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THE UNIVERSITY OF WITATERSRAND

SCHOOL OF HUMANITIES

A STUDY ON THE IMPACT OF IMF STRUCTURAL ADJUSTMENT PROGRAMS (SAPs) ON THE ZAMBIAN HEALTH SECTOR

By

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A Report submitted in the School of Humanities for the award of MA in political studies.

DECLARATION

I Getrude Mulungwe declare that this work has not been submitted to any university or academic institution for the award of a degree.

ABSTRACT

Zambia's recent economic performance can be attributed to a mix of domestic and international unfavourable factors. The Zambian economy is in a downward deteriorating situation. Right up to 1970's Zambia had one of the wealthiest economies in Sub Saharan Africa. With the economy that was and still is highly dependent on copper mining contributing about 90 % of the country's exports. There has been a prolonged slump in copper prices due to slowing demands and this has seen the Gross Domestic Product (GDP) growth to continue dropping and currently at growth rate of 3.9 %. In 1994 GDP reached record low of -8.63% where as in 1964 it was at a high of 16.65%. Zambia first adopted the Structural Adjustment Programs (SAPs) in 1983. External fragility has seemingly increased due to the worsening trade position and rising sovereign debt. It is against this backdrop of literature that Zambia particularly in the health sector found itself trapped between the SAP driven policies and the delivery of health service in Zambia. A number of literature has either argued for or against the impact of SAP driven policies in Zambia. Literature shows that the Zambian health sector progressed in the late 1970s and had programmes that enhanced this progress. However, after the Government embarked on SAP in the 1980s, this program led to the abandonment of critical health programmes and the programs that where then adopted had critical consequences on the communities.

The primary objective of this study was to investigate the extent to which health policies taken after the implementation of the IMF/WB SAPs have influenced the growth of the health sector and the impact they have had on the communities in Zambia.

In this study we used qualitative research of valuable literature from different online sources and secondary and primary sources. The study implored a systematic search of literature from websites such as the ministry of Health website in Zambia, PubMed, and the central statistical office in Zambia, world health organisation and to other academic websites. The main aim was to form empirical evidence and hypotheses on the relationship between SAP and the health sector in Zambia. In conclusion, though the policy reforms were aimed at improving the servicing of IMF loans the drastic consequences were more unbearable on the people of Zambia.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS…. Acquired Immune Deficiency Syndrome

CBOH… Central Board of Health

CSO……. Central Statistical Office

FDI…….. Foreign Direct Investment

HIV……. Human Immunodeficiency Virus

IMF……. International Monetary Fund

LSE……. London Stock Exchange

MSL…… Medical Stores in Lusaka

PHC ……Primary Health Care

SAPs…….Structural Adjustment Program

SWAP…. Sector Wide Approach

TB……Tuberculosis

TOT……Terms of Trade

UN…….. United Nations

WB…….World Bank

WHO……World Health Organisation

CHAPTER 1

Contextualization and the Dissertation Extent

1.1. Introduction

This research aims to investigate how African countries like Zambia have been influenced by International Monetary Fund (IMF) and World Bank (WB) policies such as the Structural Adjustment Programme (SAPs) (Stubbs, T. et al, 2017). The research will also investigate how SAPs have failed to foster development in developing countries like Zambia and the impact the policy has had on Zambia's Health Sector (Clausen V. and Schurenberg H.F.,2012; Sundewall, J. Jönsson, K. Cheelo, C. and Tomson, G., 2010). A detailed investigation on the impact of the SAPs on the health sector of Zambia is conducted by searching the databases of health institutions globally and in Zambia. Literature obtained from other developing countries that have implemented SAPs is also used to further craft and analyse the research.

There is a big debate about SAPs and there is a general agreement that SAPs failed in most of the developing countries that implemented it (Kentikelenis,E. A., 2017). This debate focuses around the reasons why SAPs failed. Several debates have focused on whether SAP failed as a result of the structural failure of policy implementation or the inherent weaknesses of the programme itself. However, there are consequences that came with this failure. This paper explored these consequences and mostly looking at the Zambian health sector.

The IMF is an organisation of 189 countries, working to push for a global monetary cooperation and secure financial stability to facilitate global trade, to encourage high employment and sustainable economic growth and reduced poverty around the world (www.imf.org/en/about 16th January). The IMF was established to foster the stability of the global monetary system, the system of exchange rates and international payments that enables countries and their citizens to transact. The IMF and WB's vision is that of promoting social economic cooperation among member countries and providing a financial bailout to member countries that are facing monetary crunch or a shortage of financial liquidity for international trading for global trading. The SAPs are a set of economic policies that are given to borrowing countries as conditions for gaining a loan from the IMF (Li, Larry, Malick Sy and McMurray, 2015; https://www.economicshelp.org; Bandow & Vasquez, 1994; Corsetti, Guimaraes & Roubini, 2006; James M Boughton and Domenico Lombardi, 2009).

The Zambian Government through the ministry of health came up with country wide health sectoral reforms with a vision of providing an efficient health care that provides quality health care for all. The health sector reforms were in line with the SAPs and tentative suggestions were that the reforms must ensure that the stakeholders were satisfied with the implementation of health sector aid coordination (Sundewall, J.; Jönsson, K.; Cheelo, C. and Tomson, G.,2010).

The health sector has been a major recipient of donor aid in Zambia, and both the government and the donors have argued that the aid that is given in the health sector is there to support efficiency and growth in the health sector trough transparency and accountability. However, media sources state otherwise, newspapers such as the times of Zambia have portrayed a health sector that is severely driven by; corrupt tendencies, lack of accountability of donor funds and a high rate of labour turn over (Sundewall, J., Jönsson, K., Cheelo, C. and Tomson, G., 2010; Mushota R., 2018; http://www.times.co.zm). Though, it is imperative for us to state that the aid that the ministry of health gets comes from different sources, in this study we must take into consideration only that aid provided from IMF. Which covers about 60% of the aid provided therefore, being the main source of donor aid in this sector (Sundewall, J.; Jönsson, K.; Cheelo, C. and Tomson, G. 2010). Also, it is important to note that in this research, the term SAP might be used interchangeably with sectoral policies, in certain instances, when dealing with health sector reforms in Zambia.

1.2 Literature Review

The SAPs, are defined as a set of economic policies that are given to borrowing countries as conditions for receiving a loan from the IMF (https://www.economicshelp.org). The IMF was established in 1945 with a view of promoting social economic cooperation among member countries and with a view of providing a financial bailout to member countries that are facing a monetary crunch or a shortage of financial liquidity for global trading (Bandow & Vasquez, 1994; Corsetti, Guimaraes, &Roubini, 2006; Li, Larry, Malick Sy and McMurray A. , 2015).

Bond (2003) argued that SAPs was a neo-liberal regional policy that initially intended to give people hope for a better economy. Further, Walt and Gilson on the other hand argue that the neo-liberalism of the 1980s which SAPs was founded on, was rather a response to somewhat positive economic growth and development especially in Asian countries where governments

opted for neo-liberal policies. Walt and Gilson further argued that SAPs was partly a response to the growth of what became an over-extended and weak public sector in some developing countries (Walt & Gilson, 1994).

This follows the perception of the supporters of SAP who claim that even though SAPs did not succeed, in certain countries, it was probably due to poor implementation or lack of commitment that the developing countries had towards achieving the goals of SAP (Conable, 1995; Olukoshi, 1998). Contrary, Walt and Gilson (1994) contend that policy activists did not adequately consider the political culture of some African countries. The donor countries could have had a pilot project to evaluate the effectiveness of the policies. Needless to say, the financial assistance provided by the IMF was crucial in preventing extreme financial consequences in developing countries (Gallagher and Tian, 2017). Furthermore, supporters of SAPs such as Dollar and Stevenson, attributed the failures of SAPs to the fact that the donor countries did not check if the receiving countries of the fund were committed to change or not. Donor countries should have focused on identifying countries that were willing to change and had shown commitment than trying to create new receivers that were not committed to change. It is for this reason that scholars that support SAPs argue that the inadequacies of SAPs are as a result of national political and economic reforms of both donor Countries and recipient governments (Dollar and Stevenson,1998). Muuka (1998) is in support of SAPs as an aid conditionality, he further argued that's SAPs was highly legitimate but there was need for the donor countries to take an active interest in the design of the recipient countries' policies.

The critics of SAPs have, however, argued that SAPs makes the concerned states to be more dependent on the IMF and WB. The SAPs are a set of economic policies that are given to borrowing countries as conditions for gaining a loan from the IMF. SAPs draw on similar philosophy as that of neo-liberalism and usually involve a mixture of policies such as liberal market and free trade and deregulation, policies such as privatisation and fiscal austerity. Many critics have argued that the free market policies are often what makes SAPs unsuitable for developing countries and has led to lower growth and greater inequality (Bandow & Vasquez, 1994; Corsetti, Guimaraes & Roubini, 2006). Critics have further argued that SAPs were not popular in the countries that they were implemented. Indeed, SAPs were implemented amidst protests from the trade unions and the interest groups (Bond, 2003; Simutanyi, 1996). Authors like Bhagwati and Stiglitz have argued that there is need to follow the right sequencing if results are to be achieved. Wrong sequencing could easily remove all

that has been achieved over many years. It is further alleged that WB and IMF provided policy prescription but these policies did not have sequencing. The policies that WB and IMF prescribed could have been prudently custom-made to individual countries and to circumstances both in design and in implementation and the sequence followed (Bhagwati, 1998; Stiglitz, 2006). Magumbe further agrees that SAPs were founded on traditional western economies that were not suitable to the African situations as Africa had inadequate production opportunities and lacked important factors such as the means of production, skills, capital and foreign exchange (Magumbe, 2007).

Several countries in Africa like Zambia, Zimbabwe, Tanzania, Nigeria and Kenya implemented SAPs in the hope of sustainable growth and sustainable democracy. However, literature has shown that the economies of the borrowing countries have performed even worse after implementing the SAPs. In most African countries, SAPS were adopted amidst protests from the trade Unions and some Interest groups (Simutanyi, 1976; Bond 2003). The government of Zambia adopted SAPs in Part as a requirement to receive external finance from IMF and WB. This meant adopting polices such as decontrol of prices and removal of subsidies, liberalization of trade, and public sector reforms and reduction in civil service employment (Simutanyi, 1976).

Past literature has shown that up until the late 1970s, developing countries had taken a static method to development using economic planning such as import substitution, industrialisation, price control, credit monitoring and regulating state-owned enterprises and state control of the agricultural sector (Van de Walle, 2001; Gallagher and Tian 2017). The argument of African Governments in pushing plans to move the continent away from its dependence on the export of basic raw material which had made African economies wholly susceptible to external interventions was the plan to increase Africa's self-reliance (Van de Walle, 2001). However, the advent of the oil crisis in the late 1970s, saw African countries like Zambia rescinding into debt crisis and they had to look for alternative solutions like IMF SAPs to keep their economies running. Zambia re-embarked on the SAPs in 1991, and some of the policies were implemented in 1991 itself like the health sector reforms (CEGAA, 2009; Fraser and Lungu, 2007; Moyo D. 2009).

In Zambia, copper prices started to decline in the early seventies and by 1975 conditions had worsened making the economy to tumble. This situation was similar to most resource

dependent developing countries, which were notably concentrated in Africa. We must state that the situation of indebtedness was not only more prevalent in Africa. Gavin Williams, in parallel comparison, points out that by 1980's some countries in Latin America, Eastern Europe and Africa that practiced different ideologies found themselves trapped by levels of debt to international public and commercial banks which where beyond their capacity to finance. This is where the IMF and the WB came in to persuade the commercial banks to reschedule their debts and maintain lines of commercial credit. As a result, the indebted countries asserted that economic policies required the approval of the IMF and WB and international receivers (Gavin Williams, 2007).

The IMF was established in part to provide short term structural loans to government faced with balance of payment problems so as to allow them to restructure their economies without resorting to protectionist trade policies and recurrent devaluations which was the causer of the depression of the 1930's (Gavin Williams, 2007). The IMF thereafter introduced SAPs to provide a set of economic policies that are given to borrowing countries as conditions for gaining a loan from the IMF (https://www.economicshelp.org). For example, Zambia was faced with imbalances in the terms of trade (TOT) that is the relationship of the purchasing power of one unit of the country's exports against her imports. As a result, the decline in demand for copper, TOT dropped by 70 % from 1974 to 1985 (James M Boughton and Domenico Lombardi, 2009; Moyo D., 2009; www.imf.org/en/about 16th January**).**

Therefore, to qualify for the IMF bailout, such as loans, borrowing countries were asked to carry out a series of economic policies that were suitable for IMF and its policies. These policies included: (a) fiscal discipline by cutting Government spending to reduce the budget deficit; (b) Privatisation of state-owned industries - doing so would raise money for the government; (c) Tax reform; (d) Interest rate liberalization; (e) Trade liberalization; (f) reform of the civil service and parastatal for improved efficiency and performance;(g) Price decontrol of all products (Muvunzi, 2015; Simutanyi, 1996).

1.3 Problem statement

The relationship of IMF and some countries in sub-Saharan Africa has brought heavy criticism on the IMF. SAPs and policy conditions have had a negative effect on such countries' political and social-economic standing. Powerful countries, taken contextually as

first world countries, have had a tendency to influences IMF within and outside the fund disbursement into developing countries. Within the political forces, IMF has struggled to shape economic programs for its borrowing countries and politics within. Echoing statements have criticised the IMF that in light of the perceived benefits to the social and economic structure of the country, IMF and WB found it problematic to facilitate successful policy, economic growth and development reform in Africa. It is well understood that even after decades of borrowing money from the IMF the African countries do not seem to have been doing well in their social and economic goals. Some literature on the recent assessment of the IMF Aid to Sub Saharan African countries found ambiguity and confusion about IMF policy and practices on aid and poverty reduction on the continent and disengage between the IMF's external communications on aid and poverty reduction and its practices in low income countries (Larry Li, MalickSy, Adela McMurray,2017).

