

ZAMBIA

COUNTRY HEALTH BRIEFING PAPER

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The total population of Zambia was estimated at 9.7 million in 1998, with an average annual growth rate of 2.6% between 1992 and 1998. Zambia has long been one of the most urbanised countries in sub-Saharan Africa, with approximately 40% classed as urban. Much development has been along the "line of rail" which runs from the resource-rich Copperbelt to Lusaka, and down through the south of the country.

Following the election of a new government headed by President Chiluba in 1991, market-oriented economic reform measures were introduced, including trade and exchange rate liberalisation, parastatal reform and privatisation, and removal of state subsidies. Despite this, the economy remains largely dependent on copper and cobalt production. In the context of declining international markets, combined with drought and aid stagnation due to governance concerns, this has prevented sustained economic growth. Slow progress with privatisation of the larger mines acts as a drag on the economy, and absolute levels of social spending are highly inadequate despite verbal commitments. GNP per capita in 1998 was estimated at US\$330, substantially lower than the average for sub-Saharan Africa (\$480).

The problems of low per capita income are exacerbated by high income inequality. Zambia has a Gini coefficient of 0.51, and the 1996 Living Conditions Monitoring Survey estimated that 78% of the population were either moderately or extremely poor, with figures reaching 85% and over in some districts. This figure is up from the 1991 estimate of 68% (of whom 54% were estimated to be core poor) produced by the World Bank. The impact of poverty is seen in reduced school completion rates, reduced effectiveness of traditional extended family coping mechanisms.

Health indicators

Health indicators in Zambia are extremely poor, with the heavy burden of HIV/AIDS reversing earlier improvements in life expectancy and mortality. HIV prevalence has been relatively stable over the past four years, but remains high at 19.7% of the productive adult age group



(15-49). Although lower than neighbouring Botswana and Zimbabwe, this remains among the highest in the SSA region. Current projections estimate potential population growth at 2.4% per annum without HIV and 1.3% with HIV by 2014, with a 3.8m difference in population size as a result¹. According to 1994 estimates, the costs associated with medical care and worker attrition due to HIV/AIDS would reduce GDP to 9% below projected levels without additional inflows of resources².

The AIDS epidemic affects everyone in Zambia. Some 500,000 of the estimated 1.65m orphan population (one or both parents dead) will have lost both parents to AIDS by 2000, and a 1994 study found that 37% of households were caring for orphans. Deaths from AIDS are highest in the productive age group 20-34, and education is suffering both as the teacher population shrinks, and as children are withdrawn from school due to financial hardships following the illness or death of a wage earner. The pressure on women, already suffering from low social and economic status in the country, is immense, whether in terms of caring for the sick, protecting themselves and their children, and assuming greater roles in household income generation.

A 1998 Sexual Behaviour Survey found that, during their last sexual relationship with a non-marital partner, 57% of women had engaged in a cash or kind transaction.

Key health indicators

	Zambia+	SSA*
Life expectancy at birth	43 years	51years
Infant mortality (per 1000 live births)	109	104
Under-five mortality (per 1000 live births)	197	169
Underweight prevalence	23.5%	30%
Maternal mortality rate (per 1000 live births)	649	975
Total fertility rate	6.1	-
°HIV prevalence (15-49 years old)	19.7%	-
AIDS cases (per 100,000 pop)	46.9%	11.2%

Sources:

*UNDP Human Development Report 1998 unless otherwise stated

+Zambia DHS (1996) unless otherwise stated

°MoH/CboH data

Malaria remains the number one diagnosis in health facilities, accounting for 48% of under-five outpatient visits and 42% of attendances among other ages³. Cholera remains a perennial problem, with a serious outbreak in 1998. The HIV/AIDS pandemic has been accompanied by an overwhelming increase in tuberculosis cases. Malnutrition has grown over the past decade, with an estimated 42% of under-fives stunted (chronically malnourished), of whom 18% are

¹ MOH/CBOH (1999) HIV/AIDS in Zambia: background, projections, impacts, interventions, Sept 1999

² cited in Seshemani et al (1999) overcoming barriers to Zambia's development: dismantling the tripod of deprivation, debt and disease, A UNICEF Mid0Term Review study, Aug 1999

³ MOH/CBOH (1998) Annual Report 1998.

severely stunted. Maternal mortality remains high, and is largely attributed to preventable conditions such as malaria, and anaemia, together with obstetric and abortion-related complications.

