Rural women's access to health service delivery in the light of human rights and international conventions on health

Musialela Matakala

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My mother, Nosiku Matakala, and father, Musialela Musiwa, who constantly reminded me life is a struggle and one needs to fight to succeed. My daddy who has not seen me come to the country he lived his life and had me as his only son.

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Abbreviations

AIDS	Acquired immune deficiency syndrome
CBPP	Congested bovine pleural pneumonia
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CHW	Community health worker
CESCR	Committee on Economic, Social and Cultural Rights
CSO	Central Statistics Office
DHS	Demographic health survey
HIV	Human immune virus
IEC	Information education communication
LCMS	Living conditions monitoring survey
MDGs	Millennium Development Goals
TBAs	Traditional birth attendants
UDHR	Universal Declaration of Human Rights
UNDP	United Nations Development Programme
WHO	World Health Organization

CHAPTER ONE

Introduction

The need for health services

The need for health services in Zambia and in Zambezi district in particular is enormous. This is because of the social inequalities that exist between urban and rural areas and between men and women. This is further compounded by the social status of women and often their sole dependence on government institutions to provide health services. Poverty is put at 80 per cent (LMCS, 1999) and affects rural populations more than urban populations. These characteristics indicate health services that are weak, too widely spread and poorly staffed. This is against a situation where the disease burden is high due to inadequate services and a lack of knowledge about preventing diseases.

In addition, social inequalities are a major problem in Zambia, particularly in rural parts. Rural communities experience inequalities due to a number of factors, including poor road networks, entrenched negative traditional and cultural practices, low investment and the lack of other social amenities. The Zambian *Human development report 2003* (UNDP, 2003) put Zambia, in the position of 167, among the highest ranking countries in terms of poverty. Government, through the Ministry of Health in the *Strategic health plan 2001–2005* and in their *Review report* (2005), acknowledge that health inequalities are the leading health problem in Zambia. These inequalities are also evidenced in both human and material resources distribution. It is common to find a district, for example, Zambezi, with a population of 44,770 (CSO, 2000), being served by one junior doctor. Strategies to reduce such inequalities have been attempted over the years. However, it is not a simple task. There is a significant lack of knowledge about the impact of health interventions on health inequalities. Put simply, there is a wide gap in knowledge about the dynamics at play between men and women when health fails them. Some interventions or strategies may actually increase these inequalities. Planners tend to adopt a 'one size fits all' approach in designing programmes which may result in rural people being denied access to the services they are in dire need of.

Health is a prerequisite for enjoying the highest attainable standard of physical, social and mental health deemed part of our human rights. The enjoyment of this right is vital to the lives and wellbeing of women and their ability to participate in all areas of public and private life. As defined by the World Health Organization (WHO, 1946), health is 'a complete state of physical, mental and social wellbeing and not merely the absence disease or infirmity'. Women's health involves their emotional, social and physical lives as well as their biological make-up. Thus, health is constrained by many factors, especially in the case of rural women. Most often policies are designed with little input from the rural people themselves, resulting in some appropriate strategies being left out which would significantly increase women's access to health services.

The outcome or result of this is that women cannot access the health services to meet their needs. There is continuing suffering from both preventable and curable diseases and discrimination against women in the health delivery process. Much suffering is experienced in the process of trying to get patients to health facilities.

Definition of terms

Working definitions of the terms used will be given to facilitate the understanding of the situation under discussion.

Access

Access is loosely defined as the ability to use health services at any time, without regulation or barriers. Hjortsberg (2000) defines access as the costs (both monetary and time) an individual incurs when visiting a health facility.

Access itself is problematic in the context of women as the distances that they have to cover are long and the time they spend waiting to be attended to is unduly long. Access has no supportive mechanism in terms of actions to remove the barriers. The attitudes of the health staff also takes its toll on access as health workers often lack respect for the recipients of their services, especially women.

Health

The World Health Organization (WHO, 1946) defines health as 'the state of complete physical, social and mental wellbeing and not merely the absence of disease and infirmity'. Another definition which is helpful in this discussion is:

> 'Health is the extent to which an individual or group can or is able, on the one hand to realize aspirations and satisfy needs, and on the other hand, to change or cope with the environment' (WHO, 1984).

The definition above is challenging when it talks about people realizing their aspirations, satisfying needs and changing or coping with the environment. Changing the environment in the context of women means putting in policies and programmes that will bring services as close to women and their families as possible. There is no common definition of health or being healthy. This poses a problem in defining when and whether one should seek medical advice.

Health services

These are curative and preventive services provided by the health sector through the existing structures, which include reproductive health and information, education and communication services. The definitions of both health and health services brings to the fore the problems at hand in the delivery of services to women. Women's health is usually perceived in terms of their reproductive functions. That poses a problem because, culturally, child bearing is trivialised and not considered an issue. It is seen as a role that women have to play without considering the health implications of that role.

Having looked at the definitions one might think that the right to health is confined to the right to health care. On the contrary, the express wording of article 12.2 of the Covenant on Economic, Social and Cultural Rights acknowledges that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment (CESCR, 2000).

According to article 12.1, the rights to health in all its forms and at all levels contain the following interrelated and essential elements: availability, accessibility, acceptability and quality. Accessibility in this context means health services and goods have to be accessible to everyone without discrimination, within the jurisdiction of state parties (CESCR General comment 12/2000/4).

Accessibility has four main overlapping dimensions: non-discrimination, physical accessibility, economic accessibility; and acceptability and quality.

Physical accessibility means that health facilities, goods and services must be within safe physical reach for all sections of the population – accessible to all, especially the most vulnerable women and children.

Geographical location

Zambezi district is located in the north-western part of Zambia. It is more than a thousand kilometres from national headquarters and over five hundred from the provincial headquarters. This poses many problems, particularly in relation to transport and communication. The road network is gravel and in a poor state of repair. The district has a population of 64,963 (CSO, 2000). It is one of the seven districts in North-western province which is the second poorest province in the country. It is a vast rural area with a sparse population of about 447,000 people. Like the rest of the country, more than 80 per cent live below the poverty line. The literacy levels are low, compounding the problem of access to health services. The two major ethnic groups (and by default the two major languages) in the district are the Luvales and the Lundas. Coincidently, the 'mighty' Zambezi river, which flows into the Indian Ocean, demarcates the district in half to the extent that the Luvales are largely found on the western part of the river and the Lundas on the eastern part. The river is a natural barrier and contributes to the constraints of delivering services to the areas particularly on the west bank of the river. This is especially so during the floods experienced from March to June. During this period, areas on the west bank are inaccessible for four to six months. Supervision and delivery of drug kits is really problematic during these periods.

Malaria prevalence

These swampy areas are good breeding grounds for mosquitoes so malaria is prevalent here. The preventive programmes against malaria that promote the use of insecticide-impregnated bed nets does not reach women in the furthest areas. During the research study I carried a net for my own use which was usually on the dashboard in the vehicle. Many women would come up and ask me if I had brought the nets. Some would plead with me: '*Tulanjisenu owo mushikitela, kuno katwa imona koo*' (sell us that mosquito net, we don't see them here).

Demographic characteristics

The demographic characteristics (social, cultural economic and political) are problematic to the provision of health services, especially to marginalized groups like women and children. Women and children are the major users of the health services in Zambia. However, only a small percentage of women have access to health care services, even where they are available. In addition, available health services are not sensitive to women's needs.

Treatment of any ailment is important. Treatment of any ailment without discrimination on the basis of sex, gender or social affiliation is the sure way of ensuring equity, access and equality in health delivery, as stipulated in the mission statement. It is evident from a number of demographic health surveys that have been conducted that women have different and unequal access to and use of basic health resources, including primary health services for the prevention and treatment of childhood diseases, malnutrition, anemia, diarrheal diseases and communicable diseases, including malaria (DHS, 2000- 2001). Women also have different and unequal opportunities for the protection, promotion and maintenance of their health. All rural health institutions in Zambezi district lack obstetric services which is of particular concern. (Gender strategic action plan, 2004).

The area is poor, has few health services and transportation can be costly or non-existent. Women and adolescents living in poverty are the least able to pay for services or medicine. The provision in the policy that people have to pay for services (user fees) has hindered a number of women and adolescents from accessing the health services.

Information, education and communication

The current information, education and communication situation in Zambezi can be characterized as follows: there is no comprehensive programme and no reliable information or research is being done into the best ways of reaching specific audiences. There are logistical problems in disseminating materials. Zambezi does not receive the national television signal; it relies on radio (with poor reception) and, to a lesser extent, newspapers. Low literacy levels among the population compound the problem, so do the long distances that women have to travel to reach local centres (clinics). There is a hypothesis that exposure to western ideas through the media improves peoples attitudes to health matters and sexual and reproductive health issues (Westoff and Bankole, 1997). If this is true, then these remote areas, which include the research site, pose serious challenges to the advocates of improved access to the health services including sexual and reproductive services. The outcome is that delivery of services to women is hampered by these missing links in the system. The disease burden, characterized by epidemics, continues to rock the area.

HIV/AIDS

The prevalence rate for HIV is put at 16 per cent in the country (DHS, 2000-2001). Of the infected population, the percentage for women is the highest. The HIV/AIDS pandemic, coupled with the decline in the provision of quality health care, has impacted negatively on women, thereby increasing their workload and undermining their physical and mental health. The reasons for this lie in social and economic factors as they affect women differently from men.

Women are twice as likely as men to become infected through unprotected sex. The number of women infected has risen tremendously as the root causes of gender inequalities continue to be perpetuated: unequal relations between men and women and lack of empowerment. The traditional double standards that socialize women to accept the sexual activities of their male partners as the norm, disempowers women, preventing them from exploring options or having a say regarding their sexual or reproductive health needs. For instance, traditionally, it is an aberration for married women to refuse sex at the 'beck and call' of their partners. Thus, for fear of being repudiated and for fear of 'traditional' sanctions, women are manipulated into having sex at their own peril. The HIV/AIDS pandemic has its gendered aspect in that the impact of it is felt more by women. The burden of care is borne by women and children who have nothing in common to share but their innocence. The duty of care hinders women from engaging in productive ventures, thereby reducing their income bases further.

Fundamentally, there is also lack of awareness and understanding of the ramifications of redundant social practices sanctioned under customary law. These social practices (polygyny, multiple partners) leave both women and men mutually vulnerable. While such repugnant customs are in practice, it is no wonder that statistical research indicates the prevalence of HIV/AIDs as higher among women than it is among men. Apart from high levels of poverty, the vulnerability of communities has been exacerbated by the lack of access to or control of resources (financial or human), the lack of information on health risks of the HIV/AIDs pandemic and the overall stigmatization associated with the pandemic. Therefore, addressing gender inequalities and meeting the needs of women and girls is the key to stopping the spread of the disease. It is also a way of increasing women's access to health services. The lack of knowledge must be targeted by the interventions developed.

The prevention, care and mitigation programmes are not reaching rural women. In the areas where the research was conducted, these programmes exist just on paper. The respondents said they had filled in application forms to apply for funds to implement the prevention, care and mitigation programmes. It is a clear case of no access to resources and women being marginalized. It is not disputed how much at risk a rural woman is to HIV infection, given the barriers she faces in her empowerment efforts.

Water and sanitation

Water and sanitation is a critical aspect of women's life. As the saying goes 'water is life'. It must be emphasized that access to safe drinking water is a determinant of healthy living. None of the rural communities studied have safe potable water. They take their water from shallow wells which are prone to contamination from run-off water. The sites for these wells are far from home – a kilometre or two. WHO defines safe water as water that is piped. In this context, safe water can be said to be that from a protected well and characterized by such qualities as palatability, no suspended impurities, no bacterial contamination and colourless. Furthermore, collecting water is a highly gendered activity. It is the women's job to fetch water. The non-availability of safe water within reasonable distance affects women more than men, since they are the collectors of water. They also have to care for those who suffer from the dysenteries and other diarrheal diseases. The non-availability of safe potable water poses a problem to the woman in a village who has to travel long distances to fetch water. The absence of adequate water is a factor in the spread of diseases of insanitation, like scabies. So the spread of diseases due to inadequate water sources is a factor contributing to the chores that women have to battle with every day.

