Chapter 10

Health

10.1 Introduction

The wealth of poor people lies in their capabilities and their assets. Of these, health is the most important. Health allows poor people to work. A sick, weak, and disabled body is a liability both to the persons affected and to those who must support them. Thus, if health is an asset and ill health a liability, protecting and promoting health care is central to the entire process of poverty reduction and human development. In the recognition of the link between poverty and ill health, it is important to note that for Zambia, ill health is more likely to lead to further impoverishment amongst the poor than among the wealthy. For the country, meeting the health needs of the poor is an important means to prevent the increase of poverty as they suffer a heavier burden of disease.

Meeting the health needs of the poor is important for preventing the increase in poverty. However, because often the lost income as a result of seeking care or caring for the sick can amount to approximately 70 percent of total costs, utilisation rates for the poor are lower because of the opportunity cost of time spent on seeking care. In Zambia where services are poor and incomes low, taking time off on medical grounds jeopardises the future economic situation for the poor. Poverty can also be linked to poor health in that the poor lack basic needs such as social and health services. The poor have worse health outcomes than other economic and social groups. Additionally, infant, child and maternal mortality rates and malnutrition are higher in poor communities and countries. Given these relationships, it is clear that health care is an investment good, i.e. improving human capital results into higher productivity. In Zambia, economic growth has not been sufficient to allow for significant allocations to social programmes such as health, education, and other interventions that reduce poverty.

Additionally, good nutrition is essential for healthy and productive lives and has a direct bearing on the economic performance of a country. The high level of poverty in Zambia has largely contributed to malnutrition especially among young children. The vicious cycle of malnutrition exacerbated by poverty has negative effects on human and socio-economic development for the country. The consequences of poor nutrition are stunted mental and physical growth and development, poor health, poor reproductive performance, reduced productivity and potential, and increased risk of poverty.

In general, poor people have poor nutritional status. The productivity of any society depends on its nutritional status. A link between good nutrition and economic growth of a given population has been widely documented. The economic rationale of investing in nutrition cuts across the major sectors of the economy.

10.2 Situation Analysis

Zambia has been implementing health reforms since 1992 under the framework of the Sector Wide Approach (SWAP), which takes a holistic development view of the sector. In the SWAP, resources from government and other stakeholders are pooled so as to utilise resources efficiently. The health sector, however, has several threats that have to be taken into consideration especially when planning and programming. To begin with, there is a growing recognition in Zambia of the two-way link between HIV/AIDS and poverty. HIV/AIDS is inexorably consuming more resources, which means that less is available for other life-

threatening diseases such as malaria and cholera. Another threat in some districts is refugee arrivals from neighbouring countries. It is estimated that in one of the country's provinces, around 127,000 refugees from a neighbouring country have spontaneously settled in various districts. Where the base populations are quite small, such an influx can have a significant impact on the resources available and the demands generated.

Few, if any, of the general health indicators have improved in Zambia over the last ten years and some have even deteriorated. For instance, life expectancy at birth has dropped to 37 years; the infant mortality rate has increased to 109 per 1000; and the under-five mortality rate has gone up to 197 per 1000.[6] While the maternal mortality rate (MMR) is officially recorded as 649 per 100,000 live births, figures even higher than 1,000 are being reported in some surveys. Nationally, HIV sero-prevalence seems to have stabilised over the past 3-4 years: 29 percent in urban and 14 percent in rural settings, with a national average of 20 percent in the 15-45 age group. Further, there are some indications that the HIV infection rate among young adults is decreasing. With an official annual population growth rate of 2.9 percent, Zambia's population increase is about equal to the average rate for Sub-Saharan Africa.

AIDS and AIDS-related diseases have become prominent, with the number of households experiencing chronic illness and death rising. In 1998, 17 percent of rural and 12 percent of urban households had experienced an HIV/AIDS-related death. TB-related cases have risen, and other diseases continue to have a negative impact on the health status, including malaria, diarrhoea, and respiratory tract infections that place a heavy burden on the health sector. Moreover, the country has suffered in recent years from epidemics of cholera and measles. The high MMR has been caused by prenatal complications (26 percent), complicated deliveries (25 percent), and postnatal causes such as post-partum haemorrhage sepsis (26 percent). Equally, the health situation of children has not improved, with acute respiratory infections and malnutrition remaining serious problems; according to the 2001 UNICEF Report on the *State of the World's Children*, 42 percent of children under-five in Zambia are stunted.

