

Global Agendas, Health Sector Reforms and Reproductive Health and Rights: Opportunities and challenges in Zambia

Priya Nanda¹

Many countries in Sub Saharan Africa are facing insurmountable problems of HIV epidemic, increased indebtedness, economic recession and underdeveloped health sector. As a response to these global problems and to significant paradigmatic shifts in population and health policies, such as the ICPD agenda at Cairo, countries have taken on various reform efforts within their health sectors. The ICPD mandate and health sector reforms can be viewed as overall reforms of health systems and population policies encompassing efforts ranging from new policies, integration of vertical health programs, health financing tools and decentralization of the health sector to name a few. Zambia is one such example where all these changes have taken place within the context of health sector reforms. Using primary research in the form of interviews with policy makers, program planners, service providers and NGOs in Zambia as well secondary data and research, this paper will highlight the challenges and opportunities that health sector reform process poses for the reproductive health and rights agenda in Zambia. The paper argues for more caution in relying on the success of health reforms to meet larger concerns of gender, equity and reproductive rights. This is especially true in the light of greater connectedness and vulnerability to various forces from globalization. In this current scenario of reforms within the health sector, the role of international donor and regulatory agencies becomes critical in balancing the global “bads” with global “goods”.

Introduction

Health sector reforms have been initiated in many countries primarily to address resource imbalances and inefficiencies in their health sectors. They aim to modify centralized and often bureaucratic health systems to make them more cost-effective and efficient by re-organizing and decentralizing services, resources and management. Concurrent to the ongoing process of health sector reforms, is the reproductive health agenda mandated by the International Conference on Population and Development (ICPD) in 1994. Part of the ICPD Programme of Action can be seen as a reform of international health and population policies to ensure a focus on rights and equity issues within health, specifically reproductive health care, an area of specific neglect within primary health care service delivery. The need for reforms in the health sector have gained immense attention in recent international health policy debates because of the expectations that they will promote efficiency and equity in the delivery of health care services as well as honour international agreements, such as the ICPD Programme of Action, to improve quality of health care, especially for women.

Health sector reform and the Programme of Action of the ICPD can be viewed as two overarching reform agendas that ultimately seek to improve efficiency and equity in health care for all individuals. Although a subject of immense debate, there is still little information on the relative progress of countries that are implementing these agendas, especially in light of potential synergies and conflicts between them. Moreover, both these processes are taking place in an environment of greater global integration, the benefits of which are also uncertain for an overall improvement in health and equity.

¹ Correspondence to: Priya Nanda, Program Associate, Center for Health and Gender Equity, Suite 910 6930 Carroll Avenue, Takoma Park MD 20912. Tel: 301 270-1182; fax: 301 270-2052; e-mail pnanda@genderhealth.org

The need to document and debate the experience of countries that are undergoing health sector reforms, and simultaneously implementing the reproductive health and rights agenda, is recognized by program planners, advocates, donors and researchers, especially for countries that are in earlier stages of their reform efforts. This paper presents an analysis of whether and how health sector reforms facilitate or constrain the implementation of the reproductive health and rights agenda using the case study of Zambia, a country that has and is undergoing radical reforms in its health sector in the face of many adversities.

Global agendas: health sector reforms and reproductive health

Defining the context of globalization for health sector reforms

As this millennium draws to a close public health advocates and policy makers are rethinking issues of equity² in access to primary health care for the growing world population. Many developing countries face scarcities in their resources while their numbers and needs continue to multiply. One could argue that this does not dispel gloom as there is an overall increase in the movement of global resources. The process of globalization has increased the potential for economic, political and social interdependence and global integration between states as it is accompanied by the movement and exchange of capital, people, technology, intellectual property and cultural values across national boundaries (Yach and Bettcher, 1998).

Moreover, whether globalization reflects a pessimistic trend or not seems to be less important a debate than understanding the process, its context, and the relatively disadvantaged positions of different countries within that context. The inner conscience of this debate comes from the understanding that developing countries are at unequal starting points in the process of globalization, and a disproportionate amount of benefits from this process accrue to small groups of elites within those countries. Those individuals that are most insulated from growth and the benefits of globalization also reflect the ground reality of economic scarcities, greater burden of disease, ecological disasters and starvation.