1.4 Study Hypothesis on the Zambian health sector.

The main objective is to determine the extent to which the policies implemented by the ministry of health in Zambia, driven by the world bank and IMF conditions, influenced the growth of the health sector in Zambia. Based on the literature and theories that have been put forward, the following are the main hypothesis of this research on the Zambian health sector.

Objective 1: To determine whether change in health policies had an impact on mortality rate in Zambia

H_1: IMF SAPs had an effect on the mortality of Zambia.

Objective 2: To determine the impact of SAP on human resource development in the health sector of Zambia.

H_2: IMF SAP had a significant impact on the human resource development in the health sector in in Zambia.

Objective 3: To determine the impact of SAP on the cost medical care in Zambia.

H_3: IMF SAP had an impact on the cost of medical care in Zambia.

1.5 Research Design and Methodology

This research will apply a qualitative type of study. In essence, qualitative research is characterised by its objectives and hypothesis, which relate to the understanding of some aspect of social life, and its methods which (in general) generate words, rather than numbers, as data for analysis. This research will take place in the 'social world', as the research involves systems in which people interact, explaining why people do what they do and an 'interpretive paradigm' would therefore apply. As a result, the type of data used to support the research findings will be more 'qualitative'.

1.6 The Research Method

The qualitative research method has been selected for this study. Qualitative investigates a contemporary phenomenon in the real world, and it seeks to answer questions such as "why" and "how" does a phenomenon occur within a particular context. A systematic review of websites in line with the study will be conducted. This study will delineate why certain issues as related to mortality, human personnel retention and price of medicines have increased in Zambia. Generally, the research process will start with choice of the topic, determine the research approach, conduct data analysis and end up with publication process. In a nutshell the summary the research design is as follows (See figure 1):

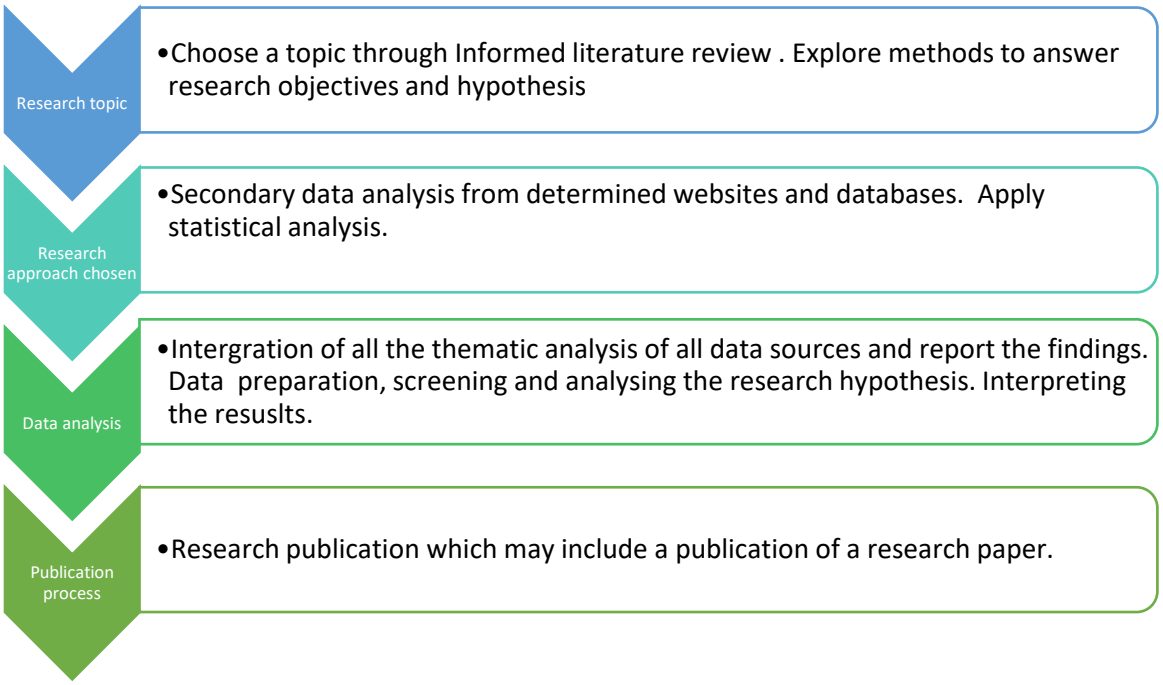


Figure 1: Research process followed in this study

1.7 Data collection methodology

The data collection methodology that will be used for this research involves the use of databases such as World Health Organisation (WHO), Ministry of Health (MoH), central statistical office (CSO), International Monetary Fund (IMF) and World Bank. A systematic review was used in the collection of both qualitative and quantitative data. The results from a health databases and websites will be analysed by means of statistical tools and methods and this will assist in ensuring that the findings and recommendations will be objective, reliable and conclusive.

1.8 Data validity and reliability

The following aspects pertaining data validity and reliability will be applied to this research study:

Content validity – the sample size will be large enough to ensure that it is representative; this will ensure good content validity

Criterion-related validity – this will entail ensuring that the criterion is relevant; it is free from any bias; it is stable and can be reproduced, and the information specified will be available for validation Reliability, is a means to determine if the study would yield similar findings, if it were to be repeated by another researcher. To ensure reliability this research will use information that can be verified and readily available so that there is very little chance of being misunderstood or misinterpreted.

1. 9 Ethics

No ethics approval is required as this study does not involve human subjects.

1.10 Research constraints

Limitations' pertaining to the research, are listed below:

The study will not include simulation analysis as an additional method for this research.

The research sample is drawn from the ministry of health in Zambia and other related organisations like the CSO

limitations' pertaining to the research, are listed below:

The research excludes any other country apart from Zambia and only includes the SAP during the second republic. The research is conducted within the Zambian setting.

In particular this study was localised to the ministry of health (MOH) instead of the global Zambian evaluation.

1.11 Significance of the study.

The study will focus on the effect of the IMF structural adjustment programmes in relation to the health sector of Zambia. Primarily this study will bring some of the intricate issues that exists between IMF and developing countries. Particularly, this study will evaluate the effectiveness of such structural adjustment programmes in promoting the Zambian health. The insight obtained from this study will help or point certain factors or criteria that might be needed for the Zambian government to effectively implement the demands as associated with structural adjustment programmes.

1.12 Dissertation roadmap.

The dissertation is structured as follows:

In **chapter 2** we present the literature review from different literature points, while in **chapter 3** the methodological procedure is presented. In **chapter 4** the results are presented and we conclude in **chapter 5**.

CHAPTER 2

Post and pre-structural adjustment programme in Africa and Zambia

2.1. Introduction

There is a big debate about the SAP and there is a general agreement that SAP failed in most of the developing countries that implemented it. This debate focuses around the reasons why SAP Failed. Several debates have focused on whether SAP failed as a result of the structural failure of policy implementation or the inherent weaknesses of the programme itself. However, there are consequences that came with this failure. This paper explored these consequences and mostly looking at Zambia's health sector. Structural Adjustment Programmes commonly known as SAPs were developed from the Washington Consensus. They refer to a set of specific economic policy prescriptions that are given by International Monetary Fund (IMF) and World Bank (WB) to developing countries that are facing a monetary crunch or a shortage of financial liquidity for global trading (Gavin Williams, 2007).

The IMF and WB are organisations under the United Nations (UN) that foster global monetary cooperation and secure financial stability to facilitate international trade, promote high employment and sustainable economic growth and reduce poverty around the world (www.imf.org/en/about 16th January). The IMF primary purpose is to ensure the stability of the international monetary system, the system of exchange rates and international payments that enables countries and their citizens to transact with each other. The IMF and WB are assigned with promoting social economic cooperation among member countries and providing a financial bailout to member countries that are facing a financial crisis or a shortage of liquidity for international trading (https://www.economicshelp.org; Bandow & Vasquez, 1994; Corsetti, Guimaraes, &Roubini, 2006; James M Boughton and Domenico Lombardi, 2009).

The IMF was established in part to provide short term structural loans to government faced with balance of payment problems to allow them to restructure their economies without resorting to protectionist trade policies and recurrent devaluations which was the causer of the depression of the 1930's (Gavin Williams, 2007). The IMF thereafter introduced SAPs to provide a set of economic policies that are given to borrowing countries as conditions for gaining a loan from the IMF (https://www.economicshelp.org).

Therefore, to qualify for the IMF bailout measures such as loans, borrowing countries are required to implement a series of economic policies in line with IMF policy. These policies included: (a) fiscal discipline also known as 'fiscal austerity' and this is by cutting Government spending to reduce the budget deficit; (b) Privatisation of state-owned industries - doing so would raise fund for the state but also, in theory privatisation can progress efficiency and productivity. Privately owned companies are said to have a profit incentive and are more efficient and this is the basis why Privatization is necessary for developing economies. The state has been viewed as being less efficient and productive due to its bureaucratic nature hence the need to privatise. The free market economy and privatisation of industries owned by the state can help boost the economies of the borrowing countries. The social programs like that of the education and the health care where asked to be privatised as much as possible so that they could be handled in a way that seemed more economically efficient. (c) Tax reforms to raising tax revenues and trying to improve tax collection by clamping down on tax avoidance; (d) Interest rate liberalization; (e) Trade liberalization; (f) reform of the civil service and parastatal for improved efficiency and performance;(g) Price decontrol of all products (Muvunzi,2015; Simutanyi, 1996; Balaam and Veseth (2008) Cited in Campbell H, 2010; https://www.economicshelp.org).

There is also the aspect to de-regulate the markets to motivate competition and to have more organisations enter the industry. De-regulation of markets opens up economies to free trade and this requires the removal of tariff barriers which protects domestic industries and the removal of food subsidies. However, this distorted the market and led to over-supply and held back diversification of the economy preferring a more industrial based economy (https://www.economicshelp.org).

2.2 Opposing and Supporting Views of SAPs as a Panacea in African States

Bond (2003) has argued that SAPs was a neo-liberal regional policy that initially intended to give people hope for a better economy. Looking further on the aspect of neo-liberalism, Walt and Gilson asserts that in the 1980s the advent of neo-liberalism was rather a reaction to somewhat positive economic growth and development of the Asian Tigers. Many governments had opted for neo-liberal policies and also partly it was a reaction to the growth of what came to be seen as over-extended and weak public sectors in some developing countries (Walt and Gilson 1994).

There have been some cases that have been cited as instances of successful implementation of SAPS. The evidence indicating that in general most countries were not able to sustain the short-term economic growth that they experienced soon after adopting SAPs is overwhelming. For example, Mmieh and Frimpong assets that Ghana's SAP has had some degree of success in many areas, this was seen as inflation lowered, there was a promotion of an environment of financial stability; opening up of previously closed sectors; removal of tariff barriers that prohibit FDI inflows; abolishing exchange controls; and reducing opportunities for the foreign exchange black market (Mmieh F. and Owusu-Frimpong N. 2004).

This follows the perception of supporters of SAP who argue that even though SAPs did not succeed, it was probably due to poor implementation or lack of commitment that the developing countries had towards achieving the goals of SAP (Conable,1995; Olukoshi,1998). Walt and Gilson (1994) further argue that policy activists did not adequately consider the political culture of African countries and it was the political culture responsible for the failure of SAPs.

Gallagher and Tian have argued that most relevant is that the financial assistance that was given by the IMF was crucial in preventing extreme financial concerns for the developing countries (Gallagher and Tian, 2017). Bringing the agreement to Morrissey's argument that in broad-spectrum the failure of aid and SAPs has been associated with declining levels of economic growth. This has resulted into success stories being an exception instead of the rule. He further argues that the unpleasant results of the moral hazards led recipient governments to treat aid as a substitute for actions viewed by donor as developmental, rather than a means for facilitating such actions (Morrisey, 2004).

Dollar and Stevenson share the same view and argue that the inadequacies associated with SAPs concern the fact that the donors poured in funds with little contemplation of whether the recipient governments were committed or not. Furthermore, the scholars in supports of SAPs have argued that if SAPs have to succeed donors needed to have been more selective focusing only on Countries that showed commitment to development and not to try to find other countries that needed assistance in the failing economies. Hence the scholars that support SAPs have argued that the inadequacies of SAPs are as a result of national political and economic factors of recipient government (Dollar and Stevenson, 1998). Muuka supports SAPs as a conditionality for Aid, he argues that's SAPs is highly important and that there is

need for the donor countries to consider important aspect of the nature and identity of the receiving countries and the policies that are implemented in that country (Muuka, 1998).

Birdsall Torre and Caicedo (2010) argue that the SAPs was basically right in its ideologies and what it intended to achieve, but the reformers were not patient and expected the results to materialise in sooner than the reasonable time frame. When the results were not forthcoming the reformers were quick to abandon SAPs. SAPs typically takes a long time to implement and the time the reforms would take to materialise is also long (Birdsall Torre and Caicedo, 2010). Collier on the other hand assert that by dictating that SAP failed because of the resistance generated around it in the first place. He further argued that the recipient countries needed to take accountability but they dodged responsibility by accusing the donors soon as the reforms failed to yield results. Furthermore, Collier argues that perhaps there should have been incentives put in place for both the donor countries and the receiving countries to motivate positive results and eventually growth and development (Collier, 2007).