Access to basic health services shows a wide spatial variation, with provinces around the line of rail having better access to services. In urban areas, 99 percent of households are within 5 kilometres of a health facility compared to 50 percent in rural areas. In Zambia, household expenditures on health vary according to location, though most poor households spend the highest proportion of their income on health – up to 10 percent of total expenditure when 'in kind' costs are included.

The Zambian health sector is facing numerous problems principally caused by the double burden of declining resources in real terms and an escalating disease burden. Management of resources is also of concern. The sector, however, has some strengths and in-built opportunities which can be utilised to make it more efficient and equitable. The country has a basic health package of service being implemented. Following the decentralisation of planning and budgeting in the public health sector, an objective and transparent resource allocation criteria has been developed for allocating funds to districts and hospitals and further improvements to the criteria are under way. In addition, a mechanism for pooling financial resources has been developed beginning with district funds (district basket), which will be extended to the whole sector at a later date. The main levels for financial allocation are the following:

- *District level*: An allocation of resources on a per capita basis and weighted for population density, price of fuel, proneness to epidemics, and the presence of a bank is used. This mechanism allows for management of funds at district level to meet specific

[6] GRZ (1996), ***Demographic and Health Survey*** (DHS)

districts needs. It is suggested, however, that social indicators such as poverty also be included in the criteria.

- *Hospital services*: Allocation to hospitals is based on cost per bed-day. Standard bed/population ratios are used to determine the number of beds per given population for 1st, 2nd, and 3rd level hospitals.
- *Other levels*: Allocations to other institutions and levels are based on estimates presented, subject to availability of resources; this includes the Ministry of Health Headquarters, the Central Board of Health, and statutory boards and bodies.

Structures for community participation in decision-making have also been established at neighbourhood, health centre, and district levels. There are Neighbourhood Health Committees (NHCs) which are composed of about 5 to 15 members, of which at least half should be women, and Health Centre Committees (HCC). Activities carried out by these committees include collecting and maintaining community-based health management information system data, providing a link between the community and the health post, health centre and other development agents, mobilising communities, selection of community health workers (CHWs), and contributing to strategic plans.

Despite having the above-mentioned strengths, the health sector has several weaknesses. These include lack of a hospital policy, outdated and obsolete legislation, distance to health facilities, and lack of transport. There are also problems of access for under-served groups, poor physical infrastructure and equipment, poor participation and empowerment, inadequate resource allocation, and the poor performance of the health system, in general. At the start of the implementation of the Health Reforms in 1992, it was erroneously assumed that the hospital sub-sector with high-level management personnel did not require re-orientation and capacity building. In addition, there has been the assumption that hospitals are high consumption areas without discernable impact on the health of the people, hence, the prior reluctance to invest in the hospitals.

Before the introduction of user fees in 1993, there was a significant decrease in the utilisation of health services. Several studies in the mid-1990s concluded that user fees play a big role in this. Antenatal and family planning attendance dropped, and there was a marked drop in new attendees at the under-five clinics than for re-attendees. Most alarming was that attendances for Sexually Transmitted Diseases (STDs) treatment dropped by 76 percent. Although government policy calls for free referrals from the first level care, the resource gap has resulted in hospitals charging even for those who have been referred. The lack of proper referral and cost sharing guidelines exacerbates the problem, as does the lack of information about cost sharing and medical fees, including "high cost" wards.

Long distances and lack of transport in a large but sparsely populated country like Zambia is a key determinant of health seeking behaviour. The distance to the nearest health facilities is the most significant variable determining access to health services as well as to exemption schemes. These costs, as well as user fees and the attitude of service providers, are also major deterrents for seeking care. While there has been no definitive analysis on specific groups who are not served well by health services, MMR data indicate that there seems to be a significant problem in meeting the needs of pregnant women and the provision of safe motherhood. Districts are unable to undertake outreach activities for maternal and child health interventions largely due to lack of transport and other logistics. Another group whose needs, such as for sexual and reproductive health services, are probably not being met, are the adolescents, whose primary concerns in accessing services include privacy and confidentiality. Orphans are another group that is under-served.