'Fetching water is a gendered activity'

Nutrition

Poor nutrition coupled with extreme poverty has made the vulnerability of communities to HIV/AIDs more pronounced. When the most productive individuals succumb to the ravages of AIDs or are infected by the virus, the functionality of the community is impeded: fields are left uncultivated because those infected are too sick to attend to them or those affected are too busy taking care of sick family members. Of great concern is the children who assume the role of breadwinners to the detriment of their future education and career development. As they struggle to earn a living, working or begging to support their families, at the end of the day these children have no time to better themselves through education. Therefore, the community continues to fall apart as the impact of HIV/AIDs continues to disrupt its social and economic viability and the possibility of stemming the cycle of lack of access to health services becomes untenable. Nutrition plays an important role in disease prevention. A poorly nourished person has low immunity to infection. Women are prone to malnutrition because of long hours of work, cultural practices emphasizing that men have to eat first and their lack of mobility when food is scarce.

Reducing poverty and hunger, coupled with promoting gender equality, is the thread that runs through the gamut of social economic growth strategies. It is also known that preventative measures, such as improving HIV/AIDs education (including on sexual and reproductive health) and cultivating awareness raising activities, are a way of promoting gender equality. These and many other activities can improve women's access to health services.

In the grand scheme of things, because of inadequate government intervention to mitigate the negative effects of HIV/AIDs on community social development – caring and supporting people living with and affected by HIV/

AIDS to enable them to live longer and better lives and building human resource capacity to fight HIV/AIDS – it has become the responsibility of local communities. Community members have to: participate actively in the wellbeing of their communities; strengthen and develop human capacity; meet internal challenges and avert social dislocation. In other words, local community-based organizations have 'picked up the slack'. In taking up all these social community responsibilities, most community-based organizations are incorporating women, adding to their burdens, hence they have begun to buckle.

Culture

The cultural practices of the people are still according to a patriarchal arrangement, with males having a bigger share in the many issues, like decision making and holding power. The culture has an entrenched patriarchal system of prejudice against women and of marginalizing their participation and leadership in all areas, including health (women's health for that matter).

Economic

Zambezi's economic activity is subsistence farming. With the persistent droughts and withdrawal of the subsidy on farming inputs, the poverty has increased. Animal diseases like congested bovine pleural pneumonia, have also taken their toll and reduced the economic base of the peasant farmers. There are no industries, especially for the very rural. This means further reduction in access to social services, like education and health. What is cardinal to remember is that poverty is put at 70 per cent in Zambia with the rural population being the most affected. North-western province where the research site is located is the second poorest district in the province (CSO, 2000).

In Zambia, the pervasive rural–urban divide that motivated the interventionist policies of the 1970s, still looms large. Investment policies and practice have favoured urban areas, with most rural facilities having deteriorated beyond repair. The quality of social and economic infrastructure in rural Zambia is not conducive for human development and the fall in the livelihood security in rural areas is attributed to this rural–urban divide (UNDP, 2003: 23).

Political

This is another problematic area for women in terms of their participation and what decisions are taken at this level. It is all about governance, accountability and responsibility. The actions of the political actors suggest a lack of political will to address the inequalities that exist between men and women. Not many women are in decision-making position and that has an impact in terms of prioritizing women's issues.

CHAPTER TWO

Research design

A stratified approach for assessing the delivery of health care to rural women was used by employing different methodologies, inter alia, the women's law approach, structures and actors, legal pluralism and the human rights framework. The crux of the research approach was to incorporate different views on access, cost and quality of the health services women receive. I have used two-dimensional frameworks based on the components of access and affordability in the health system. The most commonly used division comes from Donabedian (1998) who divides health services quality into structure and outcome (Atkinson, Songsore and Werma, 1996: 94). The qualitative interviews held with professionals and potential users of health services also explored the perceived changes towards achieving the goals of the ministry.

Statement of the problem

The problem of rural women's access to health services is due to a number of factors in the health delivery system. Some disincentives to the use of these official health facilities are the long distances that women have to cover to reach them, on the average 25 kms and the 'cost sharing' or user fees. Even though these costs are one thousand five hundred kwacha (K1500), which is low, women who are in the poorest category cannot afford this. The inadequate staffing both at the district hospital and at rural health centres has compounded the problem. Women are also aware that the official facilities are under-resourced in terms of both personnel and medicines. Services available to the women are often substandard and discriminatory attitudes and poor treatment keep them from returning to these facilities. Quality, accessibility and affordability have been greatly compromised by the situations obtaining on the ground.

At the same time, the starting point of my research was that the health of women or the health services delivery to women can be viewed differently by people or actors at different levels. The implication is that the relative importance they give to these different components may vary. The research design therefore needs to distinguish both the broad components and the different levels of actors in the system. The levels used here are those of the users – women, the service site, that is the rural health centres, the community health workers and the government at local level. The policy level is included as a level of the system. Policy is an important component as a determinant of quality. Since this is not an evaluation research, the impact per se was not the main focus of this study. The in focus problem is compounded by the social, economic and cultural environments in which the women find themselves, as explained.

Methodologies

Grounded theory

Definition of concepts and assumptions

The grounded theory style is based on the premise that theory at various levels of generality is indispensable for deeper knowledge of social phenomena (Glaser and Strauss, 1967; Glaser, 1978). The underlying assumption of this theory is that social phenomena are complex so it is imperative that during any study of a social nature, one attempts to describe and analyze the phenomena in relatively complex terms. The other assumption of grounded theory is that research should be analyzed and understood as it unfolds. Researchers ought to develop an intimate relationship with data and be fully aware of themselves as instruments for developing the grounded theory.

How grounded theory was used

I used grounded theory to look at the provision of health services for the rural population of Zambezi. Health is a social issue in that it is collective and there are dynamics at play in defining one's health. Such dynamics are: what will the treatment be, who will seek it, what will the cost of the treatment be and how far away are the health facilities?

Health providers and the individual person define illness differently. To define oneself as being ill and to set off to seek medical attention is another issue. Its in these circumstances that grounded theory was used to develop many concepts and their linkages in order to capture the great variations that characterize the central phenomena – women's access to health services.

I also studied the structures and actors to assess their adequacy in meeting the needs of the people. It was to determine whether the actors were conforming to the dictates of the structures in which they are operating. I studied women through interviews to understand their position in the given context.

Women‘s law approach

This methodology, sometimes called the 'basket approach', that I used is about getting on the ground to interact with both men and women and get the lived realities of the people you are investigating. It is a qualitative method that brings out the best of something or the worst of it. It is about what is good or bad in a situation as reported by the respondents. It can be likened to a sieve or basket as it sieves through issues. It captures the lives of men and women in their environments as the social, political and cultural forces impact on them. This methodology aimed at providing interaction and exploiting both the intellectual and emotional facets of the respondents. New knowledge is not only transmitted but also analyzed in its context. The aim is to synthesize the knowledge and experience of the respondents in the discussion sessions and come up with a new framework of knowledge. The methodology called for an experiential learning process of thinking, feeling and acting.

I used the women's law approach as most of my respondents were women. At the structural level – district offices and rural health centres – I had 90 per cent men but at the community level I had 60 per cent women. It involved finding out about their lived realities as far as accessing services in the obtaining social, cultural, structural and economic situation. The concentration was on the realities women face in their daily lives to fetch water, care for the family, attend to community responsibilities and deal with the burden of health care.

Interviewees or respondents

Interviewed	Number	Organization	Place	Training & retraining
Managers	4	Health and UNFPA	Solwezi & Zambezi	Yes (always)
Rural heal centre in charges	6*	Health	Zambezi	Yes
Neighbourhood committees	3 committees	Health	Zambezi	None
CHW	5	Health	Zambezi	No retraining
TBA	4	Health	Zambezi	None
Women	12	Community	Solwezi & Zambezi	None
Youth male	4	Community	Zambezi	None
Female	4	Community	Zambezi	None
Men	4	Community	Zambezi	None
Totals	50			

*4 nurses and 2 community officers

Structures and actors

At district health office level, I interviewed the managers. At the rural health centre, I interviewed people in charge at six rural health centres. One of the six was in Solwezi for the purpose of supervision. At community level, in the areas surrounding the rural health centres, I interviewed three neighbourhood committees. The primary health care structures looked at are the community health workers and traditional birth attendants. These, according to the underlying assumptions of the system, form the basic units and points of contact within the communities.

Legal pluralism

Like any other society, the study area observes the formal laws and their own rules which are not codified. They have traditional and cultural practices which they enforce through rewards and sanctions. Some of these, while traditional and cultural, are negative as they discriminate against women. However, the point of emphasis is that legal pluralism exists – two law systems are observed side by side.

Social autonomous fields

These are the relations either through blood or association that have an impact on the women in their efforts to make decisions. They could be church members or friends who have influence on the women in their everyday lives. In the study, family members were found to be more influential on the decisions made. These family members are always male members in the case of married women.

Customs and beliefs

The social and economic formation of a community or society shapes its belief system. The economy is important in shaping the ideas and norms and the value system. Some of the beliefs in these communities are detrimental to health, for example, a belief that schistomiasis[1] is caused by jumping over the urine of someone who is infected. The low literacy rate, coupled with inadequate information, education and communication programmes, entrench these beliefs. Some cultural practices are due to the patriarchal system and women's subordinate position. These are customs and beliefs that are harmful to health and reinforce unhealthy behaviour.

1 A waterborne disease characterized by passing blood in urine or stool, commonly referred to as bilharzias

Gender and sex analysis

Sex

Sex is the biological make-up of human beings. You are either male or female biologically. The different functions both males and females play in their reproductive functions can either increase or decrease their demand and use of health services. The exaggerated sexuality (socialization) of women puts them more at risk as they are seen more as sexual machines. Socialization is the process of learning through 'significant' others in the institutions of family, education and religion. Sexuality is socially constructed in the process of naming of the body which in turn predicts our relationship to labour, authority and performance.. This happens in the context of culture, determined by race, ethnicity, religion and class. The socialization process determines individual's behaviour sexually or otherwise. Societal pressures are put on individuals to conform to the expectations of their particular societies. Some structures are used to enforce these norms and standards. Key structures are family kinship and clan, the church and education. These have a way of rewarding the (positive) certain behaviours and punishing (negative) undesirable behaviours.

Sexuality

It is important to put the sexual analysis in the context of the research. Sexual analysis, like gender analysis, helps us to understand how exploitation of women comes through their sexuality. The sexuality of women is also socially produced as Thomas and Pierson have observed:

> 'Sexuality is something which society produces in complex ways. It is a result of diverse social practices that give meaning to human activities of social definition and self-definition of struggle those who have power to define and regulate and those who resist. Sexuality is not given, it is a product of negation, struggle and human agency. The realm of sexuality has its own internal politics, inequalities and modes of oppression: oppressive practice might then be agreed to mean wider social analyses and structures that have specific or legally defined injustices' (Thomas and Pierson, 1995).

In the process of this society produces sexual hierarchies. According to Gayle Rubin (1984), sexual hierarchy resembles a class system in which different sexual practices, expressions, identities and communities are ranked, from the most normative and sexually approved to the most stigmatized and despised in a particular society. The ranking that put others above and create a hierarchy denies others opportunities to enjoyment of the highest attainable standard of physical and mental health. Society needs to change the perception of what is sex or sexual by unlearning some of the beliefs that we always regard as cultural without understanding how they were invented or constructed.

Gender

Different people define gender differently. I subscribe to the definition by Amy S. Wharton. According to her working definition, gender is:

> '…a system of social practices: this system creates and maintains gender distinctions and it organizes relations of inequality on the basis of these [distinctions]' (Wharton, 2005).

In this view, gender involves creation of both differences and inequalities (2005:7). In the context of this research, gender was used to understand the social processes that make women and men do what they do. It was to see the specific gender identities that assign men and women to specific categories. I looked at the roles of women and how they impact on their health and the roles of men as protectors of women and how they disadvantage them. When a woman is sick, who makes a decision to take her to the hospital or rural health centre? Who does the household chores? What is the income of women? Women do not benefit from the subordinate position they are assigned by the patriarchal society.