The former president of the WB Conable brought another dimension to the argument that the failure of the liberal market forces to steer growth in Africa's economy was as a result of African governance problems. Conable further notes that the African situation would have been worse had structural adjustment not been implemented (Conable, 1995). Taking the same line of reasoning, Olukoshi (1998) incriminates the persistence of African economic crisis on widespread slippage and lack of commitment to the reform package by the local political leaders (Olukoshi, 1998).

On the other hand, critics of SAPs argue that they make troubled countries further dependent on the IMF (Bandow & vasquez, 1994; Corsetti, Guimaraes & Roubini, 2006). And this follows the fact that literature addressing the adoption of the SAPs, largely have been independent of those that address the effectiveness of the IMF, they show a lot more of failure of Africa to progress socially, politically, technologically and economically (Gallagher and Tian, 2017).

The IMF has been criticised for certain social and economic problems in Africa and this has been as a result of the bailout policies and financial regulation towards developing countries (Gallagher and Tian, 2017; Li, Sy, and McMurray, 2017; Goulas and Zervoyianni, 2016; Stubbs et. al. 2017). In some cases, some scholars believe that the Washington consensus was highly defective and thus the defectiveness of aid conditionality and bail out conditions (Muvunzi, 2015).

Magumbe asserts that SAPs were founded on traditional western economies that were not suitable to the African situations as Africa had inadequate production possibilities to compete on the global market and lacked important features of means of production such as skills, capital and foreign exchange (Magumbe, 2007).

Bhagwati and Stiglitz have argued that there is need to follow the right sequencing if results are to be achieved. Wrong sequencing could easily remove all that has been achieved over many years. It is further alleged that WB and IMF provided policy prescription but these policies did not have sequencing. The policies that WB and IMF prescribed could have been carefully tailored to individual countries and to circumstances both in design and in implementation and the sequence followed (Bhagwati, 1998; Stiglitz, 2006).

SAPs as a form of aid conditionality were condemned as they did not have an effective solution to better economies and economic policies in developing countries. Morrisey presents this fact and further puts the difficulties of the general failure of SAPs as a condition for lending as an ineffectual machinery to induce economic development from governments that were not willing and committed to development and coupled with corrupt tendencies. He further argues that it was also an ineffective means if the governments are willing and enthusiastic to reform. Therefore, scholars like Morrisey have broadly highlight that SAPs evidently failed because of the high levels of aid conditionality (Morrisey, 2004).

Easterly's views are closely related to the dangers of extremely driven policies relating development to a microeconomic wonder that is supposed to be generated from bottom up, and not from top to bottom, that is from the donors who thought they knew everything about recipient countries (Easterly, 2006).

Jauch argues that other predicaments were that SAPs produced devastating results that were opposing the perceived assumption that they were going to foster growth and improve production…SAPs made the borrowing countries to cut their budget expenditure and this saw to a reduced social services provisions, a reduction in health and education was prominent. SAPs meant the privatisation of social services such as in health and in education. Jauch alludes to the fact that SAPs was associated with the privatization of social services in Health and education, cuts in education and in health services, this led to poor and vulnerable people in communities being unable to access these services from the private sector (Jauch, 1999).

Ronald further looks at the impact of SAPs and concluded that SAPs produced devastating results of which among them included; external debt burdens, heightened inequality gaps,

intensification of brain drain, deepening capital flight weakening of balance of payment, deteriorating infrastructure, escalating unemployment and worsening political and civil strife (Ronald, 1999).

Bond (2003) argues that SAP conditionality was harsh on African countries and countries like South Africa refused to embark on IMF/WB SAPs as a result. This saw to mass protests by the students of Witwatersrand (WITS) university and interest groups around South Africa. Bond further highlights the harsh side of IMF in the stubborn way the fund refused to cancel debt owed by most impoverished African countries that are neighbouring South Africa. Since the mid-1990s the Fund refused to cancel the debts and only considered tiny amounts to be cancelled which in the incense, were insignificant to these countries. This included the loan which Zambia owed and was removed by the International monetary fund and this was through the Highly Indebted Poor countries (HIPC) programme. The HIPC completion point had to be completed before Zambia's loan cancellation could be considered. The IMF, World Bank, international financial markets and other manifestations of global apartheid were also part of the reason that South Africa refused to get on board with IMF Loans. The brutal conditionality of provisions and the harshness shown affected environmental regulation, gender sensitivity, community participation, institutional transparency, corporate accountability, and even the highlighting of poverty in the African states and to sum it up, the broader social, environmental and economic conditions worsened dramatically (Bond, 2003).

2.2.1 Outlook of African States and SAPs

Van de Walle (2001) argues that up until the late 1970s, developing countries had taken up a static approach to development by using economic planning such as import substitution, industrialisation, price control, credit monitoring and rationing state-owned enterprises and government control of agricultural marketing (Van de Walle, 2001; Gallagher and Tian 2017). The concern of African leaders in advancing the plan was to shift the continent away from its dependence on the export of basic raw material which had made African economies wholly susceptible to external interventions. The plan was to increase Africa self-reliance (Van de Walle, 2001).

However, the advent of the Oil Crisis in the late 1970s, saw most developing countries in debt and had to look for alternative solutions like IMF bailouts to keep their economies

running (CEGAA, 2009; Fraser and Lungu, 2007; Moyo D. 2009). Gavin Williams asserts that this situation was similar to most resource dependent developing countries, which mostly concentrated in Africa. He further asserts that by the 1980's some countries in Latin America, Eastern Europe and Africa that practiced different ideologies had found themselves trapped by levels of debt to international public and commercial banks which where beyond their capacity to finance. This is where the International Monetary Fund (IMF) and the World Bank came in to persuade the commercial banks to reschedule their debts and maintain lines of commercial credit (Gavin Williams, 2007).

The African states were viewed as having failed to run their economies and some of the reasons included the way the Governments were structured, for example the over-bureaucratic and unnecessary size of Government, its domination of key economic controls of society with consequential creation of rent seeking activities and its over-centralization which discouraged local initiative, SAPs therefore wanted to roll back the frontiers of the state by downsizing the state and encouraging the emergency of economic rationality (Van De Walle et, al. 2003). SAPs were hence imposed on the developing countries as a condition for providing aid and under the assumption that this would lead the developing countries to development as had been seen in the Western world (Balaam and Veseth, 2008; Cited in Campbell H., 2010 ; Williamson, 2004 ; https://www.economicshelp.org).

Several countries in Africa like Zambia, Zimbabwe, Tanzania, Nigeria and Kenya implemented SAPs in the hope of sustainable growth and sustainable democracy. However, the economies of the developing countries have performed even worse after implementing the SAPs. SAPs meant the government should cut down on the public expenditure. The social services sector like health and education hence implemented policies such as user fees in public hospital, health facilities and hospitals were privatized, wage freeze and a drastic reduction of teachers' salaries and health workers all these policies were in line with SAPs (Reimers, 2002)

Bond (2003) and Simutanyi (1996) highlight that in developing countries, SAPs were implemented amidst protest from trade unions and organised interest groups. AFRODAD further analyse the consequences of SAPs by looking at a case study of Malawi. The reduction of subsides to basic services such as education and health affected basic human rights and subsequently irreversible life impacts. AFRODAD further highlights the shortages

in electricity, health provisions and services, education and water that followed the implementation of SAPs. This led to Malawi being trapped in the vicious cycle of deterioration of infrastructure. This resulted into escalated system losses, the government was not able to collect adequate revenue following the withdrawal of public expenditures from the social services sector and other important services. Generally, the high cost of living was as a result of failing to adjust to SAPs (AFRODAD, 2007).

Rono on the other hand explains the effects of SAPs in Kenya and he indicates high levels of poverty that was associated with SAP. He further argues that in Kenya SAPs were unpopular because they came with aid conditionalities that were harsh and rapid and accordingly these conditionalities were based on traditional western economic models that did not suit Kenya's social structure and conditions. He further indicates that the time provided by IMF and World bank was too hasty and it was not possible to reform everything overnight. Furthermore, Rono concludes that SAPs increased the poverty gap, the poor became poorer and the rich became richer. SAPs did not provide any social safety nets for the poor in society (Rono, 2002).

Numerous evidence that were carried out across the African continent led to the conclusion that SAPs had shockingly negative impacts on the social services sectors and excessively affected the underprivileged and vulnerable sections of society for example Musa studied the impact of SAPs on the Sudanese economy and concluded that in Sudan as in other African countries SAPs had negative implications for labour in the formal sector. SAPs also escalated the cost of living, there were massive retrenchments, battered industrial democracy, failed to improve employee ownership and therefore pushed the ever-growing number of working employees below the poverty datum line (Musa, 2000).

2.3 Financial and economic situation of Zambia before Structural adjustment programmes.

the Oil Crisis of the late 1970s, saw African Countries like Zambia in a debt crisis and had to look for alternative solutions like IMF SAPs to keep the economy running. Zambia first adopted SAPs in 1983, dropped it for some time as it was unpopular and re-embarked on the SAPs in 1991 (CEGAA, 2009; Fraser and Lungu, 2007; Moyo D. 2009, Neo Simutanyi,1996).

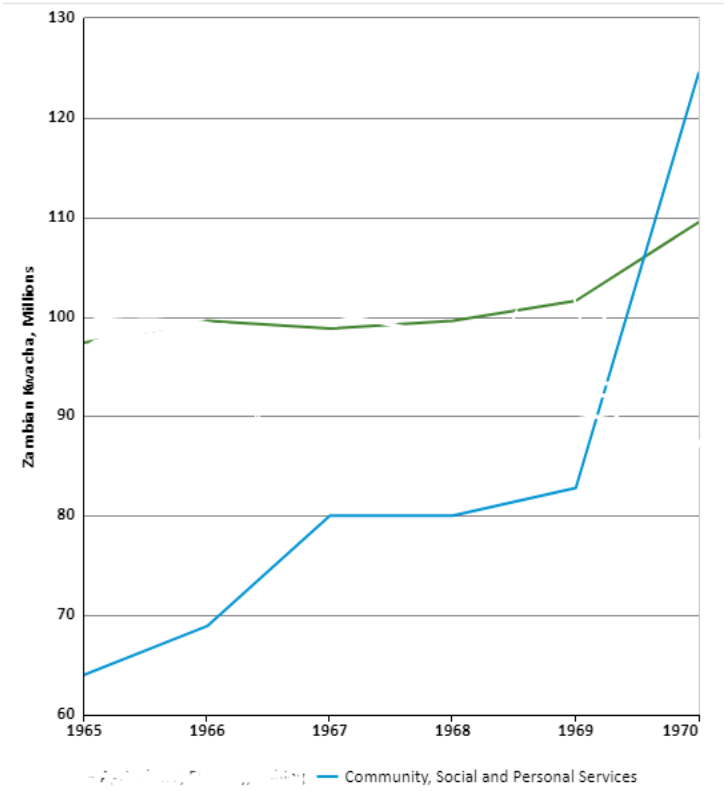


Figure 2: Community Social and personal services (source CSO)

After independence in 1964 the economy of Zambia was at its peak due to a number of factors. One of the factors that drove the economy of Zambia was the prices of copper that was well selling on the London Stock Exchange (LSE). The price of copper prices projected the economy of Zambia to great height leading to a lot of infrastructure and economic development in other sectors such as energy, agriculture and manufacturing. However in the early 70's the price of copper started to drop.

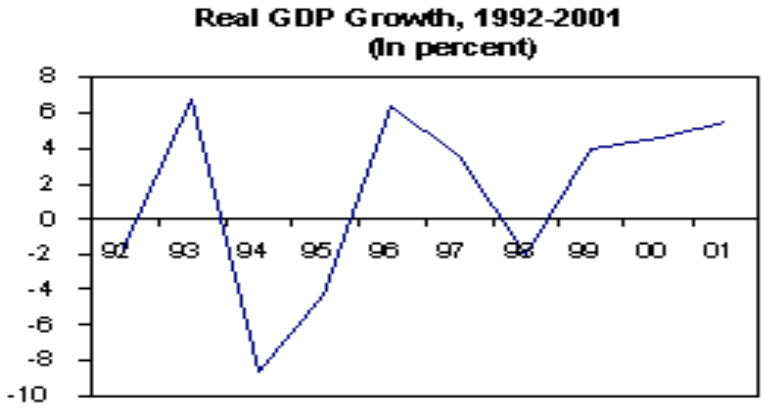


Figure 3: GDP growth of Zambia from 1992 to 2001.

Simutanyi (1996) asserts that Zambia adopted a systematic structural adjustment Programme in 1983. The long and economic decline and pressure from IMF and WB forced Zambia to adopt SAPs (Ferguson 1999; Larmer 2010; Fraser and Lungu 2007; Adam Simpasa 2010). Zambia was faced with imbalances in the terms of trade (TOT) that is the relationship of the purchasing power of one unit of the country's exports against her imports. As a result, the decline in demand for copper, TOT dropped by 70 % from 1974 to 1985 (James M Boughton and Domenico Lombardi, 2009; Moyo D., 2009; www.imf.org/en/about 16th January**).**

Zambia cancelled SAPs in 1987 due to widespread discontent with the economic reforms. During the time Zambia pulled out of the IMF agreement, Zambia remained starved of any international finance and even the Scandinavian countries could not offer Zambia loans as long as they had formal ties with the IMF. The IMF would also not compromise to suit the political situation of the country. For example, in June 1991 the Zambia government asked for a leverage on the subsidies as it would cause political chaos amidst elections. The IMF refused and instead they suspended all financial disbursement to Zambia. As a result, Inflation soared and rose to129%. Therefore, when the second government came into power, they inherited a government that was deep in debt, severe shortage of foreign exchange and inflation of over 100% an eroded social and physical infrastructure and a decline in formal sector employment. GDP per capital decreased by half from K387in the 1970s to K190 in 1991 (Simutanyi, 1996).

