

# **The University of the Western Cape**



## **Faculty of Economic & Management Sciences**

### **School of Government**



#### **Health Policy and Agenda Setting in Contemporary Zambia: The Human Resources for Health Strategic Plan (2006-2010)**

A mini thesis submitted in partial fulfilment of the requirements for the degree of Magister Public Administration in the School of Government at the University of the Western Cape

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## **KEY WORDS**

Agenda Setting

Coupling

Cooperating Partners

Health Policy

Human Resources

Kingdon

Policy Windows

Policy Entrepreneurs

Politics

Zambia



## **ABSTRACT**

Agenda setting is about how some issues get onto the policy agenda for discussion and action why others do not. Drawing critically on the “policy windows” approach of J.W Kingdon (2003) this dissertation will describe and explain the shifting of policy agendas in health with reference to human resources in Zambia between 2000 and 2006. This research explores how and why the issue of human resource shortages in health became prominent on the state’s agenda in 2005. The research is a qualitative study and data was collected using both primary and secondary sources of data across various stakeholders in the country. It tested the applicability of Kingdon’s conceptual framework to a case study of Zambian health policy by analysing the degree to which agenda-formation is influenced by such factors as issue definition, the presence of policy alternatives, presidential support, interest group advocacy, media attention, political cycles, and public opinion. The general elections scheduled for the following year, coupled with media attention and strong public action contributed to the selection of the human resource crisis as an issue on the state’s agenda for serious action. Furthermore, the slow progress on the attainment of the health related Millennium Development Goals and the poor performance of some donor funded programmes necessitated the state to act. Despite some weaknesses, Kingdon’s multiple streams approach was found to be useful in explaining the agenda-setting of the Human Resources for Health Strategic Plan (2006-2010) in Zambia.

## **DECLARATION**

I declare that *Health Policy and Agenda Setting in Contemporary Zambia: The Human Resources for Health Strategic Plan (2006-2010)* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name.....

Date.....

Signed.....



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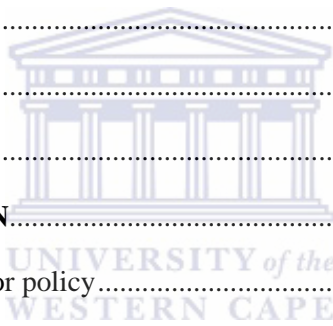
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## **LIST OF ABBREVIATIONS/ACRONYMS**

ART	- Anti-Retroviral Therapy
CIDA	- Canadian International Development Agency
CSO	- Central Statistical Office
DFID	- Development Fund for International Development
ECZ	- Electoral Commission of Zambia
EU	- European Union
GHWA	- Global Health Workers Alliance
HIV/AIDS	- Human Immune Deficiency Virus/Acquired Immune Deficiency Virus Syndrome
HRH	- Human Resources for Health
HSSP	- Health Systems Support Services
MDG	- Millennium Development Goals
MoFNP	- Ministry of Finance and National Planning
MoH	- Ministry of Health
MSA	- Multiple Streams Approach
NHSP	- National Health Strategic Plan
PEPFAR	- United States President's Emergency Fund for Aid and Relief
PSRP	- Public Service Reform Programme
SIDA	- Swedish International Development Agency
STI	- Sexually Transmitted Infections
TB	- Tuberculosis
UNDP	- United Nations Development Programme
USAID	- United States Agency for International Development
WHO	- World Health Organisation

## **CHAPTER ONE: INTRODUCTION**

### **1.1. Background**

By 2005 in Zambia, there were just over 600 doctors and about 6000 nurses working in the public health care sector and there were severe shortages of other key staff (Ministry of Health, 2005). The health workers catered for a country population of approximately 12 million people. One reason for the severe shortages of health personnel was the introduction of early retirement lump sum payments to civil servants under the structural adjustment package and Public Service Reform Programme (PSRP) in the late 1990s. Almost half the number of retrenched and early retirement employees under the programme came from the health sector, especially nurses who migrated to other countries after getting their separation packages (Hamada, Maben, McPake and Hanson, 2009). According to Makasa (2009), 5% of the total number of nurses in the country left in the 1990s to work in Europe (about 1,198 nurses). In addition, by the 2005, out of the 1,200 doctors trained in Zambia since the late 1960's, only about 391 were still practising in the public sector with most working in the private sector.

In 2003, the first Millennium Development Goals (MDG) progress report to be published indicated that the country was unlikely to attain the MDGs related to health such as tackling maternal and child mortality, HIV/AIDS, malaria and other diseases due to human resource constraints. The 2005 progress report reported the same challenges as hindering the success of the MDGs (United Nations Development Programme, 2003 and 2005). By 2004, newspapers, government officials and both local and national stakeholders had labeled the problem a crisis. As Makasa (2009:82) writes, "Zambia was on the brink of collapse due to the lack of skilled personnel." There was therefore, an urgent need to address the dire situation. The government set up a human resource task force to develop an emergency human resource rescue plan and strategies to address these constraints; these were included in the Human Resources for Health Strategic Plan (Ministry of Finance and National Planning, 2005).

In the light of this, in August 2005, the President of the Government of the Republic of Zambia, concerned about the shortage of health workers, directed the MoH to develop a plan that would *comprehensively* address the problems affecting the health sector, hence the formulation of the HRH Strategic Plan (2006-2010).

## **1.2. The Research Problem and Research Objectives**

The problem of the brain drain and inadequate human resource in the health sector has been well documented. Documentation includes the causes and effects of, and solutions to the crisis. However, most articles have focused more or less entirely on the crisis and have fallen short of explaining how the actual agenda for tackling this crisis came into being, the factors involved and how this crisis was able to attract so much attention from both policy makers and politicians, more than many other issues in the MoH around the year 2005.

The main objective of this policy research is to explore how and why the issue of human resource shortages in the health care sector became a prominent feature on the states agenda in 2005/6.

The specific objectives are:

- To establish how the condition of inadequate numbers of health personnel was defined as a problem so as to capture the attention of policy makers;
- To establish how the HRH Strategic Plan (2006-2010) was formulated and accepted for serious consideration and
- To determine what elements in the political environment helped to push the issue of Human Resources for Health (HRH) into high prominence on the agenda.

## **1.3. Conceptual Definitions**

Policies exist within different sectors of society at almost all levels. Policy can be defined as a set of decisions taken through a process of decision-making by those people with influence in a particular policy area, outlining a proposed course of action (Sabatier, 1999). Birkland (2005) argues that there is no consensus on the precise definition of public policy, rather there are certain elements common to all definitions of public policy such as policies usually made or initiated by government in the name of the "public" and that includes what the government chooses not to do in order to create public value.

Furthermore, these policies are interpreted and implemented by public and private players from corporations and non-profit institutions (Buse, Dickson, Gilson and Murray, 2008). Public policies are important as they bring about changes in behaviour and practices that are meant to generate benefit and value for society. These include smoothly functioning organisations, health, and economic development, among others. They provide a framework that contains unfair

variation between areas, for instance in health variation, as well as supporting generation of public value (Bennet, Gilson and Mills, 2008).

Health policy forms part of public policy. It embraces courses of action that affect sets of institutions, organisations, services and funding arrangements of the health care system going beyond health services, and including actions or intended actions by public, private or voluntary organisations that have an impact on health (Gilson and Watt, 1994; Leena and Lehto, 2004; Manheimer, 2007). Watt, Shiffman, Schneider, Murray, Brugha and Gilson (2008) point out that health policy is about process and power as it is concerned with who influences whom in the making of policy, and how that happens. Simply put, agenda setting is the process of deciding what goes on to the government agenda for action and what does not. It is about understanding why certain issues are selected over others (Kingdon, 2003; Zahariadas, 2007). It is contingent on factors such as the views of key policy makers, preferences of interest groups, and ability to influence different groups to action.

#### **1.4. Significance of the Study**

Human resources for health have been recognised as an important component in the provision and attainment of quality health care. The World Health Report (World Health Organisation-WHO, 2006) revealed that there was a shortage of health personnel in most parts of the world, particularly sub-Saharan Africa, thus not only hindering access to health care for most of the population but also hindering the attainment of the MDGs. In view of this, most countries, including Zambia, developed strategies to overcome this. Overall since 2005, Zambia has been relatively successful in retaining some medical personnel and improving staffing levels, even though more still needs to be done to reach the required levels.

This research was thus aimed at understanding health policy making in general in Zambia and specifically in relation to human resources for health. The study, firstly, tried to uncover why and how this policy was selected for governmental attention and action in 2005 in Zambia. In so doing, the paper also uncovered why health in general was a major issue during that period. Secondly, Kingdon's framework which emerged in the mid 1980's forms one of the most important attempts to understand contemporary public policy analyses and agenda setting. However, for a long time, it was only in the context of wealthy countries --and more recently

India-- that this approach has been tested (Ridde, 2009). With just one recent exception, (DeJaeghere et al. 2006, cited in Ridde, 2009), the framework has rarely been used in Africa. Therefore, the desire was to explore this theory of agenda setting in an African context, laying the groundwork for further analytical work.

However, it is recognised that despite having certain similar characteristics, African states are not homogenous (Allen, 1995; Hyden, 2006). It is a big continent and countries differ from one another in many areas, including political systems. There are “failed” states, heavily military-controlled countries and there are also some countries of North Africa, among others who until recently experienced domination by single political parties and very limited democracy. There are also some countries with sound democratic principles such as Botswana (The Economist, 2009). Thus, this research takes these factors into account.

It is hoped that this research will contribute to the existing body of knowledge not only on the human resource crisis in the Zambian health sector, but also on the process of health policy agenda setting. It is hoped that it will be useful to both policy makers and general members by giving insight into why certain conditions do not qualify for policy action by government.

### **1.5. Research Methodology**

The study followed a case study method of looking at Zambia in particular. This is because case studies help to unravel the answers to the ‘how and why’ questions and are also useful for studying events that a researcher has little or no possibility to control (Yin, 1994). Furthermore, the study was qualitative and exploratory in nature, characteristics which are supported by the case study method. According to Marshall (1996:522) “qualitative studies aim to provide illumination and understanding of complex psychosocial issues and are most useful for answering humanistic 'why' and 'how' questions.” They study human behavior from the point of view of social actors themselves and the main goal is to understand human behavior (Babbie, 2008). Therefore, the choice of qualitative design for this study was justified as the main aim was to explore and understand how and why the issue of human resource shortages became a prominent feature on the states agenda in 2005.

Data was collected from multiple sources including both primary and secondary sources in order to increase the validity of the findings (Neuman, 2000; Yin, 1994). Primary sources involved in-

depth interviews with key informants from the media, policy makers in government, parliament, local and international cooperating partners, trade unions and some organisations involved in health. Interviews were used because they give an opportunity to the researcher to learn and capture the complexities of people's perceptions and experiences (Patton, 1987). Furthermore, in-depth interviews allow for a more thorough examination of experiences and options because respondents express their views simultaneously in a relatively openly designed interview situation (Kitchin & Tate, 2000). In this case, since the researcher wanted to fully understand the subject matter and to allow the respondents to fully express themselves, open ended questions were used.

A review of secondary data is important because it allows the researcher to learn from what other researchers have written about in that area while also building up from there (Neuman, 2000; Patton, 1987). In so doing, one avoids duplication of efforts and gains a good understanding of the subject area (Mouton, 2001). An extensive literature review of Kingdon's work and critiques, and applications of the Multiple Streams Approach (MSA) in different settings is provided.

The research made use of purposive sampling and snowball sampling to sample respondents. According to Babbie (2008:2020), "a researcher uses his or her own judgment in the selection of sample members." In this study, I, therefore, used purposive sampling to identify certain key informants/positions, such as career civil servants close to top-level political appointees in the MoH and the trade unionists that I felt would be useful in giving insights into the agenda setting of health policy formulation for a start. This was further justified by the fact that the researcher had some prior knowledge and interactions with some of the informants during her work at the MoH.

Snowball sampling is used to obtain additional information from extended sources through existing cases by asking people already interviewed or key informants to suggest other people or places to involve in the study (Patton, 1987). In the study, informants who were purposefully sampled were asked to identify other key informants, including representatives of important interest groups who were also involved in policy making in one way or the other. The aim of this was to reach important and influential people in the health policy community to serve as knowledgeable informants and not necessarily as respondents who the researcher may have missed in her purposive sampling. They did not necessarily have to be decision makers

themselves so long as they were in close contact with key decision makers and were knowledgeable. Some of the informants who were sampled using snowball sampling came from the media, parliament and cooperating partners. Thus, a reasonable coverage was obtained from a range cutting across the executive and legislative branches of government, and non-governmental organisations.

Since the research was qualitative, it made use of qualitative methods of data analysis which basically consisted of identifying, coding, and categorising patterns found in the data (Bryne, 2001). In this case, thematic analysis was used to interpret raw data obtained from the interviews by grouping it into different themes depending on the relationship (Babbie, 2008). Data was classified into different categories according to the main themes that the researcher was interested investigating, such as causes of the human resource crisis, solutions, policy documents and key participants.

To understand how these themes relate to each other and the types of words used, content analysis used since it is the analysis and interpretation of recorded communication undertaken with written or visual material, including interviews (Babbie, 2008; Mouton, 2001). Furthermore, in order to gain insight into how different people make meaning of different phenomena, interpretative phenomenological analysis was also used (Bryne, 2001). In so doing, the researcher's aim was to identify certain insights into the participants' experience and gain some perspective into their world. Because all these methods have certain limitations relating to the reliability of the data sources and the representativeness of the texts analysed (Mouton, 2001), the researcher minimised these by reading different sources of material and combining them with the transcribed interviews in order to get a balanced view.



**Table 1: Summary of key research questions and data collection**

<b>Research Question</b>	<b>Information Needed</b>	<b>Method of Data Collection</b>	<b>Method of Data Analysis</b>
How was the condition of inadequate health personnel defined as a problem to capture the attention of policy makers?	<ul style="list-style-type: none"> <li>- Indicators</li> <li>- Focusing Events</li> <li>-Feedback</li> </ul>	<ul style="list-style-type: none"> <li>- Interviews</li> <li>- Reports and documents by the government and other partners</li> <li>- Newspapers</li> </ul>	<ul style="list-style-type: none"> <li>- Content Analysis</li> <li>- Thematic Analysis</li> <li>- Interpretive Analysis</li> </ul>
How was the proposal for the Human Resources for Health Strategic Plan drafted and accepted for serious consideration?	<ul style="list-style-type: none"> <li>- The role of Policy Entrepreneurs</li> <li>- Other policy alternatives which were available then</li> <li>- How long it took for the proposal to be accepted</li> </ul>	<ul style="list-style-type: none"> <li>- Interviews</li> <li>- Reports and documents by the government and other partners</li> </ul>	<ul style="list-style-type: none"> <li>- Content Analysis</li> <li>- Interpretive Analysis</li> <li>- Thematic Analysis</li> </ul>
What events in the political environment helped to push the issue of human resources for health to high prominence on the state's agenda?	<ul style="list-style-type: none"> <li>- National mood</li> <li>- Visible and invisible participants</li> <li>- Participation of interest groups and civil society</li> </ul>	<ul style="list-style-type: none"> <li>- Interviews</li> <li>- Newspapers</li> <li>- Reports and documents by the government and other partners</li> </ul>	<ul style="list-style-type: none"> <li>- Content Analysis</li> <li>- Interpretive Analysis</li> <li>- Thematic Analysis</li> </ul>

## **1.6. Limitations**

One of the main limitations experienced in this research was the time factor in respect of interviews with key informants. It was not easy to schedule appointments with some informants owing mainly to busy schedules. However, in some situations where it was entirely impossible to meet the desired person, the researcher was granted appointments with other officials who possessed knowledge on the required information.

Another obstacle that was encountered was the poor record keeping at the MoH. Some documents produced more than ten years ago (2001) were not easily traceable as there was no proper library. However, the researcher was able to use her previous contacts within the MoH to help locate some of these documents.

## **1.7. Ethical Considerations**

Despite the researcher having worked in the MoH before, objectivity and neutrality were maintained during the research by avoiding any bias towards a particular inclination or persons. Ethical clearance from an ethics committee that approves all research in the country was obtained, a condition laid down by the MoH. In addition, permission and consent from the Government of Zambia through the MoH Permanent Secretary was obtained so as to conduct the research in that institution and interview staff. Consent was obtained from all the informants who took time to answer the questions, as the researcher ensured that participation in the study was purely on voluntary basis. Confidentiality and the right to freely withdraw were also guaranteed.

## **1.8. Chapter Outline**

This thesis is composed of eight chapters. The first few chapters serve to introduce the topic and Zambia, while chapters four to seven describe the findings of the research and chapter eight concludes the study.

The first chapter is based on the research proposal of the chosen topic. It deals with the historical background in brief and presents the main objectives and significance of the study to health policy in general and specifically to research on human resources for health in Zambia using Kingdon's framework. The research methodology employed in the study is also incorporated into this chapter as it is not complicated. The chapter also outlines the limitations that the

research encountered, including the measures that were put in place in order to maintain proper ethical standards in the research.

In chapter two, different country literatures are reviewed with respect to policy making and agenda setting. The models of Rational Comprehensive Theory, Incrementalism, Street Level Bureaucrats, and last but not least, Multiple Streams Approach by Kingdon will be discussed. Thereafter, the chapter outlines various countries worldwide where Kingdon's model has been applied in different areas of research, more especially health. The chapter also discusses Zambia's health reforms and shows the gaps in research in so far as human resources for health crisis is concerned.

The third chapter gives an introduction into Zambia. It looks at the political, economic, geographic and demographic standing. It describes the overall health system in terms of governance, financing, health status and disease burden and human resources. The aim is to give insight into the country which forms the study of the research.

As mentioned earlier, the findings of the research are spread over four chapters, each dealing with a specific key aspect of Kingdon's framework. Chapter four is the first of the four and addresses specific objective number one, thus answering the question "how was the condition of human resources for health defined as a problem to capture the attention of policy makers?" The chapter follows Kingdon's analysis detailing how policy makers learnt of the issue of human resources through indicators, feedback and focusing events.

Chapter five focuses on the policies that were available to solve the human resources crisis, the selection criteria and who the main actors and policy entrepreneurs were in ensuring that the HRH Strategic Plan (2006-2010) was formulated, adopted and implemented as the solution. Furthermore, it also highlights how the human resources crisis overshadowed other issues that the MoH was faced with. This chapter thus relates to specific objective number two and answers the question "how was the proposal for human resources for health drafted and accepted for serious consideration by policy makers?"

The following chapter focuses on specific objective number three and answers the question, “what elements in the political environment pushed human resources for health to attain high prominence on the state’s agenda?” The chapter discusses such issues as nation mood, interest group activity, and the role of visible and invisible participants. It is the third chapter to discuss the findings.