Health service structure and Provision

Zambia benefited under the previous government from substantial expansion of primary level facilities in a move to ensure universal access. However, recurrent funding was limited and, in common with other countries in the region, actual service provision deteriorated through lack of resources for maintenance of facilities, equipment and transport, brain drain, and inadequate drugs and other supplies.

At the time of the election in 1991, health services in Zambia remained skewed towards the line of rail, and funding was disproportionately allocated towards larger hospitals in the urban areas. A substantial proportion of rural health services were, and continue to be, provided by the mission sector (30%), while the mines provided high cost services to employees and their families in selected areas.

Under the current government, a radical programme of change has been introduced. Focus is on the district level as the interface between central level policy and guidelines, and community and health facility input into planning and management of locally appropriate services.

While the public sector continues to be the major provider of health services, there has been a shift towards a purchaser-provider split, with the creation of a new executive agency at national level, the Central Board of Health (CBOH), responsible for commissioning services from newly established District and Hospital Boards. There are currently 72 District Health Boards (DHB), responsible for either direct provision or commissioning of health services up to the first referral level (formerly known as district hospital) for their respective populations. These services are provided through a network of health centers and hospitals, which may be public, private, or mission. Hospital Management Boards (HMB) have been established in all second and third level referral hospitals (the former general, provincial and central hospitals), and in a small number of larger mission facilities. Since 1998, where HMBs are providing first level referral services, a contract is drawn up between the commissioning district and the HMB, stating an agreed proportion of district grant funds to be transferred. In practice, severe funding shortages at district level have hindered this transfer.

Key health policies

The vision of the Zambian health reforms is *"to ensure equity of access to cost-effective, quality health care as close to the family as possible"*. The primary strategy for achieving this vision is through decentralisation of resources and responsibilities to the district level and below, and a policy document, National Health Policies and Strategies (Health Reforms), was approved by Cabinet in 1992. An intensive programme of training for District health staff began in 1993, and legislation passed in 1995 established District Health Boards as popular structures to

oversee the implementation of health services at that level, with appointed District Health Management Teams as the executive. In practice, the appointment of Boards has been more political than originally intended. Three key principles of Leadership, Accountability and Partnership have been emphasised for all levels of the system throughout the reform period, with Sustainability added more recently. The periodically revised National Health Strategic Plan outlines key area for focus. Substantial progress has been made in development of information systems to strengthen planning and monitoring, but the health sector remains under criticism for its limited attempts to strengthen health service delivery.

Areas of current policy focus include:

- ◆ Articulation of an essential package of health services to be funded by a combination of government and private funds. This has been largely achieved on paper for the district level, with de-linkage suspended, the focus of the project has changed to supporting the development of a 10-year human resource plan; and below, although funding constraints have hampered implementation.
- ◆ The intended “de-linkage” of staff from the public service to direct employment by Boards was initially attempted in 1997/98 and met with such opposition from unions that it was brought to a halt by a new minister in March 1998. Much work remains to develop both systems and capacity for Boards to be able to manage human resources.
- ◆ Strengthening partnerships between government and partners, through articulation of a Memorandum of Understanding and movement towards a Sector Wide Approach (SWAp). After a series of delays, the Memorandum was signed in 1999 and commits all partners to supporting health service development through “buying in” to the Strategic Plan. Partners are required to allocate 60% and government 50% of resources to the district level. A Health Sector Support Steering Committee will be established to oversee progress.

Health sector financing

Government remains the primary funder of health services, with budget allocations to the Ministry of Health estimated at 14% of the GRZ budget in 1998, and between 1.4 and 1.9% of GDP. These figures have declined over the past two years due to the worsening macro-economic picture, but place Zambia within the middle expenditure range of SSA countries according to World Bank classification. The most recent breakdown of total health expenditure estimates that government funds through various ministries and departments accounts for just over 40%, donors for almost 9%, the mine sector for 11% and direct household expenditures for almost 38%⁴. In terms of public sector financing, donors contributed an estimated 40% in 1997 and 1998⁵.

Following a period of officially free health services, user charges for health services were introduced in 1992 in large hospitals and 1993 elsewhere in the system as part of the reform package. Initial large falls in utilisation have been tempered to some extent, although overall utilisation remains relatively low in part due to the partially effective exemption policy

⁴ Preliminary estimates from the National Health Accounts exercise being undertaken by the Dept of Economics, University of Zambia.

⁵ Daura and Mulikelela (1998) Analysis of donor funding to the health sector, UNZA Lusaka; MOH (1998) National Health Strategic Plan

implementation, and frequent drug shortages at health facilities.