Zambia re-embarked on SAPs in 1991 after a change of governments. Some of the policies continued included: (a) fiscal discipline by cutting Government spending to reduce the budget deficit; (b) Privatisation of state-owned industries - doing so would raise funds for the state;

(c) Tax reform; (d) Interest rate liberalization; (e) Trade liberalization; (f) reform of the civil service and parastatal for improved efficiency and performance;(g) Price decontrol of all products except maize and maize inputs (Muvunzi,2015; Simutanyi, 1996).

In line with the SAP requirement, the social services sector like education and health implemented policies to aid government achieve the goals. For example the ministry of health came up with the health sector reforms that would Improve efficiency through proper management of funds allocated to the sector, Improving human resources and decentralisation (Helleiner G. K. and Cornia, G.A. and Jolly R., 1991). The vision was to provide an efficient health care that provides quality health care for all. To have equity of access to assured quality, cost-effective and affordable health services, as close to the family as possible (http://www.aho.afro.who.)

Simutanyi argues that amidst trying to settle in the new government and maintain popularity the new government tried to push for reforms quickly. He further argues that there was a general consensus on the need to improve the country's economic performance, but there was no agreement on the strategy to bring that (Simuntanyi,1996).

2.4 SAP's and Zambia Health Sector

Since the 1960's, consecutive Zambian governments as aimed to have an equitable health care system for all Zambians. But there have been challenges during the past five decades. Zambia inherited a very inequitable colonial health system in 1964. The health sector was initially centrally governed by a Ministry of Health (MoH). The sector's focus was on undoing the inequitable divisions in health service delivery along racial and geographical lines and involved a significant, and necessary, expansion in health infrastructure. The emphasis was on provision of basic health services, disease prevention, and health education. Hospital and out-patient services were provided free of charge. The success of the health sector was evidenced by improvements in health indicators (Garenne and Gakusi 2006), At the same time this can be coupled with the fact that there was rapid growth in the Zambia's market economy during the 1960s. However, by 1974, the country experienced economic downfall, this saw to declining revenues from its main economic resource, copper minerals. The effects of the global economic crisis, pushed Zambia from its middle-income country classification to a low-income country. By 1978, the country was heavily indebted and underwent a series of World Bank-led structural adjustment programmes (SAPs). A dramatic

decline in the health expenditure per capita, and a "SAP ideology" in which health was regarded a consumer good and not a right. This was the death blow to the provision of equitable health care in Zambia. The net results were plunging health indicators in the midst of a steeply rising poverty among the populace (Aantjes, Quinlan, and Bunders 2016).

In 1991, a new government was elected. It criticised the former government for not having been able to address the unequal distribution of health care services, particularly between urban and rural areas (Kalumba 1997). This government developed Zambia's first national health policy, and committed to reducing this disparity (MoH 1991). The new ruling party's vision for the health sector was to provide equity of access to cost-effective, quality health care as close to the family as possible. It emphasised the need to return to the delivery of comprehensive primary health care (PHC) services, and acknowledged the significance of the social determinants of health (MoH 1991). Equity was sought through the delivery of PHC and the decentralisation of authority and finance to district health management teams. These teams as well as district health boards were established in 1993/94, with the objective to match planning and budgeting processes with the realities on the ground. This was a conscious attempt to 'right-size' the budget which, after independence, had disproportionally been consumed by the larger hospitals. The governance of the health sector was restructured via the establishment of a semi-autonomous body, the Central Board of Health, which monitored the performance of the districts. The role of the MoH was confined to policy-making and sector regulation. The restructuring was based on a Swedish model (MoH 1991). The country was initially a frontrunner in the region (Cassels and Janovsky 1996) but the conditionalities attached to the SAPs and a deterioration in socio-economic circumstances for many Zambians proved major obstacles in the implementation of the health sector reforms. Via the adjustment programme and other donor aid conditionalities, neo-liberal political influences percolated into public policy in Zambia. To illustrate this, the national health policy stated that "every abled bodied Zambian with an income should contribute to the cost of his or her health" (MoH 1991). The reality was that only a small proportion of Zambians at the time were able to make such contributions. In 1991, 68.9% of the population fell below the poverty line (Thurlow and Wobst 2004; WB 1994). Poverty was particularly rampant in rural areas (88%) as a result of urban-biased government policies; in urban areas 46% of the population was below the poverty line (Thurlow and Wobst 2004). In pursuit of cost-recovery, user fees for health services were introduced in 1993. This intervention had a detrimental effect on the utilisation of health care by the poor (Blas and Limbambala 2001); a

trend which was also witnessed elsewhere in the region (Makinen et al. 2000). Two years later, these fees were exempted for certain users and conditions (e.g. children under five and chronic conditions) The human development index, a composite measure for human development, consistently ranked Zambia in the lowest group globally; Zambia has not been able to migrate from there since (UNDP 2013) (Aantjes, Quinlan, and Bunders 2016).

2.5 Health Sector Reform

In the health sector, some policies such as user fees decentralisation of the hospitals wage freeze were some but a few that were implemented after SAP was reintroduced in Zambia.
Cheelo et al. asserts that from the time Zambia got independence in 1964 to the time of transition to the multiparty democracy in 1991, the Zambian government provided free health care for all. In 1991 the government introduced user fees in line with the IMF/WB policies. The user fees were introduced with a view to raise extra income in order to have improved and quality services and to have an increased ownership of health system through community participation and to motivate the state. To have a system that takes up ownership and accountability through salary increments. In the primary care, different districts set up user fees which consisted consultation fee. The user fees were based on the willingness to pay from the community. However, Children under the age of 5 years and adults over 65 years, diseases like HIV/AIDS, tuberculosis (TB), pregnant women and indigents were authoritatively exempted from paying user fees, and all referral services to higher level hospitals were supposedly provided free of charge as long as a referral letter was presented by the patient (Cheelo et al., 2010, Government of the Republic of Zambia, 1991; Carasso, Palmer et al.2010). Every able-bodied Zambian with an income is required to contribute towards his or her cost of health as stipulated in the Zambian health policy.
Apart from the conditions mentioned above, other diseases and services excused included Cholera, dysentery; safe motherhood and family planning services; immunisation; and treatment of chronic hypertension and diabetes. The aim to keep some of the services user free was to provide a fair delivery health system to all Zambians (http://www.access2insulin.org;Sundewall, J., Jönsson, K., Cheelo, C. and Tomson, G., 2010).

However, the health sector continued to face challenges such as lack of access to medical facility due to lack of resources. The Public Welfare Assistance Scheme introduced in 1995

was intended to address inequalities in access. As highlighted above the chronic patients who could not pay were supposed to have been referred to the District Social Welfare Office for assessment. However, the referral system did not function as intended so much so as those who could not pay had no access to health services. In 1993, the Government had noticed an increase in diseases burden and this was coupled with diminishing resources, this prompted the government to introduce a cost sharing scheme and a referral pathway (http://www.access2insulin.org). Nevertheless, even after user fees were introduced this did not improve the conditions in the health sector. The CEGAA studies show that much of the quality of health services continued to be low, owing to the deterioration of facilities and equipment, shortages of drugs, and a poorly staffed, inefficient, predominantly publicly owned health system (CEGAA, 2009).

In the bid to make health services more adorable and accessible to the poor, the Zambian Government in 2006 announced the abolishing of user fees in health in all rural districts. The policy change was justified on the grounds given that user fees appeared to negatively affect equity of access to health care and contributed to the increased poverty. In January 2007, the Government further removed all user fees in all public health facilities located in the peri-urban areas and finally, in January 2012, free care was officially provided in the whole country (Masiye, Seshamani et al. 2005) in (Lepine A, 2015).

2.5.1. Effects of Privatization on the health sector

The Government implemented Privatization as a requirement of SAP. And Privatization meant Government was to sell state owned companies in order to achieve efficiency and productivity. It was alleged that Zambia's public sector was 'bloated' and that companies would benefit from the privatization, and opening up of markets to international competition. This resulted in the closure of many firms previously run by Zambians. The firms that came in and those that reopened where mostly owned by foreign nationals. Scholars such as Nellis have argued that privatization was imposed and micromanaged by the IMF and WB without sufficient attention to necessary policy or regulatory frameworks and with minimal involvement of Zambian citizens (Nellis, J. 2003).

Privatisation of state-owned industries was deemed necessary as doing so would raise money for the government. The private sector is viewed as more economically efficient than the state

and as such, any state-owned industries, must become privatized and handled completely by the free market. Many social programs, such as education and healthcare, had to privatize as much as possible so that they could be handled in a way that seems more economically efficient (Balaam and Veseth, 2008) Cited in (Campbell H., 2010).

Privatization was one of the most extensive in Africa in terms of the number of transactions, proceeds generated. It was a program that in 1998 was hailed by the World Bank as "the most successful" in Africa. (Campbell-White and Bhatia, 1998,) in (Nellis, J. 2003). But four years later, many Zambians clearly perceived privatization as almost entirely negative, and tried to put pressure on government to rethink the policy. Privatization added greatly to unemployment, poverty and inequality. Privatization resulted into job losses and scholars like Lynas assert that four people out of every five people in Zambia's community settlements are unemployed (Lynas 2000).

In the same view as above Nellis further argues that privatisation increased the incidence of corruption evidenced by the uncertainty that surrounded the allegations of unreported and misused proceeds from sales of Government properties. Privatization in general benefited the rich, the foreign, the agile and politically well-connected individuals at the expense of the poor, the domestic, the honest and the unaffiliated. The uncertainty of the proceeds of privatization in Zambia led to uncertainty in public finance of which public finance is important because it studies taxing and spending activities of government, it deals with the importance of sustaining high economic growth rate and as on the social aspect, the Government uses the revenues and expenditures it generates to reduce inequality (Rosen H.S. (2004)).

The Post Newspaper (of Lusaka; 11.28.02) published the sentiments the public had on SAPs as "the hardships Zambians were going through were primarily as a result of the neoliberalism and neoliberal globalization, and generally agreed was that it could not be denied that corruption, extravagance and lack of priorities had considerably aggravated the situation and that these factors were a product of the SAPs and that they were inherent problems of these policies. The IMF and World Bank policies breed corruption, extravagance and lack of priorities in our leaders and indeed our people." (Craig, 2000) in (Nellis,J.2003).

The Zambian Government boasted that it had the speediest privatization programme in Africa. But as seen, half the companies sold are now bankrupt. The army of joblessness has created an increase in the rate of crime. People are desperate and turn on each other: crime is

soaring in the compounds around Lusaka. Furthermore, Lynas highlights that privatization in Zambia robbed its most productive agriculture sector. The agriculture sector has performed poorly because of the inflow of foreign direct investment (FDI) which has not worked much to the advantage of the people. Lynas further explains, "take Shoprite the South African supermarket chain that has taken over the country on the back of a massive government tax rebate, Shoprite has laid waste to the economies of entire towns, undercutting local traders and putting stores run for generations by one family out of business and to make matters worse, Shoprite buys nothing locally, their tax-free produce, even maize and potatoes is trucked in from Zimbabwe and South Africa and meanwhile Zambian maize rots in the fields because the farmers who grow it cannot find a market" (Lynas, 2000). To conclude the aspect of privatization, there is need to have a political leadership that has a clear understanding of today's neoliberal world and can stand firm. This encapsulates the views, prevalent in Zambia and widespread in Africa (Nellis,J.2003).

2.5.2 Decentralised Structure of the Health Sector

As SAPs required a reduced number of public workers and a more efficient public sector, the health sector had to decentralise to achieve this. With the decentralisation, there was a number of clinics built. Cheelo (2010) highlights that 99 percent of households are within 5 kilometres of a health facility in the Urban areas. But what has continued to remain a challenge is the lack of human resources in these health facilities and thus impacting negatively on the services provision. The causes being the influx of medical personnel leaving the country for greener pastures to the USA and the UK, the medical personnel also have had an influx of those entering the private sector as a more lucrative venture for instance the results show that in 2003, those that graduated from medical school, twenty (20) of the forty two (42) graduates stayed in the public sector the others left to work in the private sector or to work abroad. HIV/AIDS also impacted of the health workers hence all this contributed to the non-performance of the public health sector (http://www.access2insulin.org;Sundewall, J., Jönsson, K., Cheelo, C. & Tomson, G., 2010).

The medical services Act of 1985 implemented decentralisation of hospitals with major hospitals that have more than 200 beds to have semiautonomous hospital management boards and these boards where appointed by the minister and were authorised to set fees and all this

was a requirement of SAP to manage staff. The health reforms implementation team that was established in 1993 independent of the ministry of health collaborated closely with the IMF and WB. the reforms were to look at the resources of which at a district level, the resources are allocated on per capita basis looking at population density, fuel price bank presence and any likelihood of epidemics. The resources were allocated on the hospital level depending on the cost per bed per day. The resources allocated is dependent on the hospital level given that there is a three-level tier and for the other hospitals that do not fall under the levels, resources are allocated depending on the budget and availability of resources. The Reforms looked at the decentralisation of the hospitals of which the lowest administrative level was the area boards of health. The area boards of health helped in the setting up of the population and divided the population into manageable health districts. The boards functions include that of recruiting and supporting of health workers and look into the training for the health workers and also to monitor and support the functions of health Centres (Ibid: http://www.access2insulin.org).