Chapter seven is the last chapter to discuss the research findings. It focuses on understanding the factors that led to the formulation of the policy document, HRH Strategic Plan (2006-2010), that is, how the factors “coupled” when a “window of opportunity” opened to make it possible. It discusses these two processes and their value in policy formulation according to Kingdon.

The last chapter of the thesis summarises the main findings of the research and offers some thoughts into the value of Kingdon’s theory on a country like Zambia and also the implications for future research on the subject matter.



## **CHAPTER TWO: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK**

### **2.1. Introduction**

This chapter provides a theoretical framework and conceptual platform for the topic of agenda setting in Zambia's health sector. The study draws on public policy literature and hence commences with a review of literature on some of the most widely known public policy agenda setting models such as the rational comprehensive model, muddling through/incrementalism, bottom up approaches and advocacy coalition framework. This will be followed by a thorough description of Kingdon's agenda setting model including the criticisms before reviewing literature dealing with the application of Kingdon's model in North America, Europe, Asia and Africa. Thereafter, literature on Zambia's health sector in terms of health reforms and human resources will also be reviewed.

Attention is given to Kingdon's concept of "the independent streams" of problems, policies and politics which come together at critical points when a "window of opportunity" opens to ensure the success of an issue emerging on the agenda during a process called "coupling". The focus of this thesis (and this chapter) is not on policy implementation and is not concerned with effectiveness of policy per se. Rather, the aim is to explore the agenda setting process behind the human resources for health and the subsequent formulation of the policy in that regard.

### **2.2. Agenda Setting**

Agenda setting refers to the process whereby some issues get onto the policy agenda for discussion and action whereas others do not. It is the politics behind the selection of issues for active policy making. Dearing and Rogers (1996:1) stress that "the agenda setting process is an ongoing competition among issue proponents to gain the attention of media professionals, the public, and policy elites." In some cases it is about how much public attention certain issues can generate (Peters and Hogwood, 1985).

Usually, those who manage to gain support to classify an issue as a public problem warranting government attention, and are able to get it on the political agenda, often control how it gets addressed. Birkland (1997) suggests that agenda setting is best considered in the context of "policy communities" as the meanings of problems and the range of acceptable solutions is

defined within such communities. The issues that are constructed as public as opposed to private matters by such networks also reflect a particular country's history and political culture. Hence, scholars have shown that not all societies draw the public private distinction in the same way. The most common divisions revolve around popular expectations of the state, autonomy, privacy, property, family and government (Barney, 2003). Nathanson (1996) argues that public health policies are neither formulated, adopted, nor implemented in a vacuum. Rather, they are the outcome of social and political processes.

Despite being related, agenda setting and problem definition are different. The former is the process by which some problems come to public attention at given times and places while the latter is more concerned with the organisation of a set of facts, beliefs, and perceptions of how people think about circumstances (Dery, 2000). Furthermore, bringing an issue onto the public agenda does not in itself generate a solution, rather "policy entrepreneurs" must ensure that their solutions are adopted on the national agenda (Baumgartner and Jones, 1993).

Agendas may be classified into two types: first systemic or macro agendas which include the widest range of potential issues that might be considered for action by the government and that might be placed on the public agenda; and second, institutional or micro agendas which may include those issues that are already for consideration of decision makers, legislatures or courts (Derry, 2000).

### **Popular models of Policy Making**

There are many competing frameworks or models of how the agenda for policy making is set. These include the rational model (Laswell, 1951) incrementalism (Lindblom, 1959; Deleon, 1999), bottom up approaches (Lipsky, 1980), and advocacy coalitions (Sabatier, 1986), among many others.

The rational model of policymaking is one of the most popular models and in this case, agenda setting is usually the first step in the four-stage cycle. It is assumed that policymaking takes place in a rational, linear and comprehensive manner, where issues are tabled on the agenda, the policy is formulated, implemented and later on evaluated. Experts and top civil servants are seen as providing neutral information (inputs). Several stages -- agenda setting, policy formulation,

policy implementation and policy evaluation-- occur in linear fashion. The model has been labelled as “top-down”.

One of the main critiques of this top-down model is that policy process does not proceed in such a linear staged fashion, with all the steps strictly followed as such (Kindgon, 2003; Lindblom and Woodhouse, 1993; Sabatier, 1999; Sato, 1999). Furthermore, it has been observed that if that were the case, then the top-down model may not be applicable to cases where policy making comes from a combination of various elements and actors acting at different levels (Sabatier, 1999). The model also has been criticised for not including the roles played by many other actors such as nongovernmental stakeholders and ordinary workers (street level bureaucrats) at each stage of the policy process (Sato, 1999; Peters, 2002; Hudson and Lowe, 2004). The real world of policy making and agenda setting is much “messier”, less stagist and more complicated by power and muddles.

The second model of policymaking, “incrementalism” looks at agenda setting and policy making as “muddling through” processes. This model, coined by Lindblom in 1959, is one of the most famous critiques of the rational model. He argues that decision making or policy making for that matter, does not follow such steps as outlined by the rational model. Rather, it is a messy process which is based on doing things according to the situation as it presents itself at the time, without paying much attention to the consequences of possible policies. He states, “one chooses among values and among policies at one and the same time” (Ham and Hill, 1984:80).

The model emphasizes the need to compromise as it argues that decisions are based more on the culture than on the specified rules or rational evidence. One of its main critiques is its lack of clarity of goals in a plan of action (Grandori, 1984; Pava, 1986 cited in Bendor, 1995). Other criticisms point out that the model reinforces and encourages the complacent attitude inherent in all humans, thus inhibiting innovative thinking (Arrow, 1964; Dror, 1964 cited in Bendor, 1995).

“Street level bureaucrats” is a key term in a model developed by Lipsky (1980), another popular theory of agenda setting. He basically argues that policy making and indeed agenda setting are not a top-down process set by formal authority as asserted by the rational model. He instead places frontline workers at the core of agenda setting as they are the ones who often bring issues to the attention of officials. Lipsky argues that policy implementation and thereafter agenda

setting in the end comes down to the people who actually implement it, the street level bureaucrats (Hudson and Lowe, 2004). As such, implementers tend to shape the public policy agenda by showing what is “implementable”, thus shaping the policy in response to their understanding of it and how it fits with their values, including work culture, thereby affecting policy outcomes (Kamuzora and Gilson, 2007).

Therefore, it is these workers who not only determine the outcomes of policies, but also the adoption of policies and agenda setting, as they are the ones on the ground doing the work. Take for instance a case of a health related policy, frontline workers such as nurses and doctors may be the ones to determine whether the policy will succeed, develop another one or simply abandon it altogether. Lipsky’s model has however been attacked mainly for failure to recognise that in some instances, workers and the policy makers worked in partnership to achieve their shared vision (Ham and Hill, 1984).

A further framework in the study of policy making that overcomes the bottom-up versus top-down polarisation is the “advocacy coalition framework” by Sabatier and Jenkins (1988). It focuses on the interaction of the many advocacy coalitions, which consist of actors from several institutions at different levels who share a set of common policy beliefs within a policy subsystem. A subsystem (or advocacy coalition) refers to a network of people (professionals, civil servants, academic think tanks) with core beliefs and values who come together to influence the formation of a particular policy (Sabatier, 1999).

The model places change to come from within advocacy coalitions because external changes allow for redistribution of power, hence favoring one belief system over another (Flora, Campana, and Fernandez, 1999) Therefore, policy agenda setting and change are a function of both competition within the subsystem and events outside the subsystem (Sabatier, 1999).

Members of coalitions can include different levels of government, researchers, journalists, and policy analysts, as well as other social interests such as labour unions who form around a desired a future condition and the shared model of how to attain that condition (Flora et al, 1999). The model encompasses a variety of individual and institutional actors and regards policy making as an iterative process that runs over years or decades as groups engage in policy debate, competing and compromising on solutions based on their core values and beliefs (Birkland, 2005).



Furthermore, policy change takes place as a result of crucial changes in the external environment, such as a change of government or in other circumstances, as a consequence of the efforts and interactions between advocacy coalitions within the specific policy community (Gilson and Walt, 2008).

The advocacy coalition framework while useful has been criticised on several grounds. It has been argued that it neither explains when policy change actually takes place nor how advocacy coalitions develop since it does not investigate fully the details of the process of how the activities of various actors actually influence the environmental change (Sato, 1999). In addition, it does not explain collective action nor the mechanisms through which newly learned beliefs are translated into policy, such as how the coalitions actually translate their beliefs into government action, and how government agencies are mobilised as part of coalitions (Schlager, 1995 cited in Sato, 1999). Furthermore, the framework has been criticised for not recognizing the competitive nature of politics and the preferences of certain actors and knowledge over others in the policy process (Bryant, 2002). This is where Kingdon comes in with his model.

Kingdon (2003) argues that in the real world, policy making does not proceed rationally, rather it is common that only one policy option is considered and that political compromise requires that policies be vaguely defined, or that politicians collect information about existing problems only to push a predetermined solution that is on their own agenda. Rather than sequential stages or phases, Kingdon argues separate streams of problems, solutions and politics converge to move an issue onto the public policy agenda for government action. The major actors in agenda setting are “policy entrepreneurs” who always look for or promote “windows of opportunity”, for example when legislation expires or certain provisions in legislation require re-authorisation (Kingdon, 2003).

### **2.3. Kingdon’s MSA view of Agenda Setting**

Kingdon’s framework was developed based upon the “garbage can model” of organisational behavior by Cohen et al (cited in Kingdon, 2003) to explain the agenda setting process in making public policies. The model views government as an organised anarchy made up of a system that manifests both order and disorder. At any given time, the particular items on the agenda are a function of the mix of “garbage” in the can whose contents consist of three separate streams: problems, solutions, and politics (Mucciaroni, 1992).

Therefore, issues get on the agenda when three elements are in place: a problem is recognised, a solution is available, and the political climate makes the time right for change (Kingdon, 2003). He defines “agenda” as “the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials are paying some serious attention at any given time.” (Kingdon, 2003:3). He distinguishes between a governmental agenda (the list of subjects that are getting attention within government) and a decision agenda, (the list of subjects within the government agenda that are already up for an active decision). He also suggests that there are three independent streams of activities that ultimately lead to the selection of one policy idea over another – “problem”, “policy” and “politics” (Kingdon, 2003:3).

The problem stream highlights the problems that need to be addressed and why they seem to occupy the attention of officials more than other problems. Policy makers find out about these through indicators, focusing events, and feedback. Both government and non-governmental agencies usually monitor various activities. Indicators such as birth rates, income disparities, death rates, and maternal mortality rates among many others are therefore used to assess the magnitude of a condition. Policy entrepreneurs in and around government constantly look out for changes in such indicators.

Focusing events draw attention to some conditions more than others. Such events like a crisis, disaster or personal experiences push certain conditions to prominence. For instance, a major accident such as a plane crash will push government to act (or appear to act) on aviation safety. Another way officials learn about conditions is through feedback about the operations of existing programmes. Feedback can either be formal monitoring and evaluation studies, or informal, such as complaints from communities.

The policy stream involves the various policy proposals and alternative solutions that are generated for many problems. According to Kingdon (2003), many ideas are present, bumping into each other and combining. However, only a few are selected for serious considerations depending on such factors as technical feasibility, congruence with the political and social values of community members, budget constraints, public acceptability and politicians’ receptivity (Zahariadis, 2007).

The political stream, independent of each of the other two streams also flows according to its own rules. Its dynamics rely on changes derived from the national or public mood, pressure group campaigns elections and elected officials. There are visible and invisible participants. Actors like the president and his top appointees, members of the national assembly, major political parties and many others in the political arena are visible participants who affect the agenda. Academics, career bureaucrats and ordinary civil servants belong to the group of invisible participants who affect the alternatives. Kingdon (2003) describes developments in this stream as powerful agenda setters and that consensus is built more by bargaining rather than persuasion.

As these three streams are independent, they come together at critical point when a window of opportunity known as a “policy window” opens. This is open for only a short while and it’s up to policy entrepreneurs to make use of these windows to attach their proposals to a problem, or to utilize the chances in the political stream for instance to push for initiatives that fit with a new administration. Kingdon (2003:179) defines policy entrepreneurs as “highly knowledgeable, committed individuals in or out of government who are willing to invest their resources to promote a position in return for anticipated future gain in the form of material, purposive or solidarity benefits.”

He however argues that the media is not as influential in agenda setting as has been perceived. It does not affect the government agenda because it reports on issues that government is already aware of in most cases, therefore its role is more of informing the public but not necessarily causing government to act on particular issues (Kingdon, 2003). Smith, McCarthy, McPhail and Augustyn (2001) analysed the relationship between the media and social movements in the US in which they found that the media misrepresents the agenda of protests, thus having little impact on public agenda and the issue in question.

### **Kingdon’s Critics**

The (MSA) has still faced a number of criticisms. The independence of the three streams has been challenged as it has been argued that much emphasis is placed on their independence instead of their linkages. The streams are viewed as being interdependent such that changes in one stream triggers changes in another, thus making coupling much less fortuitous and the process more purposive and strategic (Dorn, 2006; Zahariadis, 2007). Furthermore, Dorn (2006)

argues that Kingdon's framework alone cannot easily explain long-term patterns in a political system.

Secondly, Kingdon's idea of a political stream has also been criticised. Lee (2008) argues that Kingdon limits public opinion to a role in the politics stream of public policy-making, with no place or mention of public opinion's role in the other two streams, problem definition and policy. He further argues that the model also limits public inputs to metrics like pre-election polls, post-election vote counts, and national mood. He thus states that bottom-up inputs are key ingredients not just as a factor in shaping the political backdrop to public policy-making but are also potential keys to defining problems and specifying policy alternatives.

Thirdly, Kingdon's conclusion on the limited role of the media in agenda setting has also been the subject of much debate. It has been argued that to understand the influence of media on public opinion and public policy, one must distinguish and understand the way in which media are produced, consumed and regulated (Banda, 2008). Furthermore, an understanding of the identity politics within which media are implicated and how those identity politics are imbricated is important as one needs to understand the social context in which media are regulated, for instance when discussing such issues as the kinds of media policies in place in any given country (Banda, 2008).

Furthermore, his focus on elite institutions and policy entrepreneurs has been termed as too narrow to account for decision-making in more centralised and integrated polities with a limited number of participants, as compared to the United States of America where participation is pluralistic and the institutions are fragmented and permeable (Mucciaroni, 1992). Another critic, Odugbemi (2008) argues that the framework may not apply to developing countries, unstable polities or authoritarian states. .

Many have stressed that for a framework like Kingdon's to be both more true to empirical reality and more useful to predict policy outcomes, there is need to identify *the points of entry* for non-institutional actors and grassroots outsiders such as civil society to influence the policy-making process (Odugbemi, 2008; Lee, 2008; Sabatier, 2007). Lower level bureaucrats too who have been known to have the capacity to influence policymaking have not been adequately accounted for in Kingdon's framework.

## **2.4. Application of Kingdon's work**

### **North America**

Despite these criticisms, Kingdon's model has been relied upon to provide a useful tool for analysing the factors involved when governments everywhere are faced with the great task of choosing which issues to act upon, which to simply overlook and which to put forward for consideration, given the many decisions that have to be made against limited time and finite resources .

A number of policy scholars in several different countries, and particularly in more advanced countries, have used Kingdon's theory to explain how specific issues have emerged on policy agendas, mostly in health and education. Reich, (1995,cited in Watt et al, 2008) in explaining the higher position of the child health over adult health on the international health agenda recognised extra elements that fed into the politics stream, including symbolic, economic, organisational, scientific and politics as favouring the former over the latter all through the 1990s.

Ogden et al (2003 cited in Watt et al, 2008) also drew on Kingdon's ideas in their research on tuberculosis. They demonstrated that the emergence of the HIV/AIDS epidemic contributed to the opening of global policy windows, facilitating advocacy networks to promote DOTS (directly observed treatment, short-course) as a treatment of choice for tuberculosis.

In Ontario, Canada, Kingdon's model was also used to analyse the top healthcare issue on the government's agenda during a two week period October 22 – November 4, 2009. Dattani (2010) found that the H1N1 flu virus vaccination shortage was the top health care issue during that period as evidenced by the number of articles on the front page and in prominent sections, as well as in opinion and editorial sections of the major newspapers. He adds that a significant focusing event was the death of a 13 year old boy due to H1N1-related illness which raised fears among the general public, and further increased demand for the vaccine (Dattani, 2010).

In their study of pharmaceutical companies in the United States and Australia, Gosden and Beder (2001) used the theory of agenda setting to examine how these powerful companies used public relations techniques to manipulate public policy-making in the mental health field. They argue that public relations companies (Kingdon's policy entrepreneurs) played a major role in using the

media to set the public agenda while at the same time directly lobbying to get particular policies onto the formal agenda for active and serious consideration by decision makers.

Using information collected from major policy actors in three different states in the United States of America, Young, Shepley, Miskel and Song (2010) used the model to explain how the issue of reading became prominent on the agenda of state governments during the latter half of the 1990s through a mix of factors.

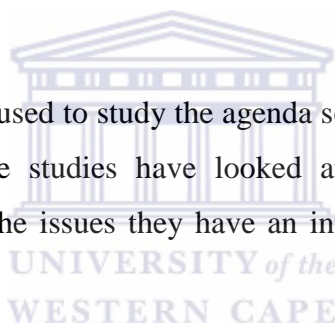
The model has also been applied to predict policy issues and to ensure they remain on the agenda. Pralle (2009) explored strategies for keeping the issue of climate change on countries agendas and moving it up the list of policy priorities, as it is something that cannot be dealt with one policy at a time. Lovell (2010) also used it to come to a conclusion that school choice alternatives in the United States would become a policy issue in the near future.

## **Europe**

Kingdon's model has been widely used to study the agenda setting in Europe, particularly within the European Union (EU). These studies have looked at the role that countries and EU institutions play in ensuring that the issues they have an interest in end up on the EU agenda (Hix, 2002; Rasch, 2000).

Pollack (2003) applied the model to study the relevance of supranational institutions in the politics of the European Community (EC; a precursor of the EU). He observed that even though the EC's supranational institutions did not enjoy any monopoly on informal agenda setting, they had a comparative advantage over other potential agenda setters. Policy entrepreneurs included the EC institutions and its Commission who appeared to push proposals closest to their own preferred policy that also could ensure a majority in the Council (Pollack, 2003).

To illustrate how the alcohol policy got featured on the EU's political agenda, Ugland (2011) argues that this was made possible by a determined group of policy entrepreneurs who managed to draw widespread public attention to a set of shared problems pertaining to alcohol, health, and social welfare in Europe. Furthermore, he states that the window of opportunity was opened by the European Commission after a number of member states, EU institutions, and non-governmental organisations had successfully raised concerns about under-age drinking and intoxication since the mid-1990s.



Green-Pedersen and Wilkerson (2006) examined how the agenda-setting attributes of an issue combine with problems to drive political attention by comparing health care attention and policy developments in Denmark and the US over fifty years. In both countries, they concluded that no matter how systems are organised or how successful they are at reducing costs, health care policy was made in the shadow of strong political attention at the national level.