According to Yach and Bettcher (1998), 'the domain of globalization includes many interconnected phenomena and risks that affect the sustainability of health systems and the well-being of the populations of both developing and industrialized countries.' Reform in the health sector arises from these 'interconnected phenomena' – increased indebtedness, structural adjustment, international policy agreements, new donor funding arrangements, new technology, ideas, and values – that have created the conditions for the global culture of health care reform. Similarly, diffusion and sharing of ideology and experience trans-nationally amongst feminists and reproductive health advocates have created the global context for the reproductive health and rights mandate at the ICPD. An analysis of these two agendas is befitting not only because of similarity in their timing and overall objectives – of democratization of power, accountability to clients and equity in access – but also because of competition for scarce resources and the ideological differences between various stakeholders that dictate these two agendas.

Health sector reforms involve radical shifts of power at a political, bureaucratic or organization level. Sometimes the magnitude and pace of change has been astounding and unsettling, and at other times it has been slow and checkered. In either case the reforms have evoked mixed responses from policy makers and planners, that of: increasing scrutiny and skepticism; belief that reforms may offer solutions to the inefficiencies that surround the resource scarce and malfunctioning health sectors; or, the more realistic demand for more evidence regarding success and failure of reforms.

² Equity in health has many dimensions, such as equity in distribution, access and need. Within health sector reform literature, the concept of equity is often based on the notion of need. This implies that the distribution of the system's resources should be guided not by the criteria of equal distribution but by consideration of distribution of resources according to need.

Despite the lack of conclusive analysis on whether health sector reforms can achieve all that they set out to or is hoped for them, it is fairly clear that these reform efforts will have strong implications for the way health care is conceived and delivered at every level of service delivery. Reforms in the health sector will also impact the way countries use their limited resources, set priorities and respond to demographic transitions, the AIDS epidemic, and increasing burdens of disease, illness and poverty.

The ICPD mandate has placed reproductive health and rights³ on the map of population policy to ensure that population policies are linked to poverty reduction and improvements in individual well-being, especially the well-being and empowerment of women. The ICPD Programme of Action also calls for governments actively to promote sexual and reproductive health services and safeguard them as areas of high priority in the context of broader health sector reform i.e., to integrate reproductive health programs fully with national health systems. Even though the five years since ICPD have witnessed significant developments in policies supporting the reproductive health agenda, desired changes in program implementation are still not that visible, and if visible, have not been evaluated in terms of their impact on equity and rights for women's well-being.

Analysis of health sector reforms in Zambia

Introduction to the study

This study is based on preliminary findings from a case study of the impact of health sector reforms in Zambia on reproductive health objectives agreed to in the ICPD Programme of Action. The findings are based on a field trip in September 1998⁴ and on an in-depth review of pertinent literature, including documents obtained from the Zambian government and from donor agencies working within the country. The rest of the paper provides an overview of the demographic, health, and economic environment in which the reforms are taking place, followed by a brief outline of the context for reproductive health policy in Zambia. This section concludes with an analysis of the challenges posed by health sector reforms to the reproductive health goals and objectives set by the Government of Zambia. The paper concludes with some generalizable lessons learnt for implementing the process of reforms in the health sector and transforming reproductive health programs and policies as mandated by the ICPD.

³ Reproductive health includes at a minimum family planning services, counseling and information; prenatal, postnatal and delivery care; health care for infants; treatments of reproductive tract infections and sexually transmitted diseases; safe abortion services, where legal, and management of abortion related complications; prevention and treatment of infertility; and, information, education and counseling on sexuality, reproductive health, and responsible parenthood, and discouragement of unsafe practices such as female genital mutilation. Where additional services such as breast and reproductive system cancers and HIVAIDs are not offered, a system should be in place to provide referral care. [ICPD para 7.6] Reproductive rights are the rights of couples and individuals to: decide freely and responsibly the number and spacing of their children and to have information, education and counseling to do so; attain the highest standards of sexual and reproductive health; and, make decisions about reproduction free of discrimination, coercion and violence. [ICPD para 7.3] Sexual rights are rights of people to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. [Fourth World Conference on Women Platform for Action, 1996].