In 1993 districts began to receive limited direct funding, and since 1995 this has been channelled through the "basket" mechanism, which allocates both government and untied donor monies through a crude population-based formula. This funding is used to support the implementation of annual district health plans developed in collaboration with health facilities and communities.

DFID involvement in Zambia

The current phase of DFID support to the health sector began in 1994 and is drawing to a close in 1999/2000. The six components of the current support package are outlined below with their aims:

- ◆ Human resource development - to promote effective planning, deployment and management of human resources through strengthening capacity in central level policy development, and HRD management skills at district and hospital level;
- ◆ School of Medicine, UNZA - to help train graduates for the Zambian environment through improving the quality of teaching, maintaining an establishment of high quality teachers, and encouraging longer-term organisational planning;
- ◆ Lusaka urban health - to improve access to appropriate service by the urban poor through strengthening clinical, diagnostic and patient management skills at health centre level, improving the effectiveness and efficiency of services, and encouraging community involvement in health promotion;
- ◆ Family planning services - to reduce the fertility rate and increase contraceptive choice through provision of supplies and promoting efficient distribution, including the development of community-based distributors;
- ◆ HIV/AIDS care - to provide greater efficiency in resource use in this area, and strengthening of district capacity to deliver services, and to support home-based care. After further consultation with the Central Board of Health, the focus of this project has changed to support adolescent reproductive health and orphans and vulnerable children in selected urban districts over the period 2000 - 2003.
- ◆ Kitwe and Ndola Hospitals management project (KANDO) - to improve the effectiveness and efficiency of hospital services through strengthening management of human and financial resources. The experience of the KANDO project is currently feeding into national hospital policy development, and the extension of Financial, Administrative and Management Systems to hospital level.

In addition, DFID provided a one-off contribution to the district basket in 1996/97 with the aim of supporting service delivery at that level as well as demonstrating commitment to the systems under development. It is likely that a further contribution will be made in 1999/2000 in advance of the new programme of support and now that the Memorandum of Understanding has been signed.

Future support will depend on the outcome of a joint donor identification mission planned for early 2000, in line with the commitment to move towards a SWAp. The planned mission

currently includes five bilateral agencies, and one multilateral, thereby meeting the Government's long-standing desire to reduce the administrative burden of individual time-intensive agency missions. DFID has been a key player in working with the MOH and others to support the move towards a SWAp

In view of the HIV/AIDS situation and its social and economic impact throughout Zambia, all future DFID support to Zambia will involve an HIV/AIDS appraisal.

Role of other development agencies

The move to proceed towards a sector-wide approach (SWAp) within the health sector currently involves five bilateral agencies (including DFID) and three multilateral agencies⁶. They will undertake a joint identification mission in early 2000 to assess future support. At present, involvement is summarised as follows:

- ◆ DANIDA (Danish Aid) has provided substantial financial, material and technical support to district health services, and to quality assurance.
- ◆ DGIS (Dutch Aid) has moved from support through direct technical (medical) assistance at district and provincial level to more broad support for provincial health service development, district management training, and financing of district health services through the "basket". In addition, the Netherlands government has co-funded the supply of essential and TB drugs.
- ◆ The EU has recently agreed a programme of support to the district basket.
- ◆ Ireland Aid has provided budget and technical support for district health services (including medical laboratories, reproductive health and access to safe water/sanitation), and to local NGOs to deal with the impact of the HIV/AIDS epidemic.
- ◆ SIDA (Swedish Aid) has provided long-standing support to the areas of national level planning and management strengthening, together with policy development in drugs policy (including co-financing of the Essential Drugs Programme), reproductive health, and health economics and financing.
- ◆ UNICEF continues to support its traditional areas of child health, safe motherhood, nutrition, and support to children in need, including the growing number of AIDS orphans.
- ◆ USAID has recently begun a five year programme focusing on child health, through the Zambia Integrated Health Project.
- ◆ Since 1995 the World Bank has supported infrastructure development and maintenance, and the capitalisation of a centralised revolving fund for drugs and supplies.

Key documents

MOH (1992) National Health Policies and Strategies

MOH (1998) National Health Strategic Plan

⁶ At the time of this briefing paper going to press agencies joining SWAp in Zambia included DANIDA, Netherlands Embassy, Sida, Ireland Aid, USAID, UNICEF, EU, World Bank and DFID. The number could rise to 10 agencies should JICA confirm its participation in the near future.

(updated regularly)
MOH/CBOH (1998) 1998 Annual Health Review

Author: Sally Lake, January 2000

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