workers to take greater workloads. This led to burnout among these social workers. More telling is the example Maslach gives of a nurse that says “When you have to care for so many people, you begin to suffer from an emotional overload...” (1982 : 2). Since this is the major complaint among the respondents, I can probably assume that most of them are burned out. In describing burnout Cherniss (1980) states that what formerly was a ‘calling’ becomes merely a job, the initial commitment and enthusiasm are gone, because of job stress. Hare et al. (1988) call this loss of idealism and purpose/mission. Disillusionment sets in. They quote Storlie who paints a vivid picture of burnout as it occurs in the nurse: “burnout [is] a highly personal happening inside the nurse...the literal collapse of the human spirit...” (in Hare et al., 1988 : 106).

This shift from idealism to disillusionment, which is a symptom of burnout, is strongly depicted in a significant number of interviews. When asked what factors make for satisfaction in her work, a nurse that has been in the service for 11 years says: “At present it is very difficult to say...I used to enjoy working in the wards...Since 2 or 3 years
ago its not really satisfying...because of staff shortage...Interest in nursing is gone" (SRN4). A similar response comes from another female nurse who says, "I joined nursing because I really wanted to. But now I am dissatisfied with most areas because of staff shortage" (SRN17). Thus, in most burned out nurses who feel the same way, the initial motivation is gone.

The situation is more akin to that found by Goldthorpe et al. (1968) in their study of British auto workers. The workers were said to have an instrumental orientation to work. That is, work simply becomes a means of obtaining means of survival, an 'instrument' used to achieve non work goals. In my study, when asked for job satisfiers one nurse said:

It's difficult with all the constraints...so much that people now have the tendency to just come for duty and...going home just like that [gestures with hands - indicating going home quietly] [SRN3].

Another demotivated worker, a head of department says:

Well, as a professional, ...I [trained] because I like the job, otherwise to work is a day to day duty [with] some...[factors that] I am interested in [HD35].

Apart from work overload and other factors, burnout is also caused by the health personnel's helplessness or inability to provide drugs (even some basic ones) for the increasing number of HIV positive patients in the district. A good example is that of the nurse I have already quoted above who says he would choose a different job if he had to start all over again because "...You go to a patient who is positive...[and] really feel embarrassed [about] how you are going to [tell them you have no drugs] [SCN11].

We also contend that field staff would experience burnout at a more intense level because they work with even fewer resources, face enormous transport problems, considerable work overload, weaker communication channels and most importantly, receive lower incomes. These workers also face another highly potential burnout
inducing stressor which they have no control over. The villagers' socio-economic position made worse by the rising cost of living, more often than not does not allow them to buy resources for constructing toilets, water wells, and cement floors for their homes, or buy ingredients for making solutions to cure diarrhoea. This was attested to by the 5 VCWs and 1 EHT in my sample as well as identified as a major source of frustration.

Thus, given the conditions and scenario I have discussed above, it seems relatively safe to say that most health personnel in Mutoko District face a significant number of job stressors and are burned out.

6.4 DISCUSSION AND CONCLUSION

The concept of job autonomy is closely linked to the idea of control over the job environment (Ganster, 1989). In fact, some use them interchangeably, with control being defined as decision authority and/or skill discretion (Santer et al., 1989: xv), or job discretion or autonomy (Cooper and Cartwright, 1994: 461). There is general consensus among scholars that job control/autonomy has a buffering or moderating effect on workers' responses (e.g. burnout and job dissatisfaction) to job stressors (cf. Cooper and Cartwright, 1994; Chernomas and Chernomas, 1989; Coburn, 1983a, 1983b, Cherniss, 1980; Lowe and Northcott, 1986; Karasek, 1989; Hurrell and McLaney, 1989; Santer et al., 1989; Ganster, 1989). Job control/autonomy also acts as a satisfier (Chernomas and Chernomas, 1989). It is positively correlated with job satisfaction (Blau, 1957; Coburn, 1983a, 1983b; Jackson, 1989). A study by Hurrell and McLaney (1989: 102) found higher perceptions of control over tasks, resources and physical environment to increase job satisfaction among nurses.

In Chapter Four, I discussed the relative absence of job control/autonomy in Mutoko District health-care system. The fact that no respondents mention this absence as
a dissatisfier, taking into consideration my previous argument that workers are presently more concerned with basic survival than self-esteem, should not make us minimise its importance. If it were present, assuming the arguments about this buffering effect cited above are true, the overall effects of the job stressors would be somewhat mitigated.

To make the point clearer, let me move on to participation in decision/policy making indicated in Fig. 6.1 as an independent variable, together with job autonomy. I indicated in Chapter Four that the MHCW has rigid hierarchical structures which concentrate power at the top (central and provincial offices), leaving district level officials and lower-level health personnel little scope for decision making and influencing policy decisions, particularly those affecting resource allocation and working conditions. The pervasive system of rules and regulations complements these hierarchical structures (of which they are a part) in decreasing workers' autonomy and decision making power and hampering smooth communication between the local and higher levels of the ministry.

According to Cherniss (1980: 97), "[h]ierarchical power structures reduce staff autonomy and control, contributing to learned helplessness and burnout". In my study only two workers mentioned lack of decision making or participation as stressors or dissatisfiers, but the fact that many workers indicated that there has been little decentralisation in decision making should make us take this as a significant stressor, especially among those in higher positions. The reason is that their job descriptions specify that they have decision making power, but in reality they do not get to make any major decisions without having to consult with the provincial or central offices. Increased decision making would enable them to remove some of the obstacles they are experiencing, thereby reducing frustration, burnout and dissatisfaction.

This connection becomes apparent when I consider the link between the two independent variables in this study (see Fig. 6.1). Studies have shown decision making to
afford workers an opportunity to acquire and direct needed organisational resources, thereby performing successfully and thereby decreasing stress levels (Lowe and Northcott, 1986; Jackson, 1989). Here I am simply arguing that, if local programme managers had enough power to determine the amount and type of resources they get from central offices, some of the frustrations and burnout experienced by health personnel could be minimised. Hence the use of a double-headed arrow between the two independent variables (in Fig. 6.1), because lack of resources to work with also puts constraints on job control/autonomy.

In this chapter I analysed the possible impact my independent variables have on the intermediate variables (Fig. 6.1). However, in the process I came up with other variables, or rather job stressors that act in concert with these independent variables to induce job satisfaction/dissatisfaction among my respondents. The diagram in Fig. 6.2 serves to summarise the relationships among my independent (Box B)\(^2\) and intermediate variables (Boxes C, D, and E).

I have established that the district health personnel are more dissatisfied than satisfied with either their jobs as a whole or facets thereof, which is a major indication of the existence of burnout. I have also found women to be relatively less satisfied than men. Between my two independent variables I have found personnel shortage, leading to work overload, to be the greatest job stressor. Among all the other job stressors in the work environment (see Box B in Fig. 6.2), I have found the workers to be most dissatisfied with their salaries. This was done by analysing the relationship between objective structures in the work and wider environment and the workers' evaluations of or perceptions on the quality of their employment. The health personnel are the ones that experience the demands and rewards of their jobs, and I have to believe the satisfaction/dissatisfaction they experience and report (which we observers cannot fully experience) as a good
indicator of their quality of employment. What they believe in is bound to directly influence their behaviour. As best put across by Maslach (1982: 33) "...the damaging impact of burnout goes beyond the individual caregiver...it can hurt the recipients [of care]..."²³

I would like to conclude this section by pointing out that all these individual complaints about different job stressors need to be taken as a 'whole' so that the responsible general patterns or aspects of the environmental deficiencies or structures of work can be identified.²⁴ This enables those responsible to avoid individual solutions for coping, of which, if not successful may paradoxically result in victim blaming. I also need to point out that greater effort is needed to change or improve the structures that bring burnout and job dissatisfaction in women. Efforts to level the playing field within the MHCW alone will not be adequate since patriarchal structures also have a multiplier effect.
ENDNOTES

1 In this study male nurses were found to face a greater risk of being attacked and injured by psychiatric patients since they are called to physically intervene when there are behaviour problems. Other job stressors were found to be have an effect on burnout levels.

2 However, taking this course of action does not necessarily imply consciousness of burnout, according to Golembiewski (1987: 154), "...but it does not reflect a sense of things out of kilter that could motivate choice and change."

3 In turn, work orientations emanate from work values, which are "broad societal standards" (Krahn and Lowe, 1993: 313) or "basic attitudes" that "...impact on work expectations, and...most likely influence the willingness to invest cognitively in the work role" (Mannheim, 1993: 6).

Formal schooling together with societal cultural and family socialisation process influence people's ideas of what kind of work is appropriate for each gender, and what to expect from a job (Watson, 1987).

4 According to Krahn and Lowe (1993) the nature of work itself has a stronger impact on work orientations in this mutual relationship.

5 In turn, the importance of job satisfaction/dissatisfaction studies to occupational health is expressed by Ford (1988: 282) who posits that "...one of the best predictors of longevity is 'work satisfaction'."

6 According to Lowe and Northcott (1986: 31) "...[o]ne might see it [the job] as oppressive and therefore experience dissatisfaction and distress and the other might perceive the same job in positive terms and suffer no adverse effects". Khan (1981: 28) goes further to say that "strain is minimized when the demands and opportunities of the job fit the abilities and needs of the individual".

7 Khan (1981) contends that if respondents are not given a middle ground, about 9 out of 10 will say they are satisfied rather than dissatisfied.

8 However, Gruenberg's results supported the contention that workers with high levels of intrinsic satisfaction are more likely to report overall job satisfaction (Hurlbert, 1991).

9 Krahn and Lowe (1991: 342) therefore argue that rather than being the product of socialisation, the different work orientations of women, to the extent that they exist, may be adaptations to the less-rewarding paid work women typically perform, and to their additional unpaid work responsibilities.

10 In quantitative studies the answer is generally recorded on a scale ranging from "very satisfied" to "very dissatisfied" or, a "yes" or "no" answer.

11 This number excludes 8 missing cases, i.e., either responses were not very audible during transcription of interviews, or that specific question was not asked.

12 This is a respondent that had earlier indicated he was doing private studies in personnel administration and showed some knowledge of management theory. So I am not certain whether this is what he feels, or what he has read about workers' psychological needs from writings like Maslow's or Herzberg's.

13 Appendix VI.II shows the nursing structure in the MHCW. When SRNs come from training they have to reach a certain salary level and, when they have been there for a year they become eligible to advance to a Senior Sister grade. According to the matron at
MDH “...it takes about 5 years for somebody to reach that level...[depending] on one’s conduct and performance of duties.” As one can see from this structure, there are quite a number of promotional ladders one can climb.

The case is different from SCNs. Their promotional post is the PSCN (Principal State Certified Nurse). According to the matron:

...There are very few posts like that. In this hospital we have got one...And below that we have the senior SCN. It is an advanced grade, not a promotional post, and many people can get stuck for a long time because there aren’t many PSCN posts.

So apart from less pay, SCNs also have a limited career structure. For example, one despondent nurse says “...we SCNs, our chances of advancement are very slim and the salaries quite low...”

14 This excludes 5 missing cases as well as VCWs.

15 We pair these two since basically what workers are trying to say (where they only mention staff shortage) is that there is not enough manpower, hence they end up doing more work than they should be doing. But some often go further to mention that they are overworked.

16 Other hypothetical questions in the same realm are: whether they would go on working if they inherited enough money to make work economically unnecessary? What advice they would give young men or women choosing that line of work? What jobs they would want for their own sons or daughters? (Khan, 1981) If you had an opportunity to take a similar job at the same pay in another organisation would you take it or stay in your current job? (Lowe and Northcott, 1986).

17 The fact that the SCN category is being phased out and all SCNs will be eligible for an upgrading course that will put them at par with SRNs might be a strong factor, despite the current structural disadvantages SCNs face.

18 On the other hand, when I consider other research findings this seems like a plausible possibility. Some scholars (e.g. Lowe and Northcott, 1986; Krahn and Lowe, 1995) have argued that, although men and women doing the same work experience the same work pressures and report identical levels of job dissatisfaction, women experience slightly more symptoms. In other words, women have additional unpaid work responsibilities (as spouse, homemaker and parent) which causes them to experience greater role overload/competing demands.

19 The major reason why this task was not undertaken is time constraints. Studies that have measured burnout levels have more often than not used a burnout inventory constructed by Maslach, called the Maslach Burnout Inventory (MBI), and then proceeded to make quantitative analyses.

20 The situation is far worse for VCWs who, unlike EHTs, do not have a career ladder or career opportunities. They also receive an income (allowance) barely enough for subsistence needs and have had no increment in more than 10 years, and this is their chief source of concern.

21 Karasek (1989 : 133) has formulated a ‘demand control model’, and its first prediction is that “...when psychological demands of the job are high, and the workers’ control over the task is low, then the most adverse reactions of psychological strain occur”. He argues that this association has been substantiated by studies from several different countries.
I hereby reiterate the fact that some of the job stressors like role/work overload and role conflict are mainly a result of shortages in manpower (as depicted in Fig. 6.1 Box 2), which is one of my major independent variables.

Although I realise the importance of studying the health problems, psychological, physiological or otherwise, suffered by stresses/burned out health personnel, that is not my main focus here. We are primarily concerned with how the effects impact the health consumers. That is the subject of my next chapter.

Many social scientists have proposed various remedies for burnout. Some of them are: job rotation, job enrichment and enlargement (Holmen, 1979; Hiscott and Connop, 1989; Golembiewski et al., 1986). The last two strategies have been discussed in Chapter 4, but the first one involves either rotation of work shifts or between wards (for health personnel) or departments so that workers are not faced with the same stressors everyday.

However, in my case all departments (of MDH) and HCs face the same noxious and stressful problems such that this strategy would not ameliorate the effects of burnout. In fact, I have already indicated that health personnel at MDH are rotated between wards every three months, "in order to motivate them to aspire to go for further training in the areas they realise they are deficient in as they go through different wards" (AP26). Therefore, even if this strategy was instituted to solve burnout/job satisfaction problems it would be quite insufficient. We do require strategies that cut down the roots of these problems.
Chapter Seven

QUALITY OF CARE

7.1 INTRODUCTION

Health care services aim to promote, safeguard and restore health. To do so amply and befittingly, the managers have to periodically assess the quality of care provided. Quality of care, however, is a multidimensional variable, some of which are: medical - surgical death rate, post surgical complication rate (Breslau et al., 1978), clinical effectiveness, economic efficiency, social acceptability (Judge and Solomon, 1993), appropriateness, sufficiency, timeliness, and efficacy (Scott and Flood, 1984). Kahn has described it as portmanteau concept, because “it carries...many things, keeps them in no particular order, and does so in a way that conceals them from view” (in Scott and Flood, 1984 : 237). Due to these and other factors, it is somewhat difficult to measure the quality of care (Scott and Shortell, 1987).

Donabedian has categorized various indicators to measure health care quality into three main groups: structure, process and outcome (Scott and Flood, 1984). There has recently been a growing recognition of the importance of health-care users' views about their experiences and expectations of health care in quality assessments (Lewis, 1994; Judge and Solomon, 1993). According to Donabedian (1983 : 220) “[t]he pursuit of quality becomes socially more relevant when it takes account of the needs of a population...”. This user/community input is generally termed client or patient satisfaction, and has many elements. All the elements are important for the maintenance of a health-care system that seeks to provide quality health care to care seekers.
Some researchers (Locker and Dunt, 1978; Doering, 1983; Gilson et al., 1994) have pointed out client satisfaction's significance in influencing compliance with treatments and co-operation with health providers, thereby affecting utilisation of healthcare services. It is also taken as a measure of the success providers have had in meeting consumers' defined needs and expectations (Doering, 1983). In other words, it is the client's judgment of the quality of care (Donabedian, 1983) or "a direct indicator of system performance" (Lewis, 1994 : 654). Hence it is one of the outcome measures of quality (Locker and Dunt, 1978; Donabedian, 1983). But most importantly, consumer satisfaction is regarded as a way of "democratising health services and counteracting the powerful interests [and definitions] of the professions and the state..." as well as a means of achieving "consumer sovereignty..." (Calnan in Gilson et al., 1994 : 767; cf. Lewis, 1994; Judge and Solomon, 1993). This aspect is quite congruent with the principles of democratisation and consumer participation in PHC.