Human rights framework

I looked at human rights instruments and important conventions that have addressed the problem of women's rights and the unfair treatment they have experienced over the years. Such conventions include the Beijing Declaration of 1995, the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) and the Universal Declaration of Human Rights (UDHR). Human rights, particularly those that guarantee the right to health, were the main focus. The African Charter on Human and Peoples' Rights (ACHPR) in article 16 states :

(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health

(2) State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

The idea of using these was to measure the collected data with the human rights framework. International human rights standards were used to measure the level of compliance on the part of Zambia as a signatory to these conventions.

Ethical considerations

The study was sanctioned by the permanent secretary of the Ministry of Health with a written letter of authority to carry out the research (appendix 2). The written letter from the Ethics committee was not obtained because the process was too long to follow. The respondents were told that the research was confidential and their responses were going to be treated with the confidentiality they deserved.

Justification

The rationale for this study is to add to the body of knowledge in the area of health service provision to women in rural areas.

Objectives

General objective

To analyze the adequacy of the system in delivering services equally, equitably and affordably to women.

Specific objectives

- To understand whether and what type of discrimination takes place at structural and cultural level.
- To establish strategies that can improve access by women to the system.
- To establish how women are discriminated against in the delivery of health services.

Research assumptions

1 There is discrimination at the structural and cultural levels that disadvantage women, leading to poor access to services.

2 There are inadequate staff members both at the district and rural health centre levels, contributing to inadequate services for women.

3 The decentralization of funding to the district level has not built the capacity of rural health centres and beyond.

4 There is lack of knowledge of human rights and international conventions on the part of the health providers, resulting in violations of the same in delivering services.

Research questions

1 Does discrimination of Women at three separate but interrelated levels: personal, cultural and structural contribute to poor access by women to health services?

2 Does inadequate staffing at the different levels at the district contribute to poor access to health services?

3 Does women's involvement in the management of health services increase their access to health services?

4 Do the contradictory legal and policy frameworks lead to poor delivery of health services?

5 Is the inadequate provision of affordable and accessible health services, including information, education and communication programmes, leading to women's failure to access services?

6 Is there inadequate knowledge of international human rights on the part of the health providers, leading to delivery of services that are not human rights based?

Methods

Interviews

The main instrument was the interview using a semi-structured guide. The main people interviewed in this study were women and health centre staff, especially at rural health centre level and in the primary care structure. In addition, I had some key informants such as chiefs (2) and managers (3). The primary care structure includes community health workers, neighbourhood committees and traditional birth attendants. I decided to interview these targets because they form the structure that provides health services to rural women.

Focus group discussion

The study used the guides; even in focus group discussions (each involving 5-7 participants) to collect qualitative, in-depth information about the following : use of health facilities; discrimination against women and its forms; cultural practices that are negative; gender issues; knowledge of human rights; and staffing and its impact.

The focus group discussion was found necessary and appropriate when talking to committees. It was easy to engage them and for them to reveal the problems they face.

It was appropriate in communities where they are highly suspicious of government workers. They may suspect that you are registering people for relief food or some other scheme. In one place I visited with my supervisor, she was referred to as a 'donor'. In such situations, group discussions dispelled their anxieties and people gave information with some guidance from me.

In addition, I had some key informants such as chiefs (2) and managers (3). I looked at secondary sources, such as strategic plans and review reports for the Ministry of Health. Other secondary sources were Internet materials which include newspapers.

Observation

Observation was one method of data collection. Sometimes I would do it in cohort style[2]. I was an activist researcher in a way. I did this to avoid disturbing the natural social environments. I was observing the attitudes of health staff, their practices, the adequacy of the structures and the queues at out patient departments. I was observing the distances that women were covering to get to health facilities. The observations were recorded in a notebook.

The internet and printed documents were useful and added to the primary sources of data.

2 Not revealing that one is doing a research but observing things in their natural settings

CHAPTER THREE

Theoretical perspectives – what lens and with what focus?

Human rights framework

The modern era of rights as applied to women's health may be said to have started with the adoption of the United Nations Human Rights Charter in 1946. The charter required nations to encourage 'respect for the principle of equal rights' by promoting universal respect for and observance of human rights and fundamental freedoms for all, without distinction as to sex.

The Universal Declaration of Human Rights which was adopted by the UN General Assembly condemned discrimination on the grounds of sex and set out a network for rights relevant to the promotion and protection of health. The declaration was developed into two general covenants adopted in 1966, namely, the International Covenant on Civil and Political rights and the International Covenant on Economic, Social and Cultural Rights.

The Universal Declaration of Human Rights (UDHR) article 25 states:

1 Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The African Charter on Human and Peoples Right article 16 states:

1 Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2 State Parties shall take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

The Cairo Declaration on Population and Development Conference on 4 September 1994 declared:

Reproductive health and family planning

5 We welcome the approach that places family planning in the broader framework of reproductive health care. We urge all national governments to make responsible efforts to resolve their population issues in a way that respects their own national and cultural identity, values and traditions. We therefore commit ourselves, as elected representatives of the people, to do our utmost to remove all remaining barriers in our countries that inhibit access to family planning services, information and education, as well as to help support the provision of reproductive health and family planning services as widely as possible. We further urge governments to ensure that all population and development policies and programmes in our countries safeguard internationally-recognized human rights.

6 We acknowledge the fact that abortion constitutes a major public health concern for women all over the world. Since the use of family planning methods may prevent the prevalence of unplanned pregnancies we call upon all national governments to reduce the need for abortion by providing universal access to family planning information and services.

Health and mortality

8 Despite some improvements in human life expectancy, preventive and treatable illness is still the leading killer of young children and women. There remain at least half a million women dying annually from the complications of pregnancy and childbirth and 99.5 per cent of these maternal deaths occur in developing countries. Large numbers of people remain at high risk from infectious, parasitic and respiratory diseases. HIV and AIDS is the cause of a high incidence of deaths. Therefore the targeting of financial resources, particularly from donor countries, to these vulnerable groups is urgently needed to focus on reducing child and maternity mortality rates.

9 We therefore support the right of all people to have access to primary health care by the end of the current decade and pledge to work to reduce the disparities in health conditions and mortality risks between and within countries as detailed in the goals contained in the Programme of Action.

The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW, articles 12 and 14)

The leading modern instrument on women‘s equal rights, however, is the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) which was adopted in 1979. Zambia ratified it on 21 June 1985. This convention, derived from the Universal Declaration of Human Rights, is the first international treaty in which member countries assume the legal duty to eliminate all forms of discrimination against women in civil, political, economic, and social and cultural areas, including health care and family planning.

This is another important convention in the efforts to eliminate discrimination against women and therefore important in informing governments in their programmes and policies. The sole aim is to provide a framework within which government should operate as a guide to the right to health of women. CEDAW article 12 states:

1 State parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.’

2 Notwithstanding the provisions paragraph 1 of this article, state parties shall ensure to women appropriate services in connection with pregnancy, confinement adequate nutrition during pregnancy and lactation.

14 (b) To have access to adequate health care facilities, including information, counselling and services in family planning.

16 (e) the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

Protocol to the African Charter on Health and Reproductive Rights

Another charter is not only important but also acts as a buffer against the general attack of human rights instruments as being ‘foreign’. It is African as the name implies and governments are obliged to implement it. It includes important articles on the right to control one’s sexuality and the right to accessible health services,

including information, education and communication programmes, as stipulated below:

14 State parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

(a) the right to control their fertility;

(b) The right to decide whether to have children, the number and spacing of children;

(c) The right to choose a method of contraception;

(d) The right to self protection and be protected against sexually transmitted infections including HIV and AIDS

(e) the right to be informed on one's status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV and AIDS, in accordance with internationally recognized standards and best practices ;

(f) The right to have family planning education.

2 State parties shall take appropriate measures to:

(a) provide adequate affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;

(b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while breast-feeding;

(e) protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the foetus.

The Millennium Development Goals

All human beings are entitled to a healthy and productive life. The right to health is central to several of the Millennium Development Goals which includes combating infant mortality and major diseases. The right to health underpins all goals for poverty reduction and development. Safe drinking water, basic sanitation, food security and adequate nutrition are necessary pre-conditions for preserving health. The ability to attain the highest possible standard of health also depends on the availability, accessibility and quality of health services.

The Beijing Platform

The struggles to see women get services equitably or equally with men has a long history. One of the most important conferences that made strides towards getting women what they wanted was the Beijing Platform of September, 1995. There were 189 countries represented at the conference which built on the consensus and progress made at previous United Nations conferences and summits – on women in Nairobi in 1985, on children in New York in 1990, on the environment in Rio Janeiro in 1992, on human rights in Vienna in 1993, on population and development in Cairo in 1994 and on social development in Copenhagen in 1995, with the objective of achieving equality, development and peace (UN, 2001:8). One critical reason for the declaration was to reaffirm the equal rights and inherent human dignity of women and men as well as other purposes and principles enshrined in the Universal Declaration of Human Rights (UDHR) and other international human rights instruments, in particular the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, as well as the Declaration on the Right to Development. There are about thirty-eight declarations which all point towards women's rights. Declaration 30 is about ensuring equal access to and equal treatment of women and men in education and health care and enhancing women's sexual and reproductive health as well as their education.

Legal framework

The Constitution

The Constitution of Zambia guarantees freedoms and treatment without discrimination on the basis of sex, gender, tribe or race. Put simply, it provides for civil and political rights. However, social and economic rights are not provided for in the constitution although they are supposed to be provided in part three (Bill of Rights). This suggests that the government is not doing enough to correct the imbalances in health services delivery. It also indicates a violation of international law.

The Constitution of Zambia also does not guarantee the right to health and education. Amnesty International says that violation of economic, social and cultural rights is not just a matter of inadequate resources; they need to be included as a matter of policy (Tomasevski, 2005).

The importance of integrating human rights into programmes should now be recognized as an approach to development. For example, the United Nations Development Programme (UNDP), in its *Human development report 2000*, stated:

> '…a decent standard of living, adequate nutrition, health care and other social and economic achievements are not just development goals. They are human rights inherent in human freedoms and dignity. But these rights do not mean any entitlement to a handout. They are claims to a set of social arrangements – norms institutions, laws and enabling environments – that can best secure the enjoyment of these rights. It is thus the obligation of governments and others to implement policies to put these arrangements in place' (UNDP, 2000: 73).

To emphasize the point there is need for nations to begin to work towards using the human rights approach in their development efforts. The right to health is the right to the 'highest attainable standard of physical and mental health', given the individual's genetic makeup and lifestyle choices, as well as the extent of scientific understanding and the maximum of resources available to the state. It encompasses freedoms (such as the right to the control of one's health and body) and entitlements (for example, to equality in access to health care) and consists of two basic components: healthy living conditions and health care[3].

The National Health Services Act, 1995

In September, 1995, the National Health Services Act (GRZ 1995) was enacted. The Act created the Central Board of Health to provide the procedures to establish management boards and hospitals and to define the functions and powers of such boards and their relationship to the health system. The main purpose of the Act was to create autonomous corporate boards, which are responsible for developing and implementing annual health plans.

3 International Covenant on Economic, Social and Cultural Rights, article 12; CEDAW article 5(e)(iv), Convention on the Rights of the Child, article 24; 11, African Charter on Human and Peoples Rights, articles 11 and 14.

CHAPTER FOUR

Guiding Principles – the Ministry of Health

Poor health indicators and a centralized, inefficient health care system were among the reasons why the Zambian government initiated some of the most radical health sector reforms in Zambia in 1992. The major thrust of the reforms was to strengthen district health systems and enable them to provide a defined set of cost-effective basic health services to their populations, especially to the poor and underprivileged. The assumptions of decentralizing were that district levels, being closer to the communities they serve, would be able to come up with programmes based on prioritized problems and activities. Sector health reforms were embarked on and donors became actively engaged in a new development policy and partnership framework which became known as the sector-wide approach' (Swap). Reform strategies were developed, inter alia, training, decentralized funding and planning, and secondment of staff to the Central Board of Health from the Ministry of Health.

With all the changes that took place it is easy to say that the reforms managed to improve the sector but did not improve access to health services, especially for women. Services related to reproduction are so much the focus that women's health is viewed as being reproductive when health issues vary for different women. The result is that women's health needs are narrowed down, ignoring the many diseases that affect them.

