2011

EQUITY WATCH

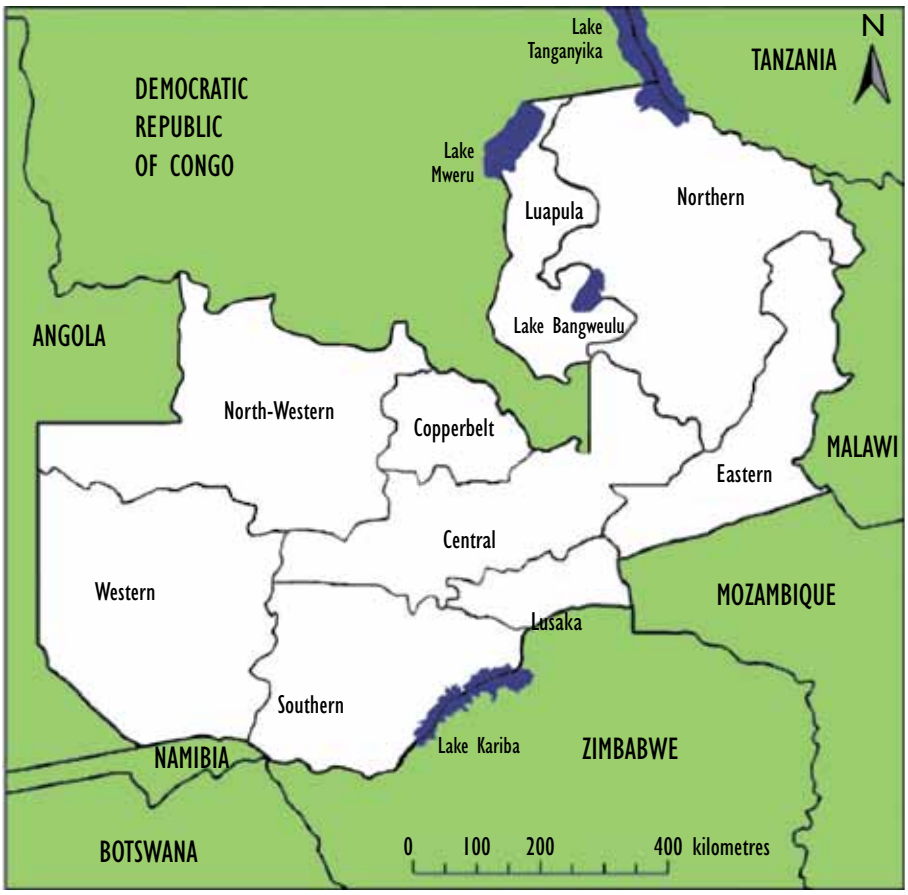
Assessing progress towards equity in health

Zambia

University of Zambia,
Department of Economics

Ministry of Health,
Policy and Planning Directorate

with Training and Research Support Centre
in the Regional Network for Equity in
Health in East and Southern Africa
(EQUINET)



Source: CSO, MoH TDRC, Unz, Macro International Inc., 2009

Map of Zambia showing districts

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Foreword

The Equity Watch tracks a health system's progress and responsiveness in promoting and achieving equity in health and health care. It provides a rare opportunity to check on national and regional planning, implementation, monitoring and evaluation in health care. The premise is that virtually all our national and regional strategic plans for health pursue *equity* as a specific or general objective. This is often based on our quest to improve our health systems in a variety of ways, for example: (a) by reducing demographic related differences (including gender, race, age, disabilities and marital, socio-economic and employment status) in availability, access to and use of health care services; (b) by eliminating geographical differences (rural-urban, provincial, district) in availability, access to and use of health care services; (c) by improving financial and material resource allocation (human resources for health, drugs, equipment and medical supplies) across demographic and geographic lines.

Eliminating differences in resource distribution and service provision requires systems and structures to facilitate the processes and mechanisms to execute, implement and achieve the targets and objectives set. This entails establishing and strengthening systems and structures as part of the effort to improve performance and service delivery. For instance, there is a drive to strengthen financing systems by developing more unified financing arrangements that also work towards achieving universal access to health care. Unified financing arrangements allow for better and greater pooling of resources, providing services to a wider population.

Other dimensions that promote equity relate to the design, availability and distribution of infrastructure, and the overall functioning of the referral system. A poorly functioning referral system is often characterized by irregular distribution of facilities – biased in favour of the urban population with high cost hospital services. Bringing about change that reflects disease priorities and appropriate strategies that favour primary health care is a significant aspect of asserting equality in health services distribution. Furthermore, differences in health indicators by socio-economic status are often associated with unequal health systems. Poor people often have poor health and poor health care. Further, recognizing the multi-attributes of health and health status, the social determinants of health, such as education, water and sanitation, nutrition, and unemployment, need to be monitored. For example, within education, it is important to explore the differences, if any, between females and males in order to address issues related to child and maternal health.

This report provides an array of evidence on the responsiveness of Zambia's health system in promoting and attaining equity in health and health care, using the Equity Watch framework. The Equity Watch work was inspired by the Regional Network for Equity in Health in East and Southern Africa (EQUINET), a partner and stakeholder in health system research in the region. Having laid the foundation in Zambia, it is important to sustain and strengthen the collection, dissemination and use of the information for policy and planning. This requires capacity development in local institutions, including civil society, academia, parliament, the private sector and the public sector as a whole. The report findings need to be subjected to additional and/or complimentary epidemiological and biological research to explain some of the salient results.

I wish to thank the team of researchers from the University of Zambia, the Directorate of Policy and Planning of the Ministry of Health and EQUINET for this work. I look forward to the work being disseminated and used to support our policy and planning processes in Zambia.

Dr Peter Mwaba
Permanent Secretary, Ministry of Health
Lusaka, Zambia, June 2011

About the equity watch

An Equity Watch is a means of monitoring progress on health equity by gathering, organizing, analysing, reporting and reviewing evidence on equity in health. Equity Watch work is being implemented in countries in eastern and southern Africa in line with national and regional policy commitments. In February 2010 the Regional Health Ministers' Conference of the ECSA Health Community resolved that countries should 'report on evidence on health equity and progress in addressing inequalities in health'.

Using available secondary data, the Equity Watch is implemented by country personnel with support and input from EQUINET through Training and Research Support Centre and peer review from HealthNet Consult and University of Cape Town Health Economics Unit. The aim is to assess the status and trends in a range of priority areas of health equity and to check progress on measures that promote health equity against commitments and goals.

This first scoping report uses a framework developed by EQUINET in cooperation with the East, Central and Southern Africa Health Community and in consultation with WHO and UNICEF. The report introduces the context and the evidence within four major areas: equity in health, household access to the resources for health, equitable health systems and global justice. It shows past levels (1980–2005), current levels (most current data publicly available) and comments on the level of progress towards health equity with a coloured bar down the right side of each page indicating whether the situation is broadly:


Improving


Static, mixed or uncertain


Worsening

Where clear, the postive or negative relationship to the average in the eastern and southern African region is also shown at the top of each colour strip (and left blank where comparisons are difficult or uncertain):


Above the regional average

Below the regional average

EQUINET defines equity as follows:

> *'Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. Equity motivated interventions seek to allocate resources preferentially to those with the worst health status. This means understanding and influencing the re-distribution of social and economic resources for equity-oriented interventions, and understanding and informing the power and ability people (and social groups) have to make choices over health inputs and to use these choices towards health.'*
>
> EQUINET steering committee, 1998

We explore in particular the distribution of health, ill health and specific determinants, including those relating to employment, income, housing, water and sanitation, nutrition and food security, and those within the health system. The Equity Watch examines the fairness of resource generation and allocation, and the benefits derived from consuming the resources for health. We also explore the governance of the health system, given that the distribution and exercise of power affects how resources are distributed and strategies designed and applied towards ensuring access to the resources for health.

Key areas

Introduction

EQUITY WATCH

Zambia is a low income country situated in southern Africa with a population of 13 million people, 49 per cent male and 51 per cent female. Nearly half of the population is under 15 years of age (CSO, 2011). The Copperbelt and Lusaka are the most densely populated provinces, with almost 25 per cent of Zambia's total population living in these two regions (see Table 1 and Figure 1).

Zambia experienced a decline in many socio-economic development indicators between 1980 and 2000. However, since 2000, there have been improvements in these indicators that carry the possibility of similar improvements in health and social equity.

The Human Development Index (HDI) in Zambia, an aggregate index of economic, demographic and social indicators, rose between 1980 and 1990, then fell until 2000 but has begun to rise again since then (see Figure 2). This trend reflected a fall in life expectancy at birth in Zambia from 52 years in 1980 to 42 years in 2000, and a rise thereafter to an estimated 47 years in 2010 (UNDP, 2010). These variations are in part attributed to the slow progress in reducing infant and child mortality and to the negative impact of AIDS, malaria, tuberculosis (TB), pneumonia and trauma.

Table 1: Population shares by age and residence, Zambia 2010

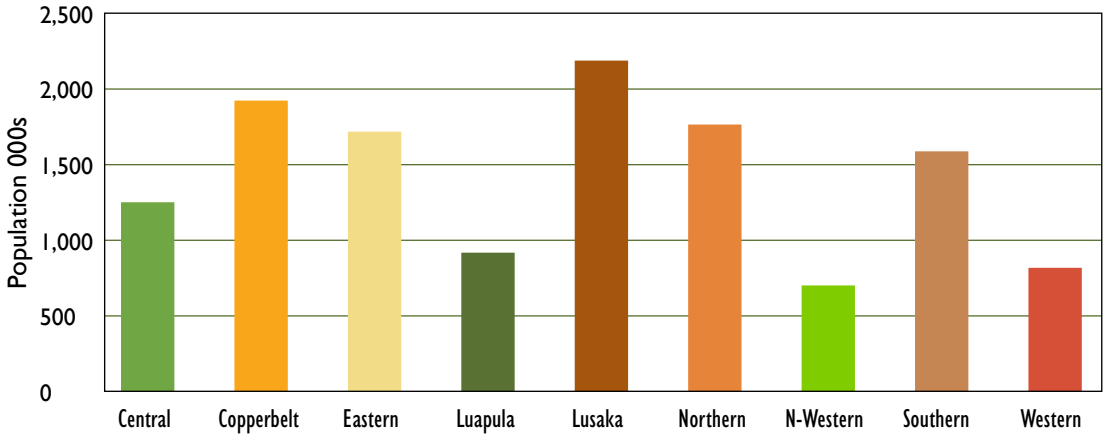
Population group	No. of people	% total
Total Zambian population	13,046,508	100
Population residing in urban areas	5,068,234	39
Population residing in rural areas	7,978,278	61

Source: CSO, 2011

The AIDS epidemic produced significant household and national burdens, including an estimated 1.2 million orphans (National Aids Council, 2009).