⁴ During the field trip, extensive interviews and focus group discussions were conducted with a variety of individuals, including ministry of health and other government officials, donors, representatives from women's NGOs and providers at the district level.

Economic and political context of the reforms

The motivation for reforms in Zambia can be traced to economic and political trends in the decades following Zambia's independence in 1964. At independence, Zambia inherited a medical system from the colonial era with a strong bias toward the urban areas and the copper mining sector.⁵

The first decade after independence was successful in keeping a strong economy reliant on the mining sector. Despite its urban bias, health care was provided free to all. In the eighties however, Zambia faced economic decline in both its external and domestic sectors, due primarily to falling copper prices. Relatively scarce foreign exchange was used to purchase oil for the mining sector. This, coupled with unfavorable macro-economic factors, led to further shortages in foreign exchange and subsequent rising external indebtedness. The external debt rose from 3.3 billion dollars in 1980 to 7.3 billion dollars in 1997, amounting to a debt of approximately \$700 per capita per annum.

The domestic economy suffered as a result of devalued currency, inflation and import restrictions. Government subsidies declined especially to the social service sector, including health. In 1964 Zambia's per capita income was \$300 with a total population of 3.5 million. By 1996 Zambia's per capita income had declined to \$264, and its population had more than doubled to 9.8 million. According to a World Bank assessment study conducted in 1991, 69 percent of Zambia's population lives below poverty line.

This period of economic decline adversely impacted the social sector, especially health and education. Health sector investments and services declined followed by a deterioration in the physical infrastructure and an acute shortage of drugs and medical supplies. Health workers became demoralized working with inadequate resources and an overly centralized management structure unresponsive to local needs and conditions. One third of senior medical personnel left their jobs to study or work abroad leaving their positions unfilled or to be filled by expatriate staff (Kalumba, 1997: 6). Child mortality rose significantly during this period. This was further reinforced by several cholera outbreaks from 1990 to 1993.

In the mid-eighties, a group of reformers in the Ministry of Health (MOH) began exploring the issues of decentralization and autonomy for hospitals and other institutions (Foltz, 1997). To move away from a centralized political and administrative system characterized by corruption and mismanagement, reformers emphasized power and autonomy for local administrative bodies. In 1991 the one-party government of Kenneth Kuanda was replaced by the Movement for Multiparty Democracy (MMD) of Frederick Chiluba. The MMD's policies emphasized liberalization and democratization of local government. Although reform in the health sector started before other public sector reforms, all political reforms got a formal impetus with the establishment of the Chiluba government in 1991.

Vision of the reforms

The vision of the health sector reforms was to build 'a health care system to provide Zambians with equity of access to cost-effective quality health care as close to the family as possible' (MOH, National Health Policies and Strategies, 1992: 28). The Ministry of Health adopted primary health care as a strategy to carry forth the vision. The vision of the reforms rested on the three principles: leadership, partnership and accountability.

⁵ Copper, Zambia's main foreign exchange earner, was discovered in the 1920's subsequent to which several mining companies were established. All through in the colonial period the mining sector was developed at the expense of other sectors such as the agricultural sector (Freund, 1986). In fact the burgeoning copper-mono-economy and relative impoverishment of rural areas led to a sizable rural-urban migration. Commercial agriculture was developed along the 'line of rail' to feed the workers. These events have influenced the patterns of urbanization and health care that exist today.

Leadership: The MOH was separated from its implementation body known as the Central Board of Health (CBOH). The MOH would take a leadership role in policy making, and the CBOH would be responsible for the implementation of reforms through delegating decision making to district health teams. The reformers had identified that the problem of dependence on donor funded projects, especially vertical programs, resulted in a fragmented management strategy and delivery of basic health services without a coherent national health strategy (Kalumba, 1997:10). To rectify this situation, it was established that donors would pool their funds into a common basket. Potentially, this would give the MOH more flexibility and efficiency in allocating funds than the usual project-based funding. It would also prevent Zambia from 'balkanizing' into distinct regions of donor predominance.