District management and district hospitals

District management structures form the base of the district health delivery system, in terms of financing and technical support. Planning of activities for rural health centres for the year is done with the districts. The idea is to prioritize the local problems. So the plans can be said to be 'owned' by the rural health centres but the problem lies in implementing the planned activities. Funding for the activities comes from the district but it is easy to divert the funds to other activities considered as 'emergencies'.

Rural health centres

Rural health centres are the centre of activities at the lower level. Though they do not form part of the primary health care structure, they oversee the activities of the structure. This overseeing should involve supervising, providing technical support and training. The structures that form the primary health care system are community health workers, traditional birth attendants, malaria assistants and the management committees at these levels – rural health centre and neighbourhood. However, rural health centres are inadequately staffed and cannot perform these functions. The problem is compounded by funds that come at the 'will' of funds dispensers. Staff morale is low due to low remuneration, poor conditions of service, work overloading and inadequate supervision. The infrastructure is not in a good state of repair in most institutions and is not adequate even in terms of space. The lack of capacity in the management committees at the lower level has impacted on the delivery of services. Rural health centre and district staff do not visit the committees at the lower level. This has incapacitated them more, especially since they are committees in transition.[4] Gender mainstreaming at these levels is problematic. It is not incorporated in the structures, even at the district level. Gender concepts are non-existent in these activities. The result is that men's attitudes, either as workers or community members,

4 They are new committees and have no knowledge of how committees function.

tend to be negative towards women. Women feel that the staff look down on them because they are poor and never went to school. One respondent remarked:

> ‘They are only in employment. If we had the education we could also be working, but they see us as nonentities.’

CHAPTER FIVE

Findings

Key themes by assumptions

Assumption 1: discrimination at both structural and cultural level

Promoting equality, equity and access involves countering discrimination and oppression. Discrimination, both its process and type, is easy to recognize when it is done at higher levels like on the basis of race. It is important to start with the definition of discrimination. According to Thomson (2003), discrimination is:

> '…a process or set of processes by which people are allocated to particular social categories with an unequal distribution of resources, rights, opportunities and power. It is a process through which certain groups of individuals are disadvantaged and oppressed. As such, it is a major obstacle to dignity, equality and social justice' (2003:82).

Discrimination processes are sometimes so subtle that people do not notice them or it becomes a question of taking things for granted. There are six processes that are closely associated with inequality, discrimination and oppression, which I will discuss in brief. There is a tendency for these processes to interact, and combine and reinforce one another. These are: stereotyping, typification, marginalization, invisibilization and social attitudes.

Stereotyping

Argyle and Colman (1995) offer a useful definition of stereotyping. It is from the Greek words 'stereo', meaning solid, and 'typos', meaning an oversimplified, biased and above all inflexible conception of a social group. The word was originally used in the printing trade for a solid metallic plate which was difficult to alter once cast (Argyle and Colman, 1995:104). It is used here to show we have fixed opinions about women which are actually a process of discrimination.

Typification

This involves establishing what is typical about a particular class of events, people or phenomena. For example, if we take a woman at a clinic, we shall start with a 'clean sheet' in terms of what we would expect of her. We are likely to start with an idea of what a typical woman is like – she has a complaint related to reproductive functions. We would then form an impression of how this woman compares with our expectations. Typifications are broad categories and do not provide the information we need to deal with specific individuals and therefore we have to adjust or abandon the typification in order to perceive the individual. Typifications are (or should be) the beginning of the process of understanding rather than the end of it. However, typifications can sometimes become fixed and rigid – they can become stereotypes. For example, the reproductive functions of women can become a negative perception, which prevents the system from catering for all their numerous other health needs. Stereotypes have some of the following characteristics: they are resistant to change as they tend not to be dissuaded by logic and evidence; they are often negative and therefore potentially oppressive; and they are ingrained to the extent that we tend not to notice that they are there and that they are affecting our perceptions and actions.

Marginalization

The marginalization process refers to the way in which certain groups of people are pushed to the periphery of society and are thus excluded from the mainstream. For example, viewing women's health as a reproductive issue has removed women's health from the mainstream of health provision. Their reproductive roles have dominated in defining their health.

Social attitudes

Social attitudes that patronize and devalue women create physical barriers that deny women access to certain areas and the lack of positive steps to combat this means rural women, in particular, cannot participate fully in social, political and economic activities.

Invisibilization

This process has much in common with marginalization but refers to specifically to how groups are represented in language and imagery. The basic idea is that powerful, dominant groups are constantly presented to us through the media – and are strongly associated with positions of power, status, prestige and influence, while other groups are rarely, if ever, seen in this light – it is as if they have been rendered invisible.

Accessing the health services – two case scenarios

There is a long process that a woman goes through to access health services. This process needs to be understood by both service deliverers and planners. I will explain this process by giving two examples as experiential data from the research. The first is of a village woman who was suffering from a dental abscess and the second is about a woman who was seeking preventive health services. The idea is to bring to the fore the dynamics at play that facilitate access or hinder it.

Scenario 1: Ill in the village with a dental abscess

Step one (feeling ill in the village)

A woman is ill in a village 35 to 40 kms away from the rural health centre. She has to undergo various processes to decide whether she can access the health services or not. She realizes she is ill and that she needs to seek treatment. However, she has a number of considerations to make. She has to consider the distance of 30 kms that she would have to walk to get to the community health worker. Another consideration in relation to the community health worker is the availability of drugs. She would also have to consider the money, as community health workers charge K500 – K1000. There is also a real measure of time and opportunity cost to take into account. She has to quantify what she would gain and lose by going to seek treatment. She has to look at her role as caretaker and imagine what will happen to the children in her absence. Who will take care of the household duties? While all this is going on, the severity of the infection is increasing due to bacilli multiplication in the case of the abscess under discussion.

Step two (I need to go)

Having gone through the processes above, her symptoms signal that the illness is getting worse which convinces her and the family that she needs to go the clinic. The issue of logistics then come into play. The decision to be made is dependent on the availability of money and transport. Having gone to the community health worker who had no drugs for a dental abscess, apart from the pain killers, she decides to go to the rural health centre. The transport to be used is an oxcart which has to be hired at a charge of K25 000 to K30 000 – the equivalent of eight or nine US dollars. This is a lot of money for a woman in

a village to afford. Looking for this money and the money to be used at the rural health centre or on the next stage at the district hospital takes time and the illness is getting more serious all the time. Finally, every effort is made and she is brought to the centre.

Step three (A day at the rural health centre – the personnel)

In order to gain an insight into the attitudes and work culture of the rural health centre members, one needs to look at the staffing levels. How many people make up the establishment and in what capacities? What are their conditions of work? Chinyama Litapi rural health centre should employ four trained staff in the capacities of clinician, environmental technician and two nurses – including one with midwifery training. It should also have two auxiliary staff, commonly called classified daily employees. However, the situation is that there is only one male enrolled nurse[5] and two classified daily employees – one male and one female. The rural health centre level is where the health system provision starts. The care has been extended beyond the rural health centre through the primary health care strategy. The problems of staffing have been highlighted at this rural health centre. There is also the problem of funding and transport. The rural health centres have no transport to use to send a patient to the district hospital. Using the improved communication of radios they can call for an ambulance from the district. It will depend on the availability of the ambulance at the station or the availability of fuel to be able to respond to the emergency appropriately. At this stage the condition of the woman is very bad and this really begs the question, 'Must I die in the village because I am poor?'

At one rural health centre I visited, Kambingimbanga, they revealed that when a patient who needs referral is brought to them, they use their radio to call the ambulance. However the patient has to be moved to the roadside (to a tarred road) where the ambulance will pick her up. There is a considerable distance between the rural health centre and the roadside. The gravel road from the centre to the roadside is fairly good, according to the local standards. Why this has to happen in this way therefore boils down to the attitudes of workers. It is the responsibility of the health staff to ensure that the patient is transported in a way that gives a minimum of comfort. For the patient to reach the district level and survive is merely by chance. The probability is that this person will die. All the above is happening at the structural level where there are issues of geographical location – distances, availability drugs and transport, affordability of user fees, attitudes of health workers and availability of health staff at the centre.

Cultural level

Culture can simply be defined as people's totality of life. It includes norms, values, beliefs and practices. These are elements that have been 'internalized' in the process of socialization and are always seen or viewed with respect and with a conservative attitude. Socialization refers to 'the processes through which individuals take on gendered qualities and characteristics and acquire a sense of self' (Wharton, 2004:30). Culture has both material and non-material elements. The material culture is the artifacts, human-made elements, while the non-material culture is that part which is about values, norms and the belief system. This part of culture is difficult to change compared to the material culture. For example, it is easier for one to buy a watch (material culture) than to keep timing (value). What I found in the study mostly were cultural elements that relate to value and norms.

Values, norms and beliefs

The lack of influence on decision making is a social reality that has an adverse impact on women's health. It is the norm to regard women as people who cannot decide. Men always have to make the decisions, even over a woman's illness. It is strictly observed that women have to be submissive and obey men's directives. This disempowering of women has a negative effect on women's health. The multiple roles women play within the family and community are some of the negative cultural practices and beliefs that impinge on their access to resources.

5 One with two years training in nursing care at a recognized nursing school

In the case of the woman with an abscess, when asked why she had not sought medical attention she clearly remarked:

> '*Lunga lyami nangu mono vene, achimuhulenu uze*' (meaning my husband has seen that I am sick and he can't take me to the clinic, can you ask him? – *pointing at the husband*).

The impact of culture on women is to make them submissive and is characterized by their silence even when things do not go their way. At one centre I visited in the company of my supervisor, we delayed the women by talking to the person in charge who was doing the examinations. When the waiting took a considerable time, it was a man who complained; not the women who were waiting to be attended to.

Alternatives

Women seek alternatives in the absence of the health delivery system or the failure of it. Having tried the community health worker and rural health centre to no avail, the woman will seek an alternative. The alternatives are usually asking for medicine from friends and using traditional medicines. In Jelle's study (2004) it was found that 88 per cent of his respondents will visit a traditional healer. And more women than men were found to visit traditional healers (Jelle, 2004:20). These alternatives further reduce women's respect, dignity and, importantly, chances of survival (their right to life). Jelle's cross-section found that out of 96 per cent of the respondents who were to give birth at a health facility, only 54 per cent actually did. The factors for this discrepancy are long distances and lack of transport, the payment of fees, a lack of adequate health education, understaffed and ill-equipped institutions and poorly-trained staff (Jelle, 2004).

Process of accessing health services in a structural and cultural context

Day	Condition/situation	Thought process or actions
Monday	Not feeling well	I will get better. I have to look after a family.
Tuesday	Really not well	Telling husband and family about ill health
Wednesday	Really ill	Ask for medication from friends in the village(self medication) or thinking of the community health worker – availability of drugs and K1000
Thursday	Illness getting worse, in bed	Visiting community health worker gives pain killers only
Friday	Not improving	The pain killers have not cured the problem. Need to go the rural health centre. Finding out whether nurse is present and drugs available
Saturday	Seriously ill	Consultation between husband and family members and organizing logistics – transport hired ox-cart and upkeep at the centre
Sunday	Seriously ill	Travelling to the rural health centre –25 kms The drugs are not adequate and the patient has to stay longer.

The descriptive table above shows how hard it is for a woman to access curative health service given the structural and cultural context in which they find themselves.

Accessing basic preventive health services

Women's preventive health services include but are not limited to information and education on their health, children's welfare, immunization and antenatal care. In the process of accessing these services women still encounter problems that impinge on their access to these services.

Response of the system

The system does not respond adequately to meet the CEDAW provision in article 14(b) which talks about having access to adequate health care facilities, including information, counselling and family planning.

The failure to respond comes as a result of the negative attitudes of health workers. Women are still being abused and made to feel like they are not real persons. The story of Merdine that follows explains this finding in detail.