Using Kingdon's model, Tervonen-Gonzales and Lehto (2004) analysed the contextual conditions of policy transfer of the World Health's Organisation Health for All (HFA) policy initiative on Finland and Portugal. They found that all the three streams of problem, policy and politics were ready for the policy. However, they argue that no significant change of health promotion policy emanated from the launch of the HFA programme in either country.

In Sweden, Mannheimer et al (2007) analysed the agenda setting, formulation, initiation and implementation of the inter-sectoral public health policy. Their findings revealed that while actors regarded the problems differently depending on their agenda and interest, politicians and experts had a higher impact on the formulation of the policy by deciding on the policy goals.

In order to determine how the political agenda was set in Norway so as to tackle the health inequality, Strand, Brown, Torgesen and Gjaever (2009) relied upon Kingdon's and other models to identify the main policy entrepreneurs who were responsible for developing policy on social inequity such as the MoH Secretariat and the Directorate of Human Resource.

### **Asia**

Reich (1994 cited in Buse et al, 2007) illustrated how the problem of ineffective and expensive pharmaceuticals had been floating in the problem stream for some time in Bangladesh without any action from the government until a new president showed interest in acting upon problems. A group of Bangladesh health professionals saw this as an opportunity to get an essential drugs policy on the public agenda and this happened when the three streams came together, resulting in far-reaching policy change.

Shiffman (2007) analysed how the convergence of different developments in problem definition, politics and policies in five developing countries (India, Indonesia, Honduras, Guatemala and Nigeria) pushed the issue of maternal mortality reduction on to the national agenda in 2005. Some of the key factors identified were that advocates were more likely to be effective in

moving political elites to action if they were able to justify to policy-makers the extent of the problem and brought into their circles well connected and influential political entrepreneurs to push the issue.

Ayyar (2009) also extended and applied the ideas of policy windows to further analyse and explain general public policy making in the Indian context; he found that Kingdon's ideas were to a large extent present and applicable.

Similarly, in Singapore, the model was used to explain how a policy window opened up to facilitate a major policy shift that changed the longstanding casino ban thus confronting the core beliefs that ran deep within Singapore's society regarding gambling. The study proved that Kingdon's model was also applicable to a parliamentary system with a small core group of decision makers, such as Singapore (Ting, 2008).

Some aspects of Kingdon's model were also used to investigate the processes by which the universal anti-retroviral therapy policy was developed in Thailand in 2001, particularly the role played by non- state actors during the agenda setting stage (Tantivess and Walt, 2008). It was discovered that non-state networks made significant contributions at almost every stage of the policy process, despite the state being dominant in the initial stages.

In China, Huang (2006) drew on Kingdon's ideas of the three streams and examined how they joined together in the 2003 Severe Acute Respiratory Syndrome (SARS) crisis to force the Chinese government to take prompt action on HIV/AIDS which had previously not been taken as a serious issue. He discovered that even in authoritarian states like China, political institutions played a huge role in each of the streams. Yu (2003) also used the model extensively to explain why the death of a new college student occupied the top governmental agenda in China in 2003.



## Africa

The assumption of Eurocentric epistemology and viewpoints in the production of historical and theoretical knowledge in Africa in particular has been a subject of much contention. It has been argued that these models do not work as they do not account for the cultural and historical perspective in which Africa finds herself. Mamdani (1996:294) has come out strongly, warning against arguments by analogy with Europe. He stresses that “issues of democracy and governance cannot be directly deduced from the analysis of a mode of production, nor can they be read off prescriptions from a general theory of democracy.”

Notwithstanding this caveat, a number of western models have been applied to the study of many African policy issues, some of which have been proven to be applicable. Kingdon’s framework, which emerged in the mid-1980s, today, forms one of the indispensable analytical frameworks for understanding public policy agenda-setting. However, as shown above, it is mainly in the context of somewhat wealthy countries that this approach has been supported for setting the agenda of national and international policies (Ridde, 2009). With a few exceptions (DeJaeghere et al, 2006), the framework has rarely been used in Africa.

In a study conducted in Burkina Faso, a lower-middle income country, Valerie (2009) found the model useful for examining public policy at the local level in which he sought to explain the failed implementation of a health policy aiming to increase equity. The research revealed that the framework can be extended to such countries and could actually lead to the formulation of several theoretical propositions.

Ashford et al (2006) used the model, among many others, to describe a model which creates a window of opportunity for policy change, thus illustrating the policy process and how to work strategically to translate knowledge into policy actions in Kenya’s health sector. Bird et al. (2010) also used the theory to explain why mental health had remained a low priority on the national agenda of most African governments by comparing four countries, Ghana, Uganda, South Africa and Zambia.

Schoeman et al (2010) analysed the role of AIDS donors and civil society in the policy process of South Africa using Kingdon's multiple streams. They concluded that the major hindrance to having real effectiveness in the South African AIDS policy in the period up to 2008 was national level politics.

## **2.5. Human Resources for Health in Zambia**

The policy literature on Zambia's health system has largely focused on donors and the implementation of treaties and ratifications that have been signed with international and regional organisations. A number of recent regional interventions have shaped the agenda for health and elevated its importance on par with other social sectors such as education. These include: the right to health which was included in the 1948 United Nations Declaration of Human Rights, the 1978 Alma Ata Declaration on primary health care which highlighted that primary health care was essential health care for all individuals and communities (Bennet et al, 2008), the Millennium Development Goals of which three are directly related to health (reduce child mortality rate, improve maternal health and combat HIV, malaria and other diseases) and the 2001 Abuja declaration in which African governments pledged to achieve significant success in the health sector by increasing government funding to health to at least 15% of the national budget.

To this end, Zambia has been pursuing health care reforms aimed at providing its people with equity of access to cost-effective, quality health care as close to the family as possible since 1992 (MoH, 2005). The reforms were subsumed in the general economic restructuring which began in many countries, especially the developing countries with an emphasis on the market, including privatisation of care provision and on partially off-loading the responsibility for financing services from government to service users through direct payment or community financing schemes (Blas and Limbambala, 2001). The controversial introduction of user fees at all public health facilities in a bid to increase resources to the health sector and the decentralization of the health care delivery to health boards has been a key feature of the reforms.

However, the reforms have not had the intended impact of improving the overall performance of the health sector. Martineau and Buchan (2000) point out that whilst the reforms focus on changes in financing and organisational structure, they often neglect the staff, thereby resulting in inappropriately skilled staff for new tasks. Furthermore, planned interventions were not being

implemented simply because there were either not enough staff at all or not enough suitably trained in the health facilities to provide the services (MoH, 2005).

Efforts to address the issue of inadequate health personnel at both international and local levels are present. One such effort is the Kampala Declaration and Agenda for Action, arising from the first global forum on human resources for health in March 2008 which sets out the vision that “all people everywhere shall have access to a skilled, motivated and facilitated health worker within a robust health system.” (McColl, 2008:95).

While much of the analysis of the human resource health crisis in Zambia has looked at describing the causes and effects of the crisis, this dissertation explores the political and bureaucratic realities shaping the pattern of policy change and its impacts. It provides a picture of the policy environment and processes on how issues enter the policy domain by considering the way agenda setting contributes to health policy making. It attempts to be more explanatory and analytical with a focus also on how different players contributed to policy formulation and setting the human resources for health agenda.

Tjoa, Kapihya, Libetwa, Schrodner and Lee (2010) pointed out that Zambia was operating with fewer than half the health workforce necessary to deliver basic health services, with an even higher vacancy in rural areas. Staff to population ratios nationally was as low as one doctor per 14, 500 people and one nurse per 1,800 people. This is far lower than the WHO recommended doctor population ratio of one doctor to 5,000 and one nurse per 700 people (MoH, 2011).

The causes of the crisis are vast and have been linked to factors such as the brain drain, HIV/AIDS, poor retention policies and inadequate training facilities (Vitols, Du Plessis and Ng’andu, 2007; Makasa, 2009). Furthermore, solutions have been identified including increasing training output by medical schools, improving conditions of service, providing retention schemes, upgrading medical facilities and equipping them adequately (Koot and Martineau, 2005; Tjoa et al, 2010; Makasa, 2009; MoH, 2007).

A few have attempted to explain the agenda setting in Zambia but it is not comprehensive. For instance, Gilson, Doherty, Lake, McIntyre and Mwikisa (2003) highlight the important role played by key political figures such as the minister of health in the process of health policy development during a moment of major political change in Zambia by choosing which proposals

to take for implementation. However, they stop short of fully exploring how these political figures were able to influence the policy health agenda or how the issues were chosen over all other issues in the country.

Most of these scholarly writings in relation to Zambia's health shortage have been largely descriptive as they do not really explain how the human resource crisis gained top prominence on the health agenda, the conditions that were present, how and why policymakers decided to act. A briefing paper by Buse et al (2008) also suggests that the study of health policy needs to take into account factors such as the role of the state, the interests of various actors and the manner in which they wield power, the nature of political systems and their ways for participation. Furthermore, the guiding principles of informal and formal policy processes must be considered.

The urgent need to address the dire human resource situation pushed the government to set up a human resource task force to develop an emergency Human Resource Rescue Plan and criteria for implementation in 2004 which identified strategies to address the constraints and included these in the HRH Strategic Plan (MoFNP, 2005).

## **2.6. Conclusion**

The chapter has provided a literature review of the MSA. It has explained what agenda setting is in general and how different models view this process. The main focus on Kingdon's model was necessary to justify why the model was favoured against the others, despite the many criticisms it has suffered. The research cited has proven that this model has been found very useful in explaining policy agenda setting in many issues, especially in developed countries like Canada and the United States in North America, in European countries, and to some extent in various Asian countries too.

However, the model has been applied to analyse policy making in Africa to a lesser extent. Only in a few countries has this model been applied, such as Burkina Faso, Kenya, South Africa, Uganda and Ghana. In Zambia, the model has only been used to look at maternal health. This highlighted why human resources for health needed to be analysed in this way, since most of the writings have focused more on the crisis, rather than the process behind this which labelled it as a crisis and the subsequent interventions.

## **CHAPTER THREE: COUNTRY PROFILE-ZAMBIA**

### **3.1. Introduction**

This chapter presents a country profile of Zambia by giving a picture of the past and current state of affairs in terms of the social, economic and political indicators. It describes demographics, the main economic activities and key political developments. The country's health system is discussed, including governance, financing, health reforms and the health status. I also briefly touch on the present situation for human resources for health according to the latest data available.

### **3.2. Geography and Demography**

Zambia is a landlocked sub-Saharan country in the central southern part of Africa. It has eight neighbours namely the Democratic Republic of Congo (DRC), Malawi, Mozambique, Namibia, Tanzania, Angola, Zimbabwe and Botswana. Lusaka is the capital city and main business hub. It has a population of about 13 million (13,046,508) according to the last national census of 2010, with a life expectancy of 51.2 years (Central Statistical Office- CSO, 2012). After the national census of 2000, the population projections were 12,956,412 by 2010.

The tables below (2 and 3) show these projections and the distribution by sex between 2005 and 2010 respectively. As can be observed in table 2, the population was seen to be increasing slightly each year for each group as compared to the previous year, except in 2008 when it reduced for the age group below 15 years. In table 3, the population growth rates are reducing from 2.8% in 2006 to 2.6% in 2009. Furthermore, male and female populations compare favourably each year as the gaps between the two are very minimal.

Administratively, the country is divided into nine provinces and 72 districts. Of the nine provinces, two are predominantly urban, namely Lusaka and Copperbelt provinces. The remaining provinces—Central, Eastern, Northern, Luapula, North-Western, Western, and Southern—are predominantly rural provinces (CSO, 2007). The official language is English but there are about 70 different local languages and dialects used in the different parts of the country.

**Table 2: Projections of Percent Population Distribution by Age Group and year (2005 – 2010)**

Age Group	2005	2006	2007	2008	2009	2010
0-14 years	5,104,675	5,247,538	5,388,701	5,528,656	5,669,049	5,811,660
15-64 years	5,919,766	6,099,256	6,279,444	6,460,491	6,641,774	6,822,337
65+ years	289,470	295,346	301,564	308,152	315,089	322,415
Total	11,313,822	11,642,140	11,969,709	12,297,299	12,265,912	12,956,412
<b>Total Population</b>	<b>11,313,822</b>	<b>11,642,140</b>	<b>11,969,707</b>	<b>12,297,299</b>	<b>12,265,912</b>	<b>12,956,412</b>

Source: CSO, 2000 cited in Mwanza, 2010: 4

**Table 3: Projections of Population Distribution by Sex (2005-2009)**

Year	Total	Male	Female	Male/Female %	Growth Rate %
2005	11,313,822	5,698,050	5,700,334	100	-
2006	11,642,140	5,875,423	5,871,193	100	2.8
2007	11,969,709	6,055,123	6,040,368	100	2.7
2008	12,297,299	6,236,333	6,208,685	100	2.7
2009	12,625,912	6,419,454	6,376,814	101	2.6

Source: CSO, 2000 cited in Mwanza, 2010: 4

### **3.3. Political Context**

Zambia is a peaceful, stable, multiparty democracy. It practices the presidential system of government where the president, members of parliament or the national assembly and councillors are elected through a secret ballot by the people during the parliamentary and presidential elections held every five years. The first multi-party elections since the 1960's were held in 1991, ending the one party state system which was in place since 1972 and beginning a new era of liberal democratic principles.

There is separation of powers among the legislature, executive and judiciary. However, the president is both the head of state and head of government as he appoints his vice president and members of cabinet from among the members of parliament. There are 150 elected members of parliament plus 8 nominated by the president, making the total number 158. The vice president

leads the house in the national assembly, which is a unicameral legislature. The main political parties are the ruling Patriotic Front (PF), Movement for Multiparty Democracy (MMD), United Party for National Development (UPND), United National Independence Party (UNIP), Forum for Democracy and Development (FDD). UNIP was the founding party of new Zambia after the end of colonialism in 1964.

In the early 1970's, the UNIP was challenged by the United Progressive Party (UPP) which was subsequently banned under the one party state in 1972. The MMD emerged in the late 1980's led by a trade unionist, Frederick Chiluba, winning 80% landslide in the 1991 elections. It suffered several breakaways and suffered a severe crisis when Chiluba tried to force a third term for himself as president. Chiluba's chosen successor Levy Mwanawasa won the election in 2001 narrowly beating breakaway parties PF and FDD. In 2006, the PF re-emerged to win 29% of the vote and PF parliamentarians won all the seats in urban seats in Lusaka and Copperbelt (Larmer, 2007:612).

### **3.4. Economic Context**

Zambia is a lower middle-income country classified as such in July 2011 by the World Bank, (*Lusaka Times, 12 July, 2011*). Since 2006, the country has been implementing the Vision 2030, which aims at transforming it into a prosperous middle-income nation by the year 2030 (MoH, 2010). This vision is being undertaken through the five year developments plans which were re-introduced after a long absence since 1991, and the usual annual budgets. The government is now implementing the Sixth National Development Plan (2011-2015).

Despite some improvements registered in its macro-economic performance such as an annual growth rate of 5%, this has not translated into positive socio-economic growth for its people as 64% of the population is classified as poor and living below the poverty datum line of \$1 a day (CSO, 2010; MoH, 2010). In addition, 80% of these live in the rural areas relying on agriculture (UNDP, 2011). Earnings from copper have continued to be the country's major economic activity. Between 1965 and 1975, this accounted for about 95% of total export earnings (CSO, 2007) but due to the decline in copper prices in the early 1970s and the rise in oil prices, the economy suffered and huge debts were accrued.

According to Cocq (2005:241)

From 1973 to 1984, terms of trade fell 77%, copper prices collapsed leaving the Zambian government with an external debt of 40% of Gross Domestic Product (GDP) by 1986. The situation led the President Kaunda to enter a structural adjustment agreement with International Monetary Fund (IMF) in 1983, which included currency devaluation, lifting of price controls on commodities and inputs. The resultant increases in the cost of living and sky rocketing prices...spurred riots in late 1986.

As such, attempts to minimize the dependency on copper exports were made by diversifying the economy through import substitution and manufacturing goods locally, which however proved too expensive to sustain (Manenga and Ndulo, 2005) and the country eventually became heavily indebted. In 2000, it qualified for debt relief under the Heavily Indebted Poor Countries (HIPC) Initiative which was agreed upon with the donors- International Monetary Fund and the World Bank in 1996 as a long-term solution to its debt problems.

From 1991 when a new government took office led by Chiluba, government began to actively pursue policies aimed at facilitating private sector growth. These policies include the structural adjustment programmes (SAPs) which involved trade liberalization, market-determined exchange and interest rates, financial sector liberalization (CSO, 2007). The period from 1991 to 2001 also saw the privatisation of most state owned companies and the liquidation of some, including the national airline (MoFNP, 2008). In 2005, Zambia became one of the first countries to complete its Poverty Reduction Strategy Paper (PRSP) as part of the SAPs and this constituted a major strategic “opportunity for Zambians to throw off their conditional chains, just at the time when mining profitability presented a feasible path to a neo-national model of development.” (Larmer, 2007:619).

Agriculture accounted for more than 20 percent of Zambia’s GDP providing employment for about 60 percent of the population, mostly the small scale farmers in the rural areas (UNDP, 2011) while the level of unemployment was around 15.5% of the total labour force of which 70% were in the urban areas and 30% in the rural areas (MoFNP, 2010). The country’s per capita Gross National Income increased from US \$680 in 2006 to an estimated US \$970 in 2009, only slightly below the lower middle-income threshold of US \$995 (MoFNP, 2010). In 2010, the



country was named as one of the fastest growing economies in sub-Saharan Africa by the World Bank (Schneidman, 2011:37).

The table below (4) highlights the trends in selected macro-economic indicators from 2004 to 2010. As can be observed, inflation dropped to single digit in 2010 and GDP continued to show some steady growth through the years.

**Table 4: Trends in selected macro-economic indicators 2004-2010**

Indicator	Year						
	2004	2005	2006	2007	2008	2009	2010
Annual inflation	18	18.3	9.1	10.6	12.4	9.9	7.2
GDP growth rate	5.4	5.2	6.2	5.7	6	6.3	7.1
GDP per capita (purchasing power parity)	1,060.78	1,127.00	1,208.50	1,295.60	1,364.80	N/A	N/A
Real GDP per capita growth	2.1	2	3	3.1	2.6	3.3	4
Total debt service (% of exports of goods, services and income)	22.1	11.1	3.4	2.5	3.1	3.8	N/A

Source: MoFNP, 2010 cited in UNDP, 2011: 38

### **3.5. Health System**

The goal of the health sector is “to improve the health status of people in Zambia in order to contribute to socio-economic development” (MoFNP, 2011:17). The overall vision is to ensure “equitable access to quality health care by all by 2030” (Ibid: 17). The National Health Policies and Strategies of 1992 provide the overall policy framework within which health services are provided (Mwanza, 2010). Others include the PSRP, the National Decentralisation Policy and other national policies, including national health strategic plans in which the health sector is operating.