For a country that is heavily dependent on donor support (40-50 percent of current health sector spending), it is a challenge for the current group of Zambian reformers to maintain their control over the process of reforms. However, there is a strong commitment of Zambian reformers and stakeholders to be in a leadership role. Through my interviews I learnt that most senior MOH officials were committed to basket funding. One of them stated that it 'is the only way that we can foresee allocation of donor funds into our health sector.' Most donors in Zambia are supportive of the concept of basket funding and have started pooling some of their resources into the basket. However, the MOH needs to work out the modalities of complete trust and transparency with donors in order to put the concept of basket funding into full effect.

Partnership: Decentralization of power was considered essential to the goal of partnership in Zambia. In order to operationalize this plan, health management teams and health boards were formed at the district level throughout the country. It was mandated that board membership be comprised of community representatives from neighborhood committees as well as administrators from district-level health facilities. The district administrative units as well as neighborhood committees were envisioned as stakeholders in the process of change underlying the reforms.

Accountability: Prior to reforms in the health sector, the pattern of funding and staffing reflected preference for high-tech curative health care. The reforms placed emphasis on making health care providers more responsible to local health boards, which were to represent the community. Greater community participation was also elicited through the formation of neighborhood committees that would act as conduits between communities and district health providers. User fees were instituted as a way to enhance accountability to the community as well as raise revenues.

Problems in establishing accountability and partnerships have arisen in the process of implementing the reforms. I will address these issues in a following section that focuses on constraints for service delivery.

Reproductive health and rights context

The context of reproductive health and rights highlights concerns that are cross cutting and not specific to Zambia alone. Overall, the lack of complete information and training to health care providers, as well as cultural biases of providers against tackling sensitive reproductive health concerns (such as STDs, sexual coercion, or adolescent sexuality), affect the provision of quality reproductive health services. At the same time, biases among individuals and communities against abortion, contraception, or other culturally sensitive issues undermine clients' utilization of related services. In a context in which poverty and gender inequality greatly constrain women's ability to make safe and informed decisions, these factors create a challenging environment for the delivery of quality reproductive health services.

The multiplicity of factors that constrain women's health seeking are clearly brought out in the case of abortion services. Unsafe and poorly performed abortions are a major cause of maternal mortality in Zambia. Although abortion services are technically legal in Zambia, access to safe services is

severely limited. Factors such as provider biases, limited information among women about the Medical Termination of Pregnancy Act, the stipulation that referrals for abortion be approved by three physicians, the limited number of sites that perform the procedure, and religious sentiments against abortion, all serve to constrain women access to safe procedures.

Providers at health centers often lack training to deal with sensitive reproductive health areas. For example, during an interview, staff members of a women's rights-based non governmental organization working on gender violence noted that sexual coercion and other forms of violence against women and girls go unaddressed. This in part is because providers are not trained to probe women closely when they present with signs of physical abuse. They argued for in-depth training of health care providers to deal with these issues above and beyond providing women with medical treatment for the physical symptoms of violence.

Cultural biases of providers can lead to discrimination in delivery of services, especially where resources are scarce. A senior administrator at the Christian Medical Association of Zambia stated that, in light of the chronic shortage of drugs, a patient with an STD might be denied treatment. In part, this is due to a culture of blame regarding STDs, and a feeling among providers that clients with such infections 'have brought it upon themselves.' These situations expand the magnitude of the problem from merely reducing the number of cases to one of changing attitudes, providing informed choice, and reducing incidence.

Given this context, the role of effective policy guidelines, and a supportive environment to implement those guidelines, becomes critical. One of the outstanding accomplishments of the Zambian health sector reform has been the articulation of clear policy guidelines and detailed process-oriented strategies to achieve the broader objectives. The goal of the National Reproductive Health Policy is 'to achieve the highest possible [sic] of reproductive health for all Zambians through the implementation of a multi-sectoral approach, which aims at addressing the reproductive health needs of individuals and families and supporting their physical, mental, emotional and social development through the life cycle' (Reproductive Health Policy, Strategies, and Guidelines, Ministry of Health, 1997). Within this broad goal, which reflects a strong adherence to the ICPD mandate⁶, are six main priorities: family planning, safe motherhood, prevention of abortion and management of complications, prevention and management of HIV/AIDS and STDs, adolescent sexual and reproductive health and prevention and management of violence against women. Detailed guidelines have also been developed for safe motherhood, adolescent health, HIV/AIDS and strategic planning for gender analysis. Although, the reforms have provided a blueprint for bringing about a positive change in service delivery, there are other strategies associated with the reforms that potentially negate its benefits for reproductive health service delivery.