Scenario 2 : the story of Merdine

> Merdine Kwanuka was born in 1985 in a village called Luneta in Chipepepe area on the western side of Zambezi district. Her home area can best be described as a hard to reach area. Merdine went up to grade two in her education. She got married in 2001. Since her marriage she has had two successive miscarriages due to an incompetent cervix[6]. After the third pregnancy she gave birth to a child who died a month later.
>
> On the fourth pregnancy, she was confined (*chipango* in Luvale, a local language) as part of treatment for the diagnosed problem by the traditional healer. During this confinement she was restricted from seeing people, especially her relatives.
>
> The nearest health facility to where Merdine stays, a rural health centre, is a two-day journey on foot. The cost of hiring an oxcart for the journey is K21, 000 (six to seven US dollars). She never sought medical advice from the nearest health facility when was having these miscarriages. She has no information on her reproductive functions, let alone her right reproductive health. When asked why she could not visit the rural health centre during the times she was having abortions she remarked:
>
> '*Lunga lyami angu mbata ikiye ali i nay uli*' (meaning my husband does not care, he is lazy).
>
> And when further asked as to why she could not start off herself she remarks in surprise:
>
> '*Mukatuka ngachilihize?*'(meaning, how do you just start off?).
>
> *What 'chipango' had to observe*
>
> During this period of isolation (*chipango*) Merdine had to drink some medicines (herbs) and mix some powder with food. She had to live within a fence that was not adequate protection in terms of adverse weather conditions – rain and wind. She could not see her relatives – those she shares the same totem with – as these are the ones who give her the bad luck of having miscarriages. Other rules she had to follow to the letter were to not wash her body or her clothes and to eat hot food. At the time she was interviewed she had been in confinement for close to a year. She had a child who was then seven months old, born on 12 May 2005.

6 A weak cervix that does not hold and fails to support the foetus

Encounter with health providers

On the 1 December 2005 a health team arrived in Merdine's village in the morning to conduct child immunization against six immunizable diseases, give antenatal care and provide any health information on any matter if needed. Merdine was in her shelter but she got word about the team being in her village. She wanted to find a way of getting her child to the immunization site without her relatives seeing her. She knew that her child of seven months had not yet received any vaccine although they were meant to start at birth. She maneuvered around and in the process some women spotted her and started to debate among themselves about whether it was okay for her to come or not. In the process, one health staff member heard the conversation. She stood up and saw Merdine standing at a distance trying to observe her relatives. The health worker shouted on top of her voice:

'You do you know that these services are for your children. Why do you believe these old stories?'

Merdine drew near and gave her child over for screening. The child received the vaccinations she was due for. A dawning silence followed. Women exchanged glances and surprise was written all over their faces. After Merdine got the vaccinations and she was heading to her shelter, I requested an interview with her. She agreed and I went ahead and got the information that you have just read in brief. I was an active participant and observer in the research process. That is the story of Merdine in relation to rights and freedoms as provided in the constitution.[7]

How women are discriminated against? Distances

The long distances that women have to cover to get to a health facility can be a barrier and discrimination in itself. In some cases they have to cross rivers or streams in small canoes. Most of the respondents interviewed had to cover over 20 kms to get to a health centre.

Distances to health facilities

Type of facility	Less than 20 kms	20 -30 kms	30- 40 kms	40 kms+
Hospital	05	07	18	20
Rural health centre	03	22	12	08
Health Post	Non existent	Non existent	Non existent	Non existent
Community health worker	32	08	03	02
Total	40	37	33	32

From the data above you can easily tell that the majority of respondents have to cover more than 20 kms to get to health facilities. About 95 per cent have to go over 20 kms to get to the hospital and 40 per cent have to go over 40 kms to get to a fir[st] level hospital.[8] The issue of distance is cardinal in the delivery of health services. The problem has been of concern even to some civil society organizations heads. The Executive Director of Women for Change, Emily Sikazwe, when reacting to the abolishing of user fees in rural areas remarked:

'Although user fees were partly preventing the poor people from accessing health facilities, other issues such as walking long distances to get to the nearest clinic, lack of medical staff and drugs also cause unnecessary deaths. For instance, in Western province, the people of Lui-Namabunga have to walk about 25 kms to reach the nearest clinic at Senanga Boma. People in Chilobe, Southern province, walk about 35 kms to reach the nearest mission rural health centre at Kabanga.

7 Anecdotal evidence on access to preventive health services

8 A lower level hospital where there is a doctor and they can perform surgical operations and other obstetric emergencies

> 'Most rural clinics do not have transport and people use ox-drawn carts and bicycles which are uncomfortable. The state of the rural road network equally adds to their toil, since these roads are impassable. This also results in unnecessary deaths.'

User fees

User fees is another issue where women are being discriminated against. This happens at the structural level. When one considers the economic status of rural women it is impossible to imagine their capacity to pay fees. It is the policy of the Ministry of Health to charge all able-bodied Zambians a fee for the services they receive. Some exemptions are there for people who are over 65 years and those who suffer from chronic illnesses, like asthma. However, the actors always ignore these instructions so they tend not to behave according to the prescribed approach. For example, at one rural health centre where I conducted an interview I learnt that the staff were punishing women by asking them to sweep around the premises because they did not come for the under-five or antenatal clinic. At another place, Zambezi hospital, the staff demand that a pregnant woman bring a bottle of Jik before she is admitted for delivery. The policy, however, is that deliveries are free. The cost of a 750 ml bottle of Jik is K12 000.00 (about three US dollars). The user fee, popularly called the registration fee, ranges from K1000 to K1500 (translating into 40-50 US cents). The economic situation of women has led to 'human poverty', which is the denial of opportunities and choices that are most basic to human development (UNDP, 2003). The poverty in Zambia, especially among the rural people, needs no emphasis. There was a general outcry about the user fee as a hindrance to accessing health services. One respondent at Kampinjimbanga rural health centre, when asked what she does when she has no money to pay, remarked:

> '*Kwiza ko pimbi chipwe nangu lomba vitumbo ku va kwetu*' (meaning: I will not come to the clinic or I just get medicine from my friends in the village).

It is evident that fees and long distances from facilities lead to exclusion of women. The problem is so immense that government abolished user fees in the rural areas with effect from 1 April 2006. Making a statement at the time, President Mwanawasa said:

> 'Zambians are dying unnecessary deaths and the abolition of medical user fees will help the situation.'

Assumption two: inadequate personnel at both district and rural health centre level

Lack of capacity of rural health centres and beyond

The assumptions of the health reforms were that they needed to strengthen and build the capacity of all the structures at the grassroots level, namely, at rural health centres and neighbourhood committees and of community health workers and the community at large. This was to be made possible with funds sent to the districts and the districts were to plan accordingly. The financial administrative management system gives the guidelines (criteria) as to how much is supposed to be spent at which level and on what. The rural health centres are allocated 45 per cent of the total funds sent to the district for various activities but more so for outreach activities in their catchment areas. The community, through the neighbourhood committees and rural health centre committees, are allocated 10 per cent of the funds sent to the district. This is also to help them participate in the delivery of services, therefore bringing in the concept of 'owning' health services as opposed to being mere receivers.

The situation on the ground is different as the guidelines are hardly followed. All the three neighborhood committees and the four people in charge at the rural health centres interviewed remarked that they have never received the money for communities. This does not mean that they don't have the need for the money but the district has to provide funds. The explanation has been that the district itself had not received funds. Rural health centre staff have equally been affected by the under-funding of the centre. The funding they get is usually used for cleaning materials and patient's food. When asked to explain why there is this under-funding to the centre, the blame is put on the other expenses that the district is incurring like rentals for members of

staff. This has weakened the capacity of the lower levels to manage their affairs, including their power to build capacities among the community health workers and neighbourhood committees.

Beyond rural health centres

Beyond the rural health centres are the primary health care structures of community health workers, traditional birth attendants and neighborhood committees. The community health workers perform both curative and preventive functions. They receive a medical kit for minor ailments. However, the kit is not adequate for the population of 500 people. The drugs are mainly pain killers and antiseptic solutions (appendix 2). The situation of community health workers is compounded by no new recruitment and lack of refresher courses for those who have served for a long time. There is a high dropout rate due to many factors, inter alia; the lack of support from the community and long hours of work. The officially agreed working hours for community health workers is not always adhered to.

Community participation, which was meant to be the cornerstone of the primary health care strategy, is insufficiently implemented. The highlighted obstacles of lack of funding to the communities and a high dropout rate have resulted in their failure to participate sufficiently. The community health workers also have logistical problems of lack of transport to enable them to visit their areas.

Assumption three: Decentralized funding to the district level has not built the capacity of rural health centres and beyond.

Funding

Funding, as has been indicated, is not provided according to the set criteria. Rural health centres are not adequately funded due to a number of factors. However, the point is that inadequate funding means they have no capacity to carry out planned activities. The lack of funding to rural health centres has been justified by the district management differently, sometimes to the dissatisfaction of those in charge of rural health centres. In a first and second quarter financial report it was acknowledged that there is expenditure above the ceiling at the district health office. The reasons given for that are the referrals to level two hospitals and additional funding from the centre (user fees), rentals and late disbursement of funds.

The below expenditure ceiling at community level is explained as being due to implementation of all planned activities in the quarter (*Health sector committee report,* September 2005).

Training

Related to funding is the issue of training of the neighbourhood committees and other members. The assumption in the policy was that the committees would be instrumental in mobilizing and strengthening communities. This was going to be possible with training that the communities were to receive. However, out of all three committees studied, none has received training. The committees were just formed and nothing followed after that. This has reduced their capacity and affected their participation. The situation has been made worse by the failure of the rural health centres to move about in their communities to offer technical support. The district office also fails to do scheduled monthly visits. At the time of the interview the neighbourhood committee in Nyilamba, over 95 kms from the district office, was doing the TB/HIV activities, which happened just recently.

Inadequate staff

The problem of inadequate staff is described as a 'crisis' in the Ministry of Health. There are many factors that led to this situation, namely, the IMF and World Bank structural programme that demanded reductions in the civil service workforce. Schemes like voluntary separation took its toll on workers, targeting those who had served less than ten years. The uncompleted health reform implementation also created some uncertainties and contradictions which to date are not resolved. The global movement is to look for greener pastures. The situation is so poor that talking of access to the health delivery seems merely a dream. The Minister of Health, Silvia Masebo, in a parliamentary statement remarked:

> 'The ministry is running at less than 50 per cent human resource capacity' (Post newspaper, 2006).

In a related development, Emily Sikazwe, reacting to the situation of health personnel said:

> 'When there are no medicines, government should address the accessibility of medical care services, the lack of drugs and lack of medical personnel. Government needs to build more clinics, make drugs available in health centres and ensure there are enough medical personnel in rural areas if they want to save lives, which is their duty.'

During one district human rights workshop organized by Women for Change and held in Nchelenge, Luapula province, she said she had learnt that Chimese rural health centre had one clinical officer who was assisted in his absence by a guard. Furthermore, this situation is common in most rural areas. Sikazwe also remarked:

> 'What life is the abolishing of medical user fees going to save in this situation!'

Staffing levels at the rural health centres visited

Institution	Category	Establishment	actual	shortfall
Kapijimpanga rural health centre – Solwezi	Clinical officer	1	nil	1
	Environmental health technician	1	nil	1
	Nurse	2	1	1
	Classified daily employees	2	1	1
Mwange rural health centre – Zambezi	Clinical officer	1	nil	1
	Environmental health technician	1	nil	1
	Nurse	2	1	1
	Classified daily employees	3	2	1
Mize rural health centre – Zambezi	Clinical officer	1	1	nil
	Environmental health technician	1	1	nil
	Nurse	1	1	nil
	Classified daily employees	2	1	1
Mpidi rural health centre – Zambezi	Clinical officer	1	NIL	1
	Environmental health technician	1	NIL	1
	Nurse	2	1	1
	Classified daily employees	2	2	NIL
Total		24	12	12
Percentages %		100%	50%	50%

The scenario existing at the four rural health centres that were covered in the study confirms the assumption that there is shortage of staff. The impact of this situation is that women and men are denied their right to health services. The situation at the district hospital is the same. It is even made worse by lack of accommodation for staff after the sale of houses to civil servants.

Outcomes

Epidemics

The outcomes of the situation both for the curative and preventive services is that there will be continued epidemics when they could have been prevented. The epidemics continue to affect more women than men.

Level of service

Women will continue to bear with the inadequate level of care. Deliveries will continue to be risky because of inadequate or demotivated staff due to low salaries and opportunities. The other likely outcome is that women will not come to the facility where they were treated with disrespect and shame. The implication is that the reservoirs[9] of infection will continue to infect in case of a communicable diseases.