Scholars like Simon (1991 : 3) denounce macro-level critiques of health-care systems that judge them suitable or not "...without consulting the actual experiences of those who utilise ...[them]". That "encourages theoretical abstraction at the expense of micro-level understanding" (Simon, 1991 : 3). He goes on to posit that the patient's point of view "...provides the observer with a firm indication of local problems and hardships relating to ill-health" (Simon, 1991 : 12). For example, Gilson et al.'s (1994) study in Tanzania used villagers' own words to bring into focus the problems they experienced in relation to health care. They were also able to identify planning lessons from this information.

One of the problems facing researchers at the moment is that most of the literature on quality care has emanated from the United States, hence it should be generalised with
caution (Lewis, 1994). Gilson and associates (1994) further note the paucity of specific assessments of patient satisfaction in developing countries.

Given all these various aspects of quality of care I have decided (as mentioned in Chapter Three) to add on to Roemer and Montoya’s 3 definition of quality of care. For this study, it is regarded as “the degree to which the resources for health care, or the services included in health care meet the health system’s objectives of care as well as the expectations and perceived needs of consumers”.

The central objective of this chapter is to assess the potential effect of the independent variables, resources and job autonomy/participation in policy decision making, and intermediate variables, burnout and job satisfaction/dissatisfaction, on the quality of health care and effectiveness of the Mutoko district PHC programmes. Apart from my analysis of the objective organisational factors likely to affect the quality of care, much of the content of this chapter derives from interviews with health-care providers and consumers (i.e. in-patients, out-patients at MDH and community members). Patients and community members have first-hand knowledge of the local deficiencies which affect their health and their search for health care. They base their observations and opinions on these experiences. Therefore, their expressions of satisfaction and dissatisfaction with health-care services are interpreted in the context of perceived needs and expectations of care.

In the next two sections I am going to analyse the relationship between the independent variables and structural quality and process quality of care. In the subsequent section I discuss the implications of compromised quality care for the effectiveness of the district PHC programmes. In this section an effort is made to situate the discussion within the study’s larger theoretical context as well as PHC objectives.
7.2 STRUCTURAL QUALITY

This section is concerned to establish the direct relationship between the independent variables and quality of care. This is depicted by arrows A and B in Figure 7.1. Job autonomy/participation in policy decision making are characteristics of the organisational setting, and together with resources are part of the health-care structure. According to Scarpaci (1988 : 211), "...mounting evidence in South American studies suggests that organisational settings affect greatly the patterns of medical care accessibility". Lack of resources has also been observed as another obstacle to the provision of quality health care (Evans et al., 1981; Jackson, 1989; Phillips, 1990; Barnum and Kutzin, 1993).

Job autonomy/participation in policy decision making ought to allow district health officials to tailor their health-care provision to suit community health needs. Fifty eight percent of senior district staff believe there has not been adequate decentralisation of decision making power. Due to the fact that "...most of the tasks...are being done at the higher offices" (AP25), and that the PMD's office "...actually throw[s] away some of the issues...raised [by district officials]" (AP24) means that major decisions that affect quality of care are made by people who are not in direct touch with district health needs. This tight bureaucratic control system from above "make[s]...it impossible [for local district officials] to run an efficient programme" (AP27), because

...in some instances [they]...have to suspend some of the hospital functions or buying ...important items because of financial constraints...at the expense of the well-being of the community [AP25].

This tight control also slows down upward and downward communication. Sixty seven percent of supervisors and programme managers interviewed indicated that they found the procedures for communicating policy from central offices inadequate. Slow responses or
reactions from central and/or PMD’s office can be cumulative and are inevitably bound to negatively affect the performance of district hospitals and HCs.

At the micro, ward or HC level, lack of job autonomy/participation in policy decision making can also negatively affect a number of things, one of which is the reaction time to emergency problems. This has implications for quality of care too, and the association is also depicted in Figure 7.1, by arrow A. As pointed out by Barnum and Kutzin (1993:31), "...rigid personnel policies...create...technical inefficiency".

7.2.1 Drugs, Supplies and Equipment

Transport shortage, in the form of bicycles and vehicles were mentioned as a tremendous impediment towards the realisation of daily targets/objectives by VCWs, EHTs and officers who have to monitor different district health programmes like maternal child health/ family planning (MCH/FP) programmes, follow up of discharged patients and supervision of HCs and field staff. All categories of personnel with these duties that were interviewed were unanimous in wishing for this problem to be resolved.

Lack of transport for VCWs and the unavailability of faster/better transport for EHTs hinders their ability to visit all households in their villages and wards respectively. Lack of transport, partly due to poor maintenance arrangements, for those responsible for outreach work translates into the under-achievement of set objectives. It also causes supervisors to make less frequent visits to help as well as monitor field and HC staff. All these factors directly have an effect on the quality of care as shown by arrow B in Figure 7.1.

At the MDH there were not many complaints about equipment, apart from the fixed X-ray that had not been repaired for more than 2 years, the new equipment required to make the district laboratory self-sufficient, as well as the specialised equipment needed
in the rehabilitation ward. It is HC personnel that showed concern about the lack of some essential basic equipment (in Chapter Five). This also has a direct effect on the quality of health services provided by HCs.

Fig. 7.1 Relationship Between Independent and Intermediate Variables
Drugs and supply shortages have been noted to cause technical inefficiency in health facilities (Barnum and Kutzin, 1993). It is also argued that drugs are important for "...the quality of health care [and]...the credibility of...health workers..." (Evans et al., 1981 : 1120). Arguing in the same vein Phillips (1990 : 105 - 6) says:

A qualitative issue in care is underlaid by quantitative deficiencies in the absence of medicines from hospitals and clinics in many of the poorest Third World countries...

Health personnel that indicated there was a problem of drug shortage were asked to mention any constraints to service delivery due to that shortage. One of the nurses at MDH that had mentioned the shortage of a number of basic drugs in the out-patients ward said, "...we are really straining, so much that when you prescribe you actually cut the duration because there are no drugs" (SRN 3). She goes on to discuss the shortage of supplies, specifically gloves. She calls this "an AIDS menace". After indicating that they "have to protect [themselves] so that [they] can be functional tomorrow", she goes on to say: "so...now we resent [/avoid] the [direct] care and do some other duties because there are no gloves" (SRN 3).

The shortage of drugs has had more impact on the recipients of care themselves. It has affected their perception of health care provision in HCs as well as their utilization patterns. Despite acknowledgment by some health personnel that drugs are sometimes in short supply at MDH, no patient or community member mentioned this fact. One possible reason is probably because of the alternative drugs the hospital manages to keep. Out of the 54 in-patients interviewed 36 said they were referred from their local HCs. Although some could not say why they were referred, 10 of these 36 said they were referred because of drug shortage at their local HCs. Of the 19 out-patients interviewed at MDH who came from outside the catchment area of the hospital, 6 said they were referred from their local HCs because of drug shortage. Eleven of these said they 'just thought of coming' to
the hospital. One possible reason is the unwillingness to visit the HCs because of anticipatory referral because of drug shortage, in which case they would end up using more money for bus fare to and from the two facilities. The other possible reason is expectation of better help at the hospital because of the availability of drugs as well as the likelihood of receiving the injection. Responses from two interviewees help to clarify these points.

One in-patient says, “The clinic [HC] close to our village is always out of medicines, so they refer most...cases to this hospital” (IP 3). When asked what problems they faced with regard to health care provision, one respondent from Sasa village said:

I would say these local personnel are trying their best...it’s just that they do not enough resources to use, so that’s why we say there is more help in hospitals... The HC we have here [Kapondoro], I do not really see its usefulness because drugs are always in short supply. So most people go to All Souls Mission Hospital ... [NP31a].

Asked the same question, only 5 respondents from Sasa village mentioned dissatisfaction with the drug shortage at their local HC as opposed to 14 of respondents from Nyadire Resettlement Village 10. Our only explanation is that Village 10 has its HC situated only less than a kilometer away, therefore villagers are more dependent on it and are therefore bound to notice any deficiencies. On the other hand Sasa village is located almost between Kapondoro HC and All Souls Mission Hospital more than 5 kilometers either way and, as the above respondent (NP31a) has indicated villagers find it more beneficial to go to the hospital. They are therefore less likely to consider drug shortage at Kapondoro HC a problem.

Similar results were obtained by Gilson et al. (1994) in Tanzania. In this study “[d]rug availability was identified by villagers as a very positive aspect of the care offered in [rural] dispensaries...” (Gilson et al., 1994: 770). They also found obtaining drugs to be the most important factor underlying community patterns of health care use. “People
go anywhere where drugs are available". Gilson and associates say (1994 : 770). Scarpaci (1988 : 199) has also found "the receipt of medicines as a positive aspect of [respondents'] visit to the clinic" in Chile. Brieger's (1988) study in Nigeria also reveals that people consider it a waste of time to visit understocked dispensaries, therefore most people feel it is more efficient to proceed directly to a private chemist, clinic or hospital.

Another dissatisfaction expressed by some villagers is the fact that VCWs do not move around providing the basic curative services they used to provide while they were still under the MHCW as village health workers (VHWs). This also makes the VCWs feel inadequate in the performance of their duties as many people keep asking for tablets for headaches, bandages etc., which they cannot provide.

Therefore, while health-care providers experience frustration and realise they are not providing the best of service because of the shortage of drugs and supplies, health-care recipients face the frustration of going to HCs to find that there are no drugs as well as getting referred to a hospital, thereby spending more on bus fare. That dissatisfaction with shortage of drugs is an indication of the community's awareness that the quality of health-care provision could be better. The relationship between these health resources and the quality of care is again depicted by the arrow marked B in Figure 7.1.

7.2.2 Personnel

According to Phillips (1990) the manning of health units by too few professionals affects the objective quality of services available. Reasons for having "too few" health providers are many, one of which is turnover. 6 Fang and Baba (1993) report that turnover among nurses in Quebec and British Columbia (Canada) is impacting on the operational efficiency of hospitals and quality of health care provided. In much of Africa, due to shortage of staff in nursing care units, it is reported that "...it is sometimes
impossible to practice even simple aseptic procedures effectively” (Osei-Boateng, 1972: 177). In other words, important aspects of care can not be given adequate attention and emphasis.

This shortage of staff (Fig. 7.1 p. 260) translates into role/work overload. Overload basically means the quantity of work begins to interfere with its quality (Bacharach et al., 1990). Simply put: there are too many people/patients and too little time to adequately serve their individual needs for the caregiver (Maslach, 1982). According to Katz and Kahn (1978: 598) coping with job overload

...could consist of doing less than was expected, doing less well than was expected, or taking more time than was expected; the constraints of quantity, quality, and time could not be met simultaneously.

What is noteworthy is the fact that not only the quantity of the contact between healthcare provider and patient is in jeopardy here, but the quality too.

Although a few patients and community members did point out the problem of staff shortage at MDH, an indication that more staff probably help clear up the long queues of out-patients faster and reduce waiting time. I am here solely concerned with the views of caregivers as I try to establish this direct relationship between human resources and quality of care (B on Figure 7.1.). Chernomas and Chernomas (1988 645) note that “...research suggests that where there is no shortage of nurses...nurses judge the quality of care provided to be good”.

As a starting point in the interviews, respondents (i.e. caregivers) were asked to explain their department’s contribution towards the achievement of the goal of ‘Health for All by the Year 2000’ which is the often quoted broad aim in most PHC programmes. Some respondents went on to give atypical answers that seemed off the mark at the outset. Although I was trying to ascertain their familiarity with this ‘goal’ as well as awareness of the value of their contribution in the health care field, I nonetheless let them
go on. In retrospect I believe these responses to be the most poignant, intelligent as well as indicative of their state of mind with regard to job dissatisfaction because of work/role overload. Above all, they speak volumes about the effect of staff shortage on the quality of care, and I hereby present only some of the more telling ones.

For example, a female nurse working in the female ward answers like this:

The contribution is very poor because of shortage of staff...because...most of the time you do things 'half half'...[i.e. a shoddy job] [as a result] we are not doing enough to educate mothers. Most children born here healthy come back with severe malnutrition. S. i think we are not giving enough health education to mothers...[SRN 4].

When she was asked if they were not educating them about the importance of breast feeding she went on to say,

We do, but we are failing because of staff shortage, we are very few...working with 40 patients is very difficult, you cannot equally attend to all of them or to what each one needs [SRN 4].

These sentiments are echoed by a male nurse working in the male ward who answers the question this way:

As I see it, the government is aiming to ensure each individual has access [to care]. but then the problem [in some] hospitals...[is shortage of] manpower. Therefore when people go there they do not get what they thought they would get. It's like here, people are flocking in [because] it is a new hospital...but as it is we have...so many patients with AIDS - related illnesses who need to be cared for, actual caring. Today there is two of us and a nurse-aide, with 36 patients, 4 on traction, 5 who need ... so you need to be there from time to time. So of course they have 'access' to the hospital, but the service they need becomes the problem...The care you are supposed to give to patients, so that you really feel 'I have done my duty' is not there [SCN 11; emphasis in original].

Another one from the paediatric ward similarly answers this way:

I think we should have enough staff so that we can do what we are supposed to do. ...We deal with malnutrition, so we need enough time and manpower to educate the mothers on how to feed their children as well as motivate them...because motivation can be more important than treating...[SCN 14].
And one from the psychiatric ward points out:

We provide health services here and go for outreach programmes, but we are understaffed such that we can not cover everybody, and we are not able to do enough of it. [SCN 6].

The question "Has the drug and manpower shortages affected the quality of care?" also prompted some significant responses. Here are some of them:

SCN 7: ...sometimes patients feel you are not giving enough treatment or nursing care. This is because of the staff shortage...So it's not the patient's imagination [it is true].

SRN 3: Because of shortage of staff and equipment...we are not functioning as expected...[we] cannot be expected to be effective.

SRN12: We no longer have enough time with our patients. We are no longer doing our work the way we were trained to do it...So...you spend less time with one patient, and you leave that patient (for another) still wanting to discuss with you.

What all the above-quoted respondents have in common is the conviction that due to staff shortage the workload has increased and there is less quality time spent with patients, thereby subverting personal, hospital and/or national [in the case of Health for All by the Year 2000] expectations and objectives. In short, quality care is compromised.

The manner in which nurses handle their day to day duties is similar to that found by Bartholomeyczik and associates (1992) among night nurses in Germany. For example when one nurse caring for 70 patients was asked how she managed her workload she answered:

[it is] very hectic. I have to steal the time from other patients when I take time for one (patient). Everything gets out of control easily. Then I get nervous and have to work twice as fast and every patient just gets a little bit [Bartholomeyczik et al., 1992: 7].

Under such a situation whereby caregivers are faced with role/work overload they inevitably begin to focus more on people's problems and less on recipients' human needs (e.g. the motivation mentioned above by SCN 14) (Maslach, 1982). This impersonal
processing of recipients of care is what Osei-Boateng (1992) calls "functional nursing". It is

...the task-oriented method of nursing care which makes patient care rather fragmented and unsatisfying to both nurses and patients. continues to be the only method that we practice [in Africa], partly due to shortage of staff [Osei-Boateng, 1992 : 177].