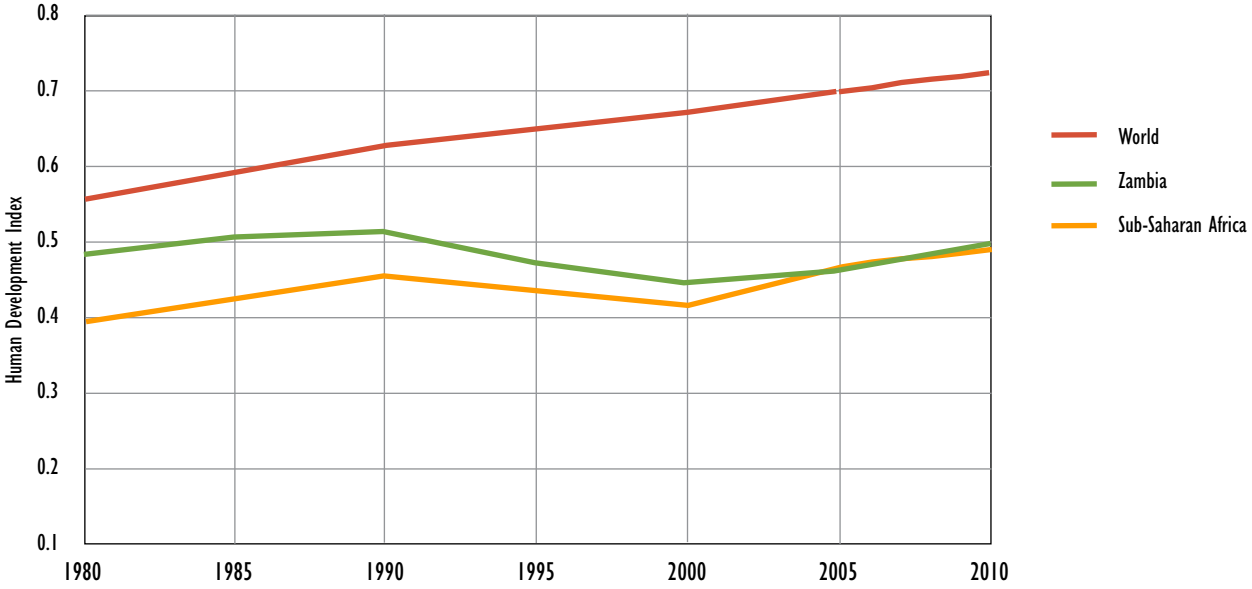
Zambia's macro-economic performance declined from the late 1970s up to 2000 but has since begun to improve due particularly to improved output in agriculture (see Figure 3) (MoFNP, 2000-2010).

Figure 1: Population by province, Zambia



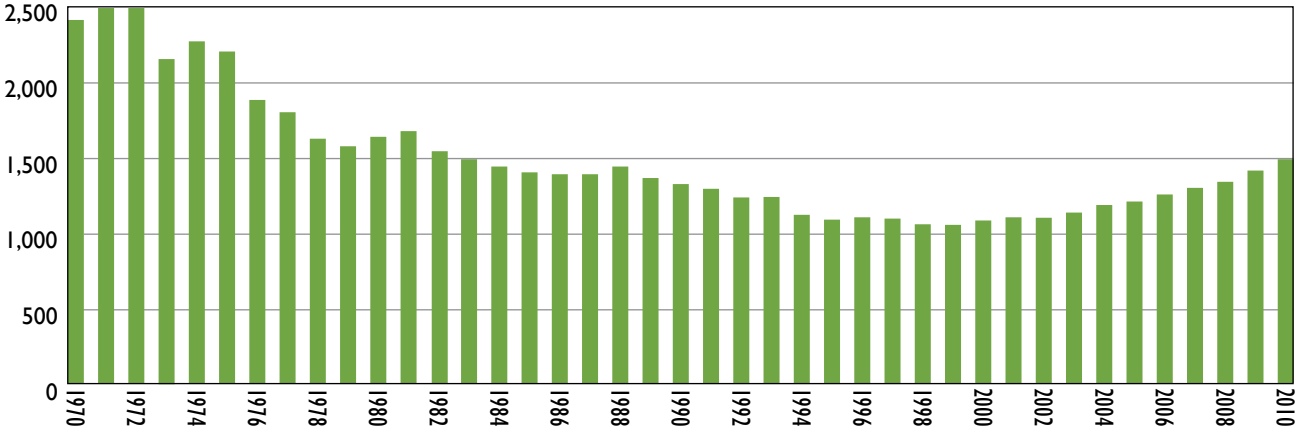
Source: CSO, 2011

Figure 2: Human Development Index, Zambia, 1980–2010



Source: UNDP, 2010

Figure 3: Per capita Gross Domestic Product PPP*, Zambia 1970-2010



*PPP = purchasing power parity

Source: UNDP, 2010

Zambia has been politically stable since its independence in 1964. The country adopted a one-party system of governance in 1972 but reverted to a multi-party political system in 1991. It is likely that this stable political environment contributed to the extensive infrastructure development in the education and health sectors. At the time of its independence, Zambia had one of the highest per capita incomes in sub-Saharan Africa. This relative prosperity made it possible to develop the country's infrastructure, abolish fees for education and health services in the 1970s, improve access to services and strengthen equity in income distribution. However, in 1994, the World Bank noted: 'As one of the most prosperous countries in sub-Saharan Africa in 1970, Zambia ranks today as one of the poorer countries on the continent. Much of the economic deterioration occurred in the 80s' (World Bank, 1994: 10). This report covers the post-1980 period up to the present and shows how the health status gains of the early equity-promoting health system measures were affected by the economic decline in the 1980s and 1990s.

This equity analysis is important as the country has had a consistent policy commitment to equity in health. Responding to geographical, demographic and socio-economic inequalities in health, Zambia's National Health Strategic Plan (NHSP) 2006–2010 stated that the government of Zambia should 'provide the people of Zambia with equity of access … to health care … and "attainment of the Millennium Development Goals and the National Health Priorities"' (MoH, 2005: iii). The report presents available evidence on the country's progress in realizing this policy goal, based on a number of dimensions of equity in health.

EQUITY WATCH

Advancing equity in health

Progress markers

- Formal recognition and social expression of equity and universal rights to health
- Achieving the Millennium Development Goal of reducing by half the number of people in poverty
- Reducing the Gini coefficient to at least 0.4
- Eliminating differentials in maternal mortality, child mortality (neo-natal, infant and under five) and under five years under-nutrition
- Eliminating income and urban/rural differentials in immunization, antenatal care and attendance by skilled personnel at birth differentials in immunization, antenatal care and attendance by skilled personnel at birth
- Achieving UN and WHO goals of universal access to prevention of vertical transmission, condoms and antiretrovirals

EQUITY WATCH

Advancing equity in health

This section presents various markers of progress in health equity, in terms of the values that underpin it, and the progress in addressing socio-economic and health inequalities.

Formal recognition and social expression of equity and universal rights to health

PAST LEVELS (1980-2006)

- Zambia's post-independence policies aimed to make health services available to all Zambians at no or minimal cost. In 1992 and again in 1996, the government affirmed its belief that people have the right to access affordable and good quality health care and that all Zambians have the right to decide the future of their health care system (MoH, 1992, 1996). Despite this policy intention and measures discussed later that were introduced to realize these policies, the right to health was not included in the constitution. The 1991 Constitution of Zambia does not include a provision on the right to health, although article 12 provides for the right to life and article 24 provides for young people to be protected from exploitation, including protection from employment that would prejudice their health (Republic of Zambia, 1991; Mulumba *et al.,* 2010). The Zambia Human Rights Commission was established in 1997 to investigate human rights violations and maladministration of justice and to propose measures to prevent human rights abuses but its focus on the right to health has been limited.
- In the period 1980–2005, Zambia became signatory to a number of international declarations and conventions that have a bearing on health, including those shown in Table 2 below, although with some qualifications on these commitments.

Table 2: Ratification of international treaties in Zambia

TREATY	DATE SIGNED / RATIFIED
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture)	Adopted 10 December 1984. Entered into force 26 June 1987, acceded to by Zambia 7 October 1998
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Adopted 16 December 1966. Entered into force 3 January 1976, acceded to by Zambia 10 April 1984
Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)	Adopted 18 December 1979. Entered into force 3 September 1981, acceded to by Zambia 21 June 1985
Convention on the Rights of the Child	Adopted 20 November 1989. Entered into force 2 September 1990, acceded to by Zambia 6 December 1991
International Convention on the Elimination of All Forms of Racial Discrimination	Adopted 21 December 1965. Entered into force 5 January 1969, ratified by Zambia 4 February 1972
African Charter on Human and Peoples' Rights	Adopted 27 June 1981. Entered into force 21 October 1986, ratified by Zambia 10 January 1984
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa	Adopted by the 2nd Ordinary Session of the Assembly of the African Union, Maputo on 13 September 2000. Entered into force 25 November 2005. Zambia included.

Source: Human Rights Watch, 2010

PAST LEVELS continued

- When Zambia ratified the International Covenant on Economic, Social and Cultural Rights in 1984, it posted a reservation specifically on the right to primary education, arguing that while it:

  > '…fully accepted the principles embodied … and undertakes to take the necessary steps to apply them in their entirety, the problems of implementation, and particularly the financial implications, are such that full application of the principles in question cannot be guaranteed at this stage' (Kamupira and London, 2005).

  Zambia is also a signatory to the 2000 United Nations Millennium Commitment and the Millennium Development Goals, the 2001 African Union Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious Diseases (2000) and the Southern African Development Community (SADC) Protocol on Health adopted by the SADC Heads of State and Government on 18 August 1999. The Protocol aims for quality integrated health services through regional cooperation.

- The right to health has thus mainly been advanced through national policies, laws and strategies that have set entitlements to health care services and created protection against financial risk, aiming to improve life expectancy (MoH, 1992). The Medical Services Act was repealed and replaced with a National Health Services Act in 1995 and further revised in 2006 to support the decentralization of services, devolution of decision making and enhanced community involvement through health boards at district level and neighbourhood health committees at health centre level. An 'essential health care package' of services was defined to make the entitlements clear and to guide prioritisation and allocation of public resources and investments (MoH, 1996). The Central Board of Health (CBoH) developed and disseminated a 'Citizens' Charter of Rights' to inform the public and clinicians about people's rights in relation to health care. These rights include the right of access to a health facility, the right to be attended to and seen by a qualified provider, if available, and the right to be involved in community planning and priority setting through the neighbourhood health committees. People also have the right to a response to any complaints they have regarding the quality of care. While this charter asserted the rights to health care, it was not incorporated in the law nor formally in the Ministry of Health policy guidelines. Its intention was to guide self–regulation as operationalized by the Central Board of Health, the district hospital management boards and the neighbourhood health committees, with government resources support to the primary care level.

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CURRENT LEVEL (2006-2010) (most recent data)

- The policy intention of enhancing equity in health was restated in the 2000s (MoH, 2005). In its Vision 2030, government recognized the right to equity in access to quality health care for all Zambians by 2030 (MoFNP, 2010b). While not yet set in law, the definition of a basic health care package has levered an increase in the number of health facilities or 'health posts' at the community level with one health post managed by a qualified (skilled) health worker intended for every 500 households or approximately 2,500 people (MoH, 1998, 2004b, 2005). Government has also made specific commitments to universal coverage in relation to universal access to prevention and treatment of HIV and AIDS, to services for sexual and reproductive health, as set out in the 2006 Maputo Plan of Action on Sexual and Reproductive Health and Rights (AU Ministers of Health, 2006), and to the Campaign on Accelerated Reduction of Maternal Mortality in Africa in 2010.
- The 2006–2010 constitution-making process in Zambia recognized that meeting economic, social and cultural rights is important in realizing political and civil rights. The Bill of Rights embodied in Part III of the current constitution provides for the protection of fundamental rights and freedoms. The National Constitution Conference responsible for drafting the revised constitution to be debated during the forthcoming session of parliament recommended that the rights to education, health, housing, employment and social security be included in subsidiary legislation rather than in the Bill of Rights. These rights appear under Part IX of the constitution dealing with directive principles of state policy which may be attained, state resources permitting. The Human Rights Commission of Zambia observed:

  'The Bill of Rights embodied in Part III of the current Zambian Constitution provides for the protection of fundamental rights and freedoms. However, the rights pertaining to the improvement of the welfare of the citizenry such as education, health, housing, employment and social security are not placed in the Bill of Rights even though economic, social and cultural rights have been recognized to be important in the realization of political and civil rights' (Zambia Human Rights Commission, 2010).