Assumption four – there is a lack of knowledge about human rights instruments among health providers leading to violations of human rights in the delivery process

The right to the highest attainable standard of health, as included in article 12 of the International Covenant on Economic, Social and Cultural Rights, means that people have entitlements. These entitlements, if given or recognized, will entail knowledge of human rights and respect of the same. Knowledge of human rights and other international conventions is problematic on the part of health workers. The very issue of patients spending long hours at health institutions because of inadequate staff is an issue of violation of human rights. Sometimes this is done with impunity. The story below, entitled, 'Right to dignity and privacy', will tell it all.

Right to dignity and privacy

On the 5 December during a 'child health week' programme at the Nyawanda community health worker post, this interesting incident happened. A big group of women had gathered to bring their children for immunization and what was supposed to be regular weighing and monitoring. Word went around that the district officers were coming for the exercise. I was part of the team but more in the capacity of an active observer for my research work. As a way of grounding my research I was mingling in the group as I administered the polio vaccine that is orally given. In the process, two girls asked me if antenatal services were available too. They were pregnant and wanted to be examined. They were *prime gravidas*.[10] I told them the woman in our team would to attend to them. I went ahead and gave them an antenatal card each, and told them to wait for the nurse who was administering vaccines.

When the time for the girls came, they walked shyly to the nurse and gave her their cards. As soon as they finished talking to the nurse, we were all greeted with information we did not wish to hear. The girls also seemed taken aback when they realized that their private lives were something for public consumption. They thought they would be sharing information in confidence, as privately as possible.

They seemed too young to be pregnant. One girl didn't manage to tell the nurse her age and one of the girls was not able to tell the nurse who had impregnated her. Then the nurse shouted at top of her voice, addressing those in attendance:

'*Enu vakwetu camucano vene owu mwana ku hasa kwijiva lunga na mu hane lijimo pimbi? Ana kungu lwezq ngwenyi aile ku mbonge kukiko awanyine owu lunga oloze kumwijiva pimbi*' (meaning You

[9] A person with bacterial disease who has the potential of transmitting it others

[10] A woman with a first pregnancy

people! – is it true that this girl cannot tell who impregnated her? She tells me she went to the boma[11] where she met this man but she cannot identify him!).

While this was going on, the people looked really surprised. I intervened to try to concentrate on the details of the pregnancy and not on who was actually the 'owner' of the pregnancy. All the formalities were done and the girls were examined. As we were leaving, our driver said that he heard the women saying that the girl was unable to say who impregnated her because it was actually her biological father. This traumatized me and I could only imagine how traumatic it was for the girl. However, this is the order of things when it comes to dealing with patients or clients. The right to privacy and indeed the right to health is compromised.

Emerging themes

Patriarchy

Patriarchy as a system of women's oppression has existed from time immemorial and men accept the relationship between men and women as being that of inequality in terms of power. The term is used here signify the control men have over women. This control is seen even in the case of a woman's illness. A man, either as a father or husband, has to decide to take the woman to a health institution. This power has consequences (Morgan, 1992:29) such as delayed medication. Patriarchy has such strong roots that cannot even decide what is good for them – this has to be prescribed by men and women have to unquestioningly take this situation as given.

Powerlessness

The point here is that women are powerlessness to make decisions and choices about what medical services to seek due to men's hegemony, control and authority. It is about socialization as a process through which people become gendered – they learn what is expected of them because they are female or male and how to display these characteristics (Wharton, 2004:7). This socialization is important to understand as it explains the formation of a person's 'gender identity' (Wharton, 2004). One of my female respondents was Merdine Kwanuka, a 21 year old who went as far as grade two at school. Merdine lives in Chipepe Area on the west bank of Zambezi district, some 100 kms from the district hospital and 60 kms from the rural health centre. As reported earlier, Merdine was confined in an enclosure and excluded from the rest of the community members as she was receiving treatment from a traditional healer after having three successive miscarriages. When I asked her why she did not visit the nearest health institution when she aborted she replied:

'Lunga lyami angumbata ikiye ali na wuli' (meaning: My husband is the one who is reluctant to take me to the health institution).

When further asked why she did not just seek medical advice herself, she answered:

'*Mukatuka ngachilihi*' (meaning: How do you just start off without permission?).

The situation above shows clearly that women have no control over their bodies even when they are sick. They are in a situation where their 'secondary position' puts them at risk as far as access to health services is concerned.

Furthermore, women's health is often viewed in terms of their reproductive functions only. This leads to some illnesses being ignored – what about the woman with a dental abscess? Reproductive functions are just one part of women's lives but it is not the only lone. This seems to indicate that other diseases in women may not be given appropriate attention.

[11] The administrative centre of the district

When I talked to the provincial director of health about my research topic, I mentioned that my area of interest was women's access to health services in relation to human rights. He responded:

> 'If you want to find out about women, you better get to maternal and child health services where there is all women want.'

This assumes that women are free to access services but in reality this is not the case. There are various dynamics at play at economic, cultural and social levels that prevent women from accessing health services.

There are competing views about this and health staff may trivialise a problem that the community itself see as a major problem. During one of the group discussions I had with neighbourhood committee members, which was attended by the nurse from the nearby rural health centre, I asked which diseases were common in the area and the women cited malaria, diarrhea and scabies.[12] The nurse said scabies was not important and there was no treatment for it, even at the districts office.

Poverty

The poverty of women need not be overemphasized here. As noted in the UNDP report, poverty was put at 73 per cent in Zambia in 2003. The bigger portion of this figure is a woman. Female-headed household are the most affected because of the gender inequalities in opportunities. Culturally-defined roles bind men and women to certain norms of behaviour, activities and benefits in society and thus shape the opportunities and constraints that women and men face in securing their livelihoods. In Zambia, gender inequality is mostly manifested in the unequal benefits and opportunities of women in relation to men. It is this that is blamed for the poverty that women experience. Women and girls are caregivers and producers of food in most Zambian cultural contexts. In a situation of extreme poverty and hunger women have to engage in selling their labour in exchange for food. This reduces the time that women and girls have to engage in really productive activities that would empower them.

Lack of capacity

Lack of capacity to challenge the situation is characterized by women's silence and obedience which is culturally accepted as 'good'. This culture of silence is the result of the long history of discrimination and oppression at structural and cultural level. This has brought about the women's exclusion from the public sphere where men dominate.

12 A skin disease caused by scabie characterized by itching and papillos on the skin

CHAPTER SIX

Discussion, conclusions and recommendations

Conclusions

The development in the international arena has helped to bring the issue of women‘s health onto the agenda. The struggle to eliminate discrimination against women on the basis of their sex has trickled down to providing health care equitably. This is what informed the health reforms in the health sector. The vigorous reforms aimed to meet the needs of the people with human rights (at least in theory) at the back of the planners' minds.

It is concluded, however, that the way government is responding is not in accordance with the African Charter on Human and Peoples Right article 16 (1) and (2) that states:

1 Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2 State parties shall take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Women still have problems in accessing health services due to stated the discrimination that exists at structural and cultural level. This discrimination is hardly recognized as such because of the socialization process. The long distances that women have to cover to get to the facilities and the fees they cannot afford to pay for services continue to be problems.

It has to be acknowledged that the health sector reforms have had their merits which could be exploited to increase women's equitable access to health services, at a cost they can afford. However, it is evident that while a lot has been invested in the system, not enough has been allocated to service delivery to the people as close to the family as possible. There are still many areas that need to be tackled to increase access. Such areas include the retention of staff, their accountability and the responsibility of health programmmes.

Women's access to health services has not been realized by the health reforms. All strategies need to be employed to address the issues at stake, including reproductive and other health concerns, primary health care, mental health, family planning and HIV and AIDS.

Discussion

The government elected in October 1991 aimed to redress the problems in the health system by constituting a new national health services policy, containing concrete proposals to radically reform the health sector (Ministry of Health, 1991, 1992, and 1994). The areas given priority were decentralizing management to the district level, forming district health boards, developing human resources, introducing cost sharing to finance health care, re-organizing and ensuring availability of assured health services. At the bottom of this thinking were the assumptions that when management was decentralized, services would reach the people, especially those in previously hard to reach areas. The structures put in place were thought to be adequate to address the

situation. It was assumed that making health a commodity that people could purchase would make people 'own' the process.

It is therefore important to acknowledge that the reforms have had some remarkable achievements in the area of system reform, such as the decentralization of both and management and financing.

However, the system has not improved delivery of services to the people. This is due to a number of factors. One of these is the global movement that attracts workers to leave and work overseas where they will earn more and another is the incomplete nature of the reform process.

Recommendations

Human rights approach

In order to eliminate the discrimination and oppression experienced in health delivery for so many years and achieve the right to health, the human rights approach has to be factored into the mainstream planning and implementation of programmes. Human rights, which include women's rights, are fundamental to reducing poverty, increasing access to health services and development, yet their importance is not always fully understood. The human rights approach is the way forward to achieve equality.

The right to health is recognized under key international and regional human rights treaties and encompasses economic, social and cultural rights, as featured in the African Charter on Human and Peoples' Rights. All efforts must be devoted to ensuring that the required strategies are developed to address inequalities in health status and to tackle the unequal access to adequate health care services for both women and men. The following strategic objectives and actions need to be taken:

Strategic objective 1: To address problems related to assumption one
Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services

Actions to be taken

By governments, in collaboration with non-governmental organizations and employers' and workers organizations and with the support of international institutions:

- Support and implement the commitments made in the Programme of Action of the International Conference on Population and Development, as established in the report of that Conference and the Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development and the obligations of states parties under CEDAW and other relevant international agreements, to meet the health needs of girls and women of all ages;

- Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation, for example. Review existing legislation, including health legislation, as well as policies, where necessary, to reflect a commitment to women's health and to ensure that they meet the changing roles and responsibilities of women wherever they reside;

- Design and implement, in cooperation with women and community-based organizations, gender-sensitive health programmes, including decentralized health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities, the demands on their time, the special needs of rural women and women with disabilities and the diversity of women's needs arising from age and socio-economic and cultural differences, among others; include women, especially local and indigenous women, in the identification and planning of health-care priorities and programmes; remove all barriers to women's health services and provide a broad range of health-care services;

- Provide more accessible, available and affordable primary health care services of high quality, including sexual and reproductive health care, which includes family planning information and services, and give particular attention to maternal and emergency obstetric care, as agreed to in the Programme of Action of the International Conference on Population and Development;

- Redesign health information, services and training for health workers so that they are gender-sensitive and reflect the users' perspectives with regard to inter-personal and communication skills and the user's right to privacy and confidentiality; these services, information and training should be based on a holistic approach;

- Ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards in the delivery of women's health services aimed at ensuring responsible, voluntary and informed consent; encourage the development, implementation and dissemination of codes of ethics guided by existing international codes of medical ethics as well as ethical principles that govern other health matters;

- Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to quality health services for women and girls; reduce ill health and maternal morbidity and achieve world wide the agreed-upon goal of reducing maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015; ensure that the necessary services are available at each level of the health system and make reproductive health care accessible through the primary health care system, to all individuals of appropriate ages as soon as possible and no later than the year 2015;

- Recognize and deal with the health impact of unsafe abortion as a major public health concern, as agreed in paragraph 8.25 of the Programme of Action of the International Conference on Population and Development;

- In the light of paragraph 8.25 of the Programme of Action of the International Conference on Population and Development, which states: 'In no case should abortion be promoted as a method of family planning', all governments and relevant inter-governmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeated abortions and laws containing punitive measures against women who have undergone illegal abortions need reviewing;

- Develop information programmes and services to assist women to understand and adapt to changes associated with ageing and to address and treat the health needs of older women, paying particular attention to those who are physically or psychologically dependent;

- Ensure that girls and women of all ages with any form of disability receive supportive service. Formulate special policies, design programmes and enact the legislation necessary to alleviate and eliminate environmental and occupational health hazards associated with work in the home, in the workplace and elsewhere, with particular attention to the needs of pregnant and lactating women;

- Integrate mental health services into primary health care systems and at other appropriate levels, develop supportive programmes and train primary health workers to recognize and care for girls and women of all ages who have experienced any form of violence, especially domestic violence, sexual abuse or other abuse resulting from armed and non-armed conflict;