I have therefore attempted to analyse the effect of staff shortage on the quality of care through the use of personal experiences of front-line health-care providers. Before I proceed to the next section I need to briefly consider another structural variable that also affects patient satisfaction. This is waiting time at the hospital or health centres. I choose to place it here because I consider it more a derivative of shortage of staff or job/work overload rather than an independent factor.

At any one time there is only one clerk at MDH to process out-patients before treatments begin. The queue sometimes gets so long that some people prefer to come an hour or more before opening time (8:00 am) in order to get a lead position. Our informal discussions, supported by observations, with potential out-patients in this waiting area and accompanying relatives waiting for their kin to finish their treatments revealed considerable dissatisfaction with the long periods of time it takes to get through this initial phase. Shortage of staff in all the other departments at MDH also mean after passing through the out-patient clerk's counter, they have to go and join other long queues in various places like the out-patients ward, laboratory, X-ray department as well as the last point of contact, the Pharmacy.

Among the out-patient respondents at MDH the average time it took from arrival, from opening time onwards, to completion of examination and going through the pharmacy after which I interviewed them, is 3 hours. When asked what problems, if any, the respondents had encountered during their visit, 36 percent of them expressed
dissatisfaction with the waiting time between arrival and examination, as well as time to go through all the relevant departments. Some of these concerns are expressed in the statements below. An out-patient that was at MDH from 8:00 am to 2:45 p.m. said, A big problem, especially today, is that one comes here sick and you are not attended to in time. You just sit there until God-knows-when...[OP15].

Another one said, “I have been here since 7:00 am till now [3:55 p.m.] and I haven’t eaten anything” (OP38).

The fact that community members (householders) interviewed did not cite this as a problem at their local HCs might be more of an indication of utilisation patterns that are skewed towards hospitals where there are more drugs than an indication of the adequacy of staffing levels.

Waiting time has also been found to be a major and consistently identified problem in out-patients departments (Judge and Solomon, 1993) and state-run primary care units around the world (Scarpaci, 1988). In a Chilean study Scarpaci (1988) found a mean waiting time of 4.2 hours.

There are a number of other relevant structural quality factors that I could go into, but I have decided to limit the analysis to those directly related to the independent variables.

7.3 PROCESS QUALITY

7.3.1 Technical Quality

There is a general belief that patients are not able to judge the technical quality of care (Scott, 1984; Lewis, 1994). Lewis (1994) argues that this is not the case and cites some studies that prove otherwise. He goes on to say:

Whether or not patients are regarded as competent judges of medical care, the fact is that they do make such judgments, which influence their perceptions of the encounter [Lewis. 1994 : 658].
In this study no attempt was made to ascertain patients' satisfaction with the technical quality of care per se, either at MDH or HCs. The two questions regarding respondents' satisfaction with their most recent encounter with caregivers and the aspects of local health-care services they wished to change for the better, prompted answers in the realm of critiques of caregivers' technical competence or curative skills. Most of these came from out-patients and community members, with very little from in-patients.  

The only in-patient respondent, the mother of a child in the paediatric ward, who raised an issue pertaining to technical quality said:

Yesterday they were supposed to...on my child...Nothing has been done.
My child is fitting. I told them so, but they gave me chloroquine, which means she has malaria? I don't know...the way they give dm...JS [IP10].

This child might have had a secondary health problem to which nurses chose to respond. But the mother who has not been told this has every right to question such an approach because the illness that they brought for attention is not being tackled.

Incidentally, much of the dissatisfaction with technical quality among out-patients and community members centred on drug prescriptions. An out-patient that faced a similar predicament as IP10 above said:

I brought my mother here last week, she has this dizziness problem. She could barely walk when we came in and they just looked at her [old] card and asked her to go and collect tablets [from the Pharmacy] for the dizziness [i.e. her chronic ailment], not knowing it's a new illness. So up to now she is an invalid because the real problem was not dealt with, and there is no joy in the family. To think we were so happy when this hospital was upgraded, hoping things would be better for us, but they are becoming difficult again [OP12].

One possible reason why nurses would not ascertain what a person's problem is or take time to do a good examination is job/work overload that I have discussed above. There is pressure to 'process' as many patients as possible. An appropriate example is this
respondent who says of local hospitals, "Oh, a lot of times you come back untreated. Or the treatment is not done well, they just do it hurriedly." (NP38).

Other criticisms concern choice of drugs. Some patients believe they know what is good for them based on what has worked before. For example, one out-patient who is used to asking his local HC staff for a particular drug that normally helps him says this of MDH staff: "but here they say no...go and use this one...and you go and realise the drug doesn't work...they just want to test it on you to find its efficacy" (OP14).

Some doubt the technical competency of nurses and prefer to be examined by doctors, which might also explain some of the self-referals (to hospitals) that I have discussed above. An unhappy out-patient said this about her encounter:

What I am not happy about is, I was getting treatments at the clinic, and I decided to come here for the doctor to diagnose the cause since the illness is persisting. And I come here and 'yet examined by the person that examined me [condescending tone], a sister for that matter. And she tells me they are giving me some drugs and that I must come back after two weeks [OP 32].

In the household interviews we came across a respondent with a similar view. He says:

[At the hospital] the doctor is the one that writes the prescription and the nurse looks for .hat the doctor has written. Now in these health centres with no doctors, they ask you 'what are you suffering from?' and you say 'headache'. And maybe I am just given tablets. I will be thinking 'I am probably being helped' but maybe the tablets are not even for headaches [NP 37].

These perceptions on the technical quality of care were very variable among the respondents, and I have tried to present those with a thematic thread. It is difficult to assess the validity of some of these judgments. But whether I can do so or not does not matter. What matters is that these perceptions affect the community's utilisation of health-care facilities. Those perceived to have poor technical quality are likely to be avoided.
7.3.2 **Interpersonal Quality**

Apart from the technical quality of care, care-seekers’ perceptions are influenced (probably more so) by the nature of the interpersonal relationships they have with health care providers. Existing literature attests to the crucial importance of these relations (Donabedian, 1993; Habicht and Berman, 1980; Hills and Knowles, 1983; Long and Harrison, 1985; Khan, 1993; Lewis, 1994). Interaction between care-seekers and service providers is inevitably the medium through which ‘front-line’ service jobs are delivered (Wharton, 1993). It is [in] those relations [that] care-seekers ideally have the opportunities to experience themselves as cared about and cared for, a key to their eventual growth and healing [Khan, 1993 : 539; cf. Hills and Knowles, 1993].

Furthermore, interpersonal care enables the caregiver to understand patient response to medical treatment (Hills and Knowles, 1983). Therefore I may conclude that inevitably, the “interpersonal skills demonstrated by...[health care providers] affect the quality of care delivered to patients” (Hills and Knowles, 1983 : 83).

In particular, the development of a positive nurse-patient relationship has been noted to be characterised by empathy, warmth and respect (Hills and Knowles, 1983), variously termed: “beside manner” (Lewis, 1994), “chairside manner” (Scarpaci, 1988), “psychosocial or ‘caring’ aspects of care” (Doering, 1978) or “sociotechnical” aspects of care (Brody et al., 1989). Khan (1993) has gone further to identify 8 behavioural dimensions of caregiving that enable careseekers to feel appreciated, valued and valuable, cared for and about, viz. accessibility, inquiry, attention, validation, empathy, support, compassion and consistency. Research indicates a strong relationship between this aspect of care and patient satisfaction (Locker and Dunt, 1978; Scarpaci, 1988, Brody et al., 1989; Lewis, 1994; Gilson et al., 1994).
With all this in mind I now focus attention on the careseekers in the study. After all, according to Donabedian (1983: 219) “[t]he client is the supreme judge of the quality of the interpersonal process”. Of the 54 in-patients at MDH, 22.2 percent indicated they were not happy with their caregivers’ interpersonal care. This category was slightly larger (38%) among the out-patients. In other words, more in-patients had positive things to say about their caregivers. Therefore comments like the following were common:

**IP22 =** ...As with nurses here I haven’t seen any one with a “bad heart”. Most of them are always happy with us. When they come in they greet us all the time.

**IP25 =** ...Some nurses look at one’s face and judge which ones can take their insults. But I haven’t come across that here.

**IP26 =** Before coming to the hospital I used to think the people would be horrible but that is not what they are.

Some in-patients compared the district hospital and the other hospitals in the district in their assessment. One woman who indicated that she was handled quite well at Nyadiri Mission Hospital (NMH) said nurses at MDH showed anger towards her. This was corroborated by a male patient who indicated he was also treated better at (NMH). Here is his reason: “Here I have told them my arm just sprained and they said how can an arm sprain on its own? A nurse said that. ...and she said that before I even finished explaining” (IP36). In this case the nurse did not allow the patient to communicate his problems, or rather did not bother to take the case history.

In a number of cases respondents (in-patients) went on to describe the nurses at their local HC. One respondent, for example, shows how some nurses dislike listening to patients' problems:

...at our local health centre when you approach some with your problem they say ‘we don’t want you dictating what we should be doing here, you must mind your own business. Maybe a child would have cried at night...and you tell them that and they say “leave her there she will stop crying sooner or later, we know the times when to give her whatever is necessary’” (IP3).
This respondent goes on to say that she is bothered to see that kind of person on duty.

Out-patient respondents also had their share of praises and criticisms. While some are "...quite impressed..." with the way they are handled (OP24) and think MDH nurses "...are very good" (OP22), others consider their local HC staff to have better interpersonal skills. While acknowledging the technical skills of MDH staff, one respondent indicated that she is not pleased with their "...interpersonal relations with patients" (OP12). She goes on to say:

...One [can] say "you cannot tell me all that ...what I have written [on the patient card] is enough, or ask you what you want while you are still some distance away, and by the time you get there your heart is beating so fast you won't be able to say what you want. At times I want to retaliate but I quickly check myself because I am the one seeking help, but I go away with that lumpy feeling in me...[OP12].

Apart from snubbing at patients as charged by this respondent, some MDH nurses are said to be too pompous, "Especially if you are unemployed, some of them do not even consider you to be anything" (OP37). One out-patient respondent who believes local HC staff show better interpersonal skills because they live in the same neighbourhood and therefore are afraid of reprisals says that those at MDH "...can give you a rough treatment...and yet away with it" (OP14). But some have had problems with their HC personnel too. For example this young man says:

At our health centres the other thing that disappoints me is you get there sick, with a sexually transmitted disease like us boys,... You tell them what you did and they ask why you did it and beat you up. I only put up with that kind of behaviour because I need their help... [OP40].

The focus of the questions changed a little bit when household interviews were conducted. Those that had visited their local HC or hospital within the year were asked to indicate their satisfaction or not. with the way they were handled. Seventy one percent of the respondents from Sasa village had more positive things to say about their local HC nurses. Respondents believe these nurses can not give them a rough treatment because
they are neighbours (NP1; NP3), they “are real people...” (NP15), and they have love (NP5a and b). Moreover, “even if someone gets sick on Sundays they can open and give help, or even make an admission” (NP19). Singled out more often was the male nurse, whom one respondent described as “number one” because “if you get there even in the middle of the night he never complains...he opens and performs his duty” (NP2b). Some of these observations were made in comparison with the behaviour of health-personnel at hospitals (in the district) once visited, particularly NMH and MDH. For example one respondent said that nurses at NMH “...do not explain things to our satisfaction. But these ones are able to explain to us well” (NP8). In mentioning these positive attributes, some respondents were quick to close to their statement by pointing out “...if only they had enough drugs” (NP5a and b; NP15; NP16).

On the other hand, respondents from Sasa village who seem not to have bonded well with health-care personnel at their closest HC, because of the distance, had nothing of this nature to boast of. However, they were nonetheless able to articulate their concerns with regard to their interpersonal relationships with personnel at that HC as well as All Souls Mission Hospital (ASMH) and MDH. The local HC nurses are accused of discrimination/favouritism, not knowing how to work with people. The ASMH personnel are reported to be nonchalant to the extent that “…you can die while the nurses are looking at you” (NP33). They are also said to be “…careless...[in] the way they handle people” (NP24). Some Sasa village respondents were also displeased by the behaviour of MDH personnel. The nurses are said to “act as if there is too much work” (NP23). Another respondent who believed she was handled better at ASMH and Harare Central Hospital indicated that she was “bothered” by being asked what she wanted when she presented herself for treatments (NP40). She goes on to say:
Other nurses just take it as a simple job, forgetting that they are also human beings just like patients...Now I am dreading going to that hospital. How can one ask "what do you old people want?" If not for the illness you would ask "would you ask that if I was your mother?" The government must have people that go around monitoring how these nurses handle patients. [including] old ones [NP40].

Respondents, including in-patients and out-patients, also generally believed doctors in these hospitals (MDH, ALMH and NMH) are more understanding and compassionate than nurses. While others (13 percent) expressed no opinion, 39 percent indicated doctors and nurses were equally compassionate while 30 percent thought doctors were more so, as opposed to 16 percent who were in favour of nurses. Those that went further to give an explanation articulated some pertinent concerns that are consonant with some of the views about nurses expressed above. Here are a few representative ones:

**OP12 =** Doctors are more compassionate because when you talk to them they look composed and stay put until you are finished.... But with nurses, if you ask...something you haven't understood well they...get angry and shout at you.

**NP19 =** Doctors do ask a number of questions in order to understand...the problem...when it started and how you feel.

**NP36 =** ...when you are with a doctor they ask you nicely and you talk freely. But with nurses some...get angry at you.

**NP18 =** A doctor handles you well, asks you in detail ... but most nurses get angry when they are dealing with you.

Therefore nurses, who ordinarily have more contact with patients than doctors are contributing more towards the community’s dissatisfaction with allopathic medicine. Yet, contrary to the doctors who largely perform an instrumental role, nurses are believed to play an expressive role “concerned with nurturant actions designed to create a ‘therapeutic environment’” (Gray-Toft and Anderson, 1981 : 645).
When asked to discuss their problems with patients, nurses generally cited illiteracy among patients which inhibits their understanding of what they are told. They also overwhelmingly cited defaulters as their main problem, especially those with chronic illnesses like tuberculosis (TB), hypertension (BP), asthma, etc. Some were quite open and minced no words about how they deal with these problems. For example a nurse working in the female ward says:

Those with BP and TB when given drugs for a period of time, most of them default and come back in a worse condition. We try to educate them. [B]ut when we meet such patients we are very rough with them [SRN4]." (my emphasis)

Another nurse working in the maternity ward said,

there is often communication break-down, especially when you are busy, you are trying to explain something and someone else is trying to ask so many questions, so much that you end up telling them ‘we are busy’...People should try to understand that we are short staffed. They do not understand it [SCN15].

This kind of behaviour and reaction therefore, need to be situated ... a wider context in order for me to analyse the possible root causes. According to most patients and community respondents it all depends on people’s natural endowments. Some are born with “bad hearts” or personalities and some with good ones. As one puts it “...Some are just born cruel and becoming a nurse does not mean they will be good people” (NP13). One respondent that was once admitted into NMH says:

It depends on one’s heart...I know like today there is a nurse so and so dealing with us and it is going to be a bad day, we will be scolded. On the other hand, other times you’d say “Ah! today we have so and so, we are going to have a happy day...” [NP8].

So it boils down to “...who you meet on each particular day...” (NP25). Hence “...when you see [the ‘bad’]... person on duty you wish the kind-hearted one was there” (IP3). There is no denying that these respondents are partly correct in believing that this behaviour depends on one’s natural endowments.
Maslach (1982) states that caregivers sometimes make callous and cruel remarks deliberately. Based on their studies, Hughes et al. (1958:154) believe that nurses are not interested in some of their duties and they can escape them by wearing a demeanour that makes them appear busy or harassed. They go further to say:

Being so constantly under pressure, the nurse may develop a harassed manner and view point, so that even if pressure decreases, she still feels busy, and communicates this to her patients by facial expression, tone of voice and general manner and appearance [Hughes et al., 1958:154].