  In contrast, the Constitution Bill on the website of the National Assembly of Zambia, Section 67, provides for the right to health as follows:

  '(1) Every person has the right to health, which includes the right to health care services and reproductive health care. (2) A person shall not be refused emergency medical treatment' (GoZambia, 2010).

  The Bill further provides in Clause 63 'Parliament shall enact legislation which provides measures which are reasonable in order to achieve the progressive realization of the economic, social and cultural rights referred to in Articles 65, 66, 67 68, 69, 70 and 71.'

  It is not currently clear until the bill is debated and passed which approach will prevail.

Progress

Policy in Zambia has, for several decades, recognized the right to health and to accessible health care and Zambia has ratified international treaties containing these rights. However, while measures have been put in place to achieve basic entitlements and involve citizens in overseeing their delivery, there continues to be a gap in terms of the legal expression of these rights, including in the constitution. This has made social service policies on access to health care vulnerable to deteriorating economic performance and to the reduction in state subsidies to social services under the structural adjustment programmes over the 1980s and into the 1990s (Masiye *et al*., 2008). The National Constitution Conference preparing the revised draft constitution to be debated at the forthcoming session of parliament recommends that rights to health be included not in the Bill of Rights to the constitution but in subsidiary legislation. This is a more limited expression of rights than found in other constitutions in the region. The caution arises in part over the resources to deliver on this and on other areas of socio-economic rights. Political debate and the level of social awareness on and demand for these rights, will contribute to the final outcome.

Achieving the Millennium Development Goal of reducing by half the number of people in poverty (and living on less than $1 per day)

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
% population living on less than US$1 a day (PPP)	62.8 64.6	1991 2003	64.3	2004
% population living under the poverty line				
(*) Overall	84	1993		
Rural	71 52	1998 2002	67	2006
Urban	24 36 32	1993 1998 2002	20	2006
Human poverty index	37.8	1997	35.5	2007
Overall poverty (*)	69 64	1996 2004	68	2006
Rural	88 92 82 83 74	1991 1993 1996 1998 2004	80	2006
Urban	49 45 46 56 52	1991 1993 1996 1998 2002	34	2006
Rural:Urban ratio	1.80:1	1996	1.07:1	2006
Extreme poverty (*) Overall	81	1991		
Rural	84 68 17 52	1993 1996 1998 2004	51	2006
Urban	32 24 27 36 11	1991 1993 1996 1998 2004	10	2006
Rural:Urban ratio	2.52:1	1996	5.10:1	2006

PPP = purchasing power parity

(*)The poverty income line is the minimum expenditure needed to buy a basic basket of items for subsistence. Food poverty is set as below the income required to sustain a defined basket of essential foods to meet the minimum recommended caloric intake for a family of six persons (MoFNP, 2002, 2005).

Source: CSO, 2010; UNDP, 1997, 2009, 2010; World Bank, 2010; UN, 2011

PAST LEVELS: 1980-2005

- Overall poverty levels fluctuated in the 1990s at around three quarters of the population, although extreme poverty fell in the 2000s (See Table 3 and Figure 4a). Poverty remained high throughout the 1990s, with the implementation of the structural adjustment programme, the reduction in spending on social welfare and food subsidies and poor output of crops such as maize, groundnuts and cotton which constitute the main sources of income in rural areas (World Bank, 1994).
- While extreme poverty fell in both rural and urban areas during the period 2000–2006, rural poverty has remained almost twice as high as urban poverty. Some closing of the gap in overall poverty in 1998 was due to a rise in urban poverty. The gap in extreme poverty between rural and urban areas remained consistently wide in the period (Table 3, Figure 4a).

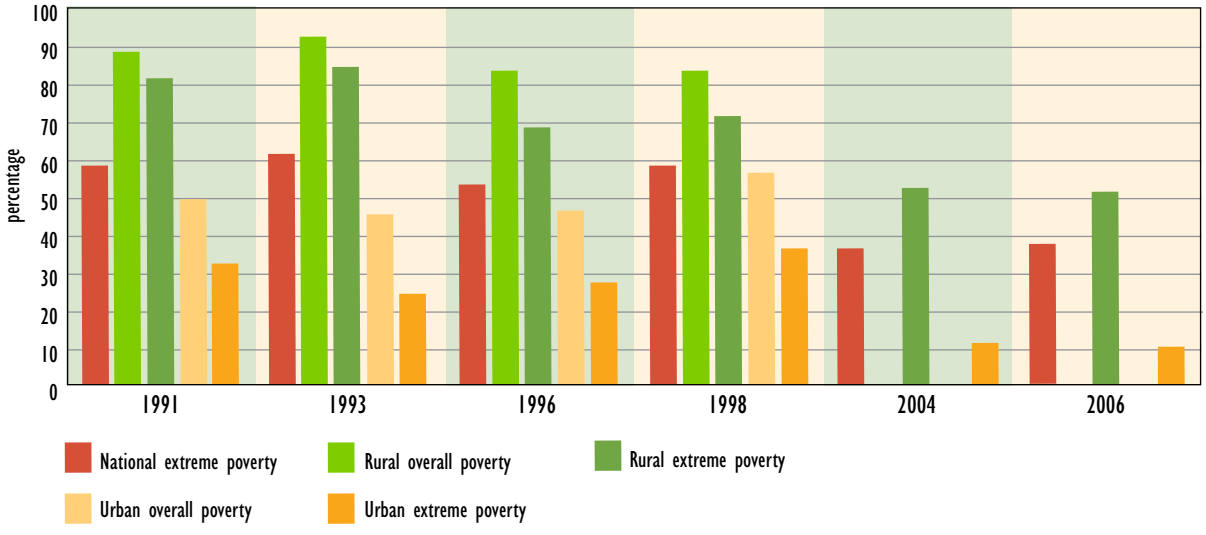
Table 3: Levels of poverty: Zambia 1980–2006

Period	NATIONAL LEVEL		RURAL AREAS		URBAN AREAS	
	Overall poverty	Extreme poverty	Overall poverty	Extreme poverty	Overall poverty	Extreme poverty
1991	70	58	88	81	49	32
1993	74	61	92	84	45	24
1996	69	53	83	68	46	27
1998	73	58	83	71	56	36
2004	n/a	36	n/a	52	n/a	11
2006	n/a	37	n/a	51	n/a	10

n/a = data not available

Source: MoFNP, 2005; CSO, 2005

Figure 4a: Poverty levels, national, urban and rural, Zambia 1991–2006

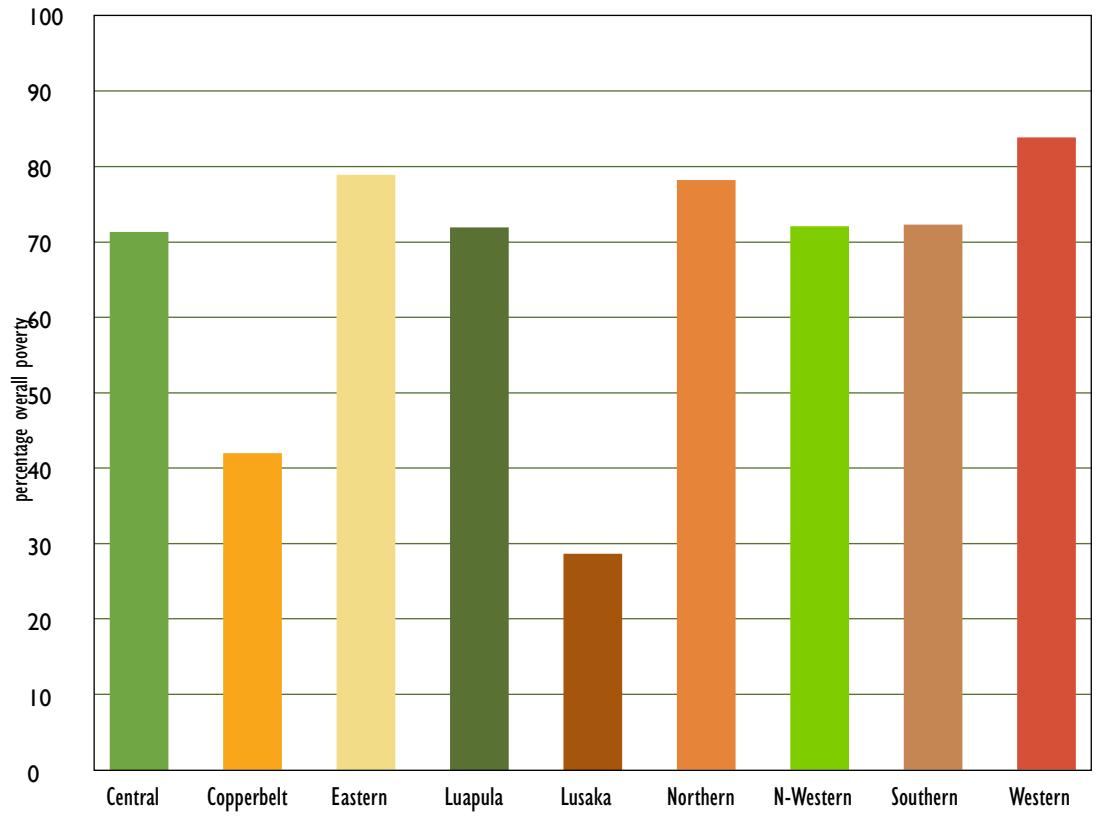


Source: CSO, 2010; World Bank, 2010

CURRENT LEVEL: 2006-2010

- By 2006, extreme poverty levels were at about a third of the population. After 2006, extreme poverty declined in both the rural and urban areas (MoFNP, 2010). However, although overall poverty fell in rural areas after 2006, extreme poverty ratios between rural and urban areas had widened from 2.52 in 1996 to 5.10 a decade later in 2006 (see Table 3). The differential between rural and urban areas has thus widened for those households in extreme poverty, with a relatively large share (about 51 per cent) not benefiting from the improved agricultural outputs in the period. The regional distribution of poverty shown in Figure 4b indicates that areas with a higher share of urban residents, such as Lusaka and Copperbelt, have lower levels of poverty than the more rural Western, Northern and Eastern provinces.

Figure 4b: Regional inequalities in poverty, Zambia, 2006



Source: CSO, 2006

Progress

Overall poverty declined between 1998 and 2006, although with high rural–urban differentials. After 2006, extreme poverty declined in both the rural and urban areas but the ratios between rural and urban areas widened. The Central Statistics Office has projected that with GDP growth rates averaging 5 per cent, the country should be able to achieve a 14 per cent growth in the reduction of extreme poverty between 2010 and 2015 and to attain the Millennium Development Goal of halving the number of people living in extreme poverty (MoFNP, UNDP, 2010). While a national decline in poverty is an important achievement, the data suggests that this may still leave high levels of extreme poverty in some communities. For example, extreme poverty has remained consistently more prevalent in rural areas. While absolute rates of rural extreme poverty have fallen, the differential between rural and urban areas in 2006 was twice that of the decade earlier, suggesting a widening poverty gap between rural and urban areas.