The area boards of health reports to district health board. The district health board's role includes that of primary management unit of the decentralised health system. Other roles are to administer the district health services affairs, ensuring that local priorities are recognised and addressed, they look into district planning and lastly, they are responsible ensuring that the ministry is working with other sectors e.g. agriculture, local government, etc. From the district health services, is the Provincial Health Office. This office has a number of key areas of activity, these include providing Technical support, the Unit is responsible for the unfolding of the action plan and budget and to give advice on implementation of the action plans. Other functions of the Unit include; preparing for epidemics, monitoring and evaluation. When there is an identified need, the unit provides counselling (http://www.access2insulin.org/zambias-health-system.html).

The Provincial Boards then report to the Central Board of Health (CBOH) and the CBOH reports to the Ministry of Health (MOH). The National Health Service Act was approved in 1995, this meant changes in the role and structure of the MOH and CBOH was as a result of the Act. CBOH was directed to screen, assimilate and organise Health Management boards programs. The CBOH hence become the main unit dealing with the health service delivery and the MOH was in charge of policy making and became a regulatory institution. CBOH was to offer technical support to health service provisions, to provide clinical care and

diagnostic services that is responsible for planning, monitoring and evaluating provision of diagnostic and pharmaceutical services, CBOH also provided public health and research which was responsible for developing guidelines on epidemiology, environmental health, health promotion, and mental health. CBOH also looked into health services planning that was responsible for the planning and contracting of health services, providing financial management, developing partnerships in health, and providing national level human resource planning and training. The MOH on the other hand was tasked to develop sectorial policies and ratification of technical ones, to be in charge of formal strategic planning, legislation, resource mobilisation and external relations, lastly to performance audit of the CBOH (http://www.access2insulin.org/zambias-health-system.html).

With the advent of SAPs, the major policy issues in the health sector has been the allocation and use of public resources. The allocation of resources to non-personnel costs in the health sector has declined in real terms over the past few years, even though the budget allocation to health services has stayed at about twelve percent (12%) of government outlays that is excluding debt service. However, committed spending has been consistent with the declared policies but the actual expenditures have fallen short. This has however raised concerns to intensify efforts to increase the allocation or the share of non-personnel expenditures (https://www.imf.org/external/np/pfp/1999/zambia).

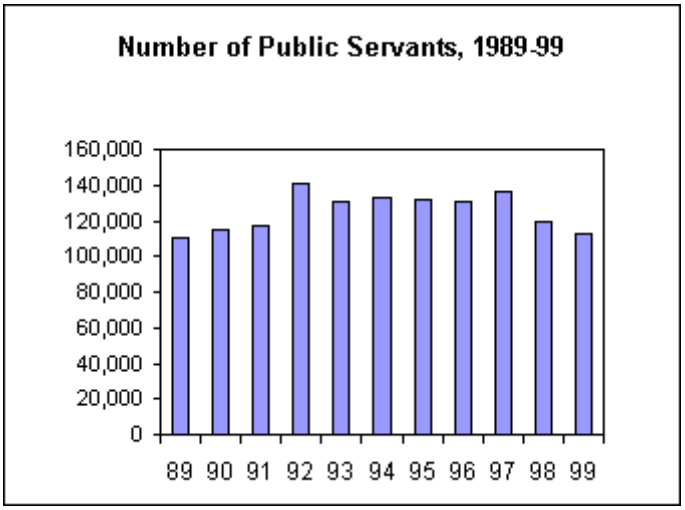


Figure 4: fluctuation in the number of public servants

2.6 A Gendered Dimension to SAP

SAP took a gendered dimension and the most affected group is the women and children. When we look at the impact of cost recovery of governments by reducing public health grant and liberalization of the health sector, these negatively affected the women and children (Tsikata D., 1995; Helleiner G. K., Cornia, G.A. and Jolly R., 1991). The government's economic choices made, often have detrimental effects on women and children. Balaam and Veseth argue that the effects that are caused by SAP are highly unseen and have not been researched because there is a small number of women representatives in the IMF programs and there has been minimum research done on the effects of SAPs on women, thus making the women invisible in this whole process and because of this "invisibility," women bear the brunt of the burden that comes with aid and conditionalities (Balaam and Veseth 2008) Cited in (Campbell H, (2010). Privatisation in Africa had detrimental effects on the local communities. Privatisation promoted the growing of cash crops such as that in horticulture and this is at the expense of food crops. The cash crop has doubled the workload for women. Women are responsible for providing the food crops for the family and at the same time help with the cash crop which in most cases does not even get a share of the income. The cash crop is however essential for providing other needs for the family such as school fees, clothing and in some cases for accommodation (Sadisavam 1997). The double workload of working on cash crop farm and a food crop farm has taken considerable toll on women's health. The women are further burdened as they lack the space to carry out family responsibilities such as getting safe drinking water for the family, fetch firewood for the house and in the worst scenario even fail to take her children to seek medical care and all this can lead to serious consequences such as diseases or even death (Campbell H., 2010).

Women are also side lined in decision making and matters concerned to them. For example, to achieve fiscal austerity, IMF recommended a decrease in government spending. IMF does not necessarily give advice as to where the governments must cut the budget to reduce expenditure, all they are concerned with is that spending must be decreased. The IMF requires budget cuts in order to give government funding. The IMF does not necessary detect which sector of Government should have the budget cuts in the essence the governments usually target the social programs and subsidies to reduce on government expenditure. Governments looks at the agricultural subsidies, welfare programs social security education and healthcare as social programs that are unnecessary and should be the first target for the

state to reduce expenditure. The consequences of the loss of the social programs are devastating and highly felt by women. Women are subjected to patriarch tendencies and usually they are at the receiving end of the bad policies that government implement. Women receive less access to public resources such as education and health care than men do (Sadisavam, 1997). As a requirement of SAPs, the hospitals removed medical subsidies and introduced user fees. The hospitals were not funded to meet capacity and because of lack of funding mothers died because of inadequate health care. The mothers were not able to get adequate care from hospitals to save their lives. The user fees introduced to hospitals meant that some mothers were not able to pay high costs medical care which resulted to loss of lives (Campbell, H. 2010). Before the SAPs the health services were predominantly free or heavily subsidized (Brunelli B., 2007).

Emily Sikazwe who is director for People-centred development in Lynas looks at the Zambia case. Emily has argued that the poverty experienced in Africa has been caused by SAP and poverty in its entirety has a woman's face. Women face the brunt of the burden when it comes to providing for the family, she further argues that when there is minimum income in the household or when the father losses a job the girl child is the first one to be pulled out of school. Emily further analyses how poverty is highly a women façade as she looks at women like Esnart Banda, a widow with five children who makes less than one dollar a day selling vegetables in a market. Most of the time Esnart and her family are only able to afford one meal a day, even though the youngest is suffering from TB. Her kids join the 40 per cent of Zambia's child population suffering from chronic under-nutrition (Lynas, 2000).

The case studies done in Nigeria, Ivory Coast, Tanzania all reached a similar conclusion that women and children were affected more by SAPs. These studies explain that more demands were put on women to provide substitutes for the deteriorating public health facilities. In most cases the women resorted to local herbs for the increasing care burden of sick members who could no longer go to hospital as prices increase (Idemuda, 1991: Steward, 1992: Mbilinyi, 1990).

Tsikata indicates that studies in Kenya and Democratic Republic of the Congo found that women's unpaid work increased after implementation of SAPs especially because of the removal of subsidies n social services (Tsikata, 2010). Referring to Uganda case McGowan (1997), concludes that user fees low government salaries and deregulated health markets made the provisions of health care a business rather than a profession. Therefore, it

outstripped the required morality and opened the sector to massive corruption where money is valued more than human life.

In the nutshell, one can conclude that SAPs have had an adverse effect on Zambia Health sector and the African economies as a whole. It is not like these African countries were just idol. They had taken up measures to development and were set back due to the oil crisis. Van de Walle claims that Up until the late 1970s, developing countries had taken up a static approach to development by using economic planning import substitution, industrialisation, price control, credit monitoring and rationing state-owned enterprises and government control of agricultural marketing (Van de Walle, 2001). The immediate solution to take up IMF's SAPs which were given as a one size fits all led to African Economies not realising their full potential to development as they have now concentrated in debt repayment and continued borrowing in the name of AID (Gallagher and Tian, 2017; Van de Walle, 2001; James M Boughton and Domenico Lombardi ; 2009).

Emily Sikazwe director for People-centred development further argues that Africa as it is, will only develop if the its own people participate in development and matters that affect them. These and many similar ideas are the focus of campaign groups against poverty. The groups like the Zambian Citizens are demanding that Africans be allowed to participate in deciding how their countries are run. Emily highlights that if IMF and WB economists are to respect Africa's demand, there is need for the delegated to borrow from Emily Sikazwe's words "*to leave their plush offices in Washington"* and have to visit ground roots of Lusaka, Nairobi and other areas such as hospitals like the University Teaching Hospital UTH and hit hard areas like Misisi. *"And for once, they'll need to listen to what people there say***"** (Lynas, 2000).

Moreover, scholars like Andersson P. A. et al. have argued that in 1991 the reforms Zambia adopted were of a more balanced portfolio and this was done in order to increase ownership of the reform by the recipient country. And according to the World Bank's own assessment of its assistance to Zambia, it seems that too much emphasis was put on short term stabilisation results and not enough on the long-term growth. It is also alleged that there has been inadequate and impractical analysis of the political situation as well as over optimism. The different projects that have been undertaken in Zambia as a result of SAP have shown that a number of projects had poor sustainability ratings. The other few projects that were successful were as a result of: (a) the project being small and not management intensive; (b)

the project had appropriate technology; and(c) There was the use of foreign contractors/consultants and involve some training of nationals. The projects that were not successful were as a result of: (a) Weak administration and management; (b) required complement funds; (c) suffered from imperfect delegation of authority; and n(d) presented co-ordination problems among agencies with unclear responsibilities (Bonnick, 1997) in (Andersson P.A. et al, 2000).

Conclusively SAPs had devastating results on the economies of developing countries. The case of SAPs brought in several challenges on the social services sector of poor countries and resulted in poor people failing to access and afford these services among other problems…problems identified are the liberalization of the health sector, reduction of government expenditures towards health, stream lining of the public sector and the adoption of user fees, all this led to the deterioration of the public sector.

2.7. Summary

Chapter 2 discuses compressively literature review obtained from different online search engines and the secondary and primary material. The chapter started with the introduction of the main content of the paper. The paper went on to debate the supporting views and the opposing views of different scholars on SAPs. The general agreement is that SAPs failed to yield sustainable growth in developing countries. But the debate is why did SAPs fail and what was the consequences of the failures of SAP. The paper debated on the outlook of SAPs African states. The SAPs zooms in on Zambia and some policies implemented in line with the SAP demands in the health sector. The paper then went to show some success of these policies and some failures of the policies. The failures of the policies seemingly outweigh the short-lived success stories of These policies and this is what seemed problematic. The financial and economic situation in Zambia is analysed before SAPs were implemented and after SAPs. The health sector reforms are critically scrutinised and the decentralisation of the health sector is looked at.

CHAPTER 3

Methodology

3.1. Introduction

In this study we used qualitative research of valuable literature from different online sources. The study implored a systematic search of literature from websites such as the ministry of Health website in Zambia, The central statistical office in Zambia, world health organisation, Google scholar and other academic websites. The main aim is to synthesise empirical evidence and hypotheses on the relationship between policies implemented by the health sector as a result of structural adjustment programmes and the health sector in Zambia.

3.2. Research criteria

In this study we took into account the overall effects of structural adjustment programme on the health sector of Zambia. In essence, the study took a look at the effects of the IMF and the World Bank on the health sector of Zambia. On the health sector certain considerations were made regarding the necessary factors that were to be established in relation to the effects of structural adjustment programme. Such considerations were the effect of structural adjustment programme on the human resource, the mortality rate, cost of access to health services in the health sector. The mortality rates defined in this study include that of children, women and men. The price will cut across different variants in terms of the access of obtaining medicine in Zambia. In particular, the study will look at after effects of SAP on the price of medicine before and after the administration of structural adjustment programme. The study will take into account the effects SAP after user fees were introduced in 1991. The study will analyse the cost of access to health care and services in Zambia before introduction of user fees in 1991 and after the introduction of user fees and the effects this had on the majority poor.