Some challenges to meeting reproductive health goals and objectives

While the current reproductive health policy under the health sector reform is unambiguously progressive and necessary to improve quality of health services, the challenges to achieving its goals are tremendous. These challenges are posed partially by the current economic, demographic and health scenario, and partially by the process of reform per se. In this section I will highlight some of the constraints underlying the process of health sector reforms. These constraints have broader implications for health care delivery and not just for reproductive health. However, they may be more

⁶The main objectives of the Zambian health sector reforms are consistent with the vision and priorities of the ICPD. Both are committed to democratization of power and decentralized decision making. The ICPD calls for a client-centered and participatory approach. The health sector reforms have a similar focus on accountability to the community and building partnerships with NGOs. The ICPD's commitment to providing the widest possible reproductive health benefits is reflected in the Zambian vision of equitable and affordable health 'as close to the family as possible.'

critical for an already underfunded reproductive health delivery system vis-a-vis needs of staff capacity, skills, drugs and infrastructure.

Decentralization and unequal capacity at the district level: Initiated through the formation of district health boards and district health management teams, decentralization of power to the level of the districts is fundamental to the process of health sector reform. The boards were formed after the district health management teams in most districts. Even though the management teams were supposed to report to the boards this was difficult to enforce, since the teams were functioning on their own before the boards were formed (Foltz, 1997: 6). Lack of clear guidelines about roles and responsibilities of the district health board versus the district health management teams have resulted in tensions between these two levels of decision making. These are compounded by the fact that each of these bodies is operating with insufficient funds, allocated to the districts from the MOH, to develop their health plans. A senior nurse administrator from a district health management team expressed her frustration with the process of devising their own need-based health plans and budgets when the funds are never sufficient to ensure even the most basic drugs and services.

The current constraints to decentralization arise not only from the fact that in some areas the relationship between health boards and management teams are tenuous but also that there are severe constraints in staff capacity across different regions. In some areas decentralization of power to effectively functioning district health boards and management teams has had a visible impact on service delivery. In other areas where there is limited staff and infrastructure, decentralization of power has had little impact.

The formation of new systems is meaningless if there is insufficient skilled capacity and inadequate inputs to carry out service delivery. My interviews with district-level providers revealed that staff continue to be demoralized when they work with such acute lack of drugs and medical supplies. Providers also indicated that resource starvation feeds into any inefficiency and corruption that exists in the system.

In a focus group with nurses in the Kafue district, I asked them whether they felt that their capacity was lacking in terms of staff skills especially pertaining to reproductive health services. They reported that they could do a lot but that they needed information and training. 'We want information about clients' rights and written policy guidelines..', stated a nurse. Only one of these eight women had been to several training workshops while the others had not benefitted from attending training or passive learning through other trained staff. The women who had not attended any training workshops felt very marginalized on this account. There is an added complexity to this feeling of marginalization. Those that attend training get a per diem which for many is a way to supplement incomes that are not adequate to meet even their basic needs.⁷ In the current economic context, differential access to income and other resources has deepened the sense of marginalization among many health workers.

Barriers to cost sharing: The use of cost sharing in Zambia, as a part of the reform strategy, has to be viewed within the context of a health system which had previously provided free primary health care to all. People's attitudes are not always supportive of cost sharing mechanisms when previously they have been used to getting free services. Fee for services can be rationalized if there are concurrent efforts to enhance quality of services. However, shortage of drugs at the point of service delivery makes user fees less attractive to clients especially with the economic scarcity that most Zambians are currently facing. A representative of an NGO that works on women's empowerment,

⁷ Many of the health staff I interviewed stated that their salaries were not sufficient to meet the high cost of living due to ongoing inflation. Their estimated food, rent, and transport expenses seem to exceed their salaries. The cost of education for their children and health expenses are not even included in these reported estimates.

reinforced these sentiments when she stated: 'people can pay with maize, but they have no cash.' This she felt was especially true for rural women.