Reducing the Gini coefficient to at least 0.4

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Gini coefficient	0.559 0.509	1991 1998	0.526 0.507	2006 2000-2010

PAST LEVELS: 1980-2005

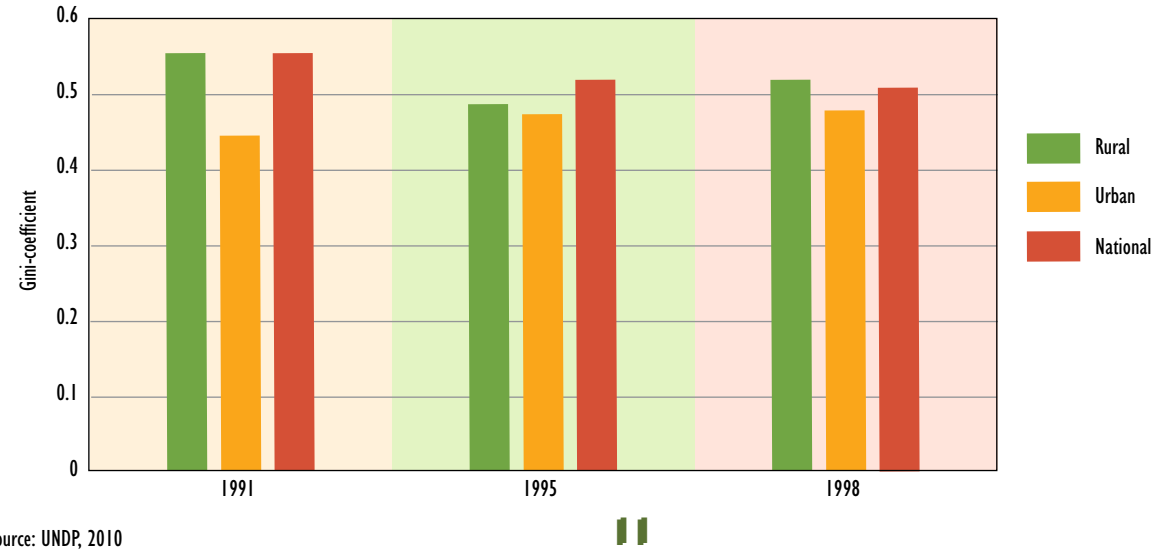
- The Gini coefficient measures income differentials. In Zambia, while there has been some fall in the coefficient, it has been relatively high throughout the past three decades.
- By 1998, the highest Gini co-efficients and thus income inequality were in the Central, Southern and North-western regions which were higher than in urban Lusaka and Copperbelt. Southern province had the highest levels of inequalities. While rural areas had higher income inequalities than urban areas in the early 1990s, by the end of the decade this gap had almost closed (see Figure 5a).

Table 4: Gini coefficient by province and national level, 1991–1998

Province	1991	1995	1998
Central	0.446	0.447	0.533
Copperbelt	0.411	0.457	0.482
Eastern	0.599	0.518	0.482
Luapula	0.519	0.561	0.450
Lusaka	0.444	0.501	0.505
Northern	0.556	0.459	0.440
N-western	0.586	0.446	0.523
Southern	0.602	0.492	0.566
Western	0.590	0.512	0.474
Rural	0.563	0.488	0.519
Urban	0.448	0.475	0.479
National	0.559	0.518	0.509

Source: UNDP, 1997/1998

Figure 5a: Gini coefficient by rural/urban setting, 1991–1998

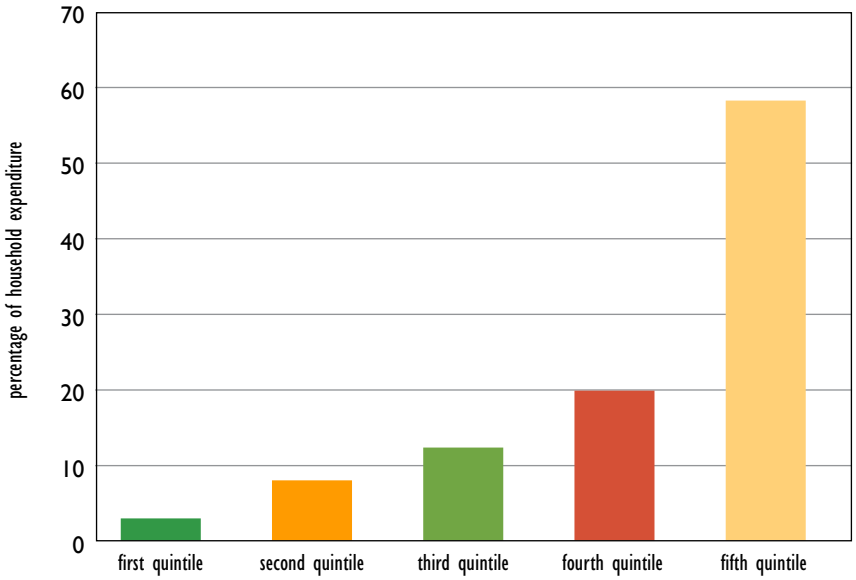


Source: UNDP, 2010

PAST LEVELS continued

- The extent of economic inequality is evident by the fact that in 2002 the poorest 20 per cent (quintile) spent only 3 per cent of total household expenditure, while the richest 20 per cent spent 57 per cent of total household expenditure (UNDP 2003; Figure 5b).

Figure 5b: Share of general household expenditure in Zambia by wealth quintile, 2002



Source: UNDP, 2003

CURRENT LEVEL: 2006-2010

- In 2006 the Gini coefficient was estimated at 0.526. An estimate for 2000–2010 sets the Gini coefficient at 0.507 (UNDP, 2010), suggesting that there has been limited improvement or even a worsening in income distribution in Zambia over the past decade. This would need to be further tested against specific post-2006 annual data.

Progress

Zambia has had a relatively high level of income inequality as measured by the Gini coefficient throughout the past three decades. Income inequalities in rural areas have been higher than in urban areas and the share of expenditure for the lowest income households is extremely low (at 3 per cent). There has been no improvement in income inequality, although the gap appears to have closed somewhat between rural and urban areas in income inequality as rural inequalities have fallen.

Eliminating differentials in maternal mortality, child mortality (neonatal, infant and under five) and under 5 year under-nutrition

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
Child mortality rate (CMR) 1–5 years / 1,000	79	1980	52	2007
	82	1985		
	94	1992		
	81	2002		
Under-5 mortality rate (0-5 years) / 1,000	152	1980	119	2007
	162	1985		
	192	1992		
	168	2002		
Infant mortality rate (IMR) /1,000	99	1980	70	2007
	123	1990		
	110	2000		
	95	2002		
Under-5 mortality rate (U5MR) / 1,000				
Rural	201	1992	139	2007
	205	1996		
	182	2002		
Urban	151	1992	132	2007
	173	1996		
	140	2002		
Ratio Rural : Urban	1.33	1992	1.05	2007
	1.18	1996		
	1.30	2002		
Under-5 mortality rate / 1,000 by wealth quintile				
• 1st	n/a		124	2007
• 2nd			148	2007
• 3rd			155	2007
• 4th			140	2007
Highest (5th)			110	2007
Ratio lowest to highest quintile			1.13	2007
Under-5 mortality rate /1,000 by education background				
No education	204	1992	n/a	
Primary education	182	1992		
Secondary and tertiary education	135	1992		
No education	198	2002		
Primary education	177	2002		
Secondary and tertiary education	121	2002		
Infant mortality rate / 1,000	99	1980	70	2007
Maternal mortality rate / 100,000				
Facility-based data	118	1980	591	2007
Household survey data	889	1992		
Household survey data	940	1995		
Household survey data	649	1996		
Household survey data	729	2002		

n/a = data not available
SD = standard deviation

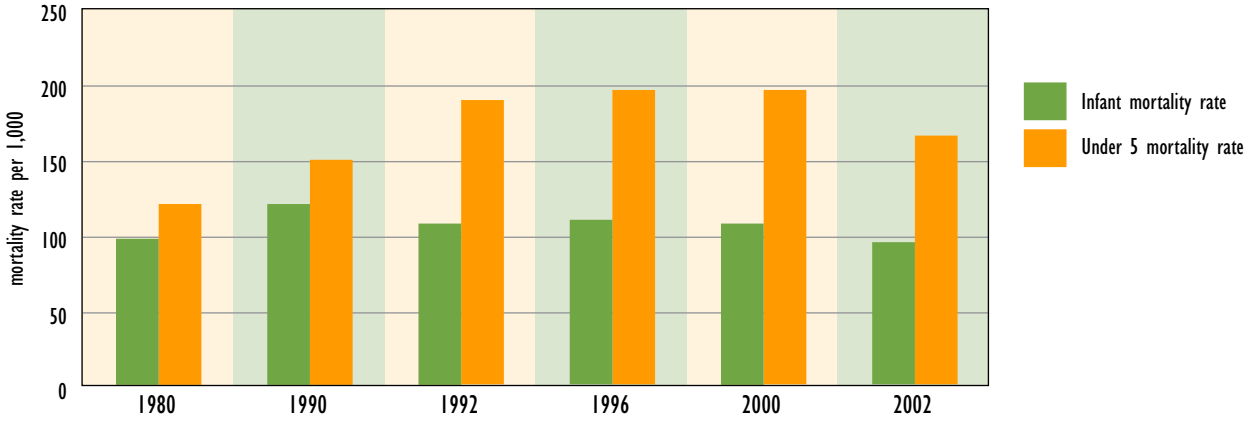
INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
Stunting in children less than 5 years (height for age <2SD)	39	1980	54	2006
% total children	40	1992	45	2007
	42	1996		
	53	1998		
	47	2000		
	47	2002		
% rural children	46	1992	48	2007
	42	1996		
	51	2002		
% urban children	33	1992	39	2007
	33	1996		
	37	2002		
Ratio rural : urban	1.39	1992	1.23	2007
	1.27	1996		
	1.39	2002		
Stunting in children under 5 years (height for age<2SD) by wealth quintile				
Lowest	53	1996	70	2007
Second	48	1996	76	2007
Middle	46	1996	71	2007
Fourth	37	1996	59	2007
Highest	25	1996	37	2007
Lowest	42	2001		
Second	40	2001		
Middle	40	2001		
Fourth	26	2001		
Highest	12	2001		
Lowest: highest education ratio	2.12	1996	1.89	2007
	3.50	2001		
Stunting in children under 5 years (height for age<2SD) by mother's education				
No education	46	1992	45	2007
Primary education	42	1992	49	2007
Secondary education	31	1992	39	2007
Tertiary education plus	9	1992	21	2007
No education	50	1996		
Primary education	45	1996		
Secondary education	33	1996		
Tertiary education plus	9	1996		
No education	54	2002		
Primary education	49	2002		
Secondary education	37	2002		
Tertiary education plus	20	2002		
Lowest: highest education ratio	2.70	2002	2.14	2007