This is perhaps what was communicated to respondents who are dissatisfied with the nurses bedside manners or psychosocial skills; more aptly pointed out by one who said that "...nurses act as if there is too much work" (NP28). So, apart from their natural traits, nurses can display such behaviour deliberately in order to cope with prevailing exigencies.

Scholars like Wharton (1993:209) assert that prolonged performance of "emotional labour" engenders an inability to feel emotion...". The result is what he calls "contact overload" syndrome", which is characterised by becoming robotic, detached and unempathetic (Wharton, 1993). Research on gender stereotyping also reveals a number of feminine gender attributes that nurses and other service workers are expected to exhibit in the performance of their duties (cf. Davies, 1992; Maslach, 1982). Some of these are care, warmth, courteousness, commitment, self-sacrifice, empathy, etc., the very interpersonal skills I have discussed above and the same skills Florence Nightingale sought to cultivate among nurses. However, it is Wharton’s (1993:209) contention that:

...because effective performance of emotional labour may require that workers display emotions that they may not necessarily feel, workers are at risk of experiencing emotion-related stresses.

Therefore societal expectations are another source of pressure weighing on caregivers' shoulders, particularly women's. 13
In the previous chapter I indicated the existence of signs that health-care personnel in the sample are burned out. Our analysis (above) of the interpersonal relations between health care personnel and patients further buttress that observation. Research on burnout indicates that burnout causes caregivers to "...shift from positive and caring to negative and uncaring" (Maslach, 1982: 17). It also induces in one an emotional detachment/withdrawal that affects the caregiver's concern and emotional feeling for care seekers (cf. Maslach, 1982; Duxbury et al., 1984; Hare et al., 1988; Khan, 1993). This distancing also causes caregivers to: go by the book, to lash out at people or get angry at them, to see care seekers as deserving of their problems (Maslach, 1982). Job burnout also transforms caring into apathy (cf. Hare et al., 1988; Macinik and Macinik, 1990; Maslach, 1982) and an attitude of "'a job is a job...''", consistent with putting a minimal time and effort into one's job and "avoiding challenges, avoiding clients, just getting by to keep job security..." (Macinik and Macinik, 1990: 247). Some of these symptoms of job burnout are prominent in the respondents' accounts of the "bedside manners" of some health-care personnel they have come into contact with in their search for health care.

While other manifestations of burnout, like extended tea/coffee and lunch breaks, knocking off early, absenteeism and quitting (Maslach, 1982) affect the quality of care in other respects, interpersonal quality is more determined by caregivers' psychosocial skills. Existing literature points out that burnout affects/decreases the quality of care given to patients/care seekers (Hare et al., 1988; Karasek and Theorell, 1990). Care seekers receive less care and are treated in a dehumanised manner (Maslach, 1982). This relationship between burnout and quality care is labelled C in Figure 7.1. This is the indirect relationship between the two independent variables and the dependent variable, an association mediated by job burnout and job satisfaction/dissatisfaction. Apart from having an impact on the quality of health-care personnel's lives, which is an important
phenomenon that merits further investigation, and job satisfaction/dissatisfaction as well as stress are also known to affect the quality of patient care in nursing (Landeweerd and Baumans, 1988), as well as general organisational productivity and efficiency (Breslau et al., 1978; Holmen, 1979; Lowe and Northcott, 1986). This relationship is also marked C in Fig. 7.1 (p. 260).

I am arguing that health-care personnel who are burned out and are dissatisfied with their jobs would inevitably ostend signs of absence of psychosocial/interpersonal skills. Hence, apart from some caregivers having it “naturally” in themselves to be rude, confrontational, contemptuous, indifferent, uncaring, and munificently exuding an attitude of “who cares”, they are considered to be reacting to structural pressures as well. Such behaviour comes from having no job autonomy/policy decision making latitude, being accountable without the necessary resources and chronic job/work overload. Whatever was natural or absent in health-care personnel is now exacerbated or instigated by these structural forces. Therefore, care givers behave the way they do because they are consciously or unconsciously trying to cope with environmental demands. Thus, I choose to call the two extremes of this behaviour as “coping indifference” and “coping belligerence”.

Ordinarily it is deemed of paramount importance that health-care personnel (as are health-care facilities) be physically accessible to care seekers. The PHC principle of accessibility calls for this. But ideally, we need health-care personnel to be accessible emotionally, psychologically and intellectually too. They become accessible in these three ways if they can meet the emotional, psychosocial and educational (health education) needs of care seekers. These needs can be met only in circumstances conducive to the nurturance of vibrant and stable interpersonal relationships between caregivers and care
seekers. Where fulfillment of these basic needs is thwarted and/or compromised, we can unreservedly call into question the integrity of the quality of health care being provided.

7.4 EFFECTIVENESS OF PHC PROGRAMMES

The concept of effectiveness is multidimensional. (Katz and Kahn, 1978), and its several specifications "...point towards the possibility of employing a variety of approaches in exploring the effectiveness of health care programme or procedure" (Long, 1985:13). In the health field it has traditionally been assessed according to clinical and economic criteria (Locker and Dunt, 1978). Most studies have also been conducted within the pathogenic model, thereby assessing effectiveness in terms of, for example, mortality rates (e.g. case fatality rates, infant and perinatal mortality rates, and life expectancy).

Generally, effectiveness means that something "...has effects that we desire or that we recognise as intentional in the design of the thing in question" (Katz and Kahn, 1978:224) More specifically, and for the purposes of this study, the...concept of effectiveness in health services performance can be defined as a measure of the degree to which the objective(s) of a policy programme, treatment, pattern of care, or resource group has been achieved [Long, 1985:11].

The initial stage, therefore, is to identify the objectives set for the service or programme.

The Government of Zimbabwe's (1986) health policy is based on achieving equity in health. This is to be done through many avenues, including: distribution of health-care resources according to need and in favour of previously disadvantaged areas (e.g. peri-urban but especially rural areas), making health care accessible and affordable to everyone in the population. Those are some of the broad objectives, which are concomitant with the basic PHC principles. Then there are specific programmes like the Maternal and Child
Health, Family Planning, and Water Supply and Sanitation, which have their specific objectives.

In this section I do not intend to do any quantitative or qualitative assessment of the effectiveness of these programmes, but (based on the findings discussed above) indicate how the attainment of the broad and programme objectives is likely to be compromised.

Firstly, limited job autonomy/participation in policy decisions prevents the DMO and local programme managers from procuring enough and appropriate resources to meet demand/local needs, as well as run their programmes timely and effectively. Secondly, there is no evidence that the prior urban bias in the distribution of national health resources has diminished. Limited resources, as I have discussed above, impacts upon the quality of care. If the population of Mutoko district gets fewer health resources (relative to need) than urban populations then the principle of equity has far not been realised. We have also discussed (above) some of the factors negatively affecting the quality of care in the facilities included in my study. According to Barnum and Kutzin (1993 : 12),

...the absolute level of resources flowing to the health sector and the quality of health services are also determinants of the structure of effectiveness of the health sector.

This position supports the argument made by Scott and Flood (1984), that “[e]ffective performance encompasses more than controlling costs through efficient production of services. it also concerns the quality of services provided”. Thus, limited resources are ultimately diminishing the effectiveness of the health facilities in the sample for meeting primary care needs.
7.4.1 **Health Education and/or Counselling**

Apart from fulfilling psychosocial needs, health-care services also aim to meet health education and/or counselling needs of patients. Health education is an integral part of a comprehensive PHC programme (Phillips, 1990). It has many purposes, all of which are important vehicles for attempts to achieve a healthier society. 

Several studies have demonstrated the importance of providing health-care information to patients as well as pointed out that its inadequacy is a major source of patient dissatisfaction (cf. Doering, 1983; Brody et al., 1989; Judge and Solomon, 1993). This dissatisfaction with inadequate communication was also expressed by some of the respondents as indicated in the last section. In fact, few of the in-patient and out-patient respondents indicated that they had been told how the diseases they were suffering from could be prevented (if possible) in the future. This is not an unexpected outcome given the prevailing systemic "task - oriented nursing care" that is a result of shortage of staff.

As pointed out in section 7.2.2, more often than not, health-care personnel do not have adequate time to give health education to the patients they are treating. Their educational labour is compromised, as they are left with only enough time for technical labour.

Although central to these health professionals’ role (cf. Bond and Bond, 1986), the WHO identifies the functions of health education as being the responsibility of everyone engaged in activities related to health and the community. It should not be... the preserve of professional health educators, although such trained personnel can act as specific promoters or stimulators for health education [Phillips, 1990: 281].

Therefore the professionals, all the field staff (i.e. VCWs, EHTs, TBAs), schools, THs and other development workers must all be engaged in health education activities.

However, despite its crucial role in health promotion, health education continues to be delivered in a resource - poor environment in many societies (cf. Jones and Moon,
1987; Bond and Bond, 1986). Incidentally, health education falls in the category of health services performed by EHTs and VCWs which (as discussed in Chapter Four) do not comport with the stereotype of interventionist medicine. According to Jones and Moon (1987: 304),

[p]reventive care is poorly funded because of ideological opposition to caring in situations which are not interventionary, high technology and high prestige. Health education falls within this underfunded arena and so is forced to adopt partial strategies such as targeting in order to make good use of inadequate resources.

In Mutoko District AIDS campaigns target schools and townships, outreach teams target those that come for immunisations, antenatal and postnatal sessions, and the professional caregivers target the sick that visit health facilities. Ideally, focus should not be limited to populations at high risk for illness or the sick.

In the mid-eighties the Government of Zimbabwe (1986: 4) indicated that:

Health education remains as a small unit at the central level and will be hard-pressed to cope with the increase in activities required by the development of strategies for the control of Acute Respiratory Infections and AIDS.

One of the respondents, the national director of MCH/FP pointed out that "little financial resources are set aside for health education. Most of it goes to disease control programmes [in fact] health education gets a very tiny amount" (AP1).

The effects at the local level are astounding. For the sake of illustrating the lack of some basic health knowledge in the community I will cite a few of the discussions I had with the respondents on one of the commonest communicable and preventable diseases in the community - diarrhoea. The first is with a 35 year old woman who had a grade 1 education (IP6).

Q: How do you prevent this diarrhoea that you suffered from?
A: I don't know but some say you boil water with salt and sugar [which is for treatments].
Q: That is after you have fallen ill. How about prevention, so that you do not catch the disease?
A: You have to come to the hospital or go to traditional healers.

The next one is with a middle-aged female respondent who did not know her age and educational level (NP17).

Q: Which are the common diseases among children in your community?
A: Diarrhoea.
Q: What causes the diarrhoea?
A: The sun.
Q: How? What about the sun?
A: It will be too hot.

Similarly, the next respondent does not know what causes diarrhoea. She is 35 years old and has reached grade 7 (NP18).

Q: What causes this diarrhoea that you say your children sometimes suffer from?
A: The way I see it... by bilharzia, because right now they are passing out urine with blood.

As long as these people do not know what causes diarrhoea as well as the preventive measures, it will continue to take its toll in the community. Knowing the treatment alone is far from adequate. According to Phillips (1990: 238), “if potentially serious diarrhoea is to be successfully treated, mothers’ attitudes to a range of illness causation must be addressed, possibly via [health] education.”

Asked what should be done to improve people’s health in her community, one in-patient respondent replied:

I think people in rural areas should get enough health education so that they can always help themselves. This will help the hospitals too, in the sense that they will get fewer patients [IP26].
Therefore, in this situation where both caregivers and careseekers recognise the importance of health education, what is lacking are the resources to accomplish this task.

The 'coming' of threatening diseases like AIDS also has important implications for the planning and allocation of health resources to combat the disease. From being the fifth country with the highest cumulative number of AIDS cases in Africa in 1987 (The Herald, September 21, 1993, p. 7), Zimbabwe is now leading Zambia and Uganda which were first and second in 1993 (The Hamilton Spectator, Nov. 25, 1994 p. A15). At present the WHO says there are officially 120 000 cases of full-blown AIDS, but this is considered an underestimate (The Hamilton Spectator, Nov. 25, 1994, p A15).

In this regard, it has been reported that in Matebeleland South Province the problems being faced by caregivers are: inadequate funds, which result in few people being covered in counselling; shortage of staff (the staff who provide medications are the same staff who are supposed to counsel patients) and lack of transport for assessment (The Daily Gazette, Sept. 8, 1993 p. 8).

The same problems apply in Mutoko. Mutoko centre, where MDH is situated as well as other townships along the highway to Mozambique have been named the "AIDS corridor". Truckers and other travellers that pass through engage in sexual activities with locals, and it is the increase in AIDS cases that has earned this community such a name. We have already documented the concerns of some nurses at MDH concerning the increasing number of HIV related patients that need more attention that they cannot give because of staff shortage. At this juncture I would simply like to point out the need to intensify the level of resources of all kinds so that health education, counselling and curative endeavours are done concurrently. Due to the shortage of human and other resources like transport, health education strategies in health facilities and in communities are denuded of their effectiveness.
7.4.2 Accessibility and Utilisation of Health Services

The Declaration of Alma Ata which lay the framework on which many PHC programmes are based "...argued for an approach to [health] provision based on the notion of 'essential health care that is accessible, affordable, and acceptable to everyone in the country'" (McPherson and Midgley, 1987: 154). Thus, PHC is akin to one of the alternatives to the biomedical approach, the "social and environmental perspective on health" which is "concerned with the consumption of care in respect of such matters as distribution and accessibility" (Jones and Moon, 1987: 1). The crucial aspects of accessibility are social equality and social justice, and these call for the reallocation of resources in order that different sections of society equally benefit (Muhondwa, 1986). The goal is to ensure that individuals have an equal opportunity to use the system according to their needs. Any inequality in the availability and use of health services in relation to need is in itself socially unjust and requires alleviation (Black et al., 1982). Equality of use, according to Jones and Moon (1987) is often termed equity, a concept emphasised in Zimbabwe's health policy.

The importance of access to prevention, care and cure by the health-care system and caregivers, is that it influences one's health status and life expectancy (Kim and Moody, 1992; Long, 1985). In developing countries "[a]ccess to health services is [said to be] very uneven, and large segments of the population are not reached" (Evans, 1981: 111). "In no society is access to health care distributed with perfect equality..." and this "...is common to all developing and developed countries" (Heller and Elliot, 1977: 10).

Access depends on a combination of a number of variables, including the human and physical resources available. According to Long (1985: 12):
Objectives of a health programme and its direction towards a particular target population may be modified by features of access to the programme because of inequitable distribution, income constraints, historical usage patterns, or patients' expectations and beliefs regarding appropriate health care services.

On top of access, people's health status also depends on their use (i.e. utilisation) of these services, not just the physical availability of health service resources (Agu and Walker, 1984; Phillips, 1990). This "use" is also determined by a number of variables, including: personal characteristics (McKinlay, 1982) like their education, income, perception of the quality of facilities (Barnum and Kutzin, 1993; Judge and Solomon, 1993); organisational phenomena and the behaviour of professionals (McKinlay, 1982); the range of providers available (Barnum and Kutzin, 1993; Subedi, 1989), and availability of resources in health facilities.