Health service outcomes are used to assess the performance of the sector and with these too, the picture is still bad especially for the poor. While the basic health care package at first point of referral level has been identified and costed at $11.5 per capita, the health sector has

available only $10.5 per capita for the whole system. As such, the sector performance has been poor and needs improvement.

In the light of the weaknesses above, there is need to identify existing opportunities and to use them to improve health. With regard to cost sharing, the overall health policy states that, "every able-bodied Zambian with an income will contribute towards his or her health". However, systems are in place to make the cost-sharing scheme more equitable, utilising the following two mechanisms:

- *Exemptions*: Demographic (children under 5 and adults over 65); disease-based (TB, HIV/AIDS, STDS, cholera, and dysentery); safe motherhood and family planning services; immunisation; and treatment of chronic hypertension and diabetes. While the disease-based exemptions have been difficult to implement, the vulnerable groups' exemption is most difficult and the scheme linked to identification and payment by the Ministry of Community Development and Social Services (MCDSS) is largely non-functional.
- *Safety Net/Health Care Cost Scheme:* The Public Welfare Assistance Scheme (PWAS) introduced in 1995 was intended to address inequalities in access. Chronic patients who cannot pay are supposed to be referred to the District Social Welfare Office for assessment, and approved fees are paid to the District Health Management board by PWAS. However, the referral system has not functioned well and those who cannot pay fail to access services.

Physical infrastructure has been given some attention but more needs to be done. Apart from the three hospital levels and health centres, the Ministry of Health has introduced health posts as a level of service below the health centres and brings the service closer to people. In line with the principle of targeting and being pro-poor, for every 3,000 people in the rural areas and for a population of between 10,000 and 50,000 in urban areas, a health post is to be established. This, however, has raised issues of affordability, human resource requirements, and the redefinition of roles and responsibilities.

The government has also been promoting community-based health care, as an alternative or a complement to extending physical infrastructure, since it strengthens partnerships. Among the principles of the Health Reforms is partnership at various levels, i.e. community participation, inter-sectoral collaboration, and international cooperation. In this regard, community involvement is fostered through the creation of a board. Recent initiatives spur communities to be involved in health matters through community-initiated programmes beyond those implemented by the health workers. This activity is funded through a Central Community Health Innovation Fund. The objective of the fund is to catalyse innovative health activities that are not part of the Basic Health Package; most of the activities funded so far are water- and sanitation-related and minor construction, particularly mothers' shelters.

The nutrition situation in Zambia has continued to deteriorate. The prevalence of stunting, which currently stands at 42 percent has varied between 38 percent and 60 percent in rural areas and 33 percent to 45 percent in urban areas, with a national average of between 41 percent and 53 percent since the early 1970s. Disturbingly, urban areas have been experiencing a faster rate of increase in severe forms of stunting in the 1990s. This situation reflects the economic deterioration experienced in the country over the same period. In both urban and rural areas, the poor are the most nutritionally affected. According to the World Health Organisation (WHO) severity index for stunting, Zambia's rating is 'critical' and 'very high'. The underweight prevalence has remained between 23 percent and 27 percent since the 1970s, a rating of 'serious' and 'high' on the WHO severity index for underweight.

Vitamin A deficiency (VAD) is mainly due to poor dietary intake. This results in lowered immunity, which leads to increased morbidity and mortality. A recent (1997) national survey showed a prevalence of vitamin A deficiency of 65.7 percent and 21.5 percent in children and

women respectively. A national baseline study on the prevalence and aetiology of anaemia conducted in 1998 showed that 65 percent of children, 39 percent of women, and 23 percent of men were anaemic. The goitre prevalence in school children ranged from 9 percent to 82 percent with a national average of 32 percent, largely attributed to inadequate intake of iodine. The only source for iodine for Zambians is iodated salt. Though legislation is in place stipulating that all salt consumed in the country should be iodated, enforcement of this legislation is poor.

The increase in child malnutrition is partly responsible for the corresponding increase in child mortality and decreased life expectancy observed over the same period. The HIV/AIDS pandemic with a prevalence of 1 in every 5 adults (20 percent) further compounds the situation, worsening the poverty levels. This is further worsened with over 70 percent of the Zambian population being food insecure. This means they do not have access to meet the individual daily nutrient requirements for an active and healthy life.