Sources: CSO, MoH, Macro International. 1992, 1996, 2001/2, 2007

PAST LEVELS: 1980-2005

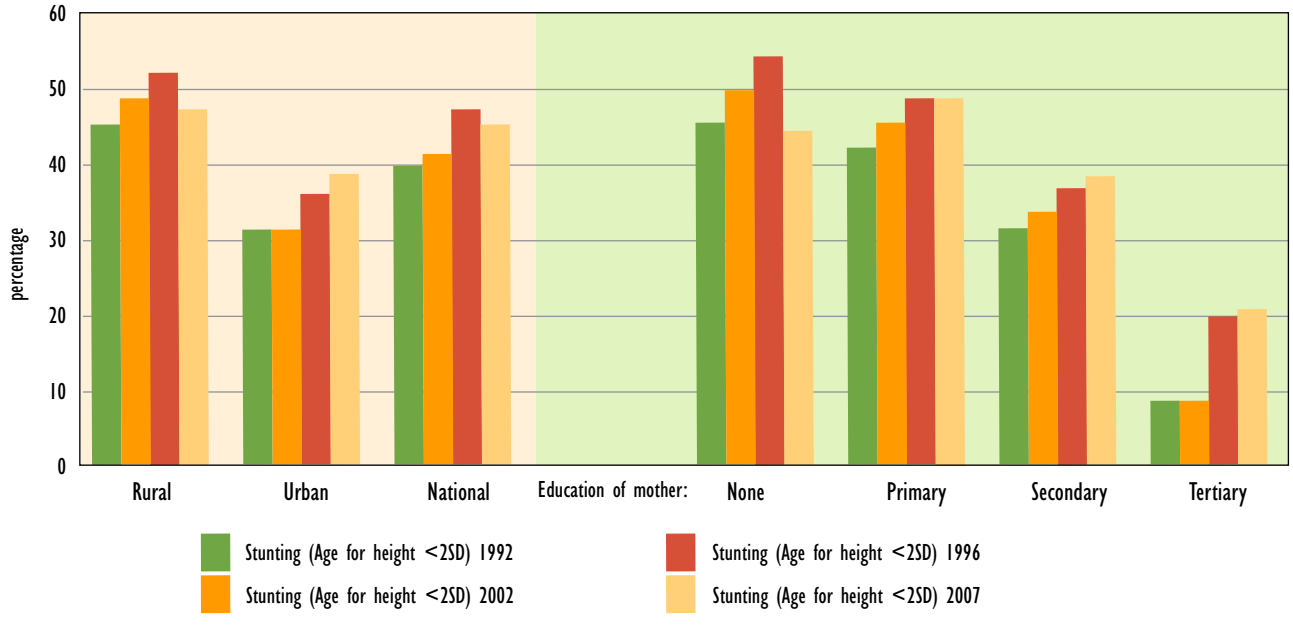
- Mortality in children under 5 rose in the period up to 1992 and then fell until 2002 (see Figure 6a). Child mortality was higher in rural than in urban areas across the whole period, although the rural–urban gap closed between 1992 and 1996, mainly due to worsening urban child mortality levels. However, the gap widened again up to 2002, due to slower improvements in mortality in rural than in urban areas. Under 5 year mortality followed a similar gradient as education, with mortality levels improving with higher levels of education.
- Between 1980 and 1998 stunting in children under 5 years rose and then fluctuated around similar levels until 2002 (see Figure 6b) (CSO, MoH, Macro International, 1996; 2002; 2007).
- Rural areas had higher levels of stunting than urban areas although rural–urban differentials fell between 1992 and 1996, rising up to 2002. Stunting rose across all levels of mothers' education between 1992 and 2002, preserving differentials between highest and lowest levels (see Figure 6b).
- Stunting fell across most wealth quintiles between 1996 and 2001, particularly for the poorest 20 per cent of the population. The middle quintile showed the slowest improvement in stunting (see Figure 6c on page

Figure 6a: Child mortality trends, 1980–2002



Source: CSO, MoH, Macro International Inc. 1992, 1996, 1998, 2002

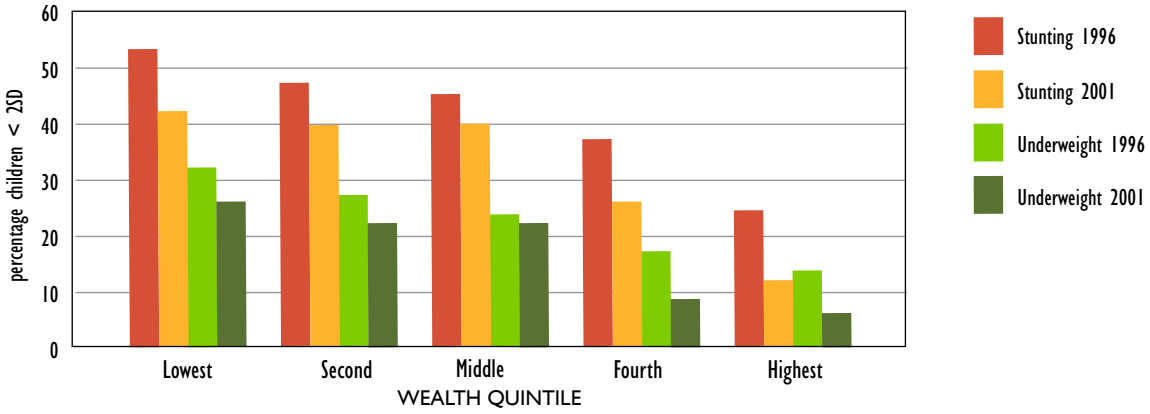
Figure 6b: Child stunting by residence and mother's education, 1992–2007



SD = standard deviation

Source: CSO, MoH, Macro International Inc., 1996, 2001/02, 2007

Figure 6c: Stunting and underweight by wealth quintile, 1996–2001



Source: CSO, MoH, Macro International Inc. 1996, 2002

18).

- The maternal mortality rate (MMR) was relatively high in earlier years, estimated at 729 per 100,000 in the period leading up to 2000. It was highest in rural areas, with Western province having the highest estimates in the country. During the late 1990s and early 2000s the UNFPA invested in maternal health equipment, medicines and health worker training in North-western province, resulting in a reduction in maternal mortality rates (Key informant interview, 2010). Evidence on differentials in maternal mortality by mother's

CURRENT LEVEL: 2006-2010

- High under 5 year mortality levels have persisted over the past five years and UNICEF rated Zambia number 14 of 195 countries with high under 5 mortality rates in 2008 (UNICEF, 2008). However, as shown in the summary table, child and under 5 mortality rates fell between 2002 and 2007 and rural–urban differentials in the under 5 category closed to almost parity due to a marked improvement in rural under 5 mortality rates. The evidence points to persistent socio-economic differentials in child mortality and nutrition. Rural–urban differentials in stunting closed significantly up to 2007 due to improvements in rural areas but they continue. Stunting rates in children under 5 years have risen up to the middle wealth quintile but fall markedly in the highest quintile (summary table; Figure 6c). Stunting levels fall the higher the mother's education level although here too the gap narrowed between 2002 and 2007.
- Maternal mortality rates also fell in the period before 2007 (see summary table) although they remain high. Disaggregations by residence, wealth, region or district would be valuable but are not available. One factor contributing to these differentials is the extent of coverage of antenatal care, nutritional advice, management of malaria during pregnancy, iron supplementation and skilled delivery at birth. These factors are discussed in the next progress marker where higher levels of inequality are noted. After 2000, the development of a Maternal and Reproductive National Strategic Plan (MoH, 2004) saw a more focused approach to maternal health to secure the investments in human resources, drugs and medical equipment for the plan. This is further discussed in the next section.

Progress

Available data suggests that the under five mortality, infant and maternal mortality rates all declined after 2002. Rural–urban differentials closed markedly in the under five category. Improvements in childhood stunting were less marked although the negative trend of worsening nutrition slowed or was reversed. Rising differentials between rural and urban areas, evident between 1996 and 2002, subsequently fell up to 2007. Stunting continues to show clear differentials by wealth and education although the gap is narrowing across groups. The evidence suggests that while mortality rates are improving, it is important to understand why the rates of improvement differ in different socio-economic groups, in order to reduce these differences. Progress is rated as mainly positive (green) based on available evidence. Information gaps in the distribution of maternal mortality need to be addressed to better understand the social differentials in the rates and their causes, particularly given the high inequality in access to services identified in the next programme marker. The Demographic and Health Survey for 2012 may include such disaggregations.

Eliminating income and urban/rural differentials in immunization, antenatal care and attendance by skilled personnel at birth

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
% Measles immunization coverage <1yrs	49	1984	84.9	2007
Rural	73	1992	83.6	2007
Urban	81	1992	88.5	2007
Lowest income	n/a		87.6	2007
Highest income	n/a		94.1	2007
% Measles immunization coverage<23 months: Overall	77.0	1992	82.4	2007
	86.5	1996		
	84.4	2002		
Rural	73.4	1992	83.7	2007
	84.5	1996		
	83.9	2002		
Urban	81.3	1992	89.2	2007
	89.7	1996		
	85.5	2002		
Urban: Rural ratio	1.11	1992	1.07	2007
	1.02	2002		
Mother's education: High:low education ratio	1.32	1992	n/a	
	1.09	2002		
Full immunization % coverage	80	1980	68	2007
Rural	60	1992	66	2007
Urban	74	1992	71	2007
Urban: rural ratio	1.23	1992	1.08	2007
Rural	67	2002		
Urban	77	2002		
Urban: rural ratio	1.15	2002		
% pregnant women with at least one ANC visit	81	2000	94	2007
Rural	68	2001	91	2007
Urban	80	2001	99	2007
Urban: rural ratio	1.18	2001	1.09	2007
No education	81	1992	88	2007
High school education+	98	1992	97	2007
High:low education ratio	1.21	1992	1.10	2007
% pregnant women with four antenatal care visits	69	1992	60	2007
% births attended by skilled personnel	50	1992	47	2007
Rural	26	1992	31	2007
Urban	81	1992	82	2007
Urban: rural ratio	3.12	1992	2.65	2007
High to low mother's education ratio	1.10	1996	n/a	
Lowest wealth quintile			27	2007
Highest wealth quntile			91	2007
Highest to lowest wealth quintile			3.37	2007

Sources: University of Zambia, CSO, MoH, Macro International Inc,. 1992; CSO, MoH, Macro International, 1996, 2001/2, 2007

PAST LEVEL: 1980-2005

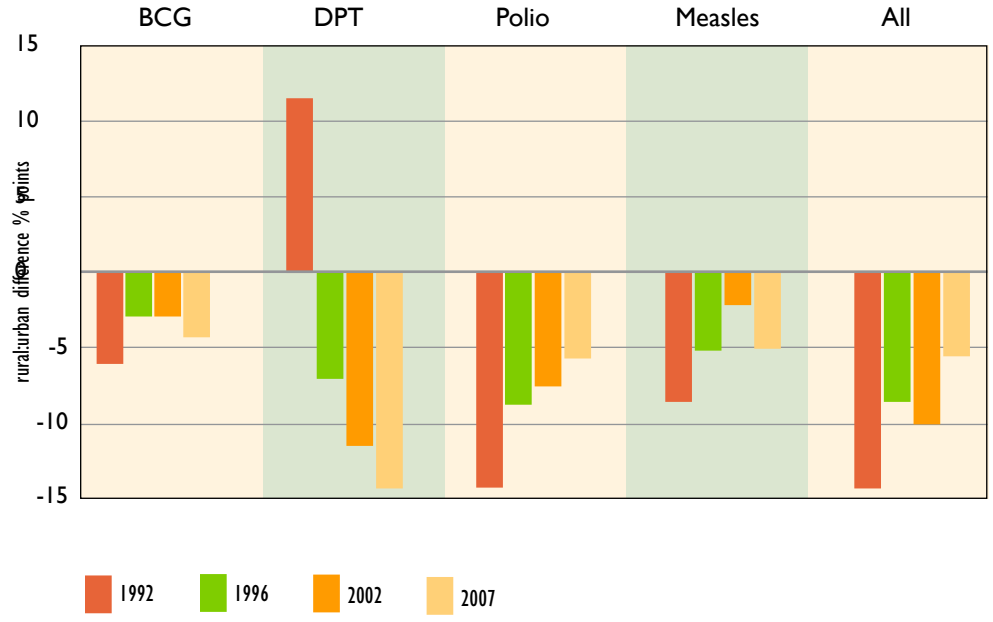
- As noted in the discussion on the last progress marker, access to primary health care services like immunization, antenatal care and skilled attendance at birth are key interventions for improving health outcomes. Their positive effect and therefore the need to secure them at the widest level is one of the arguments for publicly financed health services. The summary table suggests that immunization levels initially improved between 1984 and 1996, with reduced rural–urban differentials, but remained relatively static thereafter, with coverage falling in both rural and urban areas up to 2005. The cold chain system declined substantially over time despite it being a key determinant of successful immunization programmes (MoH, 2005). Reports highlight the need for increased domestic funding of the immunization programme and its supplies to make them less susceptible to external or donor funding. There was some improvement in domestic funding for vaccines after 2001 (MoH, 1997).
- As shown in Table 5, the pattern of decline held across all areas of immunization. By 2002 urban–rural differentials were 1.03 for BCG, 1.14 for DPT, 1.09 for polio, 1.02 for measles and 1.15 overall, indicating relatively low differentials. Other than for DPT in 1992, all other vaccinations in all the years are skewed towards higher coverage in urban areas.