In terms of Mutoko District I have already indicated one form of spatial inequality, that is, the inequalities between urban and rural areas in relation to resource allocation. This means that the population of Mutoko District have relatively less access to health-care services than those that live in towns, especially the capital city. The other form of spatial inequality that I discussed in Chapter Four is regional inequality in terms of health facilities. I have already pointed out the absence of a district hospital in the neighbouring Mudzi District. Apart from the limited access the people in that district face, their 'pouring' into Mutoko District to MDH reduces the residents' access to health-care services. One example is the ambulances which have to go further afield, forcing some urgent local 'cases' to come to hospital by bus. The workload of health-care personnel also increases and the result is task-oriented nursing which reduces the intellectual accessibility of health-care personnel.

Within Mutoko District very few respondents complained about the distance from their homes to the nearest health facility. This means that geographical accessibility is not
a major problem in the district, with a minor but important exception of course. There is no other health facility, specifically a HC, within MDH’s catchment area. As a result, everyone within the catchment area is forced to come to the district hospital - which is supposed to be a referral centre - for treatment, regardless of the nature of the ailment. These people have better access to health services because this hospital is better equipped than all the other facilities. This also increases the workload of the personnel at this referral hospital.

Apart from health facilities, other resources, especially drugs and supplies are distributed in favour of the district hospital, thereby compromising accessibility in the rest of the facilities. This brings me to the issue of utilisation of health facilities. While the issue of short supplies tempers the principle of access (Kaufmann, 1987), it also affects the use or utilisation of health facilities (Eyles and Donovan, 1990). Facilities with few resources are underutilised. In this regard Hardon (1990: 29) argues that the supply of resources is...

...a severe constraint to the implementation of comprehensive PHC because health facilities without drugs or with an irregular supply of drugs are underutilised.

Underutilisation of some health facilities goes hand in hand with self referrals to better equipped/stocked facilities where there is a perceived greater probability of receiving the desired treatment (cf. WHO, 1988; Barnum and Kutzin, 1993).

We have already discussed the issue of waiting mothers in Mutoko district, whom I said prefer to deliver at the district hospital. With regard to this phenomenon a senior hospital staff says that:

...because some health centres do not have electricity, some do not have running water so...they [waiting mothers] do not feel safe to deliver...under candle light. Although we know the delivery will be safe...but that darkness bit is worrisome. In the same situation I would also refer myself...[AP26].
In Chapter Four as well as section 7.2.1 I partially dealt with this issue of self referrals because of lack of drugs in HCs. Although HCs are cheaper (to those who pay user fees), they do not have enough drugs, that is why people go to MDH, because they know the hospital does not usually run out of drugs. As I have documented already previously, many community members seeking health care do refer themselves to the district hospital thereby overloading it. Thus, distributional inequalities within the district are exacerbating some of these pressures on services at MDH that I have discussed above.

These access and utilisation problems diminish the quality of care and effectiveness of health care facilities. On paper, the district has an ideal referral structure from HCs to the District Hospital to the Central Hospital. This seemingly unproblematic flow is rendered ineffective by lack of resources in HCs and the resultant self-referrals.

In a society with medical pluralism like Zimbabwe, issues of accessibility particularly shortage of drugs and supplies and quality of care determine peoples’ choices between alternative medical systems. In Chapter Four I indicated and showed evidence that in Mutoko, as in the rest of the country, community members freely use either traditional or modern services according to which they perceive as most efficacious for particular ailments. Gilson and associates’ (1994 : 770) recent Tanzanian study has come up with similar results and they note that “[t]he community is, therefore not a passive receiver of allopathic care but judges its value and relevance against both their needs and the alternative health providers”. Thus, health seekers are critical in their search for strategies to overcome illness. They evaluate, judge, make decisions and actions that are influenced by micro and macro conditions that affect health and health care.

In my study, the shortage of drugs in HCs and perceived quality of care in health facilities were found to push people to lay care and TM. Ordinarily, upon encountering an illness people respond to their symptoms by preparing home remedies, folk or traditional
medicine. About 56 percent of the out-patient and household respondents talked about
the use of home remedies as an important (and initial) element in their help-seeking
process. For example, when one respondent was asked what she does when her children
fall ill she said "we try everything, and when we think the medicines we get from
grandmothers can help, we do so and when that fails we then go to the health centre"
(IP45).

However, shortages of drugs in these HCs push some to a sole dependency on lay
care. One respondent responds in this manner:
...for a headache or cough...you can take leaves from a 'mupfuti' tree and
eucalyptus leaves and cook them, then drink the water...Because when
you go to the clinic they might say they have no drugs for that illness
[NP2a].

Furthermore, instead of being able to freely choose between modern and
traditional medical systems, perceived technical quality as well as structural quality, a
shortage of drugs, also force some people to utilise TM alone. In this regard I will offer
two examples. One respondent had taken his daughter to NMH where she only had an x-
ray, saliva and blood samples taken and received no treatment says:
After a month the child got seriously sick again and we went back to
Nyangiri hospital...and they kept saying results hadn't come out. They did
a poor job there...I have been meaning to change to another hospital. All
Souls [hospital] people are better but I failed to go because it is far and I
resorted to traditional medicine. That is what is at least helping us
[NP15].

With regard to shortage of drugs one respondent says:
Because generally with these health centres here, if you go you are likely
to come back without having received any treatments...you are told there
are no drugs...So around here people are getting help from traditional
medicine [NP24].

Either way, whether people resort to self/lay care or TM, a section of the
population is being denied equitable access to health-care services. Assuming health-care
personnel are effective in their communication of health education to patients, these people are likely to miss some information that would be beneficial to their lives.

The last but not least important aspect of access that was found to play a significant role in the utilisation of health facilities in the study is economic accessibility. By this I mean the health-care seekers' ability to afford either user fees or bus fare for those that receive free health care. In a rural economy where people survive on selling agricultural produce and remittances from kin working in cities and on farms even a relatively small fee of ZS1.50, as charged in HCs, is considered too much.

Here are a few of the concerns expressed by respondents in this regard:

IP22: ...I got ill last year and failed to go to the clinic because they wanted ... S$2.00 but I couldn't get it anywhere. I was sick for the whole week.

IP23: ...The reason why I came late is lack of money [for bus fare]. Like now they took an x-ray, depending on the outcome I will be discharged, given tablets and told to come for more later. But when you do not have money it is a big problem. ¹⁶

NP40: ...to tell the truth, it's a long time since I have gone to this health centre since I heard they are charging. I don't have S$3.00 but I have problems with my legs.

NP8: ...At times I stay in the house...sick...because I do not have the money...

NP22: ...At times you have no money and you just stay home and be brave.

Q: Don't you ever try to borrow?
A: We do, but last year [drought year] you couldn't borrow from anyone.

At the time of the study those who earned below ZS400 were eligible for free care, but one respondent voiced an intelligent and legitimate concern regarding this. She indicated that the cut off point does not take into account the size of one's family (OP16). She says earning ZS400/month does not mean the family can afford to pay for health care.

At the height of the 1995 April election campaign the then ruling party indicated that if they won health-care services would be free for rural dwellers. This is a positive
move towards equality of access, provided this was not just an election ploy used to amass votes.

In this section I have therefore pointed out the main variables affecting accessibility to and utilisation of health-care services. These are shortage of resources resulting from inequitable distribution of district health resources, quality of care and poverty. Poverty affects economic accessibility and utilisation of health services too. Given this set of events in my study, I can therefore argue that the objective of equal access has not been fully realised in Mutoko district.

7.4.2 Intersectoral Approach and Effectiveness of PHC Programmes: Beyond Health Services Resources

I have thus far opined that adequate health-care resources are central to the maintenance of a healthy population in Mutoko district. However, it would be foolhardy to believe that these resources are the unexampled or paramount thread in the fabric of a community’s health status. Therefore, a consummate analysis of the relationship between health-care resources and effectiveness of PHC programmes can only be achieved after a thorough consideration of other factors that affect people’s health. In other words, effectiveness of health care and PHC programmes is contingent on other structural socio-economic factors.

Scholars have long since realised the limited nature of direct bio-medical or health services interventions to dealing with common illnesses and improving health status as compared to the role of socioeconomic resources (cf. McKeown, 1979; Jones and Moon, 1987; Bolaria, 1988; Brown, 1989; Phillips, 1990; Conrad and Kern, 1990; Andes, 1992; Kim and Moody, 1992). Such an approach led Black and associates (1982: 16) to call
"...for a total and not merely service-oriented approach to the problems of health" for Britain's National Health Service (NHS). This "total approach" or "social concept of health and social model of health practice and action" (McPherson and Midgley, 1987: 196) recognises that origins of ill-health are problems for which solutions lie largely outside the NHS (Black et al., 1982). Such a social perspective on disease is central to the work of sociologists in the health field. According to Subedi and Gallagher (1992: 275), this entails "...an awareness that accepts biomedical knowledge but adds to it" on the part of sociologists. Hence, "...even diseases with known bacteriological sources...are massively affected in their occurrence by socially-determined life-chances of individuals and groups in society" (Subedi and Gallagher, 1992: 275).

By the same token PHC is an attempt to shift attention away from health services rooted in and based on the conventional medical model. PHC philosophy brings onto the scene a broader concept of health (Hexel and Wintersberger, 1986), one which seeks to achieve acceptable levels of health "...as part of social development..." (Oruhaloye and Oyeneye, 1982: 675). According to Baylies (1986: 67)

...a broad understanding of the causes of ill-health is explicitly incorporated in the WHO [PHC] guidelines aimed at bringing about improvement in health.

Black and associates (1982) contend that inequalities in health can be reduced only if various government departments make their individual contributions. This approach is one of PHC's 5 basic principles, termed multi-sectoral or intersectoral approach (Phillips, 1990). The intersectoral strategy recognises that health promotion and improvement requires contributions from other sectors of the economy and society like general economic development; income and subsistence levels; environment and physical infrastructure (Phillips, 1990; Andes, 1992). In general, this strategy is neglected partly because of insufficient additional resources other sectors/ministries would need to use to
support PHC (Mosley, 1989). Another problem concerns "...the failure of administrative lines of authority to transcend bureaucratic barriers to the actual implementation of many intersectoral activities" (Mosley, 1989 : 264).

Zimbabwe's health policy takes this principle into cognizance. At district level there is the District Development Committee (DDC) chaired by the District Administrator (DA), and at whose monthly meetings a number of ministries and/or sectors are represented, including the MHCW. According to the DA, these meetings are centred on rural development planning and the review of progress in implementation as sub-committees tasked with specific programmes (e.g. water and sanitation) report to the DDC (DA.2).17

Basically, therefore, other sectors are aware of the contributions that they can make towards the achievement of better health. For example, the AGRITEX representative said that the above-mentioned sub-committees allow them to "...get to know what [the MHCW] aims to achieve, and if [they] can facilitate the success of such a programme [they] can incorporate that in [their] programmes" (AGX.3). The ministry of education also has strong ties with the ministry of health. At the time this study was underway the District Education Officer (DEO) was the dental campaign coordinator for the district, arranging workshops and school competitions in music, drama and poetry related to dental awareness (DEO.4). The previous year (1992) sanitation was the theme of their campaign (DEO.4).

However, things do not always go smoothly between these different sectors. For example, the district social welfare officer leveled a scathing criticism of the MHCW officials whom he says, "... never involve ... us in their planning ... (but) we try to involve them as much as we can ..." (SWO.5). He goes further to say that:
... the MHCW has been kind of inwardly projected to the extent whereby a few other departments are not really necessary until transport problems face them ... But basically, in PHC there is scope that this department could actually come in if there was greater coordination. For example, if they identify poverty areas where nutrition is a problem we could take those people on our public assistance programme. But according to them we are the last resort. Its like ... a child gets malnourished first, goes to the hospital, they feed the child and when he/she has recovered they write a letter of referral to this department ... Furthermore, for one reason or the other, they prefer to have their own counsellors ... for psychological problems ... and by the time the case comes here it would have deteriorated to an extent whereby the person you are counselling does not actually benefit ... [SWO.5].

This does not surprise me because the Zimbabwean health policy has been criticised before, for failing to elaborate on the need for interministerial planning and coordination (WHO, 1986). At the local level, I observed a number of apparent gaps which indicate that the mentioned sectors working hand in hand with the MHCW work with very limited resources. As a result, the practical activity and assistance they can minister is often inadequate. I now focus my attention on some of these apparent gaps.

The most salient factor that is impeding the achievement of an appreciable health status in the district is poverty in general. At the risk of sounding redundant, I hereby reiterate the fact that some of the respondents indicated that they often fail to go for health care either because they have no money for the bus, or to pay for the services. Poverty, however, has other implications for health status. When asked if “Health for All by the Year 2000” will be achieved, one nurse aide at MDH said, “Because of poverty, it is hard for people to follow that is asked of them” (NA.B). She went on to say that the only remedy would be “[t]o have more ... health education, [but most importantly] digging water wells and building toilets for the people, because talking alone will not help” (NA.B). A similar view was presented by a nurse at Nyadire HC who answered the same question by saying:
We are facing problems which inhibit the achievement of such a goal ... [Apart from shortage of drugs we] also have sanitation problems in the area. We do not have enough boreholes and toilets ... which means there are other factors which contribute to diseases which should be looked at. Now, to reach the goal of "Health for All by the Year 2000" is simply not possible [SCN.I].

What is apparent is that most rural families cannot afford to buy cement to build toilets and protect their wells. A poignant remark was made by one respondent in this regard: "... Hospitals can treat us and we get well, but if I do not have a toilet at my house I know I am going to catch the disease again" (NP8).

One VCW asserted that "... diseases are on the increase because of many unprotected wells that people get drinking water from" (NP25). So, basically, people understand what nurses, VCWs and EHTs request them to do but, as one respondent says, they do not succeed with these projects because they cannot afford to build the food storage containers, concrete floors for their houses and toilets because of lack of money (NP3a). So "when they come with the next project we have not yet finished the first one", she goes on to say (NP3a). This is a predicament faced by most of the respondents, because they have no stable source of income. for example a respondent from Sasa village states:

At times we are even afraid of going to the hospital because the fees are high ... most of us are not working... If things were all right we would be having a better standard of living... These houses help spread diseases... , no matter how you sweep it is not an ideal home ... there is dirt and I am even ashamed to invite you in ... and we just eat "rubbish" food because things are tough for us [NP37].

In fact, life has been made tougher by "... a combination of rising prices, lower real incomes, restricted government spending in the social sectors" (Kanji et al., 1991; Kanji and Jazdowska, 1993), removal of food subsidies on basic foods, the devaluation and depreciation of the Zimbabwean dollar (Sanders and Davies, 1988). In combination,
these factors undoubtedly affect nutrition and lead to the deterioration of living conditions of especially the rural majority who are poor. The general predicament of these folks is, therefore, more aptly captured in the following excerpts:

There are so many things that displease us about our government ... Fertilizer is too expensive. food is expensive, everything in the home is expensive. And you ask yourself: is this what the new government of independence came for.... with its promise of better life and cheaper things....? (NP40).

Our problem here is, when the cheque for our agricultural produce comes, there are so many things that need to be taken care of: school fees, or children, general subsistence, clothes, seeds for the next growing season, etc. It gets finished in no time and there is not much left for hospital fees later on if they should be needed [NP5b].

Appendix VII.I shows the swiftly rising numbers of people in the district seeking various kinds of government assistance, which is partly an indication of the impoverished status of a relatively large number of families in the district. This kind of impoverishment does not augur well for PHC’s concept of community involvement, whereby communities are supposed to learn to help themselves. Pressing for community involvement will lead to failure of the projects, and victim blaming.