Strategic Objective 2

Strengthen preventive programmes that promote women's health

Actions to be taken

- Give priority to both formal and informal educational programmes that support and enable women to develop self-esteem, acquire knowledge, make decisions on and take responsibility for their own health, achieve mutual respect in matters concerning sexuality and fertility and educate men regarding the importance of women's health and wellbeing, placing special focus on programmes for both men and women that emphasize the elimination of harmful attitudes and practices, including: female genital mutilation; son preference (which results in female infanticide and prenatal sex selection); early marriage, including child marriage; violence against women; sexual exploitation and sexual abuse, which at times is conducive to infection with HIV/AIDS and other sexually transmitted diseases; drug abuse; discrimination against girls and women in food allocation and other harmful attitudes and practices related to the life, health and wellbeing of women; and recognizing that some of these practices can be violations of human rights and ethical medical principles;

- Pursue social, human development, education and employment policies to eliminate poverty among women in order to reduce their susceptibility to ill health and to improve their overall health;

- Encourage men to share equally in child care and household work and to provide their share of financial support for their families, even if they do not live with them;

- Reinforce laws, reform institutions and promote norms and practices that eliminate discrimination against women and encourage both women and men to take responsibility for their sexual and reproductive behaviour; ensure full respect for the integrity of the person and take action to ensure the conditions necessary for women to exercise their reproductive rights and eliminate coercive laws and practices;

- Prepare and disseminate accessible information through public health campaigns, the media, reliable counselling and the education system: design these to ensure that women and men, and particularly young people, can acquire knowledge about their health, especially on sexuality and reproduction, taking into account the rights of the child to access to information, privacy, confidentiality, respect and informed consent, as well as the responsibilities, rights and duties of parents and legal guardians to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in exercising the rights recognized in the Convention on the Rights of the Child and in conformity with CEDAW; ensure that in all actions concerning children, the best interests of the child are a primary consideration;

- Create and support programmes in the educational system, in the workplace and in the community that offer girls and women of all ages opportunities to participate in sport, physical activity and recreation, available on the same basis as they are to men and boys;

- Recognize the specific needs of adolescents and implement appropriate programmes, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases, including HIV/AIDS, taking into account the rights of the child and the responsibilities, rights and duties of parents as stated in paragraph above;

- Develop policies that reduce the disproportionate and increasing burden on women who have multiple roles within the family and the community by providing them with adequate support and programmes from health and social services;

- Ensure that health and nutritional information and training form an integral part of all adult literacy programmes and school curricula from the primary level;

- Develop and undertake media campaigns and information and educational programmes that inform women and girls of the health and related risks of substance abuse and addiction and pursue strategies and programmes that discourage substance abuse and addiction and promote rehabilitation and recovery;

- Devise and implement comprehensive and coherent programmes for the prevention, diagnosis and treatment of osteoporosis, a condition that predominantly affects women;

- Establish and/or strengthen programmes and services, including media campaigns, that address the prevention, early detection and treatment of breast, cervical and other cancers of the reproductive system;

- Reduce environmental hazards that pose a growing threat to health, especially in poor regions and communities; apply a precautionary approach, as agreed to in the Rio Declaration on Environment and Development, adopted by the United Nations Conference on Environment and Development, and include reporting on women's health risks related to the environment in monitoring the implementation of Agenda 21;

- Create awareness among women, health professionals, policy makers and the general public about the serious but preventable health hazards stemming from tobacco consumption and the need for regulatory and education measures to reduce smoking as important health promotion and disease prevention activities;

- Ensure that medical school curricula and other healthcare training includes gender-sensitive, comprehensive and mandatory courses on women's health;

- Adopt specific preventive measures to protect women, youth and children from any abuse – sexual abuse, exploitation, trafficking and violence, for example, including the formulation and enforcement of laws, and provide legal protection and medical and other assistance.

Strategic Objective 3

Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues

Actions to be taken

- Ensure the involvement of women, especially those infected with HIV/AIDS or other sexually transmitted diseases or affected by the HIV/AIDS pandemic, in all decision-making relating to the development, implementation, monitoring and evaluation of policies and programmes on HIV/AIDS and other sexually transmitted diseases;

- Review and amend laws and combat practices, as appropriate, that may contribute to women's susceptibility to HIV infection and other sexually transmitted diseases, including enacting legislation against those socio-cultural practices that contribute to it; implement legislation, policies and practices to protect women, adolescents and young girls from discrimination related to HIV/AIDS;

- Encourage all sectors of society, including the public sector, as well as international organizations, to develop compassionate and supportive, non-discriminatory HIV/AIDS-related policies and practices that protect the rights of infected individuals;

- Recognize the extent of the HIV/AIDS pandemic in their country, taking particularly into account its impact on women, with a view to ensuring that infected women do not suffer stigmatization and discrimination, including during travel;

- Develop gender-sensitive multisectoral programmes and strategies to end social subordination of women and girls and to ensure their social and economic empowerment and equality; facilitate promotion of programmes to educate and enable men to assume their responsibilities to prevent HIV/AIDS and other sexually transmitted diseases;

- Facilitate the development of community strategies that will protect women of all ages from HIV and other sexually transmitted diseases; provide care and support to infected girls, women and their families and mobilize all parts of the community in response to the HIV/AIDS pandemic to exert pressure on all responsible authorities to respond in a timely, effective, sustainable and gender-sensitive manner;

- Support and strengthen national capacity to create and improve gender-sensitive policies and programmes on HIV/AIDS and other sexually transmitted diseases, including the provision of resources and facilities to women who find themselves the principal caregivers or economic support for those infected with HIV/AIDS or affected by the pandemic, and the survivors, particularly children and older persons;

- Provide workshops and specialized education and training to parents, decision makers and opinion leaders at all levels of the community, including religious and traditional authorities, on prevention of HIV/AIDS and other sexually transmitted diseases and on their repercussions for both women and men of all ages;

- Give all women and health workers all relevant information and education about sexually transmitted diseases, including HIV/AIDS, and pregnancy and the implications for the baby, including breast-feeding;

- Assist women and their formal and informal organizations to establish and expand effective peer education and outreach programmes and to participate in the design, implementation and monitoring of these programmes;

- Give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality;

- Design specific programmes for men of all ages and male adolescents, recognizing the parental roles referred to above, aimed at providing complete and accurate information on safe and responsible sexual and reproductive behaviour, including voluntary, appropriate and effective male methods for the prevention of HIV/AIDS and other sexually transmitted diseases through, inter alia, abstinence and condom use;

- Ensure the provision, through the primary health care system, of universal access of couples and individuals to appropriate and affordable preventive services with respect to sexually transmitted diseases, including HIV/AIDS, and expand the provision of counselling and voluntary and confidential diagnostic and treatment services for women; ensure that high-quality condoms as well as drugs for the treatment of sexually transmitted diseases are, where possible, supplied and distributed to health services;

- Support programmes which acknowledge that the higher risk among women of contracting HIV is linked to high-risk behaviour, including intravenous substance use and substance-influenced unprotected and irresponsible sexual behaviour, and take appropriate preventive measures;

- Support and expedite action-oriented research on affordable methods, controlled by women, to prevent HIV and other sexually transmitted diseases, on strategies empowering women to protect themselves from sexually transmitted diseases, including HIV/AIDS, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research;

- Support and initiate research which addresses women's needs and situations, including research on HIV infection and other sexually transmitted diseases in women, on women-controlled methods of protection, such as non-spermicidal microbicides, and on male and female risk-taking attitudes and practices.

Strategic objective 4 : In relation to assumption 4
Promote research and disseminate information on women's health

Actions to be taken

- Train researchers and introduce systems that allow for the use of data collected, analyzed and disaggregated by, among other factors, sex and age, other established demographic criteria and socio-economic variables, in policy-making, as appropriate, planning, monitoring and evaluation;

- Promote gender-sensitive and women-centred health research (women's law approach) treatment and technology and link traditional and indigenous knowledge with modern medicine, making information available to women and enabling them to make informed and responsible decisions;

- Increase the number of women in leadership positions in the health professions, including researchers and scientists, to achieve equality at the earliest possible date; inform women about the factors which increase the risks of developing cancers and infections of the reproductive tract, so that they can make informed decisions about their health;

- Support and fund social, economic, political and cultural research on how gender-based inequalities affect women's health, including etiology;

- Support health service systems and operations research to: strengthen access and improve the quality of service delivery; ensure appropriate support for women as health-care providers; and examine patterns with respect to the provision of health services to women and use of such services by women;

- Provide financial and institutional support for research on safe, effective, affordable and acceptable methods and technologies for the reproductive and sexual health of women and men, including more safe, effective, affordable and acceptable methods for the regulation of fertility, including natural family planning for both sexes, methods to protect against HIV/AIDS and other sexually transmitted diseases and simple and inexpensive methods of diagnosing such diseases, among others; this research needs to be guided at all stages by users and from the perspective of gender, particularly the perspective of women, and should be carried out in strict conformity with internationally accepted legal, ethical, medical and scientific standards for biomedical research;

- Since unsafe abortion is a major threat to the health and life of women, research to understand and better address the determinants and consequences of induced abortion, including its effects on subsequent fertility, reproductive and mental health and contraceptive practice, should be promoted, as well as research on treatment of complications of abortions and post-abortion care;

- Acknowledge and encourage beneficial traditional health care, especially that practised by indigenous women, with a view to preserving and incorporating the value of traditional health care in the provision of health services, and support research directed towards achieving this aim;

- Develop mechanisms to evaluate and disseminate available data and research findings to researchers, policy makers, health professionals and women's groups, among others;

- Monitor human genome and related genetic research from the perspective of women's health and disseminate information and results of studies conducted in accordance with accepted ethical standards.

Strategic Objective 5
Increase resources and monitor follow-up for women's health

Actions to be taken

- Increase budgetary allocations for primary health care and social services, with adequate support for secondary and tertiary levels, and give special attention to the reproductive and sexual health of girls and women and give priority to health programmes in rural and poor urban areas;

- Develop innovative approaches to funding health services through promoting community participation and local financing; increase, where necessary, budgetary allocations for community health centres and community-based programmes and services that address women's specific health needs; develop local health services, promoting the incorporation of gender-sensitive community-based participation and self-care and specially designed preventive health programmes;

- Develop goals and time-frames, where appropriate, for improving women's health and for planning, implementing, monitoring and evaluating programmes based on gender-impact assessments using qualitative and quantitative data disaggregated by sex, age, other established demographic criteria and socio-economic variables;

- Establish, as appropriate, ministerial and inter-ministerial mechanisms for monitoring the implementation of women's health policy and programme reforms and establish, as appropriate, high-level focal points in national planning authorities responsible for monitoring to ensure that women's health concerns are mainstreamed in all relevant government agencies and programmes.

Fulfilling the promise of Human Rights calls for transformation in the underlying value system that legitimizes discrimination. That is the biggest task as it requires technological innovations and information system to change the normative behaviors of the society. There must be human rights education and active participation of those whom development efforts and decisions have passed by, this is central to a rights based approach. When people are armed with information about rights and equipped with the skills and resources to claim them, individuals and communities can become agents of change and gain control over their own destines. The programmes must be able to confer the sense of entitlement and contribute to the momentum and sustainability of a rights-based approach. The programme must target, for example, the legal system that is permeated by social norms that reinforce gender inequalities and foster mistrust among women without effective recourse to justice. Customary law sometimes takes precedence over constitutional and legal provisions for equality. This is so in the area of family inheritance and land rights and even personal status.

All human rights instruments apply equally to all people, but the two conventions the most explicit protection of the rights of women and girls are 1979 CEDAW and 1998 UN Convention on the Rights of the Child

Institution building

In as much as the September, 1995 National Health Services Act (GRZ,1995) brought in the necessary investment to bring the standards of health institutions up to an appropriate level, they have not achieved the target. There is still need to address the problems of infrastructure, low staff levels and the low morale of the few workers who are there. The proposed human resources policy submitted to Cabinet in January should be implemented to be able to retain the workers. These would refer their patient to rural health centres. In all the study areas no health post was found to have been established. At one rural health centre the officer did not know the difference between a community health worker and a health post. This has maintained the long distances to cover to the rural heath centres and defeated the goal of 'providing services to Zambians with equality of access to cost-effective, quality care as close to the family as possible'. The recommendation above should be put in place to address the problems identified in the research.