Health care in Zambia is provided by the government, private facilities and joint efforts with other organisations such as the church. The main health care providers are public health facilities under the MoH, facilities under the Ministries of Defence and Home Affairs respectively, private facilities, Non-Governmental Organisations (NGOs), mine hospitals and clinics, mission hospitals and clinics coordinated by the Churches Health Association of Zambia (CHAZ) and

traditional healers (MoH, 2006). Table 5 below provides a summary of these facilities. The government health facilities are still the largest provider of health care in the country despite the ideological penchant for privatisation.

**Table 5: Health facilities by ownership**

<b>Description</b>	<b>Total Number Countrywide</b>
Public Health Facilities	1,489
Private Health Facilities	271
Mission Health facilities	122
<b>Total</b>	<b>1,882</b>

Source: MoH, 2006

Health care is provided in five ways. The highest level is the third level hospitals, followed by second level hospitals, first level hospitals, health centres and health posts (MoH, 2005). Third level hospitals are the biggest and most specialized hospitals in Zambia, covering a catchment population of 800,000 and above. Second level hospitals cater for a catchment population of between 200,000 and 800,000 and are mainly found at the provincial level. First level hospitals are found at the district level and meant to cover a population of between 80,000 and 200,000.

Health centres are found in both urban and rural health centres. The former covers a catchment population of between 30,000 and 50,000 people while the latter serves a catchment area of 29km or a population of 10,000 people. Health posts are at the primary levels of health care, typically staffed by nurses and built in communities far away from health centres cater for a population of approximately 3,500 people. In urban areas, 7,000 persons are served by a health posts. Table 6 below shows the numbers of health facilities according to classification. Rural health centres form the largest number of public health facilities in the country, followed by urban health centres and health posts respectively.

**Table 6: Health facilities by size and type, circa 2006**

<b>Description</b>	<b>Total Number Countrywide</b>
Level 3 hospitals	6
Level 2 hospitals	21
Level 1 hospitals	84
Urban health centres	436
Rural health centres	1,060
Health posts	275
<b>Total</b>	<b>1,882</b>

Source: MoH, 2006; Mwanza, 2010

### **Health Care Financing**

Besides domestic funding from the government which accounts for almost 60% of total public health sector funds, the MoH receives about 40% from various cooperating partners, mainly for vertical programmes such as HIV/AIDS, malaria and Tuberculosis (TB) (MoH, 2011). Vertical or stand-alone schemes have been criticised as they exist *alongside* national structures but are not integrated with them.

Zambia has not had a social health insurance scheme, therefore, most individual households use out of pocket expenditures to pay for their health services (MoH, 2006; Mwanza, 2010). As a percentage of the GDP, health care spending represents 5.4% - 6.6% (MoH, 2011). However between 2001 and 2004 health spending declined by 4% (Mwanza, 2010).

When the health reforms were introduced in 1992, user fees were introduced as a way of raising additional revenue while also instilling a sense of ownership in the public health facilities by the public. Exemptions were based on age, demographics and disease (Kamwanga et al, 2000; Mwanza, 2010). In 2006, government abolished user fees at primary health care facilities in rural and peri-urban areas in an effort to ensure universal access to health care, especially for the poor (Masiye et al, 2008). In 2011 when a new government took office led by Michael Sata, it was announced that user fees had further been abolished in all health centres both rural and urban. Larmer (2007) shows that Sata's Patriotic Front party enjoyed strong urban support from around 2005.

### **Health Status and Disease Burden**

The burden of disease in Zambia is largely influenced by the high prevalence and impact of communicable diseases, particularly malaria, HIV/AIDS, TB and STIs (MoH, 2011). Malaria has been the leading cause of mortality and morbidity in the country (UNDP, 2011). However, there has been a reduction in malaria incidence among children under five due to the distribution of treated mosquito nets, indoor spraying among others (MoH, 2011; UNDP 2011).

Infant mortality stood at 102 per 1000 live births, compared to Uganda's 81 and Lesotho's 63. Maternal mortality in Zambia was 750 per 100,000 live births in 2005 (World Health Report 2006) but other countries such as Uganda were worse at 880 deaths per 100,000 live births in 2007. HIV prevalence among Zambian adults aged 15-49 was at 14.3% in 2007 (CSO, 2007; UNDP, 2011).

Table 7 highlights the ten major causes of visits to public health facilities in Zambia in 2008 for all age groups. Malaria and respiratory infections not associated with pneumonia topped the list, accounting for almost 45 % of case loads, while those associated with pneumonia and infections to do with the ear, nose and throat were at the bottom respectively.

**Table 7: Ten major causes of visits to public health facilities**

<b>Disease Name</b>	<b>Incidence per 1,000 population</b>
Malaria	251.7
Respiratory infection; non-pneumonia	197.7
Diarrhoea: non-bloody	69.3
Trauma	46.6
Skin infections	38
Muscular skeletal and connective tissue	32.3
Eye infection	31.3
Respiratory infection; pneumonia	30.8
Ear, Nose, Throat	26.9

Source: MoH, 2011:75

## **Health Workforce**

Within the health sector, human resources for health, in terms of numbers, utilization of staff and morale has been a major issue. Despite some improvements since 2000, the MoH unfortunately by the mid-2000s still operated under a critical shortage of staff. The rural areas had been the worst hit with staff population ratios almost 1:14,500 and 1:1,800 for doctors and nurses respectively, far below the WHO recommended staff population ratios of one health worker per four hundred people (1:400), with a health worker defined as a trained nurse, doctor, clinical officer, pharmacist, and laboratory, radiology and environmental technician (MoH, 2011; Tjoa et al, 2010).

WHO (2006) recognised the general lack of human resources for health worldwide, more so in Africa as hindering delivery of quality health care. The launch of the 2006 World Health Report actually took place in Lusaka, Zambia, thus highlighting the importance of the global human resources for health crisis in Africa as a whole (Global Health Workforce Alliance-GHWA, 2006). The HRH Strategic Plan (2006-2010) was the first consolidated plan to deal with the crisis in the country. Currently, the MoH is implementing the second phase, HRH Strategic Plan (2011-2015). Table 8 gives a picture of the staffing levels according to the latest data available. It shows the increase of health care staff countrywide from 2005 to 2010, against an approved establishment of 2010. There is a still a shortage of about 40% of health workers in order to reach the required levels.

The term “establishment” refers to the approved structure of the MoH (including numbers and types of posts). In this case therefore, “establishment 2010” represents the number of positions that had been approved by Cabinet Office considering the needs of the health sector for that particular year. However, these positions can only be filled when Treasury Authority is granted, if not, recruitment cannot take place. The numbers of staff for each year, 2005 and 2010 represent the number of funded positions in that particular year. Funded positions on the establishment increase depending on funds allocated in the national budget for net recruitment each year. The “gap to establishment” represents positions that were not funded. This establishment was initially developed during the restructuring process of the MoH in 2006 and has been adjusted on an annual basis based on approvals of structures for new health facilities (MoH, 2011).

**Table 8: Number of health staff employed by the Ministry of Health 2005 and 2010 versus the approved Ministry of Health establishment, 2010**

Staff category	No. of staff 2005	No. of staff 2010	Net increase	Establishment 2010	Gap to establishment No.	Gap to establishment %
Clinical						
Officer	1,161	1,535	374	4,000	2,465	62%
Dentistry	56	257	201	633	376	59%
Doctors	646	911	265	2,391	1,480	62%
Nutrition	65	139	74	31209	70	33%
Lab services	417	639	222	1,560	921	59%
Pharmacy	108	371	263	425	54	13%
Physiotherapy	86	239	153	300	61	20%
Radiology	142	259	117	233	-26	-11%
Midwives	2,273	2,671	398	5,600	2,929	52%
Nurses	6,096	7,669	1,573	16,732	9,063	54%
Env. Health	803	1,203	400	1,640	437	27%
Other health	320	363	43	5,865	5,502	94%
<b>Total Clinical</b>	<b>12,173</b>	<b>16,256</b>	<b>4,083</b>	<b>39,588</b>	<b>23,332</b>	<b>59%</b>
Administration	11,003	14,457	3,454	12,054	-2,403	-20%
<b>Overall Total</b>	<b>23,176</b>	<b>30,713</b>	<b>7,537</b>	<b>51,642</b>	<b>20,929</b>	<b>41%</b>

Source: MoH, 2011: 35

### 3.6. Conclusion

Zambia's economy is growing steadily and it has been named one of Africa's fastest growing economies. However, despite the economic indicators, the social status of most people has not improved as poverty and unemployment still remain rife. Diseases such as malaria and HIV/AIDS which are the leading causes of mortality have also shown significant decreases. Human resources for health continue to be a major problem for the health sector and the MoH has been implementing a number of measures which will be discussed further in the chapters to follow.

## **CHAPTER FOUR: THE PROBLEM STREAM- THE ZAMBIAN CASE**

### **4.1. Introduction**

After independence in 1964, the role of the state was seen as that of a development administration to correct the ills left by colonialism and uplift the living standards of people. The government thus embarked on a number of programmes, including the opening up of state owned institutions to support these programmes. This new role saw the rapid expansion of the public bureaucracy, consuming a great share of the national resources.

However, owing to the oil crisis of the early 1980s and the fallen prices copper on the international market, which is the country's major export commodity, economic performance was slow as the country plunged into huge debt, making it even more expensive to sustain the large bureaucracy. Therefore, as a condition to receive aid from the IMF and the World Bank under the Structural Adjustment Programme (SAP), the new government under Chiluba agreed to implement the PSRP, which the previous one party system of government had been hesitant to do (Kamwanga et al, 2000).

The PSRP has three major objectives; to make the Zambian public service leaner (through a targeted retrenchment programme) so that the costs of running it can be made more manageable; to improve human resource management through performance related incentives for a smaller and better remunerated work force; to and decentralize and devolve administrative power away from central ministries in Lusaka to the field stations/ and local government structures (Goma, 2008; MoH, 2005).

The wage freeze that was initiated in the entire civil service as part of the HIPC conditionalities also had a negative impact on the health sector as it meant that government was unable to employ new workers as usual, rather new employment became the exception rather than the norm as it was done mainly to replace workers who had left the service for one reason or the other (Chipenzi, 2005).

This chapter introduces the first of Kingdon's three streams, the problem stream. The problem stream has three main ways in which policy makers discover issues; through indicators, feedback and focusing events. The distinction between a "condition" and a "problem" is critical according to Kingdon as it determines whether or not it will receive the needed attention. Whilst a condition is just any situation present in society, a problem is one that seeks attention and action from government.

Therefore, the main question being answered in this chapter is "how was the condition of inadequate health personnel defined as a problem to capture the attention of policy makers?" This is in order to understand why policy makers pay so much attention to some problems and not others. The chapter does so by highlighting how Kingdon's categories (indicators, feedback and focusing events) can be applied usefully to understanding how human resources for health came to the attention of the policy makers in Zambia. Thereafter, a conclusion to the entire chapter will be drawn.

#### **4.2. Indicators**

One of the ways in which policy makers learn about problems is through various indicators that are routinely monitored or through studies conducted on a particular problem at a given point in time to assess the magnitude of a problem or to become aware of changes in the problem. These indicators are used to measure the magnitude of change in the hope of catching official attention (Kingdon, 2003).

The Zambian public health sector had suffered a shortage of human resource personnel which was labelled a crisis by both the government and external commentators from about 2004 (Makasa, 2009). This situation presented severe problems in the general health sector in as far as delivering quality health care was concerned. Migration also limited training capacity to train new health workers. In addition, death of health workers due to AIDS was also listed as the three main indicator and underlying causes of the crisis (Kombe et al. 2005). I look at these indicators in detail below.



## **Migration**

Interviews (see 1-3 in appendix A ) and literature review (GHWA, 2006; Makasa, 2009; MoH, 2005) revealed that by the beginning of 2000 through to about 2004, migration through resignation was one of the leading indicators of collapse in the Zambian public health sector. Many health professionals left for better conditions in the developed countries or joined the private sector. In fact, apart from death, resignation was cited as the highest cause of exit among health workers, especially nurses (Tim and Martineau, 2005; WHO, 2005).

A study conducted by the MoH in 2005 (WHO, 2006) in the three major hospitals in Zambia aimed at gaining a better understanding of how Zambian nurses perceived working in a public hospital and the attractions of migration, revealed that migration was a well-considered possibility for most of them. Table 9 below shows these results.

**Table 9: Rates of turnover and resignation of nurses in the three major hospitals in Zambia**

<b>Hospital</b>	<b>Turnover Rates</b>	<b>Resignation</b>	<b>Vacancy Rates</b>
Kitwe Central Hospital	32%	24%	43%
Ndola Central Hospital	23%	9%	50%
University Teaching Hospital	20%	12%	46%

Source: WHO, 2006: 19

As indicated earlier, about half the number of retrenched employees under the voluntary separation packages came from the health sector, with about 1,487 health workers across different disciplines leaving by 1999 (MoH, 2001:12).

Indicators showed that doctors had the highest attrition rate (exit from the public sector) at 9.8%, followed by nurses at 5.3% and pharmacists at 4.25% (MoH, 2005). Out of 836 Zambian doctors who graduated from the University of Zambia between 1992 and 1997, only 239 (25%) remained in the public sector by mid-1998 (Blas and Limbambala, 2001).

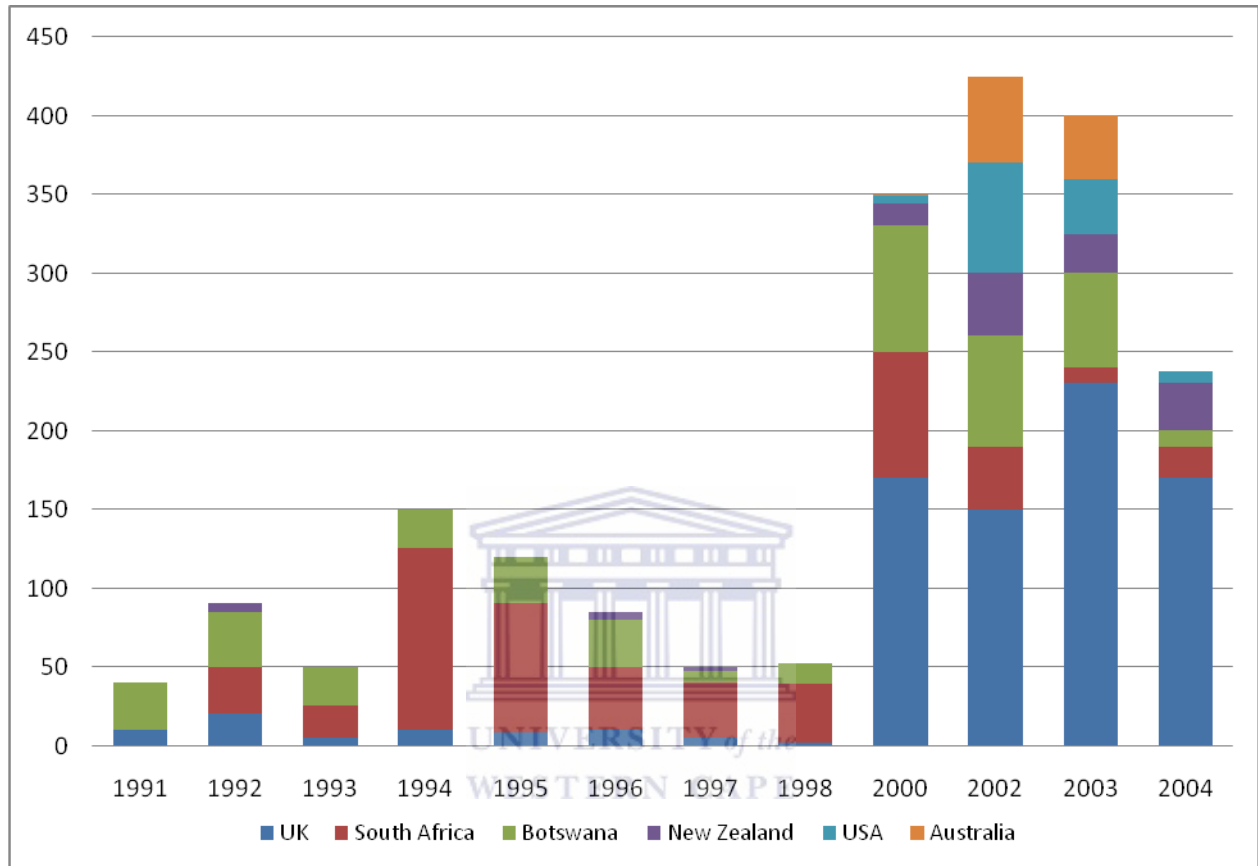
More shockingly, it was estimated that the number of Zambian-trained doctors practising in the United States and Canada alone was more than 10% of the total number practising in Zambia (Hagopian et al, 2004; Mwanza, 2010). Furthermore, according to the General Nursing Council

(GNC) in Zambia, about 1222 applications for nurses and midwives to work abroad were processed between 2003 and 2004 (WHO, 2006: 12).

Figure 1 below provides a picture of the destinations chosen by Zambia's migrating health workers between 1991 and 2004. South Africa and the United Kingdom attracted the most applicants. Before 2000, South Africa was the most preferred country. However, this may have changed due to the immigration policy introduced in 1994 to limit regional recruitment within the Southern African Development Community (SADC). The case was the opposite in the United Kingdom where recruitment from foreign nationals was being encouraged to fill in all vacancies (Hamada et al, 2009).

Table 10 below shows the extent of the shortages according to each health worker category as captured between 2004 and 2005 by the MoH. As can be seen, the staffing levels fell far below the desired establishment for all the health professionals. In total, out of the recommended quota of 49,360 health professionals for the MoH 2004-2005 countrywide, only 23,176 (47%) were available, with a shortfall of 26,184 (53%), more vacancies than filled posts. The MoH acknowledged that the problem with staffing shortages went beyond numbers and the overall headcount as there were severe staffing imbalances in terms of numbers, skills, the skills mix and geographical distribution (MoH, 2005:10).