If there should be malnutrition within any of these poor families, what can a health-care worker do to remedy the situation, as well as to prevent it in the future? Park (1987) asks this rhetorical question. In order to avoid dealing with such consequences of poverty, we should rather be dealing with its causes. What is needed is an approach that goes beyond traditional disease prevention to attacking "... the social, economic and environmental conditions of poverty that compromise health and exacerbate illness" (Sidel and Sidel 1989 : 35). In this regard, housing and a stable source of income or productive employment are important components that are considered basic needs of subsistence (Conyers, 1982; McPherson and Midgley, 1987). The PHC concept recognizes their
importance too (Manga, 1988). Once these basic survival issues have been addressed it means we have stopped people from being pushed "upstream", which lessens the unnecessary need and resources for "downstream endeavours" or pulling people out "downstream" (Bond and Bond, 1986; cf. McKinlay, 1990). After all "European history demonstrates that the struggle for health has been a struggle against poverty" (Mburu, 1983: 1153), rather than intervention after disease has occurred (McKeown, 1979). Improvements in people's standards of living, therefore, helped to reduce mortality and morbidity (Andes, 1992).

Failure to address such issues is what leads most populations in developing countries to be afflicted with diseases of poverty. Barnum and Kutzin (1993) state the leading causes of morbidity in developing countries as: upper respiratory illnesses, diarrhoea, parasitic diseases, and accidents. A study by Tumwine and McKenzie (1992) in Chimanimani district (Zimbabwe) found malnutrition, acute respiratory infections and diarrhoea to account for 69.7 percent of the 902 under fives admissions. Based on data reported monthly from HCs in the district, the district information office at MDH lists the diseases with the highest frequency as: diseases of the respiratory system, skin diseases, malaria, sexually transmitted diseases, diarrhoea, bilharzia, and a few more. When respondents were asked to mention the three leading causes of morbidity among adults and children in their communities, diarrhoea emerged as the leading cause. 44.1 percent believed it was the leading cause of morbidity among children while 28.8 percent believed it was so among adults. As shown in Appendix VII.II. coughs, malaria, AIDS and TB/Asthma were the next 4 frequently mentioned.

Appendix VII.III shows hospital admissions for all age groups due to some of the common diseases of poverty. Of these, HIV related diseases are the leading cause of morbidity, followed by respiratory infections. The 1993 figures are for January to June
alone, but they are almost equal to those of the entire previous year, which leads me to conc\ ucture that there has been a degradation in the community's general health status.

Another crude indicator of this health status is the number of in-patient deaths at MDH due to these same disease categories shown in Appendix VII.IV. The table shows a yearly increase from 1991 to 1993 in the number of deaths due to these diseases for all age groups, except for those under one year in 1993. The group most affected is the 1-4 year age group, with mortality figures of 85.7 percent, 86.5 percent and 89.8 percent for the three years.

Dealing with these preventable diseases/diseases of poverty entails a strong intersectoral approach, whereby each sector has a strong input. Selective programmes like immunisation campaigns, acute respiratory infections (ARI) programme, oral rehydration therapy (ORT), that focus on specific diseases do not change the underlying social, economic, and environmental causes of these diseases. According to Tumwine and McKenzie (1992 : 35), "the ARI programme only reduces the number of deaths due to ARI, but the problem needs a multidisciplinary approach". By the same token,

[It must be emphasized that a good deal of expenditure will be needed on environmental, sanitation, housing and nutritional improvements to defeat the conditions that favour the spread of diarrhoeal diseases and create the need for ORT [Phillips, 1990 : 238].

Hence Barnum and Kutzin (1993 : 38) argue that communicable diseases are... more amenable to broad-based primary prevention efforts ... and thus the relative share of these diseases in total hospital admissions in part reflects the effectiveness of a country's PHC...

Since these diseases still take a relatively considerable share of hospital admissions in Mutoko, I can therefore, argue that the district's PHC programme has not been effective thus far.
Another apparent gap concerns general education. Formal education is considered decisive in improving health and reducing mortality, particularly for women, because they play a major role in child care (Phillips, 1990). Data from 1979 puts Zimbabwe’s adult literacy at 39 percent. After independence, the introduction of free primary education and an increase in education services are said to have increased total school enrollments considerably (Loewenson et al., 1991). Partly as a result of this, the 1990 adult literacy figures are considered among the highest in Africa, at 74% for men and 60% for women. In my study, however, the average years of education were 5 for both male and female respondents, with 27 percent of the women having nil or 1 year of education. This is quite disconcerting, considering their role in child care. A study done in Kenya found a negative relationship between mothers’ years of education and child mortality, more so at 8 or more years of education.

According to Phillips (1990: 204)

... in the developing countries particularly in the world Fertility Survey, women with more years of schooling had a greater likelihood of using a modern family planning method and were likely to have a smaller family size.

This issue of large family sizes and frequent pregnancies was a chief concern among some nurses at MDH, particularly in the maternity and female wards, who felt that this was becoming a problem in the district. The issue of waiting mothers partly attests to that.

When asked for her department’s contribution towards the achievement of “Health for All by the Year 2000”, a nurse in the maternity department answered:

In this department? For that to happen people must become more knowledgeable about family planning. Most of our patients... become pregnant soon after giving birth. With smaller families, considering the current high cost of living, we might achieve that objective... [SCN18].

The combination of poverty and illiteracy is expected to reduce the effectiveness of health programmes as well. According to Mosley (1989: 268), “increasing poverty has a
greater impact on mortality levels for children of women with the least education, and this declines with increasing education”.

7.7 CONCLUSION

This chapter has served three functions, to establish and analyse the direct and indirect relationships between my independent variables and the dependent variable, to extend the concept of quality care to that of effectiveness to which it is closely related, and, to broaden our view from basic health services to a broader perspective on health that looks at the macro structures in as much as they impinge on the effectiveness of health care programmes.

I have argued that the quality of care in Mutoko district health system is substantially compromised by limited resources in the form of drugs, supplies, equipment and manpower. I then briefly explored the respondents’ perceptions of technical quality, particularly their lay perspective on ‘appropriate’ drugs/medications. This was seen to affect utilisation patterns of health care facilities. Of major concern to respondents, however, was the poor interpersonal skills/attitudes of some health personnel, which they thought undermined the delivery of quality care to them.

In discussing effectiveness, I have tried to relate both structural quality and interpersonal quality to some of the PHC principles (e.g. accessibility) and objectives (e.g. health education/ counselling). All components of accessibility, physical, economic, psychological and intellectual, were judged to be poor in the district.

Furthermore, the district PHC programme’s effectiveness has been noted to be heavily constrained by all the above-mentioned shortcomings, as well as by inadequate interministerial collaboration. Those few ministries tasked with coordinating their work with the MHCW have proffered minuscule benefit to the rural people, hence they continue
to be underpaid for their meagre agricultural produce and there is little structural and financial support for their farming activities. The conspicuous absence of some crucial sectors on the local scene, for example, those to do with employment creation - especially for women, and housing, has also been noted, in regard to how they can alleviate general poverty and bring about equality in health with no diseases of poverty, not simply equality in health care provision.
ENDNOTES

1Structure includes “the relatively stable characteristics of the providers of care, of the tools they have at their disposal and the physical and organisational setting in which they work” (Scott and Flood, 1984: 238).

Outcomes are “the changes in a patient’s health status that can be attributed to receiving health care, including psychological, social and physiological...” (Scott and Flood, 1984: 238).

Process indicators are “the set of activities that go on between the providers and the patient, including management of technical and interpersonal processes involved” (Scott and Flood, 1984: 238).

2Lewis (1994: 657) has given us 12 of these elements. They are: overall satisfaction, satisfaction with access (including convenience, hours, distance, perceived availability, etc.), satisfaction with cost, satisfaction with overall quality (including e.g., time spent with provider), satisfaction with humaneness (warmth, respect, kindness, willingness to listen, appropriate non-verbal behaviours, interpersonal skills), satisfaction with information provided, satisfaction with bureaucratic arrangements (including time spent waiting), satisfaction with physical facilities...satisfaction with providers’ attention to psychosocial problems, satisfaction with continuity of care, satisfaction with outcome of care.

It is up to one doing a study to choose which aspects to include.

3They define quality of health care as “the degree to which the resources for health care, or the services included in health care, meet specified standards” (in Tarimo, 1991: 56).

4These include nurses in the psychiatric ward and out-patients ward, the rehabilitation officer, community sister, DMO, DHSA, DEHO, PEHT, SEHT, an EHT and all the 5 VCWs.

5I have already documented in Chapter 5 the desire of patients to have an injection in preference to tablets or other kinds of medication. In connection with my discussion here Scarpaci (1988: 210) notes that:

...there [generally]...a strong relationship between the receipt of an “objective” medical treatment such as an x-ray, a lab test, or a prescription drug, and the perception of high - quality medical care

6In my case it is a combination of prior inadequate staffing quotas, turnover and layoffs due to ESAP. In any case, the resultant effect is shortage of staff.

7The major reason might be that in-patients might be afraid of criticising people whose care they are still depending on. McKinlay (1980) states that respondents in several satisfaction studies reported positively for fear of possible recriminations. Lewis (1994: 657) also talks of this fear of disclosure and says that in the British NHS patients are often reluctant to be critical of their health care, especially when they are sick or receiving treatment and therefore in a position of dependency in relation to the system.
Furthermore, consistent with my observation, Lewis (1994) states that community samples reflect lower levels of satisfaction than those enrolled ‘on site’. We can therefore say where in-patients are concerned there is a ‘gratitude barrier’ (to use Judge and Solomon’s (1993) term that they apply to the gratefulness of non-paying patients.

8According to Long and Harrison (1985 : 4) “the interpersonal aspects relates to need for the quality of services to meet socially defined norms and values, reinforced by the ethics of health practitioners, and the expectations of patients”

9Lewis (1994) describes this as the time caregivers can spend listening to and counselling their patients.

10The key aspects of the “validation” dimension which is defined as “...communicating positive regard, respect, and appreciation” comprises “complementing care-seekers’ acts, ideas, and efforts, asking for and incorporating their help...” (Khan. 1993 : 544). According to Khan (1993) these 8 behaviours are often woven together in daily interactions. A study of the behaviour of nurses on wards by Graffam (see Hills and Knowles, 1983 : 84) found the following results.
   - In at least 60 percent of the events, nurses responded unilaterally by informing or directing the patient.
   - In 13 percent of the interactions, the nurses actually blocked patients’ expressions by changing the subject, failing to follow a cue, or by leaving the room abruptly.
   - In only 10 percent of the interactions did the nurse encourage the patient to explore the cause distress, leading Graffam to conclude that nurses are generally not meeting the needs of the distressed patients as compassionately and as effectively as they might.

11However, accounts from some nurses as well as patients and community members indicated that defaults are more often than not caused by poverty, that is, inability to afford travelling expenses to and from the hospital. Otherwise drugs and treatments for chronic illnesses are free.

12Wharton (1993 : 205) defines “emotional labour” as frontline service work that is done for a wage in a public sphere. Nursing and teaching and social work would be some of them.

13These expectations might cause female service workers to be unfairly more scrutinised by society. By the same token male service workers may probably be manifesting relatively the same absence of psychosocial skills. In a community with large number of illiterate care seekers who think male care givers are doctors (as evidenced by answers from some of the respondents), it would then not be surprising to find more respondents saying that doctors are more compassionate and understanding than nurses. Some might have been referring to male nurses when they said doctors.

Let me take for example this piece of an interview with a 45 year old female respondent who had a grade 5 education. Asked who are helping people more in her community she said “Doctors”.
Q: More than nurses?
A: [laughs]
Q: Why do you think so?
A: Is there any difference between doctors and nurses?
Q: Yes there are.
A: Oh! [expressing great surprise] I thought they were the same.
Q: And who do you think are more compassionate and understanding between doctors and nurses?
A: Men treat people better.

14 Health education can facilitate the long term shifts in attitudes required to combat preventable illnesses (Jones and Moon, 1987), help to influence the "... adoption of risk reduction behaviours" (Mhloyi, 1991 : 8), "... facilitate the technical aspects of the patients' care as well as enhance [a]... sense of personal control and social support" (Brody et al., 1989 : 1052) - more so for those with chronic illnesses who may depend on self care and self medication (Fosu, 1992).

As far as chronic illnesses, especially AIDS, are concerned health education and counselling are essential for the relatives of the patients too, for they need to know the dynamics of the illnesses as well as how to provide proper care.

At a macro level, "[i]t can be the stimulus that encourages community participation and mobilizes popular support for all sorts of health activities" (Phillips, 1990 : 238).

The distinction, then, between health education and counselling of patients is quite subtle because the latter is a vehicle "... through which individuals are encouraged to think about their problems and potentials for improving their circumstances" (Phillips, 1990 : 282).

15 Although not related to the general examples concerning diarrhoea quoted above, I find this case quite interesting in the way it reveals the naivety and ignorance of some community members in regard to how sexually transmitted diseases are spread. One 18 year old male respondent was asked how he could in future prevent himself from getting this or other kinds of STDs and he says: "The prevention is difficult because you wouldn't know who has this kind of disease when you have sexual intercourse with them" (OP40).

Such lack of knowledge on the prevention of STDs is astounding in the wake of the ravage AIDS has already caused.

16 This patient's problem afflicts many more. In fact some nurses put this across as one of their problems regarding their encounters with patients. One out-patients nurse says:

In this department, the main problem we face is of patients who default on their medications. Some say they can not get the money to come back if you give them a review date to come and collect the medication. They always say they didn't have money for bus fare [SCN1].

17 For example, there is the nutritional programme [specifically the child supplementary feeding programme] which has the "... cooperation between health, agriculture, education, and other ministries" (AP27). The AIDS committee has representatives from different hospitals, education, community services, social welfare, environmental health (AP27).
This is a respondent from Nyadiri Resettlement Village 10 where residents are expected to be obtaining a reasonable income from agricultural activities.
Chapter Eight

CONCLUSIONS AND POLICY IMPLICATIONS

8.1 INTRODUCTION

Primary health care has, within the past decade, increasingly become a popular means of reorganising as well as reorienting health-care services in numerous developing countries. In this endeavour, some of the main foci of PHC have been: to inculcate a preventative and promotive bias in health-care systems that have been hitherto interventionist in orientation; the inversion of the health-care personnel hierarchy that entails the elevation of lower categories of workers as well as the empowerment of communities with regard to the management of their health matters and, a shift in resource allocation to reverse the urban thrust as well as in favour of the poor. Success in achieving these and other PHC objectives have been sporadic in many countries thus far. Many studies have been done (since 1987) in different countries to try to assess the success of the PHC programmes as a whole or aspects of them.

For the PHC objectives to come to fruition in order that "Health for All" be achieved, these studies are essential, more so those that focus on the structural, organisational and interpersonal dynamics above and beyond the ingenious treatment of PHC or aspects thereof in a vacuum devoid of, for example, political sleight, inter- and intra-professional conflicts, care-seeker care-giver conflicts, the care-seeker's lay perspective of illness and health. This study is one of the few that have explored these avenues in an intermarriage between Sociology of Organisations and Sociology of Health.
and Health Care. The focus of this chapter is to pull the threads together as I recapitulate the major findings of the study. The second section discusses the implications of the findings and offers some policy recommendations. Finally, the third section explores directions for future research.

8.2 OVERVIEW OF FINDINGS

The primary objective of this study was to explore the relationship between job autonomy/ participation in policy decision making, health-care resources and the quality of care in Mutoko district (Zimbabwe).

Our analysis of interviews with programme managers and other district-level officials revealed that their job autonomy is heavily circumscribed. This is due to the bureaucratic and centralised nature of the MHCW’s structure in which most decisions are made at the central level and all communication has to go through the PMD’s office. We also noted that this lack of job autonomy/ participation in policy decision making hinders their ability to influence effective resource allocation concordant with local health needs. Lower level personnel (who have more supervisors to report to) have even much less job autonomy. The absence of participatory structures at hospital or district level impedes their ability to influence policy decisions, especially those affecting their working conditions. The categories of personnel that seemed to have a semblance of job autonomy are HC personnel and field staff, largely due to their distance from the immediate control of supervisory personnel. 1 However, most decisions affecting their day to day work have to be made at higher levels too. These findings have led me to conclude that decentralisation of decision making, which is one aspect of PHC, has not yet been achieved in the MHCW.
Lack of meaningful decentralisation means local managers lack the power to deal with local contingencies in a timely fashion. Further prolongation of this structural impediment can only lead to more acute burnout and job dissatisfaction among programme managers and supervisors.