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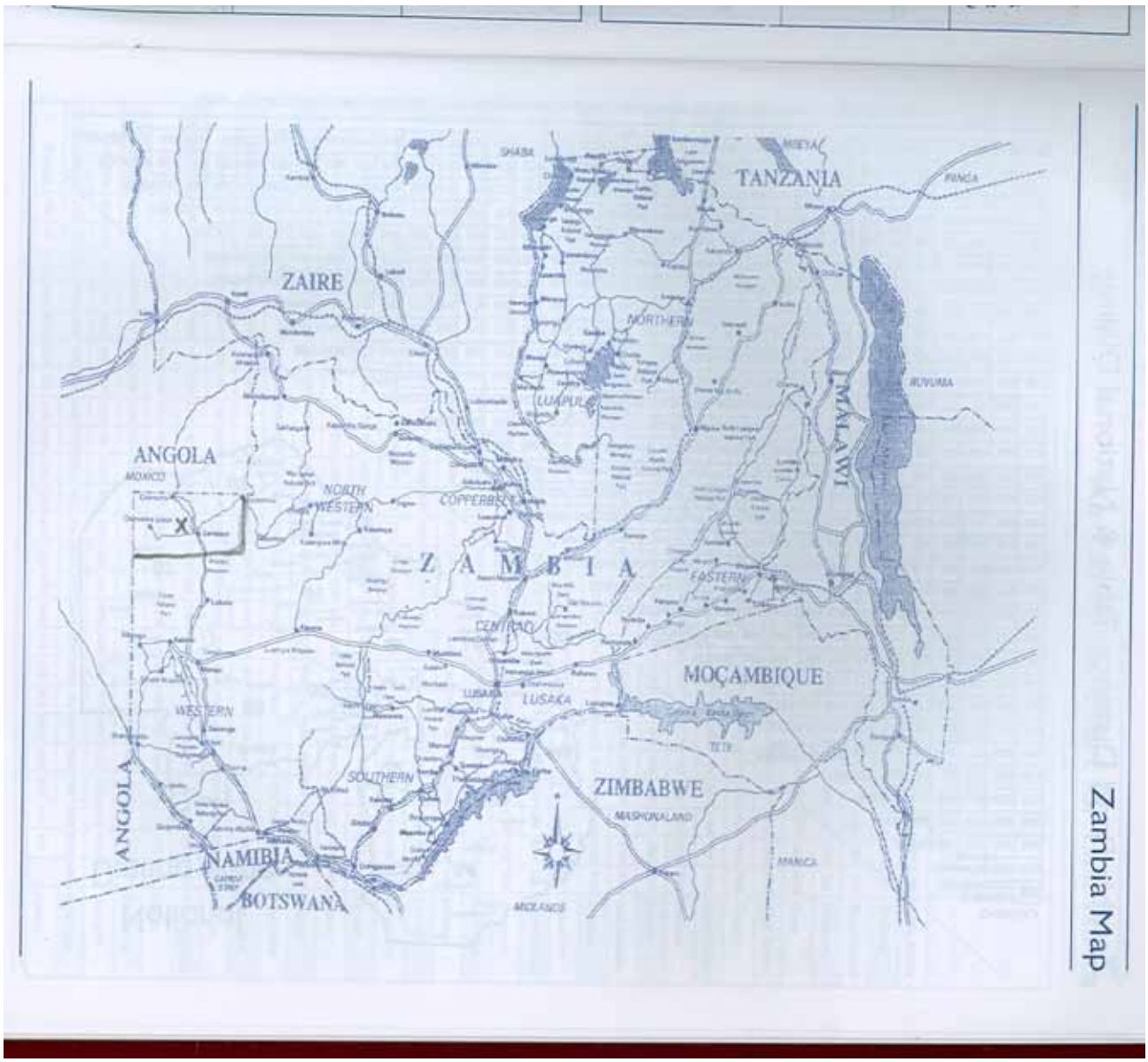
Appendix 1



Research areas marked X

Appendix 2

22nd September, 2005

The Director
Southern and Eastern African Centre
Regional Centre for Women's Law
P.O. Box MP 167
Harare
ZIMBABWE

Dear Prof J. E. Stewart,

RE: RESEARCH PERMISSION FOR MR. MUSIAELA MATAKALA

I make reference to your request on the subject above.

You may wish to know that Zambia since 1992 has been implementing health reforms whose focus is on providing equity of access to quality and cost-effective health care as close to the family as possible. Implementation of this vision has faced a number of challenges, including the need to ensure equitable access of basic reproductive health services to women in rural areas of the country. Maternal morbidity and mortality have remained unacceptably high in most parts of the country due to a number of factors that need a thorough understanding in order to improve targeting of resources.

The study proposed by Mr. Musiaela Matakala is timely and indeed expected to contribute to the understanding of the many factors associated with high maternal deaths in Zambia. I therefore grant permission on this study.

May also remind the researcher of the need to obtain written ethical clearance from the University of Zambia Ethics Committee.

I wish the student success in his studies. My Ministry will be looking forward to the findings of this study, that we may use them to improve delivery of services in the sector.

Yours sincerely,

ORIGINAL SIGNED
BY
DR. S. K. MITI

Dr. S. K Miti
Permanent Secretary
MINISTRY OF HEALTH

Appendix 3

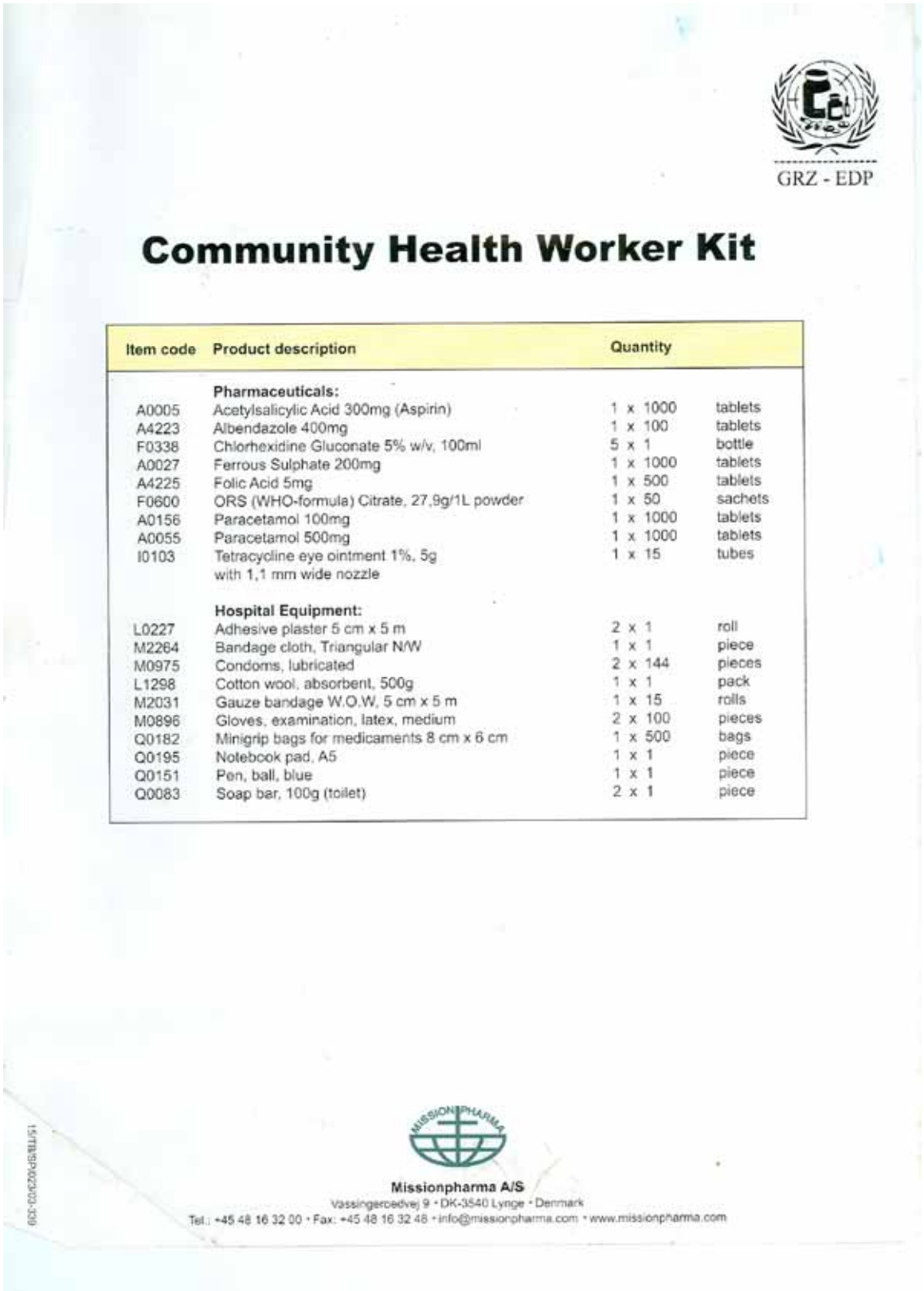
Research question guide

Centered on structure

Bio data: location, education, age, occupation, number of children, marital status. (These Qs applied to all respondents)

1. What are your experiences regarding women's access to health services in your catchment area?
2. How far is the furthest person you serve in this area?
3. How long does it take the person who is the furthest to reach here?
4. What is the cost of hiring an oxcart or a bicycle to bring a very sick person here?
5. Do women afford the money demanded?
6. Are there cultural constraints that hinder women from accessing health services?
7. How many are you at this establishment?
8. What is the establishment requirement?
9. Do the people you have entitlements?
10. What is the cost of accessing services at your institution?
11. Do women afford the user fee?
12. At cultural level
13. How far is you're nearest clinic, or community health worker?
14. How much do you pay to get services at the clinic community health worker center?
15. Are workers meeting your needs at the clinic?
16. **Who** decides whether you should be taken to the hospital when you are sick?
17. Why should they decide?
18. What transport do you use to get to the clinic in an event of serious illness?
19. How many workers are at the center?
20. Do you think you are overburdened with work at home?
21. What cultural aspects hinder women from accessing health services?
22. Do you receive information on women's health?
23. What type of information?

Appendix 4



GRZ - EDP

Community Health Worker Kit

Item code	Product description	Quantity	
	Pharmaceuticals:		
A0005	Acetylsalicylic Acid 300mg (Aspirin)	1 x 1000	tablets
A4223	Albendazole 400mg	1 x 100	tablets
F0338	Chlorhexidine Gluconate 5% w/v, 100ml	5 x 1	bottle
A0027	Ferrous Sulphate 200mg	1 x 1000	tablets
A4225	Folic Acid 5mg	1 x 500	tablets
F0600	ORS (WHO-formula) Citrate, 27,9g/1L powder	1 x 50	sachets
A0156	Paracetamol 100mg	1 x 1000	tablets
A0055	Paracetamol 500mg	1 x 1000	tablets
I0103	Tetracycline eye ointment 1%, 5g with 1,1 mm wide nozzle	1 x 15	tubes
	Hospital Equipment:		
L0227	Adhesive plaster 5 cm x 5 m	2 x 1	roll
M2264	Bandage cloth, Triangular N/W	1 x 1	piece
M0975	Condoms, lubricated	2 x 144	pieces
L1298	Cotton wool, absorbent, 500g	1 x 1	pack
M2031	Gauze bandage W.O.W, 5 cm x 5 m	1 x 15	rolls
M0896	Gloves, examination, latex, medium	2 x 100	pieces
Q0182	Minigrip bags for medicaments 8 cm x 6 cm	1 x 500	bags
Q0195	Notebook pad, A5	1 x 1	piece
Q0151	Pen, ball, blue	1 x 1	piece
Q0083	Soap bar, 100g (toilet)	2 x 1	piece

Missionpharma A/S
Vassingerodvej 9 • DK-3540 Lynge • Denmark
Tel.: +45 48 16 32 00 • Fax: +45 48 16 32 48 • info@missionpharma.com • www.missionpharma.com