**Figure 1: Number of registered nurses requesting for verifications from the General Nursing Council for top six countries (1991-2004)**



Source: WHO/GHWA, 2006: 20

**Table 10: Health Professionals in Zambia 2004-2005**

<b>Staff category</b>	<b>Staff levels 2004-2005</b>	<b>Recommended establishment</b>	<b>Shortfall</b>
Doctor	646	2 300	1 654
Nurse	6 096	16 732	10 636
Midwife	2 273	5 600	3 327
Clinical officer	1 161	4 000	2 839
Pharmacist	24	42	18
Pharmacy technician	84	120	36
Laboratory scientist	25	50	25
Laboratory technologist	100	210	110
Laboratory technician	292	1 300	1 008
Environmental health officer	53	120	67
Environmental health technologist	32	220	188
Environmental health technician	718	1 300	582
Dental surgeon	14	33	19
Dental technologist	40	300	260
Dental therapist	2	300	298
Physiotherapist (with a degree)	0	50	50
Physiotherapist (with a diploma)	86	250	164
Radiologist	3	33	30
Radiographer	139	200	61
Paramedic	320	6 000	5 680
Nutritionist	65	200	135
Support staff	11 003	10 000	-1 003
<b>Total</b>	<b>23 176</b>	<b>49 360</b>	<b>26 184</b>

Source: MoH, 2005: 12

### **HIV/AIDS among Health Workers**

HIV/AIDS was identified as the leading cause of death in the country and health workers were not spared, particularly nurses who make up about 70% of the total health workforce (CSO, 2007; Vitols et al, 2007). In the early 1990's, 40% of health workers were found to be HIV positive (WHO, 2006:23). However, by 2001, HIV prevalence was estimated at 44% among nurses and 39% among midwives (Whiteside and Barnet, 2002). A survey carried out by the

MoH on staff losses between January 2003 and June 2004 showed that while 32% were due to resignation, 38% of them were caused by death (Koot and Martineau, 2005:9). As a result, illness, absenteeism and death related to HIV were becoming more prevalent (Munjanja et al, 2005 cited in Vitols et al, 2007), resulting in an increase in workload.

The main reasons that hindered health workers from knowing their status included indecision, fear of a positive test result, concerns about confidentiality, lack of psychosocial support, fear of stigma and discrimination from fellow workers and lack of knowledge about the post-exposure prophylaxis (PEP) (Dieleman, Biemba, Mphuka, Marjdein and Kwaak, 2007; Kruse, Chapula, Ikeda, Mataka, Nkhoma and Bond, 2009; WHO, 2006).

### **Training**

The declining training output from training institutions was another major indicator that raised alarm about the human resource situation in the country. Professional and medical schools had a limited capacity to train additional numbers. By 2004, there were only 28 public training institutions and 11 private ones, with more than half of each of these being training for nursing and midwifery (Tjoa et al, 2010).

There was only one medical school producing an average of 50 doctors each year, several nursing schools and three technical colleges to graduate laboratory technicians, and pharmacy technologists (Makasa, 2009; Mwanza, 2009). In 2004, output from these produced only 49 doctors, 540 nurses, 20 pharmacists, and 38 laboratory technicians, far below the graduation rates required to maintain staffing levels (MoH, 2005; Tjoa et al, 2010; WHO, 2010). Table 10 shows that there were only 46 training institutions in the country by 2006. As a result of this, government called for an increase in current training enrolment by over 90% across all cadres (Tjoa et al, 2010). A Chief Policy Analyst at the MoH suggested

The population in the country was growing but the health workforce was stagnating. Therefore private training institutions were allowed to start operating so as to cushion the problem, health institutions such as clinics also had to be built and this has continued even with successive governments. Some actually had to be upgraded from mere clinics to mini hospitals. (Interview No.1 January 4, 2012).

**Table 10: Number of training institutions by type and ownership circa 2005/6**

Type of training institution	Type of ownership			Total
	Public	Private non profit	Private for profit	
Medicine	1	0	0	1
Dentistry	1	0	0	1
Pharmacy	1	0	0	1
Nursing and Midwifery	20	10	7	37
Health Sciences and Paramedical	3	1	0	4
<b>Total</b>	<b>28</b>	<b>11</b>	<b>7</b>	<b>46</b>

Source: Mwanza, 2010:38

According to the WHO Regional Office for Africa (2006), an evaluation showed that the training had no system of follow-up or motivation, therefore, significant financial investments were required to scale-up training for health workers in formal training institutions. Despite the fact that graduates were almost guaranteed of a government job, positions remained vacant either because there were too few graduates or that some simply turned down jobs as they were not willing to work in rural areas.

One of the major objectives of a meeting organised by the GHWA (2006:9) in April 2006 ahead of the launch of the World Health Report 2006 to discuss the human resources for health crisis in most African countries states was “to make politicians aware of the facts of the crisis, real numbers and not percentages which must be presented to help give them a concrete understanding of the extent of the problem”.

#### **4.3. Feedback**

As noted earlier, Kingdon (2003) states that policy makers also learn about conditions through feedback on the performance of various existing programmes or projects in the society. This is done through monitoring, evaluation and also by receiving complaints. As such, programmes not working according to plan or where implementation has failed are brought to the attention of officials. Policy makers learned about the condition of human resources through feedback from various existing programmes such as tracking progress on the attainment of the health reforms, MDGs, donor efforts related to tackling disease such as the HIV/AIDS and also through complaints from the general public on the state of affairs.

## **Health Reform Progress and Decentralisation**

It became clear that the health reforms, which the MoH had been implementing since 1992 and which aimed at improving access to cost effective quality health care as close to the family as possible, were not yielding much success due to unskilled and unprofessional personnel (MoH, 2005, 2011). When the reforms were initiated, some of the key strategies included the decentralisation of services and authority from the MoH headquarters to the districts, the creation of health boards and de-linkage of health workers from the civil service (Buchan and Martineau, 2000; MoH, 2005).

Health care delivery was decentralized to the health boards such as the Hospital Management Boards and the District Health Boards at hospital and district level respectively. Neighbourhood Health Committees and Health Centre Committees were also established at community level to promote and contribute to an increased sense of ownership and responsibility by the community. At national level, the Central Board of Health was created in 1995 under the National Health Services Act whose main mandate was to monitor, integrate, and coordinate the programmes of the Health Management Boards. It was tasked with running of the system and ensuring equity of access to healthcare facilities and resources (Mwale, 1999). The MoH was then left with the main responsibility of policy making and monitoring.

Through this, it was hoped that staffing would be made more flexible as the local boards would be in charge of recruitment and remuneration, thereby enabling them to pay better salaries in order to retain staff (Buchan and Martineau, 2000). Despite having human resource management structures and systems at the local level, recruitment did not follow the proper set standards by the government, partly because the boards, which had been given some autonomy on this, were not doing so in line with the laid procedures. There was a huge gap between the plans on paper and the actual operations as human resource systems at the local level had not been developed (Buchan and Martineau, 2000; MoH, 2005).

Moreover, the de-linkage of government health workers from the government was not supported by the unions. The expected benefits from de-linkage through improved terms and conditions was not happening, hence industrial action ensued (Blas, 2001; Buchan and Martineau, 2000). There was anxiety and confusion on how the de-linkage process would be done and what would

happen to pensions accrued once the process was complete. Employees remained unmotivated and the human resource situation, including service delivery in the country did not appear to be improving at all (Vujicic, Ohiri and Sparkes, 2009; MoH, 2005). This led to the government abolishing the Central Board of Health in 2006 and transferring back all its functions to the MoH (MoH, 2006).

Furthermore, the competing unions in the sector were not making things easy. One senior informant at the biggest civil servants trade union, the Civil Servants and Allied Workers Union of Zambia (CSAWUZ) said “platforms have always been there but they do not always translate into something meaningful. There are too many unions in health which makes it impossible to work together and negotiate. It disadvantages what we can do together.” (Interview No. 4, January 24, 2012).

Recent evidence has shown that there is a vital link between the number of health workers and both service delivery and health outcomes (Vujicic et al, 2009; WHO, 2006). Low staffing levels make it impossible to deliver essential health services to the population, as such, health reforms were failing due to the fact that a key component of staffing was neglected in their implementation (Buchan and Martineau, 2000). Generally, the media, trade unions and cooperating partners played a role in identifying human resources as a problem in health by providing feedback in many ways. As an interview with the Public Relations Manager from the national broadcaster revealed “our duty is to educate, entertain and inform. So in our duty to inform we did just that, informed the nation and provoked a lot of debate on the issue.” (Interview No. 6, January 25, 2012).

### **Progress on MDGs as Feedback**

The MDGs were agreed upon in 2000 at the Millennium Summit by all United Nations member states to address problems such as extreme poverty and hunger, education, women’s empowerment and gender equality, health, environmental sustainability and global partnership by the year 2015. The aim was to encourage development by improving the social and economic indicators of poor countries mostly in Africa, Asia and Latin America.

While other MDGs such as achieving universal primary education were on course, interviews held with different officials (see list of interviews, Appendix A) revealed that the human



resource crisis in health care presented a critical impediment to meeting the MDGs for health. The Director for Human Resources at the MoH indicated “we were made to pay more attention to human resources for health by the need to meet the MDGs. Also, there was a mid-term review of the NHSP (2001-2005) which revealed that there was a serious shortage of human resources which alarmed the donors.” (Interview No. 8, January 27, 2012).

The first and second MDG progress reports published in 2003 and 2005 respectively both highlighted that , the country was unlikely to succeed in meeting the MDGs related to health, (tackling maternal and child mortality, HIV/AIDS, Malaria and other diseases) by the year 2015 due to human resource constraints (UNDP, 2003 and 2005).

Whilst infant and child mortality were reported to be making steady improvements with significant reductions between 1992 and 2002, the maternal mortality rate on the other hand was reported to have increased from 649 in 1996 to 729 per 100,000 live births in 2002 (UNDP, 2003). The reasons for this included high percentages of unskilled home deliveries, limited access to facilities and the poor quality of health care owing to lack of trained staff and surgical and medical supplies (CSO, 2003). The incidence of malaria was pegged at 37% of all hospital patient attendance while HIV/AIDS infection stood at 16% of the population (CSO, 2003:57).

### **Donor efforts in health**

Cooperating partners form a significant part of the health sector in Zambia. According to information collected from various interviews, many programmes in health undertaken with donor funding and conditions were also reported to be failing due to lack of health staff. Evidence given by one of the senior government officials at Cabinet Office suggested so; “donors have been influential in ensuring that the programmes which they fund such as HIV/AIDS and others are implemented successfully. However, it was discovered that this was not the case, most of these were failing due to inadequate human resource, and they realised that they needed to deal with this too.” (Interview No. 7, January 4, 2012). This shows an indication of the failure of vertical/stand-alone programmes in that resources could not be diverted to human resources.

As access to ART in the country continued to grow, the non-availability of trained health personnel became an important limiting factor in the provision of services (Kruse et. al, 2009).

Therefore, training, re-training and retention of staff were identified as critical in the fight against HIV/AIDS (Makasa, 2009; MoH, 2011). This was a particularly pressing need so because the same staff that were required to attend to their daily nursing duties were also needed for the many other services offered by the health centres. For instance, ART clinics were opened in most of the centres to deal with the overwhelming number of HIV cases, but in most cases the centres had employed no additional staff. This placed a huge strain on the already fragile human resource base (Sanjana, Torpey, Simumba, Kasonde and Nyirenda, 2009).

Interviews (4 and 5) also revealed that there were numerous complaints from the public concerning the lack of health personnel at health centres. The media reported on people complaining of waiting in long queues waiting to be attended to, and some patients dying before they could see a doctor (Makasa, 2009). There was also increased frustration from health workers regarding their conditions of service, leading to a nationwide strike in 2003 to press government to listen to their demands. This situation, coupled with many others as discussed above provided feedback to policy makers on the human resource situation in the country.

#### **4.4. Focusing Events**

Kingdon (2003) argues that sometimes, problems are not always self-evident through indicators or feedback and therefore require a little push to get the attention of policy makers. This push usually comes through the form of a focusing event like a crisis or disaster that leaves government no choice but to address the issues surrounding the particular event.

In the Zambian case, there is no single focusing event that can be designated as a major disaster leading to the recognition of human resources for health as a serious issue by government. . Instead, there were individual cases reported and monitored such as people dying because of inadequate staff. One reason owing to this is the fact that many issues that happen in the health sector always manage to get everyone's attention because health is universal, affecting everyone (Kingdon, 2003). However, most times, focusing events do play a critical role in problem definition.

There were a number of events between 2005-2006 that played a focusing role (2006 elections, decision to have the WHO launch of the World Health Report-2006 in Lusaka and the dramatic reversal of user fees in 2006). But it is unclear whether these were in the problem stream or in

the political stream for example the 2006 election presented a problem to the ruling party of Mwanawasa since there was significant electoral uncertainty with civil society mobilization in urban areas and the rise of populism in the form of Michael Sata, a presidential hopeful (Larmer, 2007). However, I have decided to look at this problem in the political stream in chapter 6.

#### **4.5. Conclusion**

This chapter sought to understand how problems are defined as such to get the attention of government officials. It has been established that a combination of factors, more especially indicators and feedback that combined to classify lack of human resource for health as a problem. Interviews and other sources of data reviewed revealed that migration, training capacity and HIV/AIDs were the main indicators that raised awareness on the gravity of the situation.

Feedback came through the monitoring of progress on the health reforms and the provision of quality health care close to the family, progress on the attainment of the MDGs as well as progress on the donor funded programmes in the Ministry. Complaints from members of the public and the health workers themselves affirmed the situation to ensure its rise on the top government agenda. The media also played a role of informing the public on the state of affairs on the ground. Whether this affected policy makers in any way shall be established in the following chapters. It has also been established that focusing events could not be isolated on their own as most of the indicators and feedbacks alone were enough to attract attention. The recognition of this as a problem will play a very important role in the next chapters to follow.

## **CHAPTER FIVE: THE POLICY STREAM**

### **5.1. Introduction**

The policy stream is the second of Kingdon's three independent streams. In this stream, there are a number of ideas, suggestions and proposals floating around but only a few of those are ultimately considered and selected. This selection is based on a number of factors such as value acceptability and, technical feasibility, among others (Kingdon, 2003). Proposals that appear difficult to implement have a lesser chance of selection.

This chapter seeks to answer the question: "How was the proposal for human resources for health formulated and accepted for serious consideration by policy makers in Zambia?" The chapter will begin by looking at the role of policy entrepreneurs and who exactly constituted this grouping in Zambia. Thereafter, six more or less competing policy alternatives will be discussed. A table will be drawn to show the key features of each alternative and I will try to explain why these failed or were abandoned midway. The formulation of the HRH Strategic Plan will also be discussed in detail outlining the objectives, and the solutions proposed to deal with the crisis.

### **5.2. Policy Entrepreneurs**

The policy stream involves the generation and specification of policy solutions to problems by members of the policy community, which includes policy actors inside and outside of the government who interact with each other, exchange ideas, and formulate and reformulate policy alternatives (Young et al, 2010). These networks are made up academics, research think tanks, bureaucrats, staff and members of parliament, and funding organisations who share a common interest in a particular policy area (Zahariadis, 1999).

Policy entrepreneurs are those individuals who are willing to invest their time and resources in pushing for the adoption of a policy that they may have an interest in (Zahariadis, 1999). As they build acceptance for their proposals, they win over both the policy community and larger publics so as to improve wider receptiveness to their ideas. They introduce bills, hold hearings, make speeches, hold paper presentations, amend proposals, and issue studies and reports (Young et al, 2010; Zahariadis, 1999).

Field work interviews conducted (by the author in 2012) and a literature review revealed that a number of stakeholders were involved in the development of policy alternatives. Stakeholders can be defined as “organisations and individuals that are involved in a specific activity because they participate in producing, consuming, managing, regulating, or evaluating the activity.” (Hyder, Syed, Bloom, Mahmood and Peters, 2010:160). Stakeholders from individual to community level play a very important role in policy formulation as they allow health interventions to be seen from different angles.

The main multilateral partners in Zambia’s health sector are the World Bank, EU and the UN agencies such as WHO and UNDP. The main bilateral partners include Canadian Development Agency (CIDA), Swedish International Development Agency (SIDA), Health Systems Support Programme (HSSP), GWHWA, Department for International Development (DFID) and United States Agency for International Development (USAID) who all provided a significant amount of resources both financial and technical to ensure that a proposal was formulated and implemented. As for the ordinary population, there was no platform for them to make any direct input. The policy making process in Zambia generally leaves very little room for ordinary members of the population to participate directly), and health policy is no exception (Ngulube, Gilson, Erasmus, Kamuzra, Matthews and Scott, 2006). As an official from cabinet office disclosed

When it comes to policy making, there is a whole process involved starting from the Ministry ending with our office. There are different players involved at every stage of the process, usually senior people who undertake to perform the task of formulating a policy based on consultations, feedback and interactions with the people. So yes people are involved *indirectly* (my italics) because we get their concerns and try to work on them (Interview No. 10, August 13, 2012).

In the case of the HRH Strategic Plan, the document was developed by the MoH with the help of cooperating partners and was *later* circulated to other parties, such as trade unions and associations within the health sector who only then had a chance to add their input. Because these groups represent the interests of their members, ordinary citizens just have to rely on those in charge to do the right thing for the benefit of both the patient and the caregiver in all decisions.

According to interviewed sources (Interviews 6 to 8) the EU, as the lead donor for that year, 2005, and GHWA were key policy entrepreneurs who committed significant financial resources to ensure that the Plan was formulated and implemented. The WHO, in particular gave “technical” support in as far as preparation of the plan was concerned as it does not usually provide money (Interview No. 9, January 26, 2012). The table below summarises financial input for human resources from donors in 2006.

**Table 11: Ministry of Health 2006 budget estimates of human resource activities by funding source.**

<b>FUNDING SOURCE</b>	<b>AMOUNT (US \$ MILLION)</b>
EU	6.5
Expanded Basket	0.3
Global Fund	0.1
Government of Zambia	6.6
SIDA	2.6
USAID/HSSP	1.3
WHO	0.0
World Bank	0.1
<b>TOTAL</b>	<b>17.4</b>

Source: Goma, 2008: 19

As table 12 shows, the Zambian government and the EU commitment were almost the same in 2005. This can be explained by the fact that the EU was the lead donor for health activities in that year. Every year, the various cooperating partners decide which organisation will be the lead donor, to not only put in more funds but also to organise, direct and lead programmes (Interview No. 9. January 30, 2012). The MoH also consulted some renowned specialists in the development of the Plan, with a lot of input from the WHO (MoH, 2006).

### **5.3. Policy Alternatives**

Policy alternatives are generated by government officials and administrators, policy advocates, academics and all those who may be described as policy entrepreneurs. People debate and generate solutions because they have some self interest in doing so and not because the solutions are in response to the problem. Rather, these proposals are tailored to meet an anticipated budget

constraint, to win the favour of the public and also to gain approval of elected officials (Kingdon, 2003).

When asked which policy proposals related to the human resource crisis were available before 2006, interviews (1 to3) together with a review of secondary data revealed that from the year 2000, a number of alternatives were debated in the country. Furthermore, the MoH usually worked on different documents at once, each tackling a different aspect of the health sector related or unrelated to the crisis.