The general finding regarding health-care resources is that the pre-independence urban thrust that is largely concomitant with a curative orientation is still in existence. Although financial resources are generally inadequate on a national basis, whatever is available is benefiting urban populations more. Due to the limited financial resource allocations, health facilities in Mutoko are saddled with drugs and supplies shortages. However, due to the distribution problems within the district, HCs were seen to suffer more from these shortages than the district hospital. Transport (shortage of and improper maintenance arrangements) was another resource that most supervisors, programme managers and field staff mentioned as a constraint to their day to day duties. More pertinent to health-care personnel, however, is the issue of manpower shortage that has been exacerbated by ESAP policies that recommend the downsizing of government departments and less spending on social services. All levels of personnel were found to be understaffed. However, despite this shortage of manpower there is no positive move to utilise available human resources in the form of THs and TBAs. Analysis has shown that understaffing has led to role conflict and role/work overload among all categories of administrative staff and health-care personnel, including the DMO and MDH matron.

Before analysing the relationships between the independent and dependent variables I established a prior and important link between the independent variables (job autonomy/participation in policy decision making and resources) and burnout and job satisfaction/dissatisfaction which I considered as the intermediate variables. A small number of health-care personnel indicated dissatisfaction with the first independent
variable. However, most health-care personnel indicated that they are dissatisfied with the shortage of drugs, supplies and equipment, but most importantly, manpower.

In all interviews, reference was either to manpower shortage or role/work overload. These concerns were generally communicated with a lot of emotion and heartfelt conviction and concern. The respondents mentioned very few aspects of their job and work environment that they found satisfying. One of these few was helping patients. Although this is supposed to be one of the major reasons for joining the profession, most workers did not mention this as a satisfier, probably because their work orientations have been heavily tainted with the many negative aspects of their working conditions.

Apart from the independent variables, there are other factors in the work environment that were found to cause job dissatisfaction, the most prominent of which is remuneration. This leads me to conclude that due to the high cost of living in Zimbabwe, economic difficulties as well as extended family responsibilities, workers are attaching more significance to extrinsic work rewards. The relatively high level of dissatisfaction with work among the sample, as well as the objective working conditions that I observed lead me to conclude that health-care personnel in this sample are burned out.

 Armed with the above findings, I proceeded to analyse the effect independent variables directly and indirectly (through the intermediate variables) have on the quality of care. Lack of job autonomy leads to delayed reaction towards emergency situations, as well as inability, on the part of local officials, to procure enough and appropriate resources to match local needs, thereby affecting the quality of care.

Lack of drugs, supplies and manpower was also observed to affect structural quality. Both caregivers and consumers strongly believe that shortage of drugs and supplies affect the quality of health-care provision in the district. While this is a major source of dissatisfaction among health providers, it also affects the health status of the
general population. In other words, it is also a major source of discontentment with the health-care system among consumers. The district hospital is perceived to have more drugs and this leads to self referrals to MDH by many care-seekers. Shortage of drugs was also noted to have a positive effect on lay care and utilisation of TM.

Another major finding of the study is that health-care seekers are generally unhappy about the lack of interpersonal skills among some health-care personnel in various health facilities in the district. I have therefore argued that this behaviour on the part of health-care personnel is largely caused by job dissatisfaction and burnout. It is also caused by shortage of personnel which brings about task-oriented nursing care, thereby interfering with carers’ emotional labour. I have also gone further to call this behaviour coping indifference and coping belligerence. This is part of an effort to link the behaviour of health-care personnel to the organisational and societal structures. But more importantly, I should point out that this negatively affects the process quality of care. Analysis of care-seekers’ perceptions of some aspects of quality, structural, technical and process, revealed that shortage of resources and poor attitudes of health-care personnel affects utilisation patterns.

This led me into the issue of the effectiveness of the PHC programme. Shortage of resources and skewed utilisation patterns negatively affect accessibility, an important PHC concept. In this case I found geographical, psychological, and intellectual aspects of accessibility to be unfulfilled. Compromised quality of care and accessibility point towards the ineffectiveness of the PHC programme, as does inequity in resource allocation or spatial inequality.

I then situated the results of the analysis within a larger theoretical context, arguing that the effectiveness of the PHC programme cannot be based on the performance of the MHCW alone because health is determined by the organisation of social and
economic structures as well. In this regard I found the intersectoral approach to be wanting because the MHCW has resorted to selective programmes to deal with health problems, while on the other hand, some sectors do not have enough resources that could uplift the communities from the throes of poverty and cycle of illness and help seeking.

The above findings are therefore diagrammatically represented, summary form, in Figure 8.1, which shows the impact of the independent variables as well as the wider
society on organisational participants and processes and, ultimately, the behavior of health seekers.

Throughout the chapters above I have tried, wherever appropriate, to reorient the study’s focus from generalities to women in particular. They are the majority in the health-care professionals in the sample, and they are the majority in the sample of care-seekers and household respondents that were interviewed, which is representative of a typical rural scenario whereby husbands are frequently away from wage employment or other informal income generating ventures. That means the majority of people dissatisfied with their jobs, suffering from burnout, having a low quality of working life, suffering from rural poverty and ill health in Mutoko district are women. This further helps to widen the already existing chasm of inequality between men and women.

8.3 POLICY IMPLICATIONS

This study has only concentrated on a few aspects of PHC and its organisation, and findings from these few areas could serve as a basis for making a few major recommendations that could be helpful in the development and implementation of stronger PHC structures. The essence of research in this regard is aptly noted by Hughes and associates (1958: 268) as

"... obviously not an end in itself. Its value lies in the light that it throws upon the present state of affairs as an eventual guide to intelligent direction and control."

The finding that lack of job autonomy is pervasive in the district health-care system raises great concern. In order to put things right, the system needs structures that emphasize adaptiveness and creativity at all levels, and this results from having adequate decentralisation, which can also strengthen district management by making them more
accountable for resource allocation, utilisation and effectiveness of programmes. This could be accomplished by having the PMD’s office more as an advisory level not directly involved in the day to day procedures at district level. Where direct communication links with the central office prevail, the PMD could be informed later of whatever steps have been taken. Speedy and timely reaction to local health problems and needs should be regarded as one of the cornerstones of PHC. PHC entails the democratisation of societal structures, and in this scenario people’s/consumers’ voices have to be listened to and their needs attended to expeditiously. This can best be achieved in a non-rigid system that rewards ingenuity. Such a system comes with greater decentralisation that grants autonomy to local health-care providers.

Research has demonstrated the merits of job autonomy/participation in policy decisions. Therefore apart from decentralisation, structures could be set up at district level in which workers can forward their grievances and be certain action will be taken to put things right. Apart from intrinsically motivating workers, these moves would go a long way in improving the quality of working life of health-care personnel, as well as bringing a positive outlook on the way they approach their jobs. Related to this is the issue of working conditions that are the chief source of job dissatisfaction among the respondents. For example, the lack of (or limited) career ladders for certain categories of workers, especially nurse-aides, VCWs, EHTs and SCNs is disturbing. The introduction or widening of career ladders should be considered a top priority because the effects of job dissatisfaction on turnover, absences and other forms of withdrawal, poor attitudes, and consequently poor process quality, can in the long run affect the effectiveness of the district health-care system. These career ladders, as well as increments in pay, could be based on creativeness and resourcefulness and/or other criteria which decentralisation and job autonomy are more likely to engender. Improvements in these spheres would go a
long way towards empowering VCWs, firstly as women and secondly as health counsellors, whose utilisation at present is a form of exploitation of women.

The distribution of resources, particularly drugs, in favour of the district hospital distorts planned utilisation patterns. Therefore, on top of this anomaly, SRNs could also be posted to HCs to boost the confidence of the community as well as avoid unnecessary referrals to MDH by ‘lesser’ qualified staff. By the same token, construction of waiting mothers shelters at HCs would alleviate congestion at the district hospital as well as improve their living conditions, thereby reducing risks of both maternal and infant mortality.

I take the position that corrective measures indicated above would go a long way towards lessening the impact of diseases of poverty as well as new diseases like AIDS that are currently suffocating meaningful attempts to enhance the health status of Mutoko community as well as the achievement of PHC objectives. Furthermore, health is the basis of development in any society.

As my analysis showed, much of the job dissatisfaction among the respondents is caused by personnel shortages. Given the present situation whereby the community has favourable impressions of THs it would be beneficial both to modern health-care practitioners and the community if avenues were seriously explored in order to tap these available human resources in a manner that does not exploit the THs or belittle their knowledge and expertise. Furthermore, efforts to educate health-care personnel about the merits of traditional medicine, as well as weed out the negative and pejorative attitudes most of them have towards traditional healers would go a long way towards a sound working relationship between THs and modern health-care providers. There is need to lay to rest the denigratory approach modern medicine has traditionally taken towards TM.
The two should not be regarded as two competing health systems with irreconcilable differences.

One other concern expressed in this study involves the issue of intersectoral cooperation which was found lacking in form and intensity. PHC should be seen as part of the process of rural development, whereby all the factors that thwart the attainment of a more humane standard of living are identified and dealt with from all angles. Such an approach would entail the institution of structures to: increase household incomes, increase literacy levels and standard of formal education, create self-confidence in women, as well as reduce their dependence on men. Apart from improving the standard of living, such measures would enable families to afford health care. the projects recommended by VCWs and EHTs, as well as nutritious food. This will set us on the right track towards achieving “Health for All”.

A speedier road to the achievement of this seemingly illusory goal, however, is the realisation of the important role women play in development. Considering that the majority of rural dwellers are women who make a living from agriculture, in an agrarian society in which the large portion of the total national agricultural produce comes from small scale farmers, most of which are women, the hand of social justice should see to it that they are not the ones suffering more from diseases of poverty. Overworking in the fields, childbearing and family responsibilities as well as inadequate provision of health care would tend to lower the life expectancy of women relative to men. More importantly, is the way all these social inequalities/disadvantages combine to make women second class citizens. Therefore, structures ought to be put into place that empower them in various ways; politically, economically, psychologically, etc. in order that they become full and equal contributors towards development goals as well as equal consumers of the fruits of development. That way they can confidently and adequately deal with diseases of
poverty, discard 'cheap' and 'immoral' ways of earning an income (thereby helping to reduce the spread of AIDS), as well as become better carers of their children (thereby helping to reduce infant mortality rates).

The idea of training village health workers (now called VCWs) was one excellent way of empowering women in rural communities, however, the working conditions and wages are exploitative. The same can be said of nurse-aides and nurses, the majority of whom are women. Improving the working conditions of these categories of workers would go a long way towards removing barriers to women's enjoyment of life chances comparable to men as well as dismantling gender social inequalities. Their realisation that they are valued members of society would go a long way towards boosting their self consciousness as well as making them better and conscientious carers of our care seekers, thereby also contributing significantly towards our inching closer to the goal of "Health for All".

8.4 DIRECTIONS FOR FUTURE RESEARCH

This study has accomplished a number of things. The significance of the study lies in the fact that the consumers' own words about their experiences are taken into account, as well as how they would like to see things changed. Such studies allow community voices to be heard and assert the significance of their experience for future planning. Most studies in self referrals, accessibility and utilisation patterns have for the most part considered consumers only, but I have tried to put both consumers' and providers' experiences into the equation.

What is also significant about this study is its qualitative nature, whereby respondents tell their story or experiences in their own words. Moreover, the study puts into perspective the working conditions of health-care personnel who are forced to work
under stressful conditions and how they wish to see them changed. This approach underscores the importance of taking the total environment into consideration when analysing people’s work situations. This becomes even more pertinent in this case whereby ESAP has affected personnel in three different ways, viz. non-replacement of staff that get laid off or quit (resulting in work/job overload), cutbacks in social spending (resulting in shortage of supplies), and the general cost of living that inevitably forces workers to seek better remuneration in order to cope with the high inflation. Failure to achieve this objective then leads to dissatisfaction.

The findings reported above are therefore considered significantly provocative and noteworthy to strongly justify more intensive and rigorous research in these areas on a wider scale to confirm their validity. Thus, while the study offers the advantage of approaching the topic of PHC from an organisational and health standpoint, I acknowledge the essence of broadening the scope to include either more districts within a province or a comparison of two or more provinces in order that the findings can be generalised at a national level. By the same token, the independent and dependent variables could be increased in order to cover more fundamental aspects of PHC.

Beyond the issues treated in this study, another fruitful avenue of research would be to concentrate on the harmful effects of role/work overload and burnout on health-care providers’ own health. In such an approach it would be paramount to get their concerns and conceptualisations of health and illness as these relate to themselves and their coping mechanisms. Such an approach would help redress the present bias of research on PHC towards better health for the consumer. It would also enable one to explore ways of enriching the jobs of health-care providers in order to improve their quality of working life as well as cope with the negative effects of structures outside the MHCW such as ESAP.
Lastly, I would like to point out that the achievement of the goal of "Health for All" is not unattainable. Its achievement, however, depends on the success the national government makes in correcting the ills pinpointed above. To the extent that working conditions of health-care personnel are not improved, the top-down structure remains the foundation of the MHCW. resource distribution continues to favour urban populations. consumers are denied all the aspects of accessibility to health care. rural populations continue to receive inadequate and unacceptable health care and continue to spin and flounder in the cycle of poverty - illness - and help-seeking. then the goal of "Health for All by the Year 2000" will remain an utopian dream.
1 Moreover, due to lack of transport and other reasons supervisory visits are few and far between.

2 During the research one major explicit example of lack of self-confidence and self-worth among female respondents (also an example of dependency on men) became apparent. When asked what they felt about free health care, most of those that qualified for it answered in the following manner:

   OP36 : It helps me since I am divorced....
   OP37 : I don't pay because my husband does not work.
   OP47 : Yes it helps.... because I do not have a working husband.
   IP4  : No, we do not pay because my husband does not work.
   IP9  : .... if they made people like us with unemployed husbands to pay... we wouldn't be coming to hospitals.
   IP11 : Yes it is helping because if you are asked to pay and your husband doesn't work you wouldn't afford to come to the hospital.
   IP42 : ... Only those with working husbands pay user fees.

The problem here lies in policy makers as well as those providing letters for free health care and the care-givers who explain to these women the free health policy in a manner that emphasize the husband as the only capable breadwinner.
APPENDIX II.1: The Geographical Position of Zimbabwe and Mutoko District.