Policies and programmes regarding government commitment to reducing malnutrition in Zambia dates back to 1967, when the National Food and Nutrition Commission (NFNC) was established through an Act of Parliament. This Act mandates the National Food and Nutrition Commission to promote food and nutrition activities and to advise the government accordingly. In pursuance of this mandate, the NFNC has undertaken several activities aimed at nutritional improvement with varying degrees of success and failure.

Among the major interventions are those integrated in the Primary Health Care (PHC). These include a National Breast Feeding programme (supported by the Code of Marketing Breast Milk Substitutes); Growth Monitoring and Promotion, and Participatory Community Based Nutrition activities; Universal Child Immunisation; Micronutrient Control (including Vitamin A supplementation programme, sugar fortification, and promotion of consumption of micronutrient rich foods). Other programmes include supplementary feeding for malnourished children and Integrated Management of Childhood Illness (IMCI), but are not inclusive.

The appropriate national nutrition programme should encompass the labour force, the school going age group, special needs, and vulnerable groups. The main nutritionally vulnerable groups include the elderly, the physically and mentally handicapped, street children, the chronically ill, young children, and women of child bearing age. In Zambia, caregivers are usually mothers and other women and girls. Unfortunately, Zambian women (including girls) are a more disadvantaged group than men in terms of all these care-giving resources, including food. Planning and implementation of nutrition activities in Zambia has been constrained by lack of a national food and nutrition policy, inadequately trained human resources, and inadequate funding.

It is important to note that nutrition and heath are interrelated. High reported prevalence of malnutrition in the country has been attributed to high infection load with malaria, tuberculosis, acute respiratory infections, diarrhoea, and other infectious diseases contributing to the perpetuation of malnutrition through the 'malnutrition infection complex' (MIC). The HIV/AIDS pandemic has made the situation even worse. The changing lifestyles and eating habits have contributed to the disease burden through the emergence of new non-infectious diseases such as heart disease, diabetes, and lung cancer, previously uncommon in Zambia. Therefore, putting in place effective nutrition interventions will generally improve the body's immune response against infections, thereby lowering the health care costs because of fewer health complications and illness.

Nutrition issues are cross-cutting and cover many sectors, both public and private, and have a gender bias. Therefore, their effective planning and implementation requires to be well

coordinated by an independent professional and mandated body in order to realise meaningful improvements.

10.3 Programme Priorities

In line with existing programmes and the National Health Strategic plan, the PRSP will have the following pro-poor programmatic priorities.

10.3.1 Basic Health Package

As a priority, financing of the basic health care package would drastically reduce both the morbidity and mortality rates in the country and contribute to poverty reduction. For the PRSP, specific attention will be paid to components of the Basic Health Package that are pro-poor in impact. Important among these will include cost sharing through fee paying. The policy of "Every able-bodied Zambian with an income should contribute to his or her health" will be upheld. However, current mechanisms to protect and target interventions to the poor will be reviewed and refined to ensure that user fees are not a barrier to the poor accessing public health services. Improvements in the current exemption schemes will be all embracing and specific improvements will include the following:

- Demographic exemptions: Persons over 65 years with means but currently exempted will be made to contribute to the cost sharing schemes.
- Disease-based exemptions: The list will include malaria and product exemptions.
- The Safety Net: The implementation of this policy through PWAS will be continued. The management of the initiative will be improved through enhanced funding and better management and targeting of the poor.
- Operational research will be carried out to determine how best to ensure that users contribute to, and participate in, health care services while avoiding barriers to access.
- Exemption modalities for vulnerable groups such as street kids, orphans, and the differently abled will be developed.

10.3.2 Resource Allocation

The Ministry of Health/Central Board of Health will expedite the working out of new approaches to allocation of financial and human resources to districts to give more weight to poverty issues than is currently done. Moreover, mechanisms in the health system will be developed to ensure that community participation and accountability of resources to the community are promoted. Beds and cots will be rationalised so as to enhance equity in accessibility to health facilities. The Sector Wide Approach will be retained.