Apart from slight budget increases for health, some of the proposals that had been tried were the NHSP (1995-1999), national 10 year human resource plan in 2001, human resource policy 2002, Zambia Health Workers Retention Scheme in 2003, and the task shifting project in 2006 as can be seen in the table 13 below. It is important to note that while some these proposals had been tried or were being tried out, they were not in direct response to the human resource crisis as identified in 2005, rather, they related to the general human resource needs of the health sector, before the situation was labelled as a crisis by both international commentators and the government. However, because of most of these were not adequate to deal with the crisis on their own, the HRH Strategic Plan (2006-2010) was formulated as a comprehensive and all-encompassing document to address many issues, being implemented alongside other plans such as the task shifting project.

**Table 12: Overview of proposals for human resources for health in Zambia up to 2007**

<b>FEATURES</b>			
<b>Policy Document</b>	<b>Aims/objectives</b>	<b>Solutions/strategies</b>	<b>Funding/revenue</b>
National Health Strategic Plan (NHSP) 1995-1999	Define new standards to implement health reforms and motivate workforce; decentralisation	Develop HR policy and redesign organisational structure and job descriptions	Government, cost sharing, private medical schemes
National 10 year HR Plan for the public health sector, 2001	Define staffing as at 2001, define future staffing, define changes to be made to achieve future staffing	Increase training output by 70%, budget for salaries and increments and routine monitoring	Government, Department for International Development (DFID)
Zambia Health Workers Retention Scheme, 2003	Replace Dutch doctors under a bilateral agreement between Zambia and Netherlands	Offer an attractive retention allowance to doctors to serve in rural Zambia	Government, Royal Netherlands Government
Synopsis document on current staffing and action proposal, 2004	Define staffing as at 2004 and outline action plan to address the situation	Find immediate solution to human resource crisis based on identified criteria	Government, HSSP
Task shifting project, 2006	Having enough health workers to deliver universal access to health care	Shift tasks from highly specialized to less specialized health workers to be trained	Government, WHO and PEPFAR
Human Resources for Health Strategic Plan 2006-2010	Tackle all problems related to HR in a more systematic and coordinated manner	HR planning, training, monitoring and evaluation	Government and several partners both local and international



i. **National Health Strategic Plan (1995-1999)**

The NHSP (1995-1999) was formulated against the backdrop of decentralisation with the sole purpose of defining new standards for implementation of the health reforms so as to ensure the most efficient and effective delivery of health services to the people. It was not really a plan as such but more of setting standards and regulations. The standards were intended to provide guidance to districts in setting local standards, provide estimates on resources needed to transform the health system into a cost effective one as envisioned (MoH, 1996). Besides the National Health Policies and Strategies document of 1991, this was the first plan by the government to articulate the standards of the health reforms (Ibid: 5).

Because the development of human resources is critical to the implementation of the health reforms, the Plan gave attention to developing the appropriate skills, competencies, knowledge and attitudes required to deliver the essential package of health care during the five year period of implementation. The vision of the Plan in this regard therefore was “to provide a well-motivated workforce, operating in a conducive environment in which the right skills were available in the right place at the right time to deliver cost effective quality health care service as close to the family as possible.” (MoH, 1996:37).

The focus here was more on ensuring that the right mix of personnel was available in order for the reforms to succeed. There was not an emphasis on human resource per se or that it was a critical issue that needed its own solution. However, the strategies identified to achieve this included redesigning organisational structure and job descriptions for all levels, developing human resource and selection practices such as appraisal and reward systems, introducing training plan, developing retention policy and developing a human resources policy taking into account the overall MoH gender policy. Most of these were actually developed, however implementation was poor and funds were inadequate in the case of retention, hence this was only implemented two years later with external funding.

The next NHSP (2001-2005) also provided for the strategic objectives and outputs for the management and development of the human resources for health (Koot and Martineau, 2005). The MoH subsequently formulated a 10- year human resource plan.

ii. **National 10 year human resource plan for the public health sector, 2001**

In 2001, the MoH developed a 10 year plan which laid out staffing levels at that time. The Plan was divided into three phases. Phase 1 was to define the current staffing situation, phase 2 was to define staffing standards for the future and phase 3 was to project the changes that would need to be made to achieve the desired staffing standards.

The situation analysis in phase 1 showed that collecting data on staffing levels proved a challenge as initiatives to do so in the past were incomplete and failed to produce reliable data. In 1998, data was collected despite uncertainty as to whether de-linkage of staff from the MoH to the boards was to occur, and the implications of collecting data on MoH staff if and when there was to be a radical movement of staff across the country in the future eventually. Furthermore, by the end of 1999, it was reported that many health workers had left the service due to voluntary separation and fresh data had to be collected again (MoH, 2001).

Generally, it was revealed that there was not an up to date establishment hence vacancies could not be determined. The recruitment system by the boards was marred by irregularities, bonding rules after training were not enforced, salary imbalances existed among staff with similar training, and there was a lack of adequate human resource information and poor staff retention (MoH, 2001).

In phase 2 and 3, staff projections to 2010 were made on the basis of simple population ratios. Considering the impact of HIV/AIDS on population growth, the population growth rate was estimated at 2.3% up to 2004 and thereafter 1.7%, thus assuming that by 2010, the national population would have grown to 13.4 million. In order to maintain staffing levels therefore, staff needed to increase by 12.3%. This would only be addressed through training, with projected salary increments of 71% (Ibid: 26). Constant and comprehensive human resource planning and monitoring was recommended.

However, the MoH and the Central Board of Health acknowledged that the Plan was only a rough first attempt to define practical and sustainable staffing needs for the future. In addition, more effort was needed to develop better approaches to determining these needs in relation to the delivery of the health care at each level (Koot and Martineau, 2005). Nonetheless, the Plan

offered guidance and information for decision-making and a great foundation for development of future proposals.

iii. **Zambia Health Workers Retention Scheme, 2003**

To tackle problems of inadequate levels and distribution of health workers, the Government of the Republic of Zambia in partnership with the Royal Netherlands Government embarked on a pilot health workers retention scheme for health professionals in 2003. The scheme had as a first objective to replace the Dutch doctors, working under the bilateral agreement between Zambia and the Netherlands (Koot and Martineau, 2005). As such, the scheme began initially with attracting doctors to work and be retained in the rural and deprived areas.

The overall objective of the scheme was improved service delivery in the rural and underserved parts of the Zambia, thus contributing to not only the attainment of the health related MDGs but also ensuring environmental sustainability, developing a global partnership for development by providing access to affordable and essential drugs to rural communities, meeting basic needs and expanding economic opportunities thus reducing poverty and hunger (Koot and Martineau, 2005).

The scheme provided both non-financial and financial incentives. The non-financial included priority consideration for further studies, improves working environments and annual performance assessments. Financial incentives were in the form of a fixed hardship allowance, school fees per child (maximum 4) up to 21 years, assistance with post-graduate training at the end of the three-year contract, loans facility for a car or a house, including funds for renovation of government housing (Ibid).

By the end of 2005, there was some level of success, 66 doctors had been attracted to work in rural areas. According to the *Times of Zambia* (28 December, 2006), Zambian medical doctors abroad were returning home. Because of the success scored, the scheme has since been extended to other health workers considered as critical in the rural areas, among them tutors and nurses. Despite success, it has not been sufficient as it does not apply across all disciplines in the health sector, leaving out other workers such as those in the pharmacy and lab. Government has argued that this is because the latter are not at the level of primary health care especially in the rural

areas (Ngulube et al, 2006). The number of supporting partners has since increased and includes USAID, HSSP, EU, SIDA, DFID and CIDA (Makasa, 2009).

iv. **Synopsis of current staffing and outline proposals for action, 2004**

This document, prepared in 2004 provided a situation analysis of the human resource crisis and included corrective measures whose findings reached cabinet office, leading to the presidential directive to develop the HRH Strategic Plan (2006-2010) (Chankova and Sulzbach, 2006).

Tasks and activities in the synopsis document were grouped under four main activities for action with an associated timeline namely, actions to create a strong structure to manage the crisis, actions to respond immediately to the crisis, actions to strengthen systems to improve human resource management capacity and actions to remedy deep seated human resource problems (Chankova and Sulzbach, 2006; Koot and Martineau, 2005).

In order to create a strong structure to manage the crisis, the document recommended replacing the human resource task force or steering committee which comprised senior members of staff from the MoH and donors with a high level human resource crisis group chaired by the Permanent Secretary and comprising members from various government departments. Actions for immediate response included developing a comprehensive human resource data base as an urgent priority and also to tackle absenteeism through provision of free ART to those living positively to boost morale and to reduce on the amount of time spent attending workshops.

To improve management capacity of human resource, the synopsis document recommended introducing a payroll management establishment control to monitor payroll and avoid “ghost workers” from being paid. This was achieved within a short period of time and the appointment freeze that had been there was removed. Suggestions for addressing deeper problems associated with human resource in the long term included measures such as requesting migrant countries to assist in controlling Zambian health workers’ migration and developing a revised strategic plan specifically for human resources. Overall, this Plan was successful as most of the recommendations presented in the document were implemented subsequently and some were incorporated in the health strategic plan for implementation (MoH, 2005).

v. **Task Shifting Project**

Following the launch of a comprehensive HIV/AIDS policy in January 2005 and the provision of ART free of charge at all public health centres in the country, the MoH had to strengthen its overall capacity to positively respond to the challenges posed by the virus which was one of the biggest challenges facing the health sector (CSO, 2007). Realising that there were not enough health workers to deliver universal access to health care, especially HIV prevention, treatment and support, government agreed on task shifting, a project which was advocated by the WHO in order to attain the MDGs on health and to expand the pool of human resources for health began in 2005.

Task shifting is a process of delegation whereby tasks are moved from highly specialised health workers to less specialised ones who can be trained to do the task (WHO, 2007). In this case, tasks normally performed by doctors, nurses and pharmacists, such as, counseling were reallocated to other health workers. Once problems were identified, staff members from the clinical side designed and implemented specific interventions to address targeted areas.

PEPFAR, the single biggest donor in the health sector (Pereira, 2009) and WHO collaborated with the government in this project so as to increase the numbers and skills of the health care workforce as response to the HIV epidemic by improving the overall access to and quality of HIV/AIDS prevention (Makasa, 2009). Since 2004, when spending for HIV/AIDS began to rise most rapidly, most increases can be attributed to the PEPFAR alone. By 2006, PEPFAR money constituted 62% of HIV/AIDS resources in Zambia (Oomman, Bernstein and Rosenzweig, 2007).

The WHO (2007) warned that the strategy must be implemented within a system that contains adequate checks and balances to protect both health workers and the people receiving treatment and care, with the necessary health legislation to enable and regulate it. In line with this, the MoH developed a national training programme for peer educators so that they could officially be a part of the structure (Morris, Chapula, Chi, Handson and Mwanza, 2009).

Community volunteers began to be trained as lay counselors in order to cushion the problem of staff shortages generally and with specific reference to HIV counseling and testing. The national training package, which began in 2005, included being in class for two weeks where role plays

and case studies were done, followed by a supervised practicum of four weeks after which the trainees were certified. In a task shifting project conducted in Lusaka between 2005 to 2007, 516 health providers in adult HIV treatment were trained, 270 in pediatric HIV treatment, 341 in adherence counseling, 91 in a specialty nurse "triage" course, and 93 in an intensive clinical mentorship programme. (Morris et al, 2009: 40). The task shifting was made in such a way as to meet the health care worker needs and also to sustain ART scale-up activities.

Before the introduction of lay counselors, counseling and testing services were provided primarily by nurses during their free time and the challenges faced in human resource did not make this any easier as some health centres did not have staff dedicated to providing these services (Sanjana et al, 2009). While the approach may have been successful, long-term solutions to the human resource crisis were urgently needed.

vi. **The Human Resources for Health Strategic Plan (2006-2010)**

**Introduction**

Following the severity of the crisis and the failure of other previous documents to address the crisis, government, together with its cooperating partners saw the need to come up with a formidable way of tackling the situation. The HRH Strategic Plan (2006-2010) was formulated as a directive by the Republic President of Zambia in 2005. It is the first comprehensive and integrated plan to adequately address the human resources shortage in the health sector by harmonising all the other efforts in this regard. A senior staff from the MoH stated,

The human resource strategic plan is a product of so many other plans in the past to try and address issues with human resource but this one is the most serious. Others did not achieve much but this one came from the President so we are worked up to ensure it works (Interview No. 3, January 24, 2012).

The aim of the Plan was “to ensure an adequate and equitable distribution of appropriately skilled and motivated health workers providing quality services.” (MoH, 2005:24). The HRH Strategic Plan was thus formulated as a tool to improve staffing by 2010 so that the MoH could achieve its aim of providing health services as close to the family as possible. This was done after consultations with various stakeholders and co-operating partners who included both

international and local development organisations, trade unions and the various professional health associations. The Plan examined the scale of the problem and its effect on the delivery of health services in Zambia. It described the fundamental causes of the problem, suggested solutions, potential impediments to the solutions, and ways to overcome the potential impediments. It called for increased staffing levels from about 23,000 in 2005 to about 51,000 by the year 2010.

### **Scale of Problem and Solutions**

Among the causes of the problem identified were poor working environment such as inadequate medical and surgical supplies, dilapidated work facilities, weak human resources management systems resulting in delays in processing appointments, promotions, confirmations, transfers, payments of salaries and other conditions of service to health workers. Also cited were inadequate education and training systems, absence of approved structures for health workers and support staff and the inadequate funding to the health sector. As a result of this, health workers were attracted elsewhere by better conditions of service and career development opportunities.

Therefore, key areas which were identified as a solution to the above problems were making jobs more attractive through improving conditions of service, creating an enabling and conducive workplace environment and utilising staff more effectively and efficiently through improved human resource management and practices. Furthermore, the government was committed to increasing the budgetary allocation to the health sector in the first year of implementation of the Plan to facilitate recruitment of new graduates and retention of existing skilled workers by paying them an allowance.

The MoH also acknowledged that while data for employees in the government sector and in mission-run institutions was available, it was drawn from several different sources as there was no single source providing all types of data needed. This may have resulted in some discrepancies in the data provided on the actual number of staff in various categories. Improving the availability and timely collection of data was therefore an activity included in the strategic plan (MoH, 2006)

## **Objectives and Strategies**

The main objectives of the Plan were to ensure a coordinated approach to planning across the sector, increase the number of trained and equitably distributed staff, improve productivity and performance of health workers and strengthen human resource planning, management and development systems at all levels (MoH, 2004).

This was to be achieved by developing monitoring and evaluation systems to track progress regarding the implementation of the Plan, making adjustments so as to inform further development of the Plan, ensuring human resource planning is coordinated across the health sector and is based on the best available data, and increasing the training output by expanding the number of training places available in training colleges as well in service training.

### **4.4. Criteria for selection in the Ministry of Health**

Since not all proposals can be selected for implementation at a given point due to resource constraints, the selection criteria are important. Interviews with officials from the policy and planning department at the MoH revealed that once a year during the planning for the MoH, different departments are asked to submit plans of what they want to be achieved so that this can be in the action plan. Because of such competing needs, the planning team indicated that it picks the most critical ones, and not necessarily the ones that are easier to resolve and score success.

In previous years submissions had been made for healthcare human resources, resource constraints had militated against them being included. As a result support was given to piecemeal projects that cushioned, but did not adequately address, the problem. It was because of the presidential directive that the Plan was formulated. The issue was on the government's agenda and due to the fact a number of alternatives had been tried previously without success, finding a solution had become pressing.

If a problem presented by one department also happens to concern other departments, the stakeholders are called upon to discuss the issue. It was also revealing that in choosing which issues to put forward, the MoH paid attention to what is obtaining on the political scene. A senior staffer in the planning department at the MoH stated "in deciding which plans to formulate, we also look at political statements and what the government of the day wants to achieve, and then



we as a Ministry must formulate plans according to this because we are part of government.” (Interview No. 3, January 24, 2012). Therefore, governments manifesto is a major guiding principal and the MoH submits a proposal to cabinet office for approval and allocation of funds, which in most cases feedback is always positive.

Aware of the fact that the MoH largely depends on donor funds for most of its programmes to succeed, the informant at the MoH added “we have a SWAp (sector-wide approach) method between ourselves and cooperating partners where our priority needs are identified and presented to donors to see which ones they can fund.” (Interview No. 3, January 25, 2012). The SWAp which was introduced in 1994 is in line with the Paris Declaration on Aid effectiveness of 2005. However, other officials pointed out that in most cases, donors fund specific programmes, particularly those related to HIV/AIDS, malaria and TB and such monies cannot be diverted to other areas that may need funding (Interviews No. 4, 5, 7, 8 and 9).

## **5.5. Conclusion**

This chapter shed light on some of the proposals which were available to address the human resource crisis, programmes to scale up treatment for all people living with HIV, including health workers by providing them with free ARVs, and task shifting which proved a success. Thus, in answering how the proposal was considered for serious action and who was involved, it has been established that cooperating partners and especially the main donors played a huge role in ensuring the formulation of this plan as they provided both technical and financial support. They worked tirelessly to ensure that government showed that it was ready to deal with the situation so that programmes aimed at fighting diseases such as HIV/AIDS especially were on course. They played the role of policy entrepreneurs to demand that such a plan be in place prompting the Presidents intervention. The strategic plan was thus formulated within a very short duration of three months and was ready by December 2005 even though it was only officially launched in January the next year.

## **CHAPTER SIX: THE POLITICAL STREAM**

### **6.1. Introduction**

According to many policy analysts, developments in the political sphere alone can be powerful agenda setters (Birkland, 2005; Huang, 2006; Kingdon, 2003; Sabatier, 1999). In this chapter, the focus is on the last of Kingdon's three independent streams, the "political stream". The political stream follows its own dynamics and rules, with factors such as: the national mood, pressure group campaigns and administrative or legislative turnover being the most vital contributors to influencing the prominence of an issue on the state's agenda. For instance, a new administration might bring new agenda items while at the same time existing issues are shelved until an opportune time comes by.

The chapter will look at how such dynamics and factors developed in Zambia and the role that visible and invisible participants played in putting the human resource crisis on the agenda. The question being answered in this chapter is: "what elements in the political environment helped to push the issue of human resources to high prominence on the state's agenda?" The chapter begins by describing the general roles of both the visible and invisible participants, before describing the national mood and the influence of interest and pressure groups as articulated by Kingdon. The chapter will finish with a summary of the contents of this last stream.

### **6.2. Visible Participants**

In as far as agenda setting is concerned, those actors who receive the most press and public attention such as the president, his top appointees, members of parliament and other elected officials, top opposition party leaders, and other media houses make up the visible participants. They are the ones seen in the public domain and it is assumed they are directly responsible for policy. As such, they seem to affect the agenda more than the invisible participants even though they do not always get their way in specifying alternatives or implementing decisions (Kingdon, 2003).