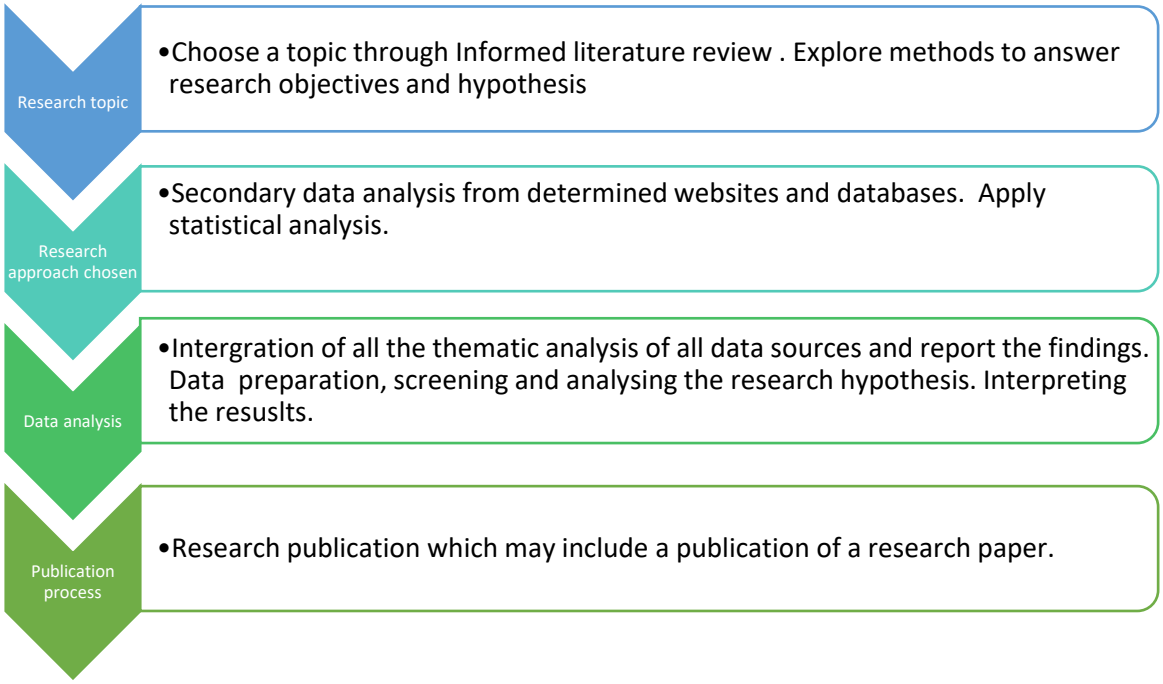


Figure 5: Research design followed in this study

3.3. Systematic sourcing of literature.

The articles used in this study were taken from different sources on the web. Particular the literature came from the websites such as the IMF website, World Bank website, the ministry of health in Zambia and central statistical office in Zambia. Extant literature was also retrieved from websites such as the science direct, Google scholar, and other medical websites such as PubMed/Medline, as well as by scanning reference lists. Other supplementary data was sourced from the Ministry of Health to add on to the already existing data from the search engines and other data bases. Most of the data was taken from the central statistical office (CSO). Our pilot data search was limited to English articles which were written had the relevant information dating from 1964 up until 2018. Our key search words were “SAPs” “infant mortality rate” Health policies” Effect of SAPs” “Health personnel” “Price of medicine Zambia” and “medical price”. An inclusion and exclusion criteria were used on the articles obtained. A critical analysis of the title and the abstract was used to determine which articles were suited for the study. After an exclusion of certain articles and datasets, only 46 articles and datasets which were, in strict sense, relevant to the study and in line with the formulated objectives and hypothesis were included. In this screening full-text that distinguished empirical studies for systematic review from conceptual and review articles to be retained for subsequent discussion, and further eliminated texts with

misleading relevancy to the selection criteria, or only a secondary focus on the research question of this review.

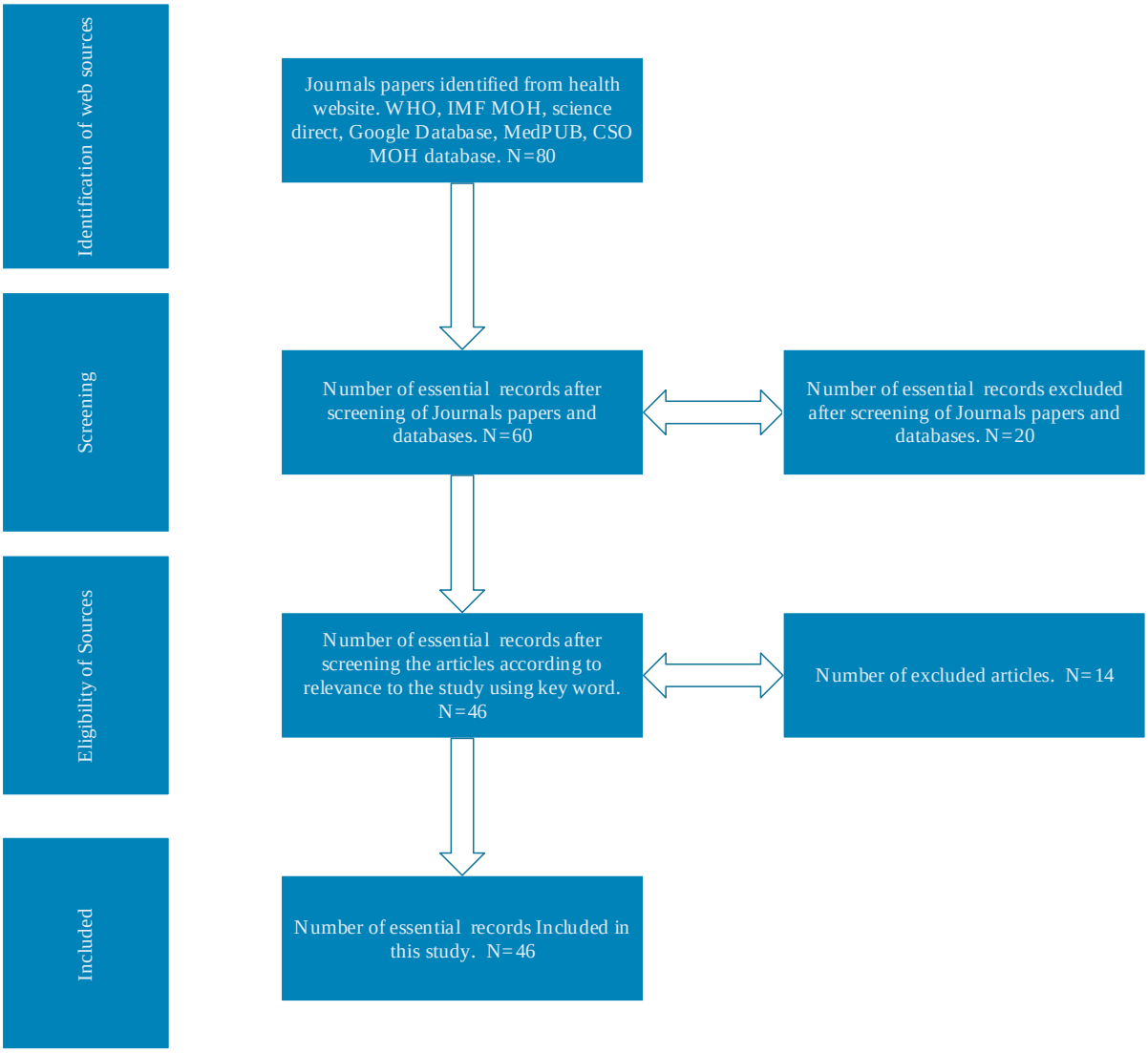


Figure 6: Systematic review of health articles obtained from WHO, CSO, MoH, and IMF

3.4 Data validity and reliability

The following aspects pertaining data validity and reliability were applied to this research study:

Content validity – the sample size will be large enough to ensure that it is representative; this will ensure good content validity

Criterion-related validity – this will entail ensuring that the criterion is relevant; it is free from any bias; it is stable and can be reproduced, and the information specified will be available for validation Reliability, is a means to determine if the study would yield similar findings, if it were to be repeated by another researcher. To ensure reliability this research will use information that can be verified and readily available so that there is very little chance of being misunderstood or misinterpreted.

Sentimental Analysis:

A contextual mining of text identified and extracted subjective information in sourced material. this was done to help the reader understand the social sentiment of the research topic. The sentimental analysis helped in underlying intentions and reactions concerning the researched topic.

3.5 Ethics

No ethics were required as this study involved the systematic review of health databases and websites for the data. Should the database administrators require permission, such would have been solicited from the owners.

Publications - The research findings and recommendations will never be manipulated or altered in order to enhance the likelihood of the publication of the research. The research is not conducted for the sole purpose of going to publication or any other reason other than addressing the research problem.

3.6 Research constraints

Limitations' pertaining to the research, are listed below:

There was no additional data from another country that was used except for the information that was gathered from the databases and websites

The study did not include simulation analysis as an additional method for this research.

The research sample is drawn from the ministry of health in Zambia and other related organisations like the CSO. Limitations pertaining to the research are listed below:

The research excludes any other country apart from Zambia and only includes the SAP during the second republic. The research is conducted within the Zambian setting.

In particular this study was localised to the ministry of health (MOH) instead of the global Zambian evaluation.

3.7 Summary

Chapter 3 looked at the methodology used which was the qualitative research of valuable literature from different online sources. The study implored a systematic search of literature from websites such as the ministry of health website in Zambia, The central statistical office in Zambia, world health organisation and to other academic websites. The main aim was to synthesise empirical evidence and hypotheses on the relationship between policies implemented by the health sector as a result of structural adjustment programmes and the health sector in Zambia.

Chapter 4.

Results and Analysis

4.1. Introduction

In this section we present the analysis of the results. As stated in our methodology, this section will only evaluate the results in line with mortality rate, the price of medicine and the effects of SAP on human resource retention in the health sector. Our results after searching the databases and website or information relating to structural adjustment programme are as shown in the table below

Table 1: Correlation on the effect of SAP and health sector in Zambia: Sentiments from the people

	Source	Main contribution	Infant mortality	Human resource	Access to health care
1	Structural Adjustment and Health Policy in Africa Rene Loewenson First Published October 1, 1993 Research Article https://doi.org/10.2190/WBQL-B4JP-K1PP-J7Y3	Effects of SAPs on Infant mortality rate and access to health care	"The evidence indicates that SAPs have been associated with increasing food insecurity and undernutrition, rising ill-health, and decreasing access to health care in the two-thirds or more of the population of African countries that already lives below poverty levels. SAPs have also affected health policy, with loss of a proactive health policy framework, a widening gap between the affected communities and policy makers, and the replacement of the underlying principle of equity in and social responsibility for health care by a policy in which health is a marketed commodity and access to health care becomes an individual responsibility".		"The evidence indicates that SAPs have been associated with increasing food insecurity and undernutrition, rising ill-health, and decreasing access to health care in the two-thirds or more of the population of African countries that already lives below poverty levels. SAPs have also affected health policy, with loss of a proactive health policy framework, a widening gap between the affected communities and policy makers, and the replacement of the underlying principle of equity in and social responsibility for health care by a policy in which health is a marketed commodity and access to health care becomes an individual responsibility".
2	http://www.times.co.zm/?p=90647	Effects of SAPs on Human Resource		. "Apart from putting many workers out of employment and leaving many families destitute, SAP and privatisation are considered to have failed to yield desired results for Zambia".	
3	McGowan 1997	Effects of SAPs on access to medical care			"User fees low government salaries and deregulated health markets made the provisions of health care a business rather than a profession. Therefore it outstripped the required morality and opened the sector to massive corruption

					where money is valued more than human life".
4	Jauch (1999)	Effects of SAPs on Human Resource and access to health care		"SAPs meant that most countries had to cut their budget expenditures, thereby reducing social services provisions".	"Saps meant that most countries had to cut their budget expenditures, thereby reducing social services provisions".
5	Musa (2000)	Effects of SAPs on Human Resource		"the impact of SAPs on the Sudanese economy concluded that in Sudan as in other African countries SAPs had negative implications for labour in the formal sector. He argued that SAPs significantly raised the cost of living resulted in massive retrenchments eroded industrial democracy, failed to improve employee ownership and therefore pushed an ever-growing number of working employees below the poverty datum line".	
6	Tsikata (2010)	Effects of SAPs on Human Resource		indicates that studies in Kenya and Zaire (Congo DRC) found that women 's unpaid work increased after implementation of SAPs especially because of the removal of subsidies n social services.	
7	Kalima Nkonde Lusakatimes.com	Effects of SAPs on Infant mortality rate	In Zambia, the IMF program has been associated with death, poverty and human rights violations with regard the right to decent jobs, education, health care and housing.		
8	Kalima Nkonde Lusakatimes.com	Effects of SAPs on Infant mortality rate and access to health care	The programme resulted in towns like Livingstone, Luanshya, Kabwe, Ndola and others being turned into ghost towns. Companies like Zambia Airways, United Bus Company of Zambia, Zambia Consolidated Copper mines and others were wipe out from the face of the earth resulting in hundreds of thousands of Zambians losing jobs and being consigned to meeting early deaths through depression, curable an avoidable illness etc.		The programme resulted in towns like Livingstone, Luanshya, Kabwe, Ndola and others being turned into ghost towns. Companies like Zambia Airways, United Bus Company of Zambia, Zambia Consolidated Copper mines and others were wipe out from the face of the earth resulting in hundreds of thousands of Zambians losing jobs and being consigned to meeting early deaths through depression, curable an avoidable illness etc.
9	Patrick Bond	Effects of SAPs on access to			"Southern African countries were pressured into

	2003	health care			implementing [IMF and World Bank] programmes with adverse effects on employment and standards of living" …
10	(Campbell H., 2010).	Effects of SAPs on Infant mortality Rate	"The women were further burdened as they could not have time to prepare clean drinking water, get enough fuel for the house or even take her children to get medical care, or do many other necessary things. The farm must take precedence over other responsibilities which often led to serious consequences, such as death or disease"		
11	Mark Lynas (2000)	Effects of SAPs on Infant mortality rate	People are dying. Quietly, but in huge numbers, all over Zambia. Not because of some accident of nature but as a direct result of economic policies imposed by faceless Western planners. For over 20 years the World Bank and the International Monetary Fund have been forcing Structural Adjustment Programmes (SAPs) on the bankrupt countries of Africa, blind to the havoc they are causing. Almost every country on the continent has succumbed		

4.2. Mortality rate: Results to the H_1 hypothesis

Within the health sector of Zambia, it is pivotal at this point to state that demographics regarding the mortality are vital in determining the effect of health policies, in this case, driven by the SAPs programme. Information on the number of deaths by age and sex in a population is a critical input for the determination and evaluation of health policies and programmes (WHO, 2002). Specifically, child mortality data forms an important evaluating and monitoring tool regarding the progress on governments' child survival targets and intervention measures. Equally important for planning and programme implementation purposes is information on adult mortality. This is of particular importance in the era of HIV/AIDS as the pandemic affects the most productive and reproductive ages (15-49 years). Mortality refers to the occurrence of deaths in a population. To understand the effects better, sentimental analysis which is "the mining of text which identifies and extracts subjective information in sourced material and websites" is used to enhance the association between SAP driven policies and the health sector in Zambia. Several sentiments were associated

with an increase in Mortality rates in Zambia. Few of the following sentiments describes the gravity of the situation on in Zambia (https://towardsdatascience.com).