10.3.3 Governance Issues (Procurement Systems)

There is an immediate need to restructure the procurement system so as to ensure that purchasing of drugs is done more efficiently and on a need basis as well as improving the relationship amongst participatory structures, health management teams, and other stakeholders. Concerted efforts will also be made towards the development and enforcement of health-relevant laws.

10.3.4 Improving Access to Health Care

Focus will be to improve access to health care in hard to reach areas and under-served areas as well as vulnerable groups.

10.3.5 Public Health Priorities

Within the framework of an integrated approach to health care, the following will be given priority:

- Malaria – within the framework of the Roll Back Malaria initiative.
- HIV/AIDS, TB, and STI – through the National HIV/AIDS Strategic Framework.

- Integrated Reproductive Health – which includes family planning, safe motherhood, adolescent health, abortion and post-abortion care, infertility, and (sexual) violence against women.
- Child health – which will aim at reducing morbidity and mortality due to childhood diseases.
- Epidemics – improved public health surveillance and control of epidemics.
- Hygiene, sanitation, and safe water.

All the services above are included in the basic health care package.

10.3.6 Support Services

Support services will be an integral part of the focus in the sector. This will ensure quality and efficiency in the provision of services. The areas of focus will be the following.

- *Development of physical infrastructure and provision of medical equipment:* The focus will be on rehabilitation of existing infrastructure and construction of new facilities especially in areas where access to health care is a problem. More health posts will be established to enhance health care access. Obsolete medical equipment will be replaced in health facilities in order to improve the quality of service.
- *Human resource development:* This will involve training of staff, redistribution of staff according to the defined package of care, and strengthening the capacity of training institutions.
- *Support systems:* Focus will be on the development of new policies and legislation, including the revision of existing ones so that these are in line with the current reform environment. The implementation of existing management systems will also be strengthened, including the provision of support supervision to various health boards.

10.3.7 Interventions in Nutrition

Although many institutions are involved in nutrition activities, there is little or no coordination between them. Further, there are no explicit sectoral guidelines for developing and implementing nutrition interventions as a result of which there is little or no effort to incorporate nutrition considerations in sectoral policies and programmes. The NFNC's mandate to oversee all nutrition activities in the country has not had adequate support and resources for effective operationalisation. For NFNC to carry out its mandate of advising government on issues of nutrition, back-stopping on technical issues, and coordination of nutrition activities in the country, there is need to strengthen its institutional capacity.

10.3.7.1 Overall Goal

The overall goal is to achieve sustainable food and nutrition security among the poor and to eliminate all forms of malnutrition in order to have a well-nourished and healthy population that can contribute to national economic development. To redress the constraints outlined in the situation analysis, the overall objective will be: To strengthen the institutional capacity of NFNC in the coordination, facilitation, advocacy, and provision of IEC in the prevention of malnutrition and promotion of appropriate diets in the life cycle.

The strategies will be:

- To incorporate nutrition objectives into development policies and programmes; improve human resources and institutional finance; and establish strong nutritional networks.
- To strengthen nutrition care practices for the poor, the HIV/AIDS infected, and vulnerable groups
- To prevent and control specific macro and micronutrient deficiencies and promote appropriate diets and lifestyles throughout the life cycle.

10.3.7.2 Strengthening Institutional Capacity of NFNC

This strategy proposes finalising and implementation of the national food and nutrition policy, which provides NFNC with the mandate to coordinate and facilitate all nutrition activities in the country. To be able to do this, human resource and financial capacity will need to be improved. This will enable NFNC to coordinate nutrition programmes of sectoral line ministries and those of the private sector, NGOs, community, bilateral, and multilateral agencies.

10.3.7.3 Strengthening Nutrition Care Practices

This strategy will ensure that nutrition safety nets are provided, and that the nutritional needs of infants, young children, vulnerable groups, and the HIV /AIDS infected are met.

10.3.7.4 Prevention and Control of Macro and Micronutrient Deficiencies and Promotion of Appropriate Diets

In this strategy, emphasis will be placed on improving the physiological and growth state of nutritional vulnerable groups. The programme components that will be promoted include dietary diversification, supplementation, fortification, and control of worms and other parasitic infections. In addition, this strategy will advocate for improved household food security through improved availability, access, and diversity. Food security will be emphasised in terms of own and household food production in order to have a reliable food base.