Following many reports and documents by both the government and cooperating partners such as: "Sharing Experiences- Meeting Report", "Strengthening Human Resources for Health", "Synopsis of current staffing levels", "Millennium Development Goals Progress Report", (GHWA, 2006; HSSP, 2005; MoH, 2004; UNDP, 2003, 2005) and revelations of the human

resources crisis by the media in newspapers and television (Makasa, 2009 ), the President , Levy Mwanawasa in August 2005 directed the MoH to come up with a solution to deal with the crisis, leading to the formulation of the first HRH Strategic Plan (2006-2010), which has since gone into a second phase (2011-2015). The revelations contained in the synopsis document on the human resource crisis produced in 2004 prompted this. As such, the plan was largely conceived from the top, showing a clear top down structure.

The President's role in setting the agenda for human resources for health was very clear and very powerful as the first draft of the plan was ready by November, 2005 and officially launched in January 2006 in Lusaka where different stakeholders were invited to witness (WHO, 2006). Top appointees such as the ministers and permanent secretaries in the MoH and Labour respectively were also very instrumental as they form part of the technical committee and responsible for reporting progress to the president (Cabinet Office, 2010). Issues of human resources in the government are a function of the Ministry of Labour since it is the overall governmental body in charge of labour and employment policy, therefore, the two ministries worked together.

Members of parliament in Zambia (both from the ruling party and opposition) are elected by the people in the various communities using the simple majority or first past the post system. The speaker who is elected by the members is the chairperson of the national assembly while the vice president is leader of the house in parliament. According to articles 62 and 63 of the Constitution of Zambia, parliament consists of the president and the national assembly. The republican president, through the powers conferred by the constitution, calls parliament to meet, orders elections to take place and gives final approval to laws (the presidential assent) but does not otherwise play an active role in parliamentary work. It is the national assembly, which consists of elected and nominated members of parliament that carries out a wide range of important public responsibilities (Republic of Zambia, 1996:35)

The major functions and powers of the national assembly include making laws, monitoring the executive, passing the national budget by approving the proposals presented in the house, impeachment of the president should there be serious cause to, ratification of various appointments and proposals (Mwanza, 2010). There are various parliamentary committees which are responsible for looking into specific issues as their mandate stipulates. The parliamentary committee on health, community development and social welfare is responsible for studying,

reporting and making recommendations to the government through the house, on the mandate, management and operations of the ministries of health, community development and social services and departments and/or agencies under its portfolio.

However, this mandate is very limited as the committee can only monitor and evaluate the use of funds for the health sector for example by reviewing the auditor general's annual financial report. The committee neither has the legal authority to change or provide input into the establishment of the health-sector ceiling nor the power to follow up on whether or not the MoH accepts their budgetary recommendations (Inter Parliamentary Union, 2009). Members of parliament can only report any misuse of funds because they are not authorized to follow up on whether the government takes action against those accused of misappropriation. In an interview on the role of the parliamentary committee regarding health and the human resource crisis, a senior staffer at parliament responded

The Ministry develops policy while the parliamentary committee provides oversight, checks on programmes and organisations related to health if they are in compliance with the law and if programmes are being implemented accordingly. We have never looked at the human crisis as an issue on its own, it has always been discussed in passing. So the committee usually writes a report based on its investigations about a particular issue and then presents it to government through the minister. Whether or not those recommendations are worked on is something else (Interview No 11, August 14, 2012).

Therefore, in contributing to discussions and debates surrounding human resources for health in the country, involvement of members of parliament was more pronounced after the plan had been developed than before as there is little or no interaction at policy level between the legislature and the executive. The Minister of Health then, Sylvia Gazebo informed the house in a ministerial statement on March 23, 2006 that the country was selected as the first African country to host that year's World Health Day on April 7, 2006 at which the World Health Report 2006, "Working Together for Health" would be launched. The country was chosen as it was one of the 57 countries worldwide suffering from a critical shortage of health workers. The minister stated;

Mar. Speaker, as a country which has been affected so much by the human resource crisis, this event poses a unique and great opportunity for Zambia to sell itself, to raise awareness on the gravity of our problem. This is also an opportunity for us, as a country, to lobby for support from our co-operating partners in our quest to resolve the human resource crisis. It is also a great opportunity for us to raise awareness even among the policy makers so that next year as I continue sitting in Cabinet after the elections under the New Deal Government, the hon. Minister of Finance and National Planning, will give me 15% of the budget because he will have appreciated being part of this process. ([http://www.parliament.gov.zm/index.php?option=com\\_content&task=view&id=339&Itemid=86&limit=1&limitstart=1](http://www.parliament.gov.zm/index.php?option=com_content&task=view&id=339&Itemid=86&limit=1&limitstart=1))

The process the Minister refers to are the activities that preceded the launch of the report and the outcomes expected thereafter. However, only 10.8% of the national budget was allocated to the health sector in 2007, no different from 10.7% allocated in 2006 (MoFNP, 2007)

The fact that the country was chosen to host the occasion enhanced the debates and the activities leading to the launch of the report. It also helped to enlighten people about the circumstances in which the health sector was operating and parliamentarians used the opportunity to ask questions around the HRH Strategic Plan and its implementation. Issues raised included ensuring that training institutions in all provinces were well equipped to take on additional numbers and the need to engage the recipient countries of the health personnel so that some kind of compensation could be made for the resources spent on their training by the Zambian government. Parliament also approved the 18% of the 2006 discretionary budget to be spent on the health sector to cater for HIV/AIDS control and mitigation, primary and community health care, purchase of medical equipment and drugs, transfers to hospitals and clinics as well as out-patient services. In addition, government pledged to increase salaries and other allowances and to recruit 800 medical personnel to address the problem of inadequate staff in all health institutions particularly in rural areas (Magande, 2006).

The World Health Report highlighted the global human resource crisis and emphasised the importance of having enough health workers and finding ways to train and recruit more of them. The report also recommended that hardest hit countries develop national health workforce strategies whose ultimate goal was a delivery system that could guarantee universal access to

health care and social protection to all citizens and that each nation was to devise its own plan based on its situation and social consensus (WHO, 2006).

Because 2006 was an election year to vote for the president, members of parliament and councillors, there is no doubt that this had a significant influence on the pronouncement made by the president to have human resources dealt with, including the scrapping of user fees. The election year could not have been a better time for the government to show the electorate that they were a listening and attentive government committed to providing quality health care for all Zambians, and this was affirmed by the minister of health in her statement in parliament.

The election was tightly contested with five candidates vying for the presidency in the fourth general elections since the restoration of multiparty politics in 1992. The BBC reported that health was considered one of the key issues for the polls, with the Minister of Health stating that if his government were re-elected, it would liaise with foreign governments like the UK to allow only a limited quota of nurses to work for a limited period of time (Swinburne, 2006).

However, the ruling party faced stiff competition from two opposition political parties, one of which was favoured to carry the day by some opinion polls conducted before the election (Centre for Policy Dialogue, 2011). Nonetheless, the ruling party emerged victorious according to simple majority system practised in Zambia, with 43% of the votes and the incumbent earned a second term in office, while his closest rival stood at 29% (Electoral Commission of Zambia- ECZ), 2006). The elections were deemed generally free and fair by many observers both local and international despite allegations of rigging from the losing candidates. The media reported that some supporters of the candidates, particularly those of the closest rival in the election took to the streets to protest and dismiss the results as fraud (<http://news.bbc.co.uk/2/hi/africa/5398252.stm>).

### **6.3. Invisible Participants**

As opposed to visible participants, invisible participants are not usually in the lime light. According to Kingdon (2003), they include such people as consultants, researchers, career bureaucrats, academicians, staff at parliament, and analysts working for interest groups. This hidden cluster of participants forms a loosely knit community of specialists in a particular area of interest where they usually try out various proposals in a variety of ways through speeches,

hearings, business lunch or dinner meetings, parliamentary committee hearings and bill introductions.

The national political system partly shapes which domestic actors have policy power and how much. Similarly, government and health care system structures shape which actors have policy influence and how much influence in the health sector. Bureaucrats such as staff in the department of human resource at both the MoH and cabinet office were responsible for much of the analysis of the crisis and supporting the MoH in ensuring that a solution was reached. They compiled reports and sat on various committees that were dealing with the issue, for instance the Task Force on Human Resources for Health Implications for Universal Access to HIV Prevention, Treatment, Care and Support which was sponsored by the GHWA had representation from the two government departments (MoH, 2011).

Because the head of cabinet is the republican president, all decisions within government including funding, appointments and dismissals are made in his name and on his behalf. While most of the bureaucrats may be neutral with no affiliation to the ruling party, they serve the government of the day. Therefore, the President's declaration to the MoH to do something about the crisis meant that cabinet was obligated to offer all the support it could. As such, when the HRH Strategic Plan was presented, funds were set aside for its implementation with a lot of support from cooperating partners.

Researchers and consultants were invited to meetings to discuss the impact of the crisis on service delivery and to discuss solutions. For instance, two consultants on HRH were hired by the MoH to work with local staff in conducting a mid-term review of the Zambia Health Workers Retention Scheme and to recommend solutions. Further meetings were held among different cooperating partners and organisations dealing in health to analyse various documents and discuss long lasting solutions to the crisis. Researchers in the department of economics and those in the school of medicine at the University of Zambia, supported by cooperating partners also conducted various research on the crisis, including one that was submitted to the MoH on how to increase training output (Goma, 2008; Tjoa et al, 2010).

Other partners such as the media and trade unions were invited at a later stage to offer input after the draft had been prepared, perhaps also to report these new strides that the MoH was making in improving the general health of the country to the public. As for trade unions, their main role and interest was to ensure that workers conditions had indeed been improved (Interview No. 4. January 25, 2012).

When asked about how the media contributed to setting the health agenda for human resources, one of the Chief Policy Analysts at the MoH indicated ‘the media is not as influential. It is only influential indirectly as it brings issues to the attention of the public.’ (Interview No 2. January 24, 2012).

However, in a separate interview the Public Relations Manager of the main broadcasting corporation responded “we are extremely influential because of the three main roles we play which are providing information, education and entertainment and these provoke a lot of debate. We reported on the lack of trained medical personnel in rural areas and the lack of health centres. And now, most of these have been addressed.” (Interview No. 6, January 26, 2012). He added that this was because it was their duty and not because they had any vested interests -- being a state owned corporation. However, according to most people interviewed, the media brought out issues that government was already aware of and addressing in one way or the other or not.

#### **6.4. National mood**

The national mood according to Kingdon (2003) is the general climate in the country whereby it is believed that a large number of people are thinking along certain lines. This mood changes from time to time and the changes have significant impacts on policy agendas and policy outcomes, as such government senses the mood in the country and promotes those items on its agenda that seem to favour this. When it detects that the mood has changed, it also changes its agenda in line with the new mood.

Because of the many public complaints about the quality of health care received at public health institutions, many, international and local civil society organisations, including the media, felt that government needed to do something as a matter of urgency (Makasa, 2009). A senior staffer at the WHO in Lusaka noted that a factor in pushing the formulation of the strategic plan was that “people’s complaints became too much.” He continued, saying, “It is the people who go to



access health services and they complained, government and the President took note of that, hence the presidential directive to come up with a solution.” (Interview No. 9, January 30, 2012).

Zambia, being a relatively stable and upcoming vibrant democracy, public opinion can be said to be quite strong, especially around election time. There have been instances where people’s views in certain aspects have been respected and politicians have acted in public interest, for instance the third term bid by second Republican President, Chiluba was strongly opposed (Banda, 2008). In terms of the human resource crisis in 2005, there was indeed a general feeling among most people that government needed to act. Therefore, the President’s pronouncement was also partly a reaction to this sentiment, and in 2006, the health sector received 10.7% of the total national budget and user fees were scrapped in rural areas- a stronghold of the MMD. Despite being an improvement from the previous years (9.4% in 2004 and the 7.5% in 2005), this still fell short of the levels that were required to deal with the problems in the sector and still far short of the 15% to which African heads of state committed in Abuja in 2001 (MoH, 2011).

#### **6.5. Pressure Group and Civil Society Campaigns**

Civil society organisations and interest groups play an important role in development and policy formulation. Apart from supplementing government’s efforts in many areas, they also act as watchdogs in ensuring that government’s commitments are fulfilled. However, according to Kingdon, much of interest groups’ activity in these processes consists not of positive promotion but rather of negative blocking (Kingdon, 2003). In Zambia’s the health sector however, civil society organisations take part in the Health Sector Advisory Group (SAG), which is the highest policy making body for the sector and meets twice a year. This brings together a wide variety of stakeholders including the government, civil society and cooperating partners, to participate in the planning, monitoring and review of health policies and implementation (MoH, 2011; Domingo and Wild, 2010).

Civil Society organisations such as Churches Health Association of Zambia (CHAZ), Alliance Zambia and Treatment Literacy Advocacy Campaign (TALC) are some of the local organisations that actively engage in pushing the agenda for health. Other organisations include professional bodies such as the Medical Council of Zambia and General Nursing Council and trade unions such as the Civil Servants and Allied Workers Union of Zambia (CSAWUZ). These organisations used various means and collaborations to ensure that the issue of human

resources was acted upon by the government by placing it on its agenda, besides taking part in the SAG (Mwanza, 2010).

As one trade unionist stated “one of the strategies of the union is to work with the media and see how our issues can be carried forward. We invite them to be a part of our union meetings.” (Interview No. 4, January 24, 2012). He however stated

Even though we were not part of those drafting the strategic plan, we did provide some input generally, especially in the labour-management committee meetings where all issues affecting workers are tabled by the union and management commits to finding a solution. Human resource was always one of the issues discussed because health workers have always been under staffed.

The private media called for a quick solution to the crisis in order to achieve the MDGs. *The Post* (April 7, 2006), one of the leading privately owned media published an editorial comment on the health crisis in which it condemned the policies that the country was forced to implement for about 15 years as having negatively impacted on the sector and therefore urged government to seriously implement measures to tackle the crisis.

According to Sabatier (1999) different participants and actors from the different sectors come together to form advocacy networks in order to pursue their objectives effectively. This is precisely what the labour union and the media engage in to push their agendas. Similarly, analysts of various organisations may come together to mount pressure on government. Even though government had already shown that it was acting on the situation through the strategic plan in 2005, results were not immediate and people were frustrated. As such, a number of mechanisms were applied to put pressure on, government, among them a strike by health workers in June 2006 to push for better conditions of service. The health workers were demanding a 40% increment in housing allowances, back-dated to 2002, long-service bonuses and on-call allowances, some of which had been in arrears since 2003. According to the *Weekend Argus*, June 6, 2006) the Resident Doctors Association president, Ameck Kamanga, said in an interview that three years of negotiations with the government for better wages and conditions of service had yielded nothing, the association had resolved not to resume work until

government met their demands for better wages and housing, on-call allowances and transport to work. According to Kamanga,

Doctors live in deplorable and risky conditions, often with no water supply and face regular evictions due to poor housing allowances from the government that instead of working, doctors have to spend their time looking for accommodation. Doctors are tired of going over the same circles of discussion with no results.

There was a state of panic and the editorial comment of Zambia's leading private newspaper, *The Post* (August 22, 2006) noted "we feel it's unfair for the nurses to try and negotiate with the government that is in a virtual state of impotence. Surely, our nurses can wait another 40 days or so and address this issue with a new government that can follow up matters arising from it over the next five years."

Government assured health workers of payment of the arrears which was being implemented slowly as and when funds were available (*Times of Zambia*, June 3, 2006). The on off strike which lasted about two months had adverse effects on health care delivery as most public health institutions had inadequate staff to attend to patients and some pregnant women were forced to give birth without the assistance of midwives.

Considering that the system of policy making is usually a top down approach, including the formulation of the HRH strategic plan (2006-2010) where the top officials and those around them are more engaged in deciding what is to be acted upon, the use of strike action by workers to get issues to be addressed implies government's failure to adequately address their demands, thus using forceful means such as strike to do so (Lipsky, 1980).

It has been argued that the way a society lobbies for its interests and rights from government determines government's response (Kabeer, 2005). While actions such as strikes and protests which are usually the last resort by disgruntled groups, are capable of producing desired outcomes, many have argued that they do not always lead to expected results as governments usually take time to react to such situations in the way that protestors want (Kabeer, 2005; Tapscott and Thompson, 2010). However, in this case the timing of the strike was perfect as it was within months before elections in September. Government assured health workers of payment.

## **6.6. Conclusion**

The chapter has discussed the elements in the political environment that helped motivate the adoption and formulation of the HRH Strategic Plan. Basically, it has been established that the fact that 2006 was an election year could have significantly contributed to the President's directive to have a proper plan in place to tackle the human resource crisis. The strike and the launch of the World Health Report 2006 in Lusaka was a focusing political event that also contributed to creating awareness and presented an opportunity for government to show the progress it was making towards improving services in the health sector. Furthermore, the health workers strike in 2006 had a great impact on the commitment made by government in the Strategic Plan to improve conditions of service as health workers were not content. The chapter has also revealed that contrary to what may be expected, members of parliament were not very vocal in this matter for one reason or the other.



## **CHAPTER SEVEN: COUPLING AND POLICY WINDOWS**

### **7.1. Introduction**

“Coupling the three streams is more likely when entrepreneurs frame issues appropriately. Coupling involves more than persuading policy makers to adopt a particular proposal. It involves activating particular dimensions of the problem to fit the solution in language that appeals to different policy makers.” (Zahariadis, 2007:70).

As has already been stated, the three independent streams of problems, policy and politics each have lives of their own but come together at critical points in time when a window of opportunity opens. A problem is recognised, a solution is developed and readily available in the policy community, a political change makes it the right time for policy change and a policy thus comes into being. This chapter discusses the findings of this research. The purpose of this chapter is to bring out the key issues, which made it possible for the streams to be coupled when a window of opportunity opened.

To begin with, policy windows will be discussed in brief, what they are, when and how they open. Thereafter these will be analysed in relation to the HRH crisis in Zambia by first explaining how the activities discussed in the problem and political streams (chapters 4 and 6) created a perfect opportunity for the human resource crisis to be addressed. The role of policy entrepreneurs in the process will also be highlighted in the discussion.

### **7.2. Coupling of the streams**

Advocates in and around government keep their ideas about proposals and problems at hand, waiting for a policy window to open as this is an opportunity to push these proposals or bring attention to their problems. They may have pet solutions, and wait for problems to float by to which they can attach their solutions, or they might wait for some events in the political stream that may be used to their advantage (Kingdon, 2003). Windows are opened by events either in the problem stream or the political stream, such as a new problem creating an opportunity to attach a solution to it or significant political events that lead to the adoption of certain policies.

Human resources for health had been an issue in Zambia for some time, at least since the beginning of 2000. However, only around 2005 was there so much attention paid to it by policy makers and recognised as a serious problem requiring urgent attention. Solutions to address this existed as evidenced by the number of policy documents and developed initiatives developed discussed in chapter 4. For this reason, when the issue was labelled a crisis calling for immediate attention, one of the already existing documents (synopsis HR document 2004) provided a good foundation for the formulation of the HRH Strategic Plan (2006-2010) as it was the latest document to analyse the situation in terms of staffing levels and proposed solutions.