Exemptions exist for vulnerable groups such as pregnant women and those with STDs but often providers lack clear information about who is exempt. Patients with STDs may be charged despite being exempt because of provider biases against patients with STDs. There is a rule that ten percent of the revenue from user fees can be allocated as staff bonus. Exemptions can be disregarded by providers to raise more revenue for the health centers as well as for staff bonus. Finally, people may be reluctant to pay for services if they do not get drugs. The current situation with drugs is such that often people pay the fee and get a diagnosis, but the health center has no medicines to offer. Often there is no other source of drug supply, such as a private pharmacy. This reinforces the hostility toward actions such as nominal cost sharing.

Restructuring/de-linkage of health staff: One of the objectives of the reform process was to enhance the efficiency of the health system through a process of staff de-linkage. De-linkage of staff is part of a larger public service reform to re-allocate staff to appropriate skill based positions as well as from high capacity to low capacity areas. In practical terms, this has implied that all health staff reapply for their current positions. However, this process has been stalling in the last year. Most health personnel feel disillusioned by this process because of lack of clear information about new roles and benefits, especially for those who will potentially be transferred or lose their jobs, and perhaps a disinclination to be posted to more remote areas. In the meantime they continue to work with unclear and insufficient information. Many of the staff I interviewed stated that they experienced low motivation for their work on account of these uncertainties. Some of them expressed a desire to leave the country to work for better wages or for more certain jobs.

In the face of such uncertainties, the proposal for a new cadre of workers, Public Health Practitioners (PHP), to implement the essential health package may undermine the status of those workers who are not selected to be retrained as PHPs. This implies that efforts to build capacity and enhance skills of some staff could further undermine motivation and skills of other staff. All these issues underscore the fact that health personnel need to feel empowered and informed as the system is restructured. An inability to do so will have serious implications for reproductive health service delivery by reducing the motivation of those bearing the weight of service delivery at the most critical levels.

Drug shortage: Zambia is facing a severe and critical shortage of drugs on account of mismanagement in the process of restructuring the drug supply and procurement system. To say this critically affects service delivery and perceptions of future use of health services would only be stating the obvious. Nurses in several district health centers talked about the difficulties of working in this resource constrained environment. Several of them stated that they have to give oral rehydration salts to HIV positive patients on home visits because of a lack of drugs to treat opportunistic infections. Some of them felt that their low work motivation was associated with both the uncertainty of their jobs as well as not having drugs to treat sick people.

A senior administrator of the Christian Missionary Association of Zambia shared his frustration about the drugs shortage and how that impacts STD management. In his experience, providers are constantly having to ration out drugs. For example, since a common drug like Gentamycin can be used for treating STDs as well as several other common infections, providers face tough trade-offs between using it to treat patients with STDs or those with other ailments.

Interestingly, while the drug management situation has been so lamentable, the supply of contraception has not suffered. This is because supply and procurement for contraceptives has been funded by DfID for the last five years. Although there is an essential package of health care that is being delivered at the district level, TB drugs, Vitamin A and contraceptives are not included in

the essential drug list. This reflects the remnants of previous vertical programs and perhaps prioritization of donor funding.

Barriers to integration of services: The move toward integration of services to ensure delivery of the essential health package has been initiated in several ways: a move toward basket-funding and away from vertical funding at the donor level, a dissolution of vertical programs at the Central Board of Health (CBOH) level, and an integrated package of services with a one-stop shopping approach to delivery at the district level. However, constraints to realizing these changes have arisen at each level.

Donors are still funded vertically and therefore have a tendency to monitor and evaluate on a project-by-project basis. Several donor-agency officials stated that although they support the concept of basket-funding, they require complete transparency in how funds are used by the MOH and CBOH to enable a full pooling of resources. At the level of the CBOH, technical expertise from erstwhile vertical programs is considerably underused. Staff heading the old vertical programs are now playing more diffused roles within the administration of the MOH and CBOH.