Zimbabwe
APPENDIX III.II: Map of Mutoko District Showing Hospitals and Health Centres
APPENDIX IV.1: Standard Staffing Patterns: Provincial Medical Director Office

<table>
<thead>
<tr>
<th>CATEGORY OF WORKER</th>
<th>MINIMUM REQUIREMENTS</th>
<th>IDEAL/OPTIMUM REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Medical Director</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ministry of Health (MCH)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MCH (Epidemiology)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PNO (Provincial Nursing Officer)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Deputy PNO</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PEH (Provincial Environmental Health Officer)</td>
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<td>1</td>
</tr>
<tr>
<td>Deputy PEHO (Principal EHO)</td>
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<td>1</td>
</tr>
<tr>
<td>Principal EHT (Disease Control)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Provincial Pharmacist</td>
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</tr>
<tr>
<td>Provincial Records Officer</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Provincial Health Education Officer</td>
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<td>1</td>
</tr>
<tr>
<td>Health Education Officer</td>
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</tr>
<tr>
<td>Senior Nutritionist</td>
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<td>3</td>
</tr>
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<td>PHSA (Provincial Health Services Administrator)</td>
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</tr>
<tr>
<td>Executive Officer</td>
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<td>1</td>
</tr>
<tr>
<td>Clerks (All Grades)</td>
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<td>12</td>
</tr>
<tr>
<td>Field Officer (Disease Control)</td>
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<td>2</td>
</tr>
<tr>
<td>Other General Categories</td>
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<td></td>
</tr>
<tr>
<td><strong>SUB-TOTAL</strong></td>
<td><strong>70</strong></td>
<td><strong>84</strong></td>
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</table>

Adapted from: Zimbabwe Health Human Resources Master Plan (1993 -1997)

APPENDIX V.I: DISTRICT SUPERVISORY VISITS TO HEALTH CENTRES

<table>
<thead>
<tr>
<th></th>
<th>KATUKUNYA</th>
<th>MT. SHIMBO</th>
<th>NYADIRI</th>
<th>KAPONDORO</th>
</tr>
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<tbody>
<tr>
<td>DMO</td>
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<td>3</td>
</tr>
<tr>
<td>DNO</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DHSA</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DEHO</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PEHO</td>
<td>2</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>COMMUNITY SISTER</td>
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<tr>
<td>DISTRICT PHARMACIST</td>
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</tr>
<tr>
<td>PEHT</td>
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</tr>
<tr>
<td>SEHT</td>
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</table>

* 1993 VISITS WERE ACCOUNTED FOR UP TO SEPTEMBER.

** 1992 DATA WAS NOT AVAILABLE AT TIME OF VISIT.
APPENDIX V.II: WASTAGE AT NATIONAL LEVEL IN THE PUBLIC SERVICE

<table>
<thead>
<tr>
<th>CATEGORY OF PERSONNEL</th>
<th>No. LOST</th>
<th>PER YEAR</th>
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<tbody>
<tr>
<td></td>
<td>1991</td>
<td>1992</td>
</tr>
<tr>
<td>SCN\textsuperscript{S}</td>
<td>116</td>
<td>87</td>
</tr>
<tr>
<td>SRN\textsuperscript{S}</td>
<td>170</td>
<td>187</td>
</tr>
<tr>
<td>PHYSICIANS**</td>
<td>80</td>
<td>78</td>
</tr>
<tr>
<td>SPECIALISTS CONSULTANTS</td>
<td>38</td>
<td>5</td>
</tr>
<tr>
<td>TOTALS</td>
<td>404</td>
<td>357</td>
</tr>
</tbody>
</table>

\* (1993) Figures are for the period January through July only
Data was collected from MHCW central office

\*\* (includes: Junior and Senior Officers, DMOs, PMDs, Registrars, Dentists, etc.)
## APPENDIX V.III: MUTOKO DISTRICT HOSPITAL ESTABLISHMENT (1993)

<table>
<thead>
<tr>
<th>TYPE OF HEALTH WORKER</th>
<th>APPROVED ESTABLISHMENT</th>
<th>POSTS FILLED (1993)</th>
<th>MIN. POSTS REQ.</th>
<th>IDEAL POSTS REQ.</th>
<th>NEW POSTS REQ. BASED ON MIN.</th>
<th>NEW POSTS REQ. BASED ON IDEAL</th>
<th>1995 TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMO/MEDICAL SUPERINTENDENT II</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>GOVERNMENT MEDICAL OFFICER</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>MATRON III/CLINICAL OFFICER</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>NURSES (ALL GRADES)</td>
<td>44</td>
<td>44</td>
<td>80</td>
<td>95</td>
<td>36</td>
<td>51</td>
<td>70</td>
</tr>
<tr>
<td>PHARMACISTS (ALL GRADES)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>PHARMACY TECHNICIANS</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>RADIOGRAPHER</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>HOSPITAL ADMINISTRATOR</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>EXECUTIVE OFFICER</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>DENTIST</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DENTAL THERAPIST</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>DENTAL TECHNICIAN</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DENTAL ASSISTANT</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>REHABILITATION ASSISTANT</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
APPENDIX VI: FACTORS THAT MAKE FOR JOB DISSATISFACTION AMONG MUTOKO DISTRICT HEALTH PERSONNEL

<table>
<thead>
<tr>
<th>TYPE OF DISSATISFIER</th>
<th>SRNs</th>
<th>SCNs</th>
<th>DEPT. HEADS/ ADMIN.</th>
<th>OTHER</th>
<th>TOTAL No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowances/compensation/incentives</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>Accommodation</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>Career Opportunities</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Communication</td>
<td>-</td>
<td>3</td>
<td>7</td>
<td>-</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Channels (With head office)</td>
<td>-</td>
<td>3</td>
<td>7</td>
<td>-</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Rural Transport</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Allowance</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Travel and Subsistence Allowance</td>
<td>5</td>
<td>9</td>
<td>5</td>
<td>1</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Salary / Pay</td>
<td>7</td>
<td>12</td>
<td>6</td>
<td>3</td>
<td>28</td>
<td>70</td>
</tr>
<tr>
<td>Saff Shortage/ Work Overload</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Shortage of Equipment/ Drugs/ Supplies</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Opportunities for Further Education</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Shortage of Transport</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Influence on Policy Decisions/ Decision Making</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Role Conflict</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

*This is percent of total respondents (40)
**APPENDIX VII.1:** Government Assistance Cases Filed with the Department of Social Services in the Whole District of Mutoko.

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>1990</th>
<th>1991</th>
<th>1992 *</th>
<th>1993**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Health Services #</td>
<td>11</td>
<td>72</td>
<td>44</td>
<td>6258</td>
</tr>
<tr>
<td>Public Assistance</td>
<td>1518</td>
<td>2252</td>
<td>1076</td>
<td>12130</td>
</tr>
<tr>
<td>Drought Relief</td>
<td>9</td>
<td>14020</td>
<td>144475</td>
<td>206395</td>
</tr>
<tr>
<td>School fees Exemptions</td>
<td>315</td>
<td>333</td>
<td>167</td>
<td>10601</td>
</tr>
</tbody>
</table>

* Data available for the first 6 months only.

** Data accounted for up to time of visit (July).

# from 1993 letters for free health care could only be obtained from the department of Social Services. Previously they could also be obtained from ward councillors.
APPENDIX VII: Diseases Most Frequently Mentioned by Respondents as Being Common in their Community

<table>
<thead>
<tr>
<th>Disease</th>
<th>Common Among Adults</th>
<th>Common Among Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea</td>
<td>28.8</td>
<td>44.1</td>
</tr>
<tr>
<td>Malaria</td>
<td>24.3</td>
<td>5.4</td>
</tr>
<tr>
<td>AIDS</td>
<td>25.2</td>
<td></td>
</tr>
<tr>
<td>TB/Asthma</td>
<td></td>
<td>17.1</td>
</tr>
<tr>
<td>Coughs/ Flu</td>
<td>20.7</td>
<td>25.5</td>
</tr>
</tbody>
</table>
APPENDIX VII.III: Percentage of Total Inpatient Deaths (at MDH) Due to the Five Common Diseases in Appendix VII.II

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1991</th>
<th>1992</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1</td>
<td>64.3</td>
<td>76.6</td>
<td>75.9</td>
</tr>
<tr>
<td>1 - 4 Years</td>
<td>85.7</td>
<td>86.5</td>
<td>89.8</td>
</tr>
<tr>
<td>5 Years &amp; Over</td>
<td>43.5</td>
<td>60.1</td>
<td>69.5</td>
</tr>
</tbody>
</table>
RESEARCH INSTRUMENTS ONE

PATIENTS (Questions modified to suit In, Out and non-Patients, Adults & Youngsters)

1. Marital Status.
2. Age.
3. Educational level.
4. Number of children (if any).
5. Means of transport to the hospital and/or time spent traveling to the hospital.
7. Were you accompanied by someone to the hospital?
8. Is this the nearest hospital/health unit to your home?
   -If not, which one is? Have you been there with this complaint? If yes were you referred?
9. Duration of complaint/illness.
10. Did you use any other medicine for the complaint before coming here?
    [from a medical unit, from a shop, from a traditional healer, home made medicine, other sources].
11. Have you ever visited any hospital(s)/clinic(s) for treatment?
12. In your village, which are the three most serious kinds of sickness that children get?
    that adults get?
13. Did you or your children suffer from an illness between last year and now?
14. Are there any specific diseases which you preferably would have treated at a hospital/clinic, by a traditional healer, or by yourself at home?
15. Do you sometimes fail to go to the clinic/hospital for treatment because of work pressure, or lack of money?
16. In your opinion, is there a difference in treatment of patients by government and mission hospitals? In what way?

17. Which of the following g workers contribute most to the health of the district (in what order?)
   a) at the hospital - doctors, nurses, nurse aides.
   b) in the villages - traditional birth attendants, village health workers, nurses in clinics, traditional doctors, environmental health workers.

- Between those at the hospital and those in the villages - which category of workers contribute most to people's health?

18. Can you rate this hospital vis-à-vis other hospitals or clinics you have visited in terms of its performance (efficiency) and the caring nature of the health personnel?

19. Do you have any grievances about your experience at this hospital, the way you have been handled? - Are you satisfied with the services?

20. If paying or non-paying patient, what they think about their situation? The fairness of the system, and how the situation could be made better.

21. Explain in your own way how diseases are caused.

22. Are you ever consulted about any development projects carried out in your home area?

23. Which aspects of health would you like to see improved in your home area?
RESEARCH INSTRUMENT TWO

DISTRICT AND MEDICAL OFFICER, MATRON AND DISTRICT HEALTH (hospital) ADMINISTRATOR.

1. What are your responsibilities as a ................. in this hospital? Have they changed with the implementation of PHC?

2. Has the district health organization changed to suit the needs and requirements of a Primary Health Care strategy?

3. Is there a district health team? If so, which organisations and departments are part of it and how often does it meet?

4. Are you consulted when a district budget is being prepared? Are the various allocations enough for the existing needs?

5. Are there ever any shortages of - drugs, equipment, transportation manpower? etc. If yes, how does this affect the running and effectiveness of the hospital?

6. Any constraints to service due to shortage of technical support?

7. Do you feel the training given to health personnel is enough for them to deal with rural communities? If not, what are your suggestions for a change?

8. Have there been any regular workshops or in-service training for health personnel since the implementation of PHC?

9. Are personnel deployed within the district according to need? Are there any areas you feel are underserved?

10. Do you feel roles for health and administrative personnel (at district level) are adequately defined?

11. Do you sometimes feel that your work is hindered by bureaucratic central control?
12. Is there enough decentralisation of authority? Do you feel you have enough power as a local decision maker in terms of resource allocation?

13. What organisational changes would you suggest in order to improve managerial efficiency and effectiveness?

14. Do you feel PHC activities in the district are supported by enough health education?

15. Are you satisfied with the present referral system?

16. What are the common problems that you face in dealing with and/or managing health personnel?

17. Is there any conflict regarding relations between these two categories of nurses - SCNs and SRNs?

18. How do you normally deal with interprofession and intraprofessional conflicts?

19. Generally, what conditions affect staff morale and motivation?

20. Are there any incentives for health personnel working in rural areas?

21. Are there adequate career structures for health personnel?

22. Has your working in the hospital affected your attitudes and aspirations?

23. Do you feel there are certain skills you need to acquire in order to function well in your position?

24. If you were to start all over would you choose the same profession?

25. What is your opinion on the contribution of traditional medicine to PHCs “Health for All by the Year 2000” objective?

27. Years working for the ministry: .................(current post)
RESEARCH INSTRUMENTS THREE

PROGRAM OFFICERS

(District and Principal Environmental Health Officers, District Nursing Officer, Community Nurse, District Laboratory Technologist, District Pharmacist, District Health Information Officer [some Qs tailored to suit particular job descriptions])

1. May I first of all please know what a ....................... is supposed to be doing in a district hospital like this?
2. Are your roles clearly defined? Have they change with the implementation of PHC?
3. How is planning carried out? Is it you who plan or you do it together with officers from other departments?
4. Specifically what are the objectives and targets for the programs that you supervise? And are these targets set at head office or you have your own? Do you have a time schedule for the implementation of the programs?
5. For your targets, do you ever make use of all that information in the records office?
6. Do you have a separate budget for your programs, and is it enough for your needs?
7. What are the means (if any) of monitoring or evaluating your programs?
8. What achievements have been made so far in terms of your programs?
9. What are the major problems you encounter in implementing these programs?
10. Do you feel the referral system is working efficiently?
11. What are the means of integrating your work with that of other departments?
12. Do you integrate your programs with those of other departments outside the ministry of health?
13. Are you ever consulted when a budget for your activities is being made?
14. Have personnel been given enough training to prepare them to work with rural communities?
15. Are personnel deployed according to local needs?
16. Do you feel the qualifications of health personnel are adequate for the services they give?
17. Do you think there is enough decentralisation in terms of decision making? Are you given enough latitude to make decisions about the programs you supervise and in terms of resource allocation?
18. Do you feel the way policy is communicated from the provincial level or head office is convenient for you?
19. What things do you feel should be changed (within the health system) in order to increase effectiveness and efficiency?
20. Do you think adequate attention is being paid to staff motivation?
21. Are there incentives given to staff working in rural areas?
22. Are the PHC activities being supported by enough health education?
23. Are you part of the District Health Team? How does it meet?
24. What do you see as the major problems associated with the management of health personnel?
25. What methods do you use to solve intraprofessional conflicts among personnel under you?
26. Are there any problems regarding the division between SCNs and SRNs? Do they work well together?
27. What factors affect the motivation and morale of health personnel in the district?
28. Are your day to day duties sometimes hindered by central bureaucratic control?
29. What factors contribute to their satisfaction and dissatisfaction?

30. What do you think traditional healers could contribute towards the achievement of PHC objectives?

- Do you envisage a time when hospitals and traditional healers would be referring patients to each other?

31. If you were to start all over again, would you choose ....... as your profession?

32. Age: ......................

33. Years in current post: .........................

34. Total years worked in the ministry: ......................
RESEARCH INSTRUMENT FOUR

HEALTH PERSONNEL: Nurses = SRNs, SCNs

[Modified for ‘other workers’ e.g. kitchen staff, ambulance drivers, clerks, nurse aides, village health workers]

1. Are you aware of the national goal of health for all by the year 2000?
2. What do you think is your department’s contribution to the achievement of that goal?
3. Do you feel the training you to is enough to make you work in rural communities?
   Do you feel your qualifications are enough to enable you to function in this organisation and deal with the current health problems?
4. Have you ever gone for in-service training? If you were to get a chance to go for this, which area would you want to concentrate on?
5. Are your responsibilities well defined, such that you know what you are supposed to do on a daily basis?
6. Can you say your roles have changed after the implementation of PHC?
7. Is there adequate delegation of authority, such that you can make decisions on your own?
8. Are there any factors which make for satisfaction in your work environment? Any which make for dissatisfaction?
9. Any constraints to service delivery due to shortage of staff, drugs, equipment?
10. Has your working in this hospital affected your aspirations in any way?
11. Are there enough career structures in your field?
12. Do you feel management gives enough attention to staff moral and motivation?
13. If you were to start all over again, would you be interested in getting into the same profession? If no, please indicate the things that you would wish to be changed.
14. Are there any times when there are conflicts between SCNs and SRNs or doctors and nurses in general?

15. If these conflicts do occur, how are they usually solved?

16. Are there problems you face in dealing with patients?

17. What role do you think traditional medicine can play towards the achievement of the goal of health for all by the year 2000?
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