SENTIMENT 1: *"In Zambia, the hardships caused by SAPs led to an increase in divorces. Men left their homes because they were unable to look after their families. As a result, more women were forced to look after their children on their own".* (https://newsrescue.com/how-the-imf-world-bank-and-structural-adjustment-programsap-destroyed-africa/)

The, divorces in Zambia led to an increase in women having to look after the families. Traditionally, and within the context of African culture, a man who cannot work is regarded as a failure and usually it is an awkward moment for a man. This can result in a trickle-down effects and associated outcomes on infant mortality rate. Other sentiments such as in sentiment 2 shows how the health sector policies, derivatives of SAPs, had an effect on the Zambia health system.

SENTIMENT 2: *"The World Bank claims that Zambia's reformed healthcare system is a model for the rest of Africa. "It's true that there are no queues," says Dickson Jere, a freelance journalist formerly with the Zambia Post. "But that's because people are simply dying at home." They're called BIDs - 'brought in dead's. At Casualty in Lusaka's University Teaching Hospital (UTH), they are an increasingly common phenomenon, especially among children. "If you want to see the impact of Structural Adjustment in Zambia," Emily Sikazwe, director of the anti-poverty group Women for Change, told me: "Go to UTH".* (http://www.converge.org.nz/pma/apzamb.htm)

Sentiment 2 sees SAPs as the main cause of poverty among the people of Zambia. Particular mention in this sentiment is given to the girl child and the woman. Of course, extant literature has shown that the most affected people in any society is the girl child and the woman. Such deep-rooted concerns as portrayed by Emily Sikazwe show that the effect of SAPs on the health sector of Zambia had drastic consequences. Several other sentiment as pointed out in sentiment 3, sentiment 4 and sentiment 5 all point out that SAPs had a negative effect on the mortality rate in Zambia.

SENTIMENT 3 *"SAPs cause poverty," says Women for Change's Emily Sikazwe. "And poverty has a woman's face." Women shoulder the main burden of providing for families, and girl children are the first to be withdrawn from school when a father loses his job. Women like Esnart Banda, a widow with five children, who makes about 2000 Kwacha (60 US cents)*

a day selling vegetables in a market near Misisi. Most days she can only afford one meal for her children, even though the youngest is suffering from TB. Her kids join 40% of Zambia's child population in suffering from chronic under-nutrition."

SENTIMENT 4: *"It's worth pausing here to look at the figures. In 1980, under the former 'socialist' government of Kenneth Kaunda, the infant mortality rate was 97 deaths per 1000 births. It's now 202 per 1000. That means one in five children in Zambia die before reaching the age of five. The average life expectancy has fallen from 54 in the mid 1980s to 45 now. With the AIDS epidemic, this can only get worse. Over the same period the primary school enrollment rate has plummeted from 96% to 77%. Half a million children are now out of school, out of a total national population of Zambia."* (http://library.fes.de/pdf-files/iez/global/02055.pdf)

SENTIMENT 5: *"There will be no austerity measures that will be accepted that will increase the cost of health care. There will be nothing that will be accepted that will make life for the poor more miserable than it is now," Mr. Chanda said.* (https://www.lusakatimes.com/2016/08/31/will-not-accept-imf-austerity-measures-will-hurt-poor-state-house/"

Figure 4.1 point to the fact that the mortality rates, as depicted by the figure 4.1, show that mortality rates decreased. This mainly due to the fact that Zambia, and after 2000 qualified for the removal of loan and grants obtained from the IMF. The loan which Zambia owed was removed by the International monetary fund through the Highly Indebted Poor countries (HIPC) programme. As such Zambia had more money in its reserves to spend on the health sector. Figure 4.1 demonstrates this trend.

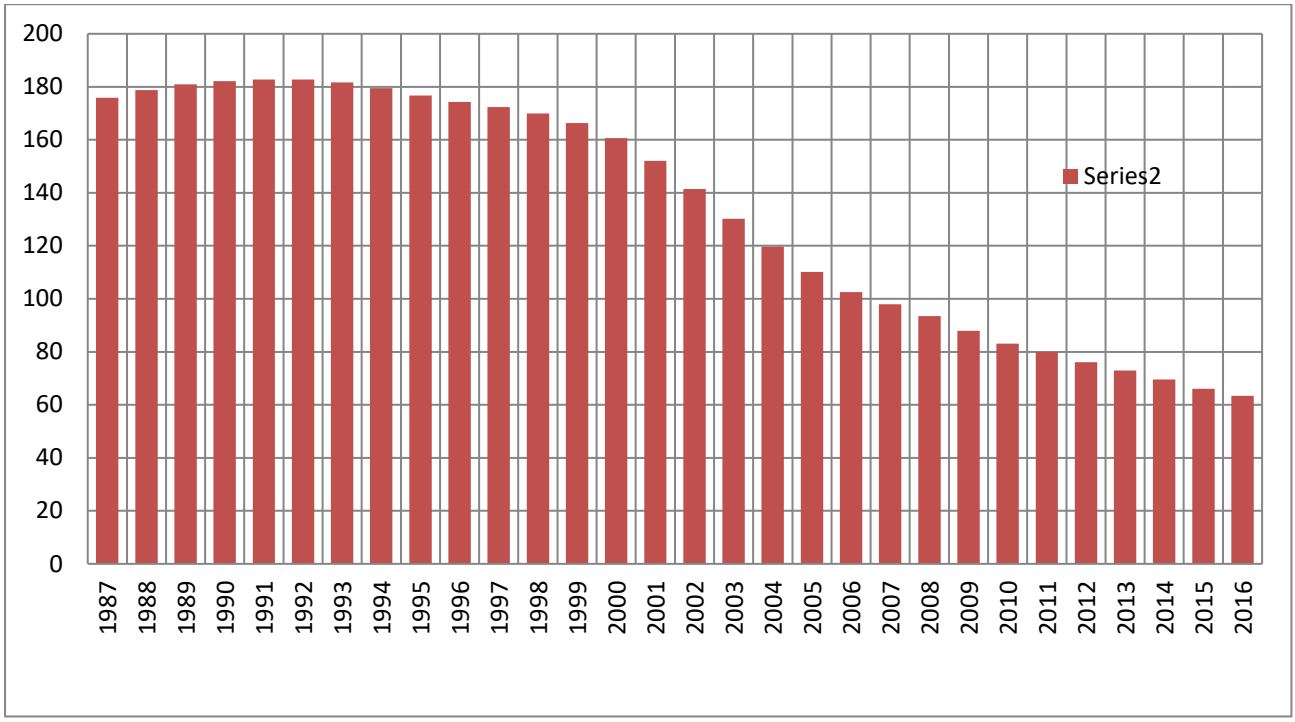


Figure 7: Mortality rate in Zambia

4.3. Human resource retention in the health sector: Hypothesis H2

The structural adjustment programme (SAP) had serious effect on the retention of personnel in the health sector. Several health sector reforms were implemented so as to suit the requirements of SAP conditions. Before the implementation of the SAP, health personnel, which included the cleaners, were laid off as part of the conditions on the economic reforms imposed on the country. Only critical staffs, such as doctors and nurses were retained. Also some of the support staff was also laid off. Also one must note that the loss of medical person is also attributed to low salaries that were imposed by the reforms on medical personnel. A disparity in income levels also necessitated the movement of medical personal from Zambia to other countries. Others such as Forster et al. (2019) found that …., "*overall, policy reforms mandated by the IMF increase income inequality in borrowing in countries"* As such a substantial amount of medical personnel, doctors and nurses have been lost to other developed countries. UK in particular records some of the highest medical personnel that migrated from Zambia in search of the so called "greener pastures". In Zambia the number of medical personnel that migrated increased dramatically during the SAPs regime. Because of the salary cuts, trends show that doctors had the highest attrition rate of (9.8 percent) followed by nurses (5.3 percent) and pharmacists (4.6 percent). As such most of the countries that were involved

in the SAPs suffered churning rates (see Figure 4.2.) of medical personnel to greener pastures. To cement this argument a lot of sentimental views are recorded in this dissertation.

Sentiment 1: *"These measures forced countries on a path of deregulated free market economies. The IMF/World bank basically determine countries' macro-economic policies, they take control over central bank policies and over public expenditure through the so-called 'Public Expenditure Review'. SAPs promote the principal of cost-recovery for social services and the gradual withdrawal of the state from basic health and educational services. Under its 'Public Investment Programme' the IMF even decides what type of infrastructure should be built while an imposed system of international tender ensures that public-works projects are carried out by international construction and engineering firms"* (https://newsrescue.com/how-the-imf-world-bank-and-structural-adjustment-programsap-destroyed-africa/)

Sentiment 2: *"Only one in five people in Misisi are employed. The unemployed are part of an army of jobless, created when economists from the World Bank and IMF decided that Zambia's public sector was 'bloated' and that companies would benefit from the tonic of privatisation and an 'opening' of markets to international competition. The Zambian government boasts that it has the speediest privatisation programme in Africa. But half the companies sold out of the state sector are now bankrupt. Over 60,000 people have lost their jobs as a direct result of the economic, h programme introduced after 1991. With many mouths dependent on one breadwinner, this has thrown an estimated 420,000 into destitution."* (http://www.converge.org.nz/pma/apzamb.htm). Naturally Zambia, and probably because of SAP and projected population growth, has a shortage of nurses, doctors and midwives. The number currently stands at about 14960. It is projected that due to population growth and the loose of medical personnel to other nations the deficits will reach alarming of about, 25,849 in 2020, and 46,549 in 2035, at the current rate of human resource production.

Table 2: Ministry of Health filled capacity

	2011			2016		
HRH Cadre	Approved	Actual	Gap %	Approved	Actual	Gap %
Doctor	2,939	1,076	63.4	3,119	1,514	51
Clinical Officer	4,813	1,509	68.6	4,883	1,814	63
Midwife	6,106	2,753	54.9	6,322	3,141	50
Nurse	17,497	7,996	54.3	18,484	11,666	37
Pharmacy	1,108	777	29.9	1,219	1,159	5
Radiography	483	276	42.9	542	419	23
Lab	2,023	713	64.8	2,110	921	56
Environmental	2,063	1,367	33.7	2,319	1,796	23
Physiotherapy	421	297	29.5	448	432	4
Nutrition	330	170	48.5	350	202	42
Dental	865	278	67.9	908	312	66
Admin	6,115	1,683	72.5	22,353	19,254	14
Total	**44,763**	**18,985**	**38**	**63,057**	**42,630**	**32**

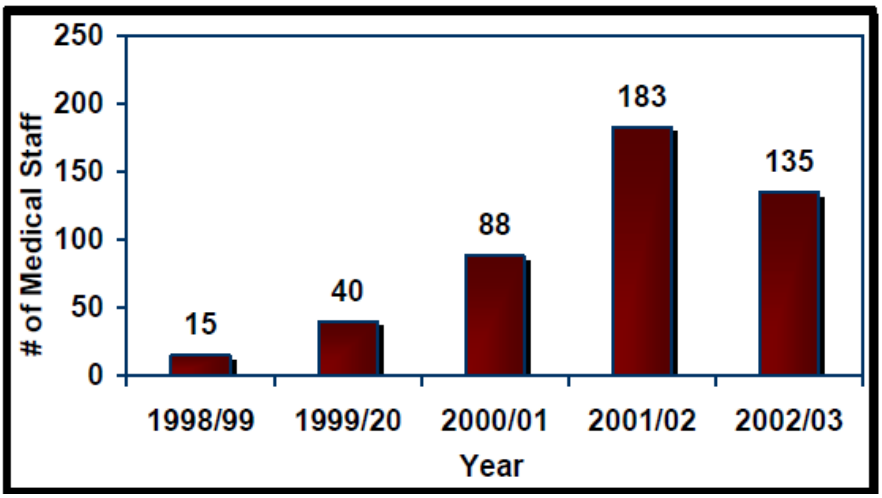


Figure 8: Number of nurses recruited in the United Kingdom

4.4. Medicinal price

Before the structural adjustment programme was implemented the cost of medicine in Zambia was actually free. Patients were not required to pay to for any kind of medicine in the first republic. In the second republic and probably the time when SAP was fully introduced, the hospitals required that patients pay a substantial amount of a fee towards their treatment at any hospital. A lot of private pharmacies at government hospital mushroomed so as to cater for the unavailability or shortages of medicine in the hospital. Patients were usually referred to buy their own medicine in bid of recovering cost and adhering to the SAP conditions. Within that ambit the IMF was accused of administering the same medicine to patients without any proper pharmaceutical analysis of the medicines administered. **Sentiment 2** actually gives the support the statement as shown below.