At the delivery level, the concept of integration has not been internalized entirely. Several issues came up in interviews with providers. The staff had problems either understanding the concept or conceptualizing the 'how to's' of integration. There also are structural problems such as those articulated by a nurse at the Kafue district health center, who noted that 'the health sector reform efforts have taught us a lot. We could potentially deliver the services if we had transportation and regular supply of drugs. [But] our clinics do not even have privacy to insert IUDs.' Inadequate infrastructure and staff training undermine the potential for integration of services at the decentralized level of the districts.

Weak NGO collaboration: The reproductive health policy document issued by the government recognizes the crucial role that NGOs play in bridging the gaps between communities and providers. In reality, however, several NGOs stated that they feel disconnected from the reform process because they do not have complete information about government actions and have been isolated from the changes in policies and decisions carried out by the government. An NGO that works on issues of domestic violence felt that even though they had been involved in the process initially, they 'do not have a real forum with the government or any say in shaping the process.'

The one NGO that felt most isolated from the reforms was also more critical of the process. While this NGO was less informed about current governmental policies, it works in areas where there are no health facilities. One of its staff members, who lives in a remote southern province, reported several instances where women's lives had been compromised because of lack of services. She asked, 'What stories are those rural women going to have about the reforms?'

Sustainability of the process of reforms: There are several constraints to the sustainability of the reform process. First, there has been a tremendous amount of brain-drain in that several key reformers have left Zambia and taken up international positions. Many others are looking for positions in neighboring countries where the economic situation is better. The appointments of new ministers to head the Ministry of Health, over a short span of time, has added to bureaucratic inconsistency in the implementation of policies and programs. Each new minister brings in a fresh set of priorities that sometimes arrests progress in old priorities. Due to greater reliance on donor funds, reform efforts may become more dependent on the direction and focus of external donors, countering the basic premise of internal leadership on which they were initially based.

Other than top-level political will and leadership, the success of reforms also rests on the energy and motivation of the health staff, which evidently is slowly fading. Health staff feel distanced from the very process which had initially energized them by its overwhelming pace. Commenting on this pace, a nurse from the MOH's reproductive health unit stated: 'We went too fast. We should have piloted and learnt from our success and failures.' Perhaps because everything was done at once,

there are more visible failures than successes. People want to see results and may exert negative political pressure to stall the process. A senior administrator at the Christian Medical Association of Zambia pointed out that, 'from a cultural perspective, Zambians are not concerned with process. They want results.' A senior SIDA official reinforced these sentiments as he noted, 'reforms have laid down the institutional and conceptual framework but now they really need to touch the community with its impact.' Finally, the weak economic situation and its bleak prospects for future growth may severely hinder the reform process by exerting a greater resource crunch. A senior doctor at Lusaka's University Teaching Hospital, defines reforms as a 'process of re-defining health systems within a poorly funded sector in an attempt to rationalize health service provision.' A further decline in the resources available to its 'poorly funded health sector' will severely constrain Zambia's ability to rationalize health care for all Zambians.

Immediate concerns

The process of the health sector reforms in Zambia has been remarkable for its strong equity-oriented vision and the pace at which it has been carried out despite the challenges. Although the Zambian experience cannot be fully condensed in the brief overview provided here, some of the most critical constraints that the reforms are posing to service delivery, especially for reproductive health, have been outlined above. Success in achieving the Zambian vision of equity in health care, especially for reproductive health care, continues to be contingent on how the transitional steps toward implementing health sector reforms and the reproductive health agenda are managed.

In the interim, immediate steps need to be taken to alleviate the shortage of drugs, and proactive steps need to be taken to prevent a similar shortage of contraceptives in the near future. Given the magnitude of the AIDS epidemic, it is critical to enhance the role of STD management through an improved drug procurement and supply system. District health staff need clear signals about new roles and responsibilities, which will not only assist in the process of decentralization but also make the staff feel more included in the process of change. In addition, there is a strong need to build capacity at the district level especially in regions that were already low on capacity and skills prior to the process of reforms. Communities and providers need to be sensitized and informed about laws and women's rights, especially those that question the existing gender norms. Lastly, there is a need to foster better linkages with grassroots and women's NGOs so that the vision of partnership is realized in a more meaningful way.