A combination of factors in both the problem and political streams opened a policy window for policy entrepreneurs (the different cooperating partners discussed in previous chapters) around the health sector to direct attention to human resources and to push their proposal for a solution through. The revelations of the MDG reports coupled with events such as the general elections scheduled for the following year-2006, national mood and the vigorous lobbying by the different concerned parties all combined to create a great opportunity for the cooperating partners to ensure that a plan to address the crisis was in place. According to Odugebmi (2008), the influence of donors on policy making in developing countries lies at the heart of feasibility of processes of pro-poor change in because their engagement in policy dialogue with governments can move issues up the agenda.

As discussed in chapter 4, cooperating partners were alarmed because the large number of programmes that they provided financial assistance for were reported to be underperforming to expected standards and lack of adequate human resource was identified as the major contributing factor. Efforts to fight malaria, TB, HIV/AIDS, maternal mortality and child and reproductive health were all reported to be lagging behind and the MDGs on health were unlikely to be attained if the human resource crisis was not addressed urgently (UNDP, 2005). More significantly, failure to meet the MDGs opened a problem window by highlighting the threat of the human resource crisis to socio-economic development as diseases such as malaria and HIV/AIDS which were at the time, and still the leading causes of death in Zambia place a real burden on families.

Recognising that the health system is generally very labour intensive, a situation analysis of human resources for health by a team of experts funded by the GHWA (2006) to determine the effects of scaling up efforts on HIV prevention, care, treatment and support noted that such efforts would not succeed unless there was a corresponding commitment to increase staffing levels at all levels of the health care delivery system.

The identification of human resources for health as a problem directly affecting delivery of health care at all levels by cooperating partners, and the subsequent admission of government was an opportunity for the former to recommend that a solution be identified immediately. This led to the formulation of the HRH Strategic Plan, whose main contents were informed by the synopsis document of 2004. According to Kingdon (2003), those who are quick to label something as a problem usually are the first ones to come up with a solution. It is not surprising, therefore, that cooperating partners were fully involved. However, it was not clear during the interviews whether or not they threatened to withdraw funding for the various programmes if government did not show full commitment to addressing the issue. What is clear though is that this came at an opportune time when elections were due to be held the following year.

In the political stream, the general elections, more than any other factor, played a very pivotal role in joining the three streams to open a policy window. As Kingdon (2003) states, windows can either be predictable or unpredictable and in this case, it was quite predictable as it is well known in Zambia that general elections are held every five years. With elections scheduled for September 2006, therefore, it can be argued that cooperating partners knew when and how to confront government to seriously address this issue. Their position was strengthened through being a major stakeholder in the country's health sector considering the extent of their financial and technical support; the Zambian government owes a lot of its success in the health sector to these. A consequence of government's inability to alone adequately finance the health sector is that heavy reliance is put on donors and cooperating partners; it has been argued that this may make recipient governments more accountable to donors than to their citizens (Hudson and GOVNET, 2009 cited in Domingo and Wild, 2010:56)

Furthermore, because government needed to secure itself a win in the competitive elections, it was vital to show commitment to addressing an issue that had caused concern among the public and the international community, hence the President's directive was carefully timed. While the

allocation to health in the 2006 national budget was only 10.7%, an improvement from 7.5% in 2005, the percentage share of in the discretionary budget that year was a clear demonstration of commitment health as it increased from 12% in 2005 to 18% in 2006.

Coupling of the three streams was also enhanced by another significant event in the political environment; the launch of the annual World Health Report on in 2006 by the WHO Director General. Despite the fact that the report came after the HRH Strategic Plan had been formulated already, the international scene had shown that human resources for health was a growing concern not only in Zambia but also in many other sub-Saharan countries. Consequently, the WHO saw it fit to focus the world's attention on this aspect of the health system in that years report. In a speech delivered at the meeting convened by the GHWA in Lusaka a few days before the launch with participants from Kenya, Tanzania, Namibia, and Malawi among others, the Zambian Minister of Health stated "The current crisis in human resources for health in Zambia directly threatens global efforts to achieve the WHO's MDGs which has resulted in severe imbalances in terms of the number of staff, skill-mixes and the geographical distribution of the workforce, causing significant disparities in population-to-staff and urban-to-rural ratios." (WHO, 2006:8).

Because information and concerns on the crisis was public knowledge even before the launch, cooperating partners, who have been identified as the policy entrepreneurs took on government to face the situation seriously so as to have the health MDGs on target, hence the President's directive to the MoH to develop a long term plan. By the time the announcement was made in February 2006 that the country would be leading the activities for World Health Day, the HRH Strategic Plan had just been officially launched a month earlier, and everything was falling into place.

Finally, the "economic stream" and the global environment tend to be neglected in Kingdon's MSA. In this and the previous chapters, I have tried to incorporate the dynamics and strategic opportunities presented by the "economic stream" (Hudson and Lowe, 2003 provide for more focused appraisal of macro factors).



### **7.3. Conclusion**

In order to ensure that the human resource crisis was not just an issue that everyone was aware of which was going to die a natural death one day, a major window of opportunity opened in the political stream through the general elections that were to be held the following year linking the problem, policy and politics together. Cooperating partners used this as an opportunity to couple the problem of human resource to the solutions which they had helped identify, in that way also dealing with their concerns on the attainment of the health related MDGs. Furthermore, all this was enhanced by the launch of the World Health Report-2006 in Zambia, the first African country to do so, as such government couldn't have shown more commitment.



## **CHAPTER EIGHT: CONCLUSION**

The central objective of this research was to establish how and why human resources for health crisis became a central feature on the state's agenda in 2005 despite competition from other issues in the health sector such as disease, and in the country at large. The paper also sought to test Kingdon's theory in Zambia as it has been rarely applied in Africa by analysing the degree to which agenda-formation is influenced by such factors as issue definition, the presence of policy alternatives, presidential support, interest group advocacy, media attention, political cycles, and public opinion.

The paper has described who policy actors are, that is, those who prevent problems or issues being considered, shape the design of proposed policies, block the implementation of proposals, develop the strategies through which policies are developed and implemented, and shape the practice of implementation, thereby influencing the impacts achieved through policy changes. The paper has therefore identified those who were involved in ensuring that human resources for health was identified as a key issue deserving attention such as the various cooperating partners that fund programmes for various diseases in the sector.

Issue definition was central to ensuring that the human resource crisis was given enough attention by policy makers. Indicators such as numbers of people migrating to other counties, HIV/AIDS deaths and training output from health tertiary institutions and feedback from MDG progress reports, progress on health reforms and scale up efforts on diseases such HIV/AIDS and malaria were vital in issue definition. There was however no major focusing event that pointed policy makers in this direction.

Additionally, different policy proposals in the health sector related to tackling shortages of human resources were available but they did not adequately address the issue. Thus, the HRH Strategic Plan (2006-2010) was the first policy document to receive serious attention from the state as it was a directive from the President. Factors at play in the political stream that have influenced this include the general elections which were due to take place the following year and pressure from cooperating partners.

Factors in the problem stream such as the revelation that the country was one of the countries in sub-Saharan Africa with a severe shortage of health workers, thus compromising the quality of health care delivery and impeding the attainment of the MDGs, coupled well with events in the political stream opening policy window to enable the formulation of the HRH Strategic Plan. Undoubtedly, cooperating partners were largely influential and have thus been identified as the policy entrepreneurs. They invested funds and time in ensuring that government acted upon the crisis.

The research did not identify any actors who were opposed to the formulation and implementation of the policy to tackle the crisis as all major stakeholders worked together to pressure government to address the situation. The research has also highlighted the fact that policy is much about power as it is about processes. Those with the most power and are able to use it successfully are the ones who influence policies the most and in the case of Zambia, cooperating partners are quite influential in setting the health care agenda because of the amount of resources they invest in the health sector. In addition, the research helps to highlight the fact that political will is indeed cardinal in ensuring the formulation and implementation of policies, which is why political figures are such powerful agenda setters even in Zambia.

A key factor I identified in Kingdon's MSA is coupling. This is so because timing is very critical in having an issue addressed. Strategic thinking, observing and paying attention to key events in the political stream is essential and can even be applied to advance the health agenda for the benefit of the people, particularly the more vulnerable groups. In addition, democratic tenets such as strengthening the role of civil society in health policy making can be promoted when one is aware of this coupling and can try to anticipate when a policy opportunity may open.

The problem and politics streams in particular were very useful, as events occurring in these streams were very powerful in addressing the human resource crisis being largely responsible for the coupling. Interesting to note is how policy entrepreneurs are able to ensure a situation is labelled as a problem so that policy makers can pay attention to it, working hard to direct resources towards that issue and ensuring it is classified as such, thus helping in identifying solutions.

## **8.1. Critiques and implications for policy**

While Kingdon's theory has proved applicable and helpful to understanding how the health crisis drew so much attention from the state in 2005/6 in Zambia, it nonetheless raises certain questions about a few issues. Contrary to Kingdon's assertion that the streams are independent and have lives of their own, the research discovered that there was a very thin line between the policy stream and the problem stream in terms of independence. This is so because as stated already, various proposals were available in the health sector in response to human resources for health in general even before it was labelled a crisis. Proposals were not drafted entirely in isolation of activities in the political stream. In fact, these proposals had already been tried, albeit little success. Kingdon (2003:200) argues that proposals are not drafted in response to meet a particular identified problem but because people have an interest in doing so.

Secondly, the role of the media and public opinion in setting the health agenda can be said to be more than otherwise. The media brought out issues to the attention of the general public that government may not have been willing to share, such as the large number of people at health centres waiting to be attended to. While this may not have been news to government as it was aware already of the situation, it affected the national mood and resulted in public opinion calling for a solution to the crisis, which led to putting a strategy in place. Therefore, the media cannot simply be dismissed as a non-entity in agenda setting as Kingdon (2003) argued.

Additionally, Kingdon's three streams (problem, policy, and politics) are not adequate in explaining all the various circumstances leading to the formulation of policies. Events in the general economy both local and international that do not fall in either of the streams have not been fully accounted for in the framework. Such economic issues are important because they affect policy in terms of both formulation and implementation, thus a fourth stream "economic stream" could have been ideal. As discussed in the chapters, Zambia's policy making in general, and health policy in particular has largely been influenced by the global environment and international economic trends particularly the SAP. This further re-affirms the position that discussing policy making in many developing countries like Zambia is incomplete without considering the role of donors.

Therefore, the Ministry's heavy reliance on support from cooperating partners to run the health sector also raises concerns about the sustainability of this dependency situation. There needs to come a time when reliance is significantly reduced to the extent that the MoH can manage and control most health systems including human resources.

A major observation made in this research is that the three specific objectives set out at the beginning of the research all depict some subfields of political science and public policy and administration studies such as the presidency, interest groups, political parties, public opinion, and political communication. Therefore, it may not have been possible to cover all the literature in each area and explore it in relation to the human resources for the health crisis. This leaves a gap for further research on the objectives within the different sub-fields.

The critiques notwithstanding, the findings of this research indicate that overall, Kingdon's model is useful in understanding agenda setting behind the human resource crisis in Zambia in 2005/6.



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## **APPENDIX A**

### **INTERVIEWS**

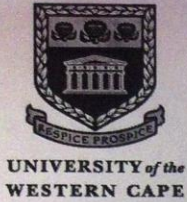
#### **PURPOSIVELY SAMPLED**

<b>NAME</b>	<b>DATE</b>	<b>INSTITUTION</b>
1. Judy Mwila- Chief Policy Analyst	16 January, 2012	Ministry of Health
2. Monica Mbewe- Chief Policy Analyst	24 January, 2012	Ministry of Health
3. Brian Mwambazi- D/Director Planning	24 January, 2012	Ministry of Health
4. Henry Fumpa- Director Research & Info Allied Workers Union of Zambia	25 January, 2012	Civil Servants and
5. Kamoto Mbewe- Spokesperson	25 January, 2012	Ministry of Health
6. Jere Mwila- Director HR	27 January, 2012	Ministry of Health

#### **SNOWBALL SAMPLED**

7. Masuzyo Ndlovu- Public Relations Manager Broadcasting Corporation	26 January, 2012	Zambia National
8. Isaac Kakumbi- Chief HR Officer	26 January, 2012	Cabinet Office
9. Solomon Kagulura- National Professional Officer Organisation- Zambia	30 January, 2012	World Health
10. Davies Muunga- Documentation Head	13 August, 2012	Cabinet Office
11. Doreen Nkombo- Asst. Committee Clerk Zambia	13 August, 2012	Parliament of
12. Tawanda Marowa- Asst. Committee Clerk Zambia	13 August, 2012	Parliament of

## APPENDIX B



UNIVERSITY of the  
WESTERN CAPE

### FACULTY OF ECONOMIC AND MANAGEMENT SCIENCES

### SCHOOL OF GOVERNMENT

Office of the Postgraduate Co-ordinator

25 November 2011

To whom it may concern:

#### RE: CONFIRMATION OF STATUS

This is to confirm that Ms. Kabaso Kabwe (student number: 3169600) is a registered student with the School of Government at the University of the Western Cape reading towards the Masters in Public Administration (M.P.A).

The M.P.A is a structured degree comprising of a 50% course work component and 50% research component. Ms. Kabwe is in your city doing research for her mini-thesis, the topic reads as follows: "Health Policy and Agenda Setting in Contemporary Zambia."

We hope that Ms. Kabwe can be accommodated in her research efforts and we thank you in anticipation for your co-operation.

For further details please contact the student affairs office at the contact details above.

Sincerely,

**Ms Bridgett Maart**  
Assistant Administrator



Private Bag x17, Bellville 7535, South  
Africa  
T: +27 21 959 3803/50 .  
F: +27 21 959 9849

A place of quality,  
a place to grow, from hope  
to action through knowledge



## APPENDIX C

All Correspondence should be addressed to the  
Permanent Secretary  
Telephone: +260 1 253040/3  
Fax: +260 1 253344



### REPUBLIC OF ZAMBIA MINISTRY OF HEALTH

In reply please quote

No. ....

MH/101/ND/12  
NDEKE HOUSE  
P.O. BOX 30205  
LUSAKA

9<sup>th</sup> January, 2012

Ms Kabaso Kabwe  
Ndola Central Hospital  
**NDOLA**

Dear Ms Kabwe,

#### **Re: Request for Authority to Conduct Research**

The Ministry of Health is in receipt of your request for authority to conduct a study in control districts on "**Health Policy and Agenda Setting in Contemporary Zambia**". I wish to inform you that following submission of your research proposals to my Ministry, our review of the same and in view of the ethical clearance, my Ministry has granted you authority to carry out the study on condition that:

1. The relevant Provincial and District Directors of Health where the study is being conducted are fully appraised;
2. Progress updates are provided to MoH quarterly from the date of commencement of the study;
3. The final study report is cleared by the MoH before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the MoH, the final study report is shared with all the relevant Provincial and District Directors of Health where the study was being conducted, and all key respondents.

I consider your research topic to be of policy relevance.

Yours sincerely,

Dr. P. Mwaba  
Permanent Secretary  
**MINISTRY OF HEALTH**

## APPENDIX D

My name is Kabaso Kabwe. I am a master's student at the University of the Western Cape in South Africa. I am carrying out a research on the topic "Health Policy and Agenda Setting in contemporary Zambia: The Human Resources for Health Strategic Plan (2006-2010)", in partial fulfilment of the Master of Public Administration. I, therefore, kindly request your cooperation in providing necessary information on the foregoing topic. All information collected is strictly for academic purposes only.

JOB TITLE OF INTERVIEWEE: .....

INSTITUTION: .....

DATE: .....

### **SECTION A: General**

#### **The Three streams (Problems, Policies and Politics)**

1. How did policymakers get to pay so much attention to human resources for health (HRH)? How did they learn about this condition? (use of indicators, crisis/focusing event, feedback)
2. How did it get to be defined as a problem?
3. What other problems or issues were there in the Ministry before HRH gained such dominance?
4. What ideas or policy proposals existed during this time in the health sector for the various issues?
5. What criteria were used to pick any of these proposals for consideration over others? Which ones were picked? (technical feasibility, value acceptability etc)
6. Which group of specialists was involved in debating, studying or formulating these policies? Was it bureaucrats, academics, researchers etc?
7. Were any resources in the Ministry reserved for activities which appeared to have the greatest chance of success? Which activities are these?

8. What elements in the political environment would you say influenced HRH issue to be that prominent? Was it say a general national mood, pressure group campaigns, administrative/legislative turnover etc?
9. How did Parliament, the media, health workers, various partners, NGOs, political appointees contribute, if at all to setting the agenda for HRH?
10. What about international organisations like WHO, World Bank, UNDP etc. To what extent did they contribute to HRH agenda setting?
11. Which networks or coalitions were most influential in setting the agenda?
12. What mechanisms did all these actors use to ensure that HRH was placed on the government agenda?

### **Coupling and Policy Windows**

13. HRH had been an issue for quite some time. What would you then say finally made this become a serious one requiring policy formulation and implementation in 2005? What is it that captured the attention of government officials and those round him? (eg was it as a result of a problem or political stream?)
14. What other proposals in health or nationally were being pushed during this period?
15. How much attention was paid to this issue during this period? Eg by the media or even government itself?
16. Which actors were the most influential in pushing for the formulation of the HRH policy and how did they push this?
17. Why was it necessary that HRH was addressed then and not later on?
18. How many other proposals to tackle the HRH crisis existed during that period?
19. Would you say that these proposals for HRH or health in general were formulated with specific reference to HRH or they had simply been around in the sector?
20. The Ministry largely depends on donor aid to fund its programmes. What activities/programmess in the Ministry do international donors seem to favour?
21. What would be the reason for that?

## **SECTION B: Cooperating Partners**

1. How do you contribute to health policy making in Zambia? (is it limited to funding or you help to formulate the policies?)
2. What was your role in the formulation of the Human Resources for Health Strategic Plan (2006-2010) by the Ministry of Health?
3. In funding any programmes or activities in the health sector, what do you consider?
4. Which kind of activities do you mostly fund?
5. The Millennium Development Goals progress reports of 2003 and 2005 both indicated that the health related MDGs were unlikely to be attained by 2015 due to human resource constraints, among others. Was this a contributing factor to funding the Strategic Plan?
6. How are you affected by happenings in the political environment in your line of work?
7. What challenges do you face in working with the Ministry of Health?

## **SECTION C: Media**

1. How do you contribute to policy making (health) in Zambia? What is your role as the media?
2. By the year 2005, the lack of human resource in the Ministry of Health was being labelled as a crisis. What issues did you as the media bring out to the attention of the public and to the government in particular?
3. How influential is the media in setting the health government agenda?
4. To what extent do you cover a particular story prominently? When do you decide that it is time to move to another item?
5. How do you determine that an item is news worthy?
6. How are you affected by happenings in the political environment in your line of work?
7. What challenges do you face as you work to report on what is affecting citizens?