Sentiment 1: *The IMF was accused of administering the same medicine to patients with different diseases through its structural adjustment programme (SAP).* (https://www.lusakatimes.com/2016/10/26/how-the-imf-of-the-80s90s-has-changed-in-the-21st-century/)

The results of the analysis indicate that there are inequalities among residential areas, especially between rural and urban areas. In particular these differences exist because of differing distances to the nearest health facility. Large distances make it very costly for rural dwellers to seek medical care, especially during the high season for farming. The analysis suggests that obtaining equality of access to health care poses a challenge for the Zambian Government. The introduction of SAPs led to liberalised economy where anyone could put a price on their commodity. This included the health sector where a lot of pharmaceuticals retailers mushroomed. **Sentiment 2** actually indicates the post SAP effects of the neo-liberalization of the economy in the SAP era.

Sentiment 2: *"The Health Professions Council of Zambia (HPCZ) has called for the introduction of minimum standardised pricing of Health care services. Council Registrar and Chief Executive Officer, Dr. Aaron Mujajati says lack of standardised pricing for health care, provision of medicines has contributed to exploitation of patients by some health practitioners. He said when patients seek private health care, they were prescribed with alot of medicines and other medical tests which were not necessary but designed to extort money from patients at exorbitant prices".*

Other studies such as v d Geest et al. (2000) have shown that the introduction of user fees as conditionality of achieving IMF reforms had a negative effect on the minds of the Zambian people. More so given the people who did have a salary later on pay for medical expenses.

Sentiments 3: "*The fees preoccupied them, and nearly always negatively. Only four people expressed some support for them. All other informants denounced the new measure which they had come to see as the sobering truth behind the attractive slogans of the health reforms. One teacher said: 'The pay of a teacher is the lowest in the country. How do we manage the escalating cost of living now that we have to pay for health services too? We do not get enough to pay user fees".*



Figure 9: Medical expense in post SAP era in relation to the type of hospital

4.5 Summary

Chapter 4 gave the results based on our systematic review. The results obtained a conclusive view based on sentimental analysis and a deep analysis of the results. The results showed that there is a deep correlation between IMF SAP reforms and their effect on the health sector. Particular attention in this chapter was a discourse analysis on the effect of reforms on the medical prices, mortality rate and health personal retention in the health sector. The results show that SAP had an effect on the three sectors in the ministry of health.

Chapter 5

Conclusion and future works

Conclusively, the concept that IMF and the WB took that SAP was a panacea to Africa's debt crisis was erroneous. The African countries did not respond positively and the fact that the effects are still felt up to now is a reason that this topic should be reviewed and researched to prevent future reoccurrence. Chapter 1 sets out the tone for the research addressing the need and the why the research had to be done in the introduction and a brief overview of literature was given to highlight the paper content. The problem statement argues that the relationship of IMF and some countries in sub-Saharan Africa has brought heavy criticism on the IMF. SAPs and policy conditions have had a negative effect on such countries' political and social-economic standing. This led to the objectives looked at to determine the extent to which the policies implemented by the ministry of health in Zambia, driven by the world bank and IMF conditions, influenced the growth of the health sector in Zambia. Based on the literature and theories that have been put forward, the objective was to determine whether change in health policies had an impact on mortality rate in Zambia, to determine the significant impact on the human resource development in the health sector in in Zambia and the impact user fees policy had on the cost to health services access in Zambia.

Chapter 2 discuses comprehensively, the literature obtained from different online search engines; that is the secondary and primary material. The chapter started with the introduction of the main content of the paper. The paper went on to debate the supporting views and the opposing views of different scholars on SAPs. The general agreement is that SAPs failed to yield sustainable growth in developing countries. But the debate is why did SAPs fail and what was the consequences of the failures of SAP. The chapter debated on the outlook of SAPs on African states. The review in essence zooms in on Zambia and some policies implemented in line with the SAPs demands in the health sector. The chapter then went to show some success of these policies and some failures of the policies. Failures of SAPs seemingly outweigh the short-lived success stories of the reforms and this is what seemed problematic. The financial and economic situation in Zambia is analysed before SAPs were implemented and after SAPs. The health sector reforms are critically scrutinised and the decentralisation of the health sector is looked at in detail.

Chapter 3 sets forth the methodology used; which was the qualitative research of valuable literature from different online sources. The study implored a systematic search of literature from websites such as the ministry of health website in Zambia, The central statistical office in Zambia, world health organisation and to other academic websites. The main aim was to synthesise empirical evidence and hypotheses on the relationship between policies implemented by the health sector as a result of structural adjustment programmes and the health sector in Zambia.

Chapter 4 presented the results based on the systematic review. The results obtained a conclusive view based on sentimental analysis and a deep analysis of the results. The results showed that there is a deep correlation between IMF SAP reforms and their effect on the health sector. Particular attention in this chapter was a discourse analysis on the effect of reforms on the medical prices, mortality rate and health personal retention in the health sector. The results show that SAP had an effect on the three sectors in the ministry of health. The chapter looked at some successes of these policies and some failures of the policies. Failures of SAPs seemingly outweighs the short-lived success stories of the reforms and this is what seemed problematic. The financial and economic situation in Zambia is analysed before SAPs were implemented and after SAPs. The health sector reforms are critically scrutinised.

There is the notion that SAPs were implemented amid crises in Africa and Latin American countries. Zambia adopted SAP in 1983, and during the 1980 the Government did not implement the reforms as the reforms were not popular amongst the people of Zambia. This led to Zambia abandoning the reforms in 1987. They were later readopted in 1991 and this time around, the Bank chose a more balanced portfolio to the kind of lending given to Zambia and a support for long term lending (Simutanyi 1996; Andersson P.A. et al, 2000).

It is alleged that in the Zambian case, SAP were implemented rapidly because there was a transition of governments from the Kaunda Government to the Chiluba Government. There was a general consensus that there was need to get the deteriorating economy back on truck but there was no plan on how this was to be achieved. In the essence, the government fast track SAP in order not to lose popularity from the population. SAP meant many things and among them was the government to carry out austerity measures and reduce public expenditure. It did not matter where the money was cut from as long as there was a decrease in Government spending. More often than not, countries begin the budget cuts with social

programs and subsidies. They typically cut from programs such as health care, welfare programs, social security, education, and agricultural subsidies. Social programs are seen as unnecessary, high cost expenses that must be cut in order for a state to decrease its debts. The government hence reduced funding and removed subsidies on social programs. Literature shows that the Zambian public health sector was noting a steady growth after independence from 1964, owing to the commitment for equality in social provision that was prompted by the socialists ideologies of the Kaunda Government. However, after the adoption of SAP Health indicators showed a decline and there was generally poor performance of the health sector.

However, scholars like Andersson P. A. et al. have argued that in 1991 the reforms Zambia adopted were of a more balanced portfolio and this was done in order to increase ownership of the reform by the recipient country. And according to the World Bank's own assessment of its assistance to Zambia, it seems that too much emphasis was put on short term stabilisation results and not enough on the long-term growth. It is also alleged that there has been inadequate and impractical analysis of the political situation as well as over optimism. The different projects that have been undertaken in Zambia as a result of SAP have shown that a number of projects had poor sustainability ratings. The other few projects that were successful were as a result of: (a) the project being small and not management intensive; (b) the project had appropriate technology; and(c) There was the use of foreign contractors/consultants and involve some training of nationals. The projects that were not successful were as a result of: (a) Weak administration and management; (b) required complement funds; (c) suffered from imperfect delegation of authority; and n(d) presented co-ordination problems among agencies with unclear responsibilities (Bonnick, 1997) in (Andersson P.A. et al, 2000).

The above sentiments are typical examples of what the donors face in Africa. It is noted that when projects are in a limbo, neither the donors nor the recipient country would want to take full responsibility. The suggested solution to this was perhaps the donors could take full control. Then they can make the projects work for the period that they are in charge, but the sustainability of the projects in the longer term was highly uncertain. The alternative approach is to put responsibility more squarely with the recipient, which should enhance project sustainability. The Bank and other donors have in recent years attempted to increase Zambian ownership of the development programmes, by giving the Zambian authorities a greater responsibility for co-ordination and implementation. The pattern is the same

throughout Africa, but the results are as yet uncertain. The recent debate on Africa's poor growth performance has tended to shift the focus away from the failure of policy as such to a discussion of the failure of the African state. This has meant that the aid relationship for countries like Zambia has changed from a non-paternalistic one to one with extensive conditionalities and strict economic and political monitoring. While donors are still concerned with projects and macro policy, the development of political and market institutions is now much more in focus. Early critics of foreign aid, like Bauer and Friedman, argued that the development problem was not one of capital shortage, since that would have been solved by private capital markets, but one of shortcomings in political and economic institutions. Shortages of physical and human capital were just symptoms of these systemic shortcomings. They also argued that with poor institutions aid would be wasted or even unfavourable to growth by strengthening the position of the government against rival domestic constituencies (Andersson P.A. et al, 2000, Pg:36).

The critics of SAP have argued that Zambia was improving as seen by the health programmes that were provided in the sector for example free maternal health education, child care and reduction in malnutrition reduction in diseases and increase in life expectancy and the positive statistics alludes to this. However, these policies and programmes that facilitated the positive development in the public sector were abandoned' following the adoption of SAPs. This was one of the reasons why the SAPs were not popular amongst the people of Zambia.

As soon as the nation adopted SAP major downfalls were seen in the public health sector. Policies such as the liberalization and privatization had an impact on the health sector. Policies implemented in the Health sector as result of the adoption of SAP prompted a reduction in the health grant, reduction in the number of health workers and cuts in public expenditure. There were retrenchments in the sector and governments could not maintain the infrastructure, shortages of drugs and equipment in hospitals, Privatization also meant the public hospitals had an improved and stiffer competition from the private hospitals, of which the majority of the population poor could not afford the health costs in these private hospitals.

The health sector plunged into a mess as the private hospitals were not motivated to work in the rural areas and the majority of poor failing to afford medical fees. Since then and up to this day, health indicators continue to show a decline in the health indicators. The major reason for this is alluding to the abandonment of socialist welfare policies in favour of the liberalization policies.

However, literature has shown that the poor performance of the health sector has not been entirely as a result of SAP, It is a few things coupled with the lack of political will by the state to implement workable policies, coupled with poor management and financial mismanagement of the ministry of health alluding to the recent corruption that have surfaced. The recent corruption case of a civil servant (Kapoko) who amassed wealth from the ministry of health is an example of the cases of corruption in the sector. The Advent of HIV /AIDS is this era is another issue that caused the health sector to perform poorly. Adam and O'Connell (1997) in Andersson P.A. et al. argue that, the failure of governments to intervene in matters concerning the economy could hold back growth, for example provision of public goods and services. Zambia has both failed to provide incentives to provide goods and to provide services. One of the reasons is that the elite that has been in power has been able to control the political scene without being challenged by the rural population. Only after notably failures of SAP that forced changes in the country. Government revenues fell, as did public salaries. Aid inflows could not compensate for this, and eventually donors became unwilling to support policies which were considered to be counterproductive. Once reforms were considered, the donors proved willing to support the government again. There is no clear evidence that government expenditures contribute to long term growth, although one would suspect that for example improvements in human capital through education and health service provision should have beneficial long-term effects. Transport costs are considerably higher in Africa than in other regions. Electricity costs are higher than elsewhere and water supplies are unreliable. Projects in education have performed badly. Why is this? Partly the reasons are the same as for the private sector that is a bad policy environment, which contributes to the low returns to public projects. Moreover, the government uses the public sector to further its own private interests and to build political support. Extensive corruption makes it hard to create an efficient system (Andersson P.A. et al., 2000; Http://Www.Times.Co.Zm).

The study also concludes that the decline in the public health took a gender dimension given that more women were disproportionately affected by the crisis. Up to this day Zambian women have continued to endure the burden of increased care roles exacerbated by shortages in health personnel. Additionally, as less attention was given to preventive and community health awareness education programs women's health needs were compromised. Indeed the implementation of liberalization policies in Zambia public health sector worsened the health of women and children and exacerbated maternal deaths and other health risks women face.

The Zambia economy at the time of implementation of SAP was not as strong and liberalization policies just weakened the already weak state. The implementation of SAP was based on miscalculated assumption from their inception. There is need for Zambia to get back to the drawing board; it needs the support of external donors and stakeholders to implement a public health program that is sustainable. The government should give a call towards stakeholders and there should be a needs necessity identified and drawn and thereafter a visibility study of the sector should be done. Strong strategic vision that should be negotiated among the stakeholders spelling out the nature and extent of the health crises and the resources required to meet the public health sector.

What is much needed is the financial muscle and technical assistance in the health sector and the push can target investments in health infrastructure and revival of the community health programs availability of well serviced ambulances and equipment and incentives for health personal and donors can facilitate the reforms in a well - structured manner. There should be a model that should have worked similar to the African ordeal and lessons learned. Zambia and the other developing countries cannot afford to be hit by another ordeal that involves implement of policies without a needs necessity and visibility studies done appropriately.

Taxes to fund the health sector is inadequate therefore there should be other means that need to be looked at, for example the implementation of user fees could be done in a way that works and a research into this is much required. There is need for government to work alongside the private health institution. Programmes such as the preventive and community-based approaches that were vital to the rapid health improvements of the sector in the socialist government should be further studied and maybe adopted again. Finally, there is a need for the policies to be revisited so that lessons are drawn and improvements done.

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