Conclusion

The discussion of Zambia's health sector reforms highlights the predicament of a poor country, going through an aggressive process, in trying to meet its reproductive health needs and priorities as envisioned by the ICPD. Zambia's health sector reform process has brought to the fore critical questions pertaining to equity and quality of reproductive health care: Is it possible to deliver an essential package of health care without adequate supplies of drugs, manpower or resources? Can Zambia meet its external debt burden as well as sustain its vision of providing 'cost-effective quality health care as close to the family as possible'? How can the transition to integrated service delivery be such that it enhances quality of health care? Can restructuring of staff take place without adversely affecting the morale and motivation of health workers? How can reforms create a work ethos such that providers truly respond to clients' needs? How can cost-recovery strategies, such as user fees, be implemented so that they do not conflict with goals of equity i.e. so they do not hurt the most vulnerable groups? How can exemptions act as safety nets? Can sector reforms effectively promote gender equity and reproductive rights?

All of these questions reflect a concern with different aspects of equity. Attaining equity in health, however defined, is not a costless proposition. For countries with fewer resources, technical know-how, and health infrastructure, these costs could be out of proportion with their budgets. It is not

clear if poor developing countries whose national health agendas clearly espouse equity have the resources and ability to meet such costs.

We should not lose hope since we have made significant first steps in the policy arena. On one hand globalization bodes well for policy and program development: in an environment of greater openness and integration there is optimism on account of shared experience, greater access to technology, lower-cost ways to transmit information and greater involvement of the Southern countries in international debates. Countries in earlier stages of reform efforts can avoid the mistakes that other countries have made. On the other hand, globalization brings attendant challenges for developing countries because of factors like greater global financial insecurities, greater risks of disease especially the AIDS epidemic and more vulnerability to priorities of donor governments. Fostering a balance between the positives and the negatives of globalization will hence be critical in steering countries successfully through the process of reforms in their health sectors and implementing the ICPD agenda toward meeting the ultimate goals of efficiency, equity and improved quality in health care delivery.

References

- Freund, Peter J. 1996. 'Health Care in a Declining Economy,' *Social Science and Medicine*, 23(9):875-888.
- Foltz, Anne-Marie. 1997. In Mahler, D.H., ed., *Comprehensive Review of the Zambian Health Reforms (Vol I and II)*, Ministry of Health, Lusaka, UNICEF, WHO and The World Bank.
- Kalumba, Katele. 1997. *Towards an Equity Oriented Policy of Decentralization in Health Systems under Conditions of Turbulence: The Case of Zambia*. World Health Organization. WHO/ARA/97.2
- Ministry of Health. 1994. *National Wealth Through Better Health: A Guide to Zambia's Health Reforms*. Lusaka, Zambia: MOH.
- Ministry of Health. 1995. *The National Health Services Act*. Lusaka, Zambia: MOH.
- Ministry of Health. 1996. *National Strategic Health Plan (1995-1999)*. Lusaka, Zambia: MOH.
- Ministry of Health. 1997. 'De-linkage of Civil Servants from The Civil Service.' Press Statement. *The Times of Zambia* (Lusaka).
- Ministry of Health. 1997. Joint GRZ/Co-Operating Partners Statement.
- Ministry of Health. 1997. *Reproductive Health Policy, Strategies, and Guidelines*. Lusaka, Zambia: MOH.
- Pan American Health Organization. 1997. *Gender Equity in Health Care Reform*. PAHO-Special Committee on Women, Health and Development. Washington, D.C.:PAHO.
- Phiri, D. D. 1997. *Family Planning in Reproductive Health-Policy Framework Strategies and Guidelines*. Lusaka, Zambia: MOH.
- Dreze, Jean, and Amartya K. Sen. 1997. *India Economic Development and Social Opportunity*. Oxford University Press: New Delhi.
- Silwamba, D. G. 1998. *Strengthening Public Health within Health Sector Reform*. Ministry of Health. Lusaka, Zambia: MOH.
- Standing, H. 1997. 'Gender and Equity in Health Sector Reform Programmes: A Review.' *Health Policy and Planning* 12(1): 1-18.
- Yach, Derek and D. Bettcher. 1998. 'The Globalization of Public Health I: Threats and Opportunities.' *American Journal of Public Health*. 88(5): 735-737.