Table 5: Immunization coverage for vaccine type and by residence, 1992–2007

YEAR	% Immunization coverage									
	BCG		DPT		Polio		Measles		All	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
1992	92	98	70	58	70	84	73	81	60	74
1996	96	99	83	90	81	89	85	90	75	83
2002	93	96	77	88	78	85	84	86	67	77
2007	91	95	76	90	76	81	84	89	66	71

Source: CSO, MoH, Macro International Inc, 1992, 1996, 2002, 2007

Figure 7: Rural–urban differentials in immunization coverage, 1992–2007



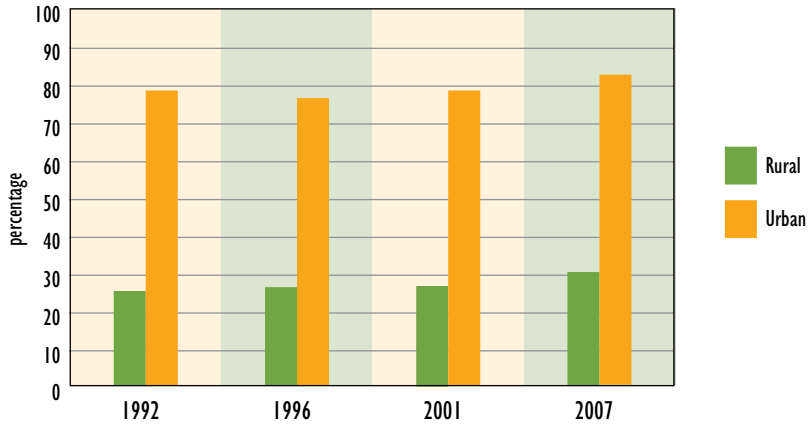
Sources: CSO, MoH, UNZA, Macro International Inc., 1992; CSO, MoH, Macro International 1996, 2001/2, 2007

CURRENT LEVEL: 2006-2010

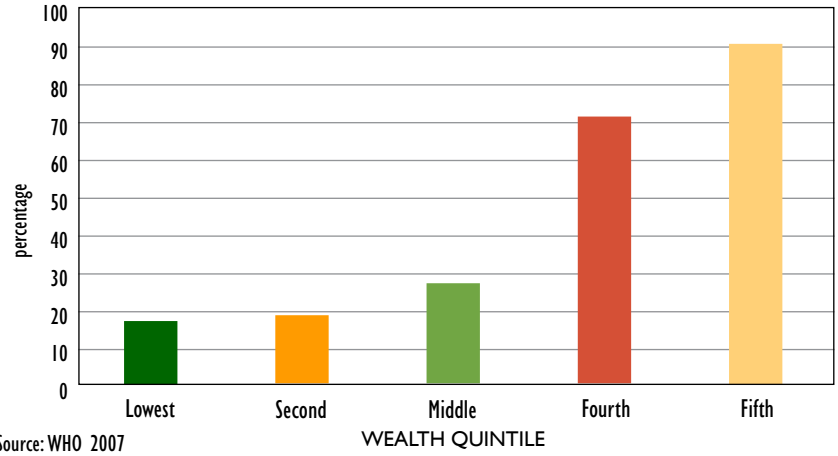
- Data for 2007 shows either relatively static or fluctuating levels in immunization coverage rates between 2002 and 2007. The reduced gap between urban and rural coverage is due to falling urban coverage (see Figure 7). However, immunization coverage data quality may be affected by people using services outside their catchment area. Reversing and improving immunization programme performance is strongly associated with improving the cold chain but activities relating to this are not discussed in the current Health Strategic Plan, raising questions of how positive changes can be achieved and inequalities addressed.
- Antenatal care coverage improved up to 2007, with lower rural–urban and education level differentials in 2007 compared to 2002 (see summary table). However, skilled birth attendance fell up to 2007 and urban–rural inequality and wealth differentials remain high, with a ratio of 3.37 between highest and lowest wealth quintile in attendance by skilled personnel at childbirth. Figure 8a shows up to 50 percentage point differences between rural and urban areas and Figure 8b shows over fourfold differences between highest and lowest wealth quintile in use of maternal health services in 2007 (MoFNP, UNDP, 2010).

Figure 8: Percentage of pregnant women using maternal health services

(a) by area, 1992–2007



(b) by wealth quintile, 2007



Source: WHO 2007

Progress

While there was some improvement up to 2007 in immunization and antenatal care coverage and in closing rural–urban differentials, wealth differentials remain wide. Although the previous progress marker indicated improvements in mortality, these inequalities in service access threaten gains, especially for the poorest groups. The low coverage of births attended by skilled personnel, the decline after 2002, limited changes in the wide area and wealth gaps in coverage have repercussions for wider economic and social inequalities and for maternal and child mortality. The evidence suggests that especially for maternal health, disaggregated data is needed of health services access and maternal mortality to identify those with highest health need.

Achieving UN and WHO goals of universal access to prevention of vertical transmission, condoms and antiretrovirals

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
Adult HIV prevalence (%)	15.6	2001	14.3	2007
Estimated Maternal Prevalence	19.4 18.1 18.5 18.6	1995 2000 2002 2004	16.6	2006
% women attended VCT and taken an HIV test	4.6 5.1 7.8	2000 2003 2005	32.7	2009
Rural women	2.9 2.4 5.3	2000 2003 2005		
Urban women	6.4 9.7 17.6	2000 2003 2005		
Urban: rural ratio	2.2 3.3	2000 2005		
% pregnant women having VCT as part of ANC				
Rural	92 95	2000 2003	94	2005
Urban	98 98	2000 2003	97	2005
People accessing treatment			32.9	2006
% in need on ART	30–40	1985–2000	50.5 66.0	2007 2008
% Pregnant women on ART	5.7	2003	29.7	2006
% Pregnant women on PMTCT	14.3	2005	39.1	2007
Contraceptive prevalence	24	1998	46	2007
Condom use (15–59 year age group)	37 39 35	2000 2003 2005		

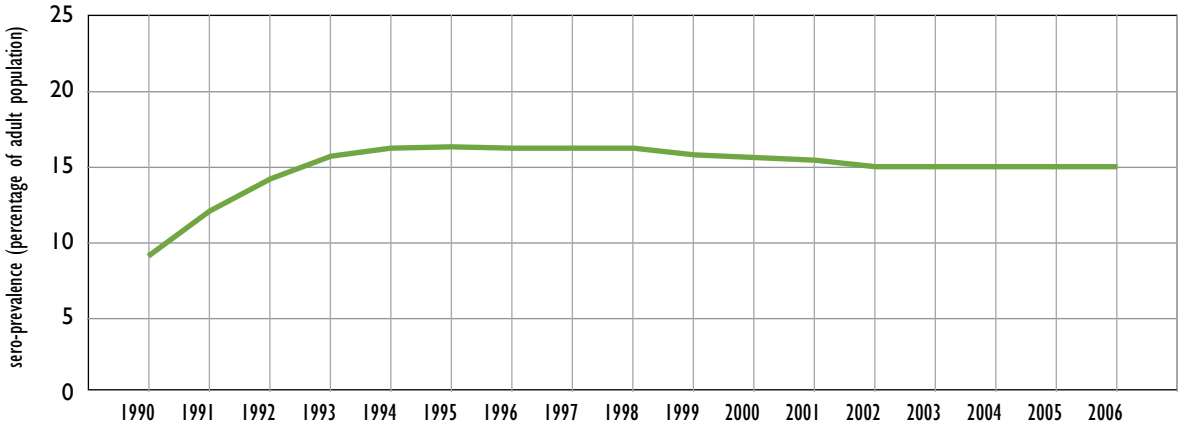
VCT = voluntary counselling and testing
ANC = antenatal care
ART = antiretroviral therapy
PMTCT = prevention of mother to child transmission

Sources: CSO, MoH, Macro International, 2002, 2007; CSO, MoH, Measure International, 2005.; NAC, 2008, 2010; MoH, 1994

PAST LEVEL: 1980-2005

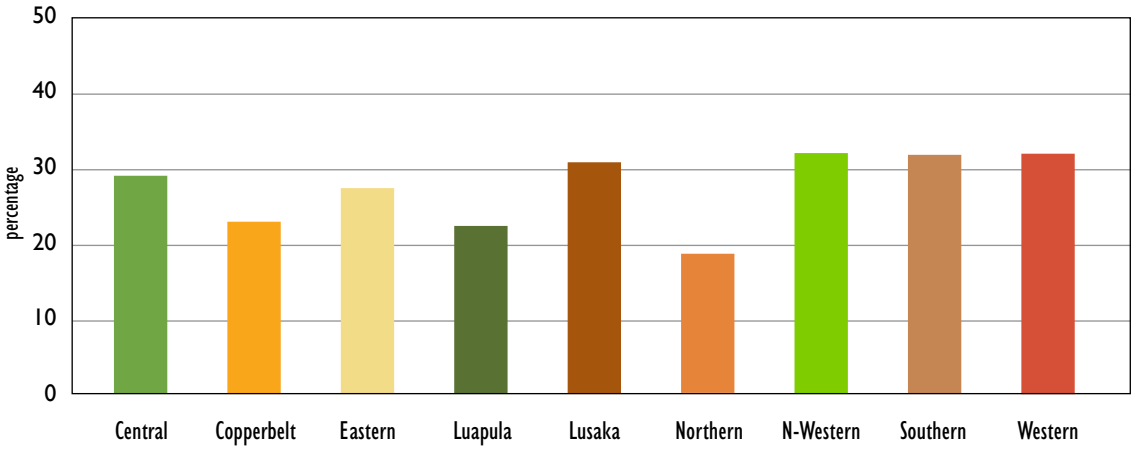
- The prevalence levels of HIV in the 1980s are uncertain due to the absence of an appropriate information sub-system to provide reliable data. More reliable data collection established through the Demographic Health Survey estimates shows increasing HIV prevalence through the early 1990s, peaking at about 17 per cent of adults by 1995 and reducing thereafter to about 15 per cent by 2006.
- HIV prevalence is higher in females aged 14–24 years and males 25–49 years, and higher in urban areas than in rural areas (CSO, MoH, Macro International, 2002, 2007; NAC 2008, 2009). Figure 9b shows higher HIV prevalence rates in Lusaka, Southern, Western and North-western provinces.
- Antiretroviral (ARV) therapy coverage began to improve after 2003, after an ARV programme was initiated in public health facilities. Condom distribution also rose steadily between 1998 and 2005, rising to coverage of about a third of 15 to 59 year olds (see summary table).

Figure 9a: Adult HIV prevalence 1990–2006



Source: World Bank, 2010; CSO, MoH, Macro International Inc, 2001/2, 2007; UNAIDS, 2010

Figure 9b: HIV prevalence among pregnant women by province, 2005

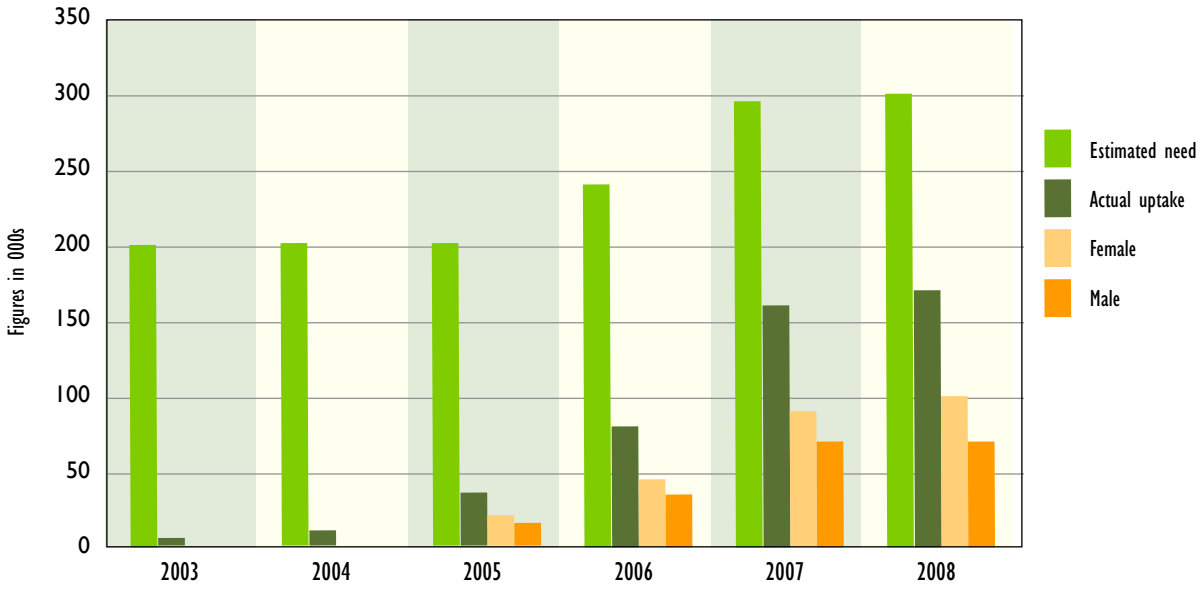


Source: MoH, ADDDATEHERE

CURRENT LEVEL: 2006-2010

- Major improvements in universal access to prevention, treatment and care for HIV/AIDS have taken place since the launch of the treatment programme in 2003. Coverage of ARVs (antiretrovirals) for people in need has increased significantly to over 60 per cent, while prevention of mother to child transmission (PMTCT) coverage has doubled to 66 per cent. Voluntary counselling and testing (VCT) and HIV testing of pregnant women also increased up to 2005 (see summary table and Figure 10). From fewer than 3,000 people living with HIV on ARVs in 2003, now almost 284,000 of an estimated 420, 000 people in need are receiving treatment.
- By 2010 there were 939 sites or health facilities providing prevention of mother to child transmission services against the national target of 1,500 sites (NAC, 2010).
- Differentials have persisted or widened, even as coverage has improved. As coverage of voluntary counselling and testing and HIV testing improved, so the urban–rural differentials in access have widened. Figure 10b shows regional differences in prevention of mother to child transmission coverage, with highest coverage in Southern province (89 per cent) and lowest in Luapula province (46 per cent) and in three of the most rural provinces, Northern, North-western and Luapula. While the rate of ARV coverage has seen an increase in adult uptake of about 60 per cent of the people in need receiving treatment, less than 40 per cent of children under 14 years in need of ARVs receive the necessary medication.
- Part of the explanation for this impressive expansion but the persistent differentials lies in the financing mechanisms. The principal financing initiative contributing to the HIV response has been the Global Fund and Zambia was one of the first beneficiaries to receive funding for HIV/AIDS and ARV treatment scale up under the WHO 3 by 5 initiative. However, evidence of the distribution of the benefits of the programme indicate that children have not benefited at the same rate as adults and people living in rural areas have not benefited at the same rate as the urban population. By inference, the benefit has been concentrated in the wealthier socio-economic groups and districts.
- Condom uptake increased up to 2007, based on HIV prevention through effective and consistent use of condoms. However, over 2008 and 2009, condom use is reported to have declined although precise data is not available (NAC, 2010). Although the reasons are not clear, particularly in view of the HIV/AIDS funding Zambia has been receiving, the reduction has been partially attributed to weaknesses in planning, procurement and a decline in advocacy and promotion of condom use.

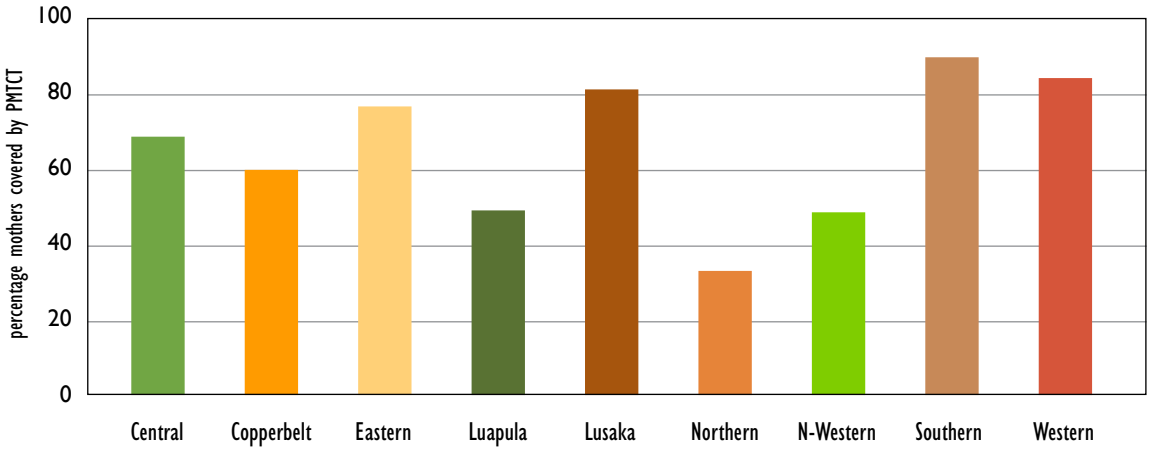
Figure 9c: Antiretroviral treatment coverage 2003–2008 (absolute figures)



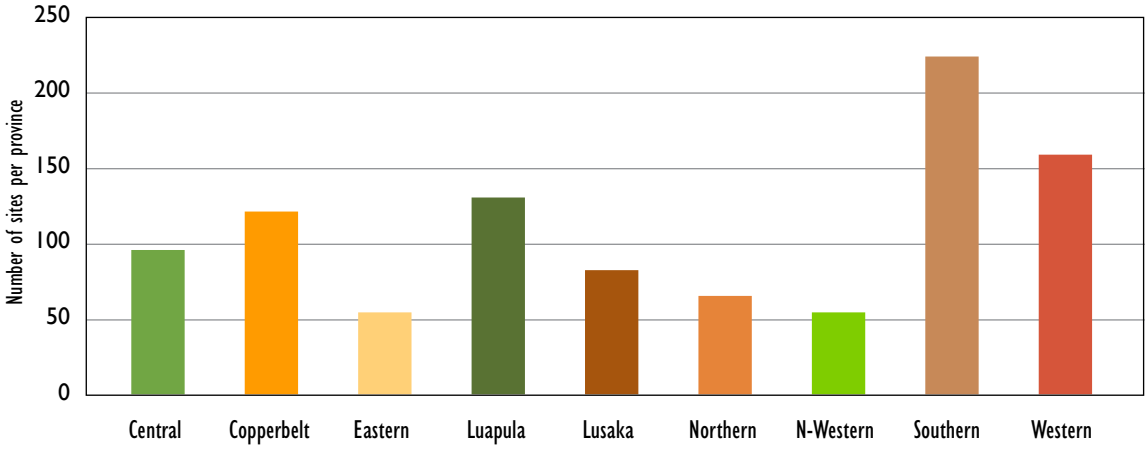
Source: NAC, 2009

Figure 10: Prevention of mother to child transmission, 2008

(a) Coverage by region



(b) Prevention of mother to child transmission sites by region



Source: NAC, 2009

Progress

Since the commencement of the antiretroviral programme, significant measures have been taken to improve coverage of treatment for HIV and AIDS. Achievements include initiating prevention of mother to child transmission sites across all districts in the country, introducing paediatric antiretroviral programmes with appropriate formulations and recruiting adults on the antiretroviral programme. The programme has grown from covering only two districts (Lusaka and Ndola) to covering all the districts in the country. This significant expansion in the programme was made possible with the additional resources of PEPFAR and the Global Fund. Differentials have persisted or widened, even as coverage has improved. For example, coverage of voluntary counselling and testing services and HIV testing improved but urban–rural differentials in access to services widened. Further, uptake of prevention interventions still needs to be improved. Condom use has, for example, declined.

EQUITY WATCH

Household access to the national resources for health

Progress markers

- Achieving and closing gender differentials in attainment of universal primary and secondary education
- Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
- Increasing the ratio of wages to Gross Domestic Product (GDP)
- Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems
- Abolishing user fees from health systems backed up by measures to resource services
- Overcoming the barriers that disadvantaged communities face in access to and use of essential health services

EQUITY WATCH

Household access to the national resources for health

The health inequalities and their determinants described in the previous section are addressed by households accessing resources for health through redistributive health systems and through wider national and global policies. This section explores progress in selected parameters of how far households are accessing the social determinants of health, that is the educational, environmental, income, health care and social protection resources they need to improve their health. It also explores how far differentials in the social determinants of health are being closed. The parameters chosen are consistent with those identified by the WHO Commission on the Social Determinants of Health (WHO CSDH, 2008).

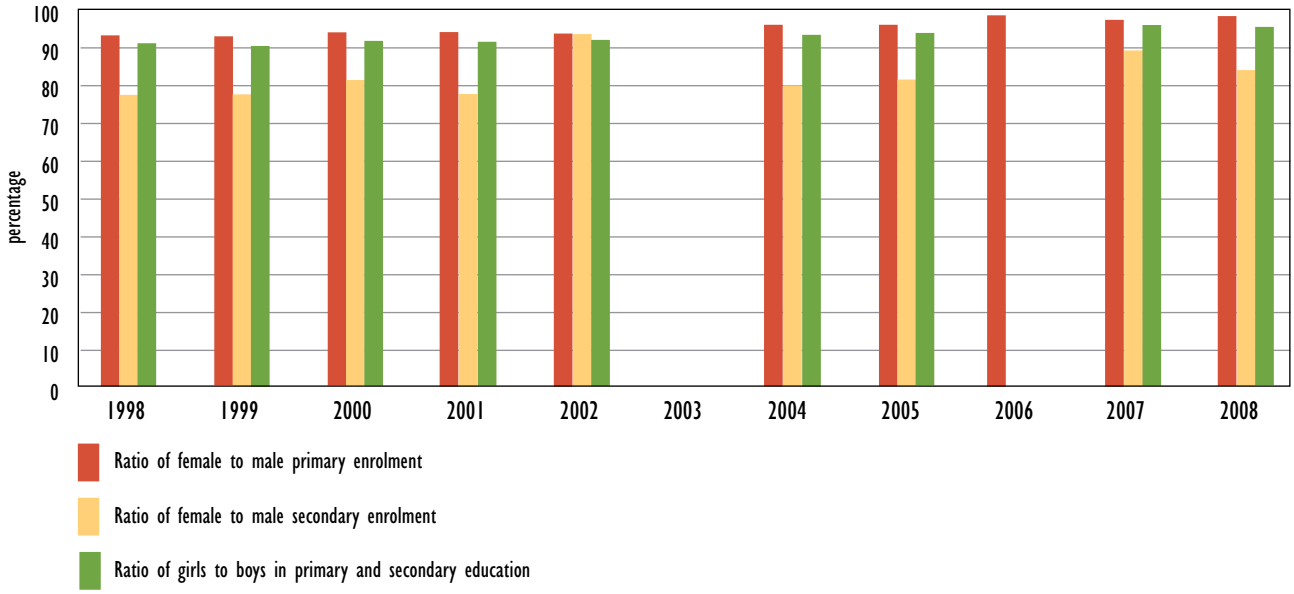
Achieving and closing gender differentials in attainment of universal primary and secondary education

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
% net enrolment in primary school of primary school age children	72	1998	92	2006
	84	2004	95	2008
Females	66	1980	80	2006
	60	1998	81	2007
	56	2000	87	2008
	67	2004		
	68	2002		
Males	90	1980	90	2006
	73	1998	98	2008
	66	2000		
	77	2004		
Overall	81	1980	87	2006
	67	1998	89	2007
	61	2000	92	2008
	73	2004		
Male: Female ratio	1.4:1	1980	1.13:1	2006
	1.0:1	2000	1.13:1	2008
	1.1:1	2004		
% adult literacy (overall)	65	1990	70	2008
	68	1999		

PAST LEVELS: 1980-2005

- The performance of the primary education sub-sector shows a mixed picture from 1980 to date. The net overall enrolment ratio fell from 81 per cent in 1980 to 60 per cent in 2000. Two particular policy measures in the early 1990s and 2000s may be associated with this. In 2002 school fees at primary level were abolished and enrolment improved. Poverty levels, which peaked during the mid 1990s, especially in rural areas, may also have accounted for the drop in enrolment as fees posed barriers for households and households withheld labour, particularly of female children, for household use (MoFNP, 2002). The gender gap in enrolment which was biased towards males in 1980 closed over the period (as shown in the summary table), with greater gender parity in the lower grades (1–9) than in grades 10–12 (MoFNP, UNDP, 2010).

Figure 11 Primary and secondary school enrolment by gender, 1998–2008



Source: CSO, MoH, Macro International Inc, 2002, 2007; Ministry of Education, 2003; World Bank, 2010

CURRENT LEVEL: 2006-2010

- The net overall enrolment ratio rose in 2006 and 2008 to 87 per cent and then to 92 per cent. The abolition of user fees for primary education in 2002 and the introduction of accelerated programmes such as the Programme for the Advancement of Girls Education (PAGE) may have partly contributed to this increase in enrolment, particularly for girls, bringing male: female ratios closer to parity. Completion rates at secondary school have also improved from 35 per cent in 2002 to 53 per cent in 2009 for Grade 9, although those for Grade 12 rose from 15 per cent to only 20 per cent over the same period (MoFNP, UNDP, 2010).

Progress

There have been marked improvements in enrolments and a reduction of gender differentials in the recent past. The last five years in particular have been characterized by investments in infrastructure which have led to a marked improvement in access as a way of increasing school enrolment. Resource allocation to the education sector has increased and averaged about 16–18 per cent (MoFNP, 2000-2010). This has been accompanied by an improved recruitment drive for teachers. The greater investment in school construction, an increase in staff recruitment, the abolition of primary school fees and an increase in pupil enrolment have improved overall access to education. Improvements in the ratio of female enrolment in relation to male enrolment has slowed in recent years and, while gender parity is high, inequalities are higher in the higher grades.

Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015

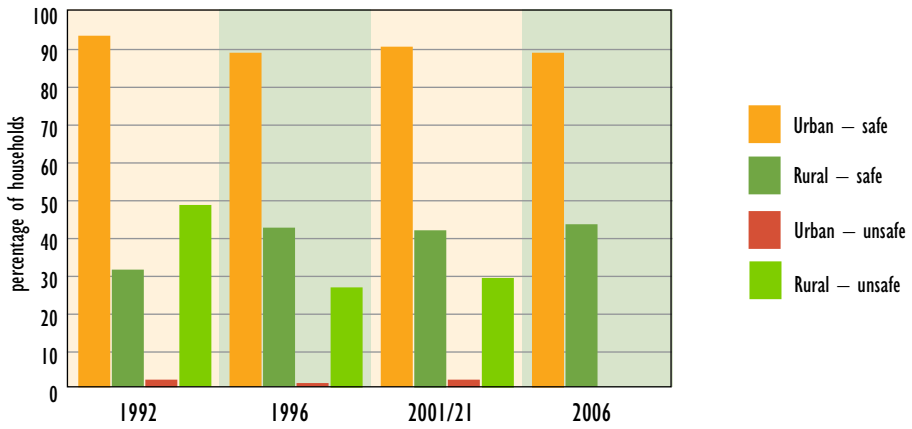
INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
% households using improved water source – Overall	51	2002	58	2007
Rural	31 42 41	1992 1996 2002	43	2007
Urban	93 88 90	1992 1996 2002	88	2007
Urban: rural ratio	3.0:1 2.2:1	1992 2002	2.1:1	2007
% households using improved sanitation – Overall	23 18 17	1992 1996 2002	24	2007
Rural	1 1 3	1992 1996 2002	11	2007
Urban	48 46 46	1992 1996 2002	37	2007
Urban: rural ratio	48.0 :1 15.3 :1	1992 2002	3.4:1	2007

Source: CSO, MoH, Macro International, 1992, 1996, 2002, 2007

PAST LEVELS: 1980-2005

- Access to clean water is a progress marker that shows high levels of inequity, particularly between urban and rural areas (see Figure 12).

Figure 12: Access to safe water by area, 1992–2006



Source: CSO, MoMacro International, 1992, 2002, 2006

PAST LEVELS continued

- Urban: rural ratios narrowed from 3:1 in 1992 to about 2.2:1 in 2002. This was partly due to improving access in rural areas but also due to falling access in urban areas in the period. Household surveys showed that access to clean water in rural areas rose from 31 per cent in 1992 to 41 per cent in 2002, while in urban areas access fell from 93 per cent of households to 90 per cent in 2002 (CSO *et al.*, 1996, 2001/2, 2007). A similar shift was observed in access to sanitation, with an overall decline between 1992 and 2002, and a small rural improvement and urban decline, closing the urban: rural ratio. Nevertheless urban: rural differentials in sanitation were high.

CURRENT LEVEL: 2006-2010

- After 2006, rural access to safe water continued to improve, while urban access continued to fall. This closed urban–rural differentials, although due in part to worsening urban coverage. One explanation may be in the rapid pace of urbanization with the increasing urban population putting pressure on services, while in rural areas there was a countrywide programme to provide clean water by sinking boreholes.

Progress

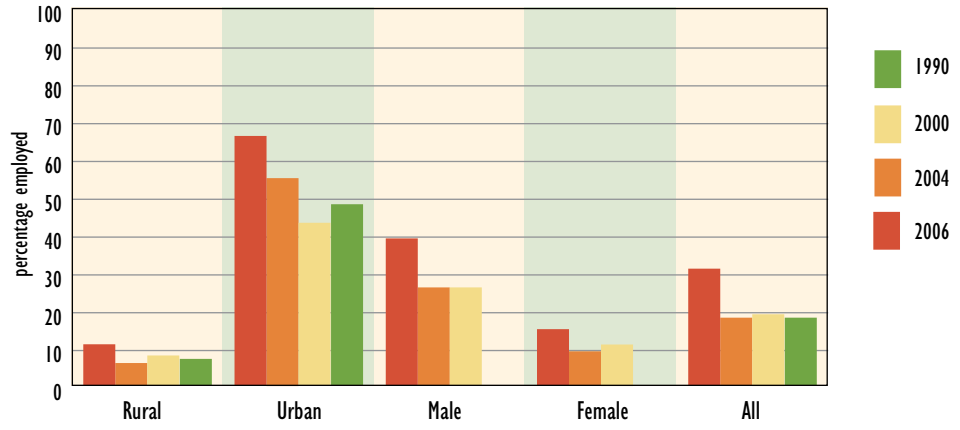
The evidence with respect to water and sanitation performance is mixed. There has been a deterioration with respect to urban consumers' access to safe water and sanitation while rural access has improved, narrowing differentials. However, low and stagnant overall levels suggest that this is an area where greater attention and resource allocation is needed to reach Millennium Development Goal commitments and reasonable levels of population coverage. However, the current 6th National Development Plan, expected to commence in 2011, should begin to address this gap through a planned increase in investment in this area to greatly improve coverage and raise public health status (MoFNP, 2010).

Increasing ratio of wages to Gross Domestic Product (GDP)

PAST LEVELS: 1980-2005

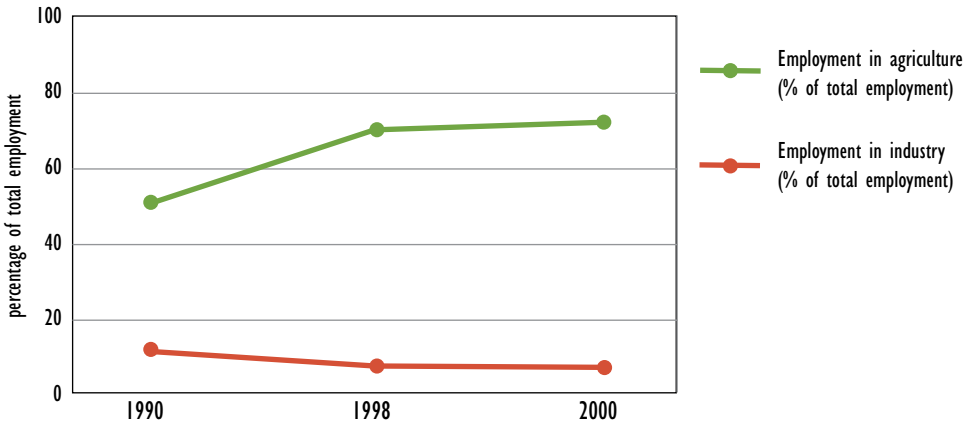
- In the absence of comparative or time series wages data, employment data, as a proxy, has been used as indicative evidence on the returns to labour from economic growth. Formal employment, generally associated with higher incomes, benefits and employment security, declined between 1990 and 2004, in both rural and urban areas and for males and females, although with a small recovery for women and rural workers in 2004 (see Figure 13a).
- Figure 13b shows the relative share of agricultural and industrial employment, with a fall in industrial employment and an increase in agricultural employment in the period 1990-2000. The increase in agricultural employment took place despite a period where the share in the GDP of both agriculture and manufacturing fell (see Figure 13c on page 34).

Figure 13a: Employment by area and gender, 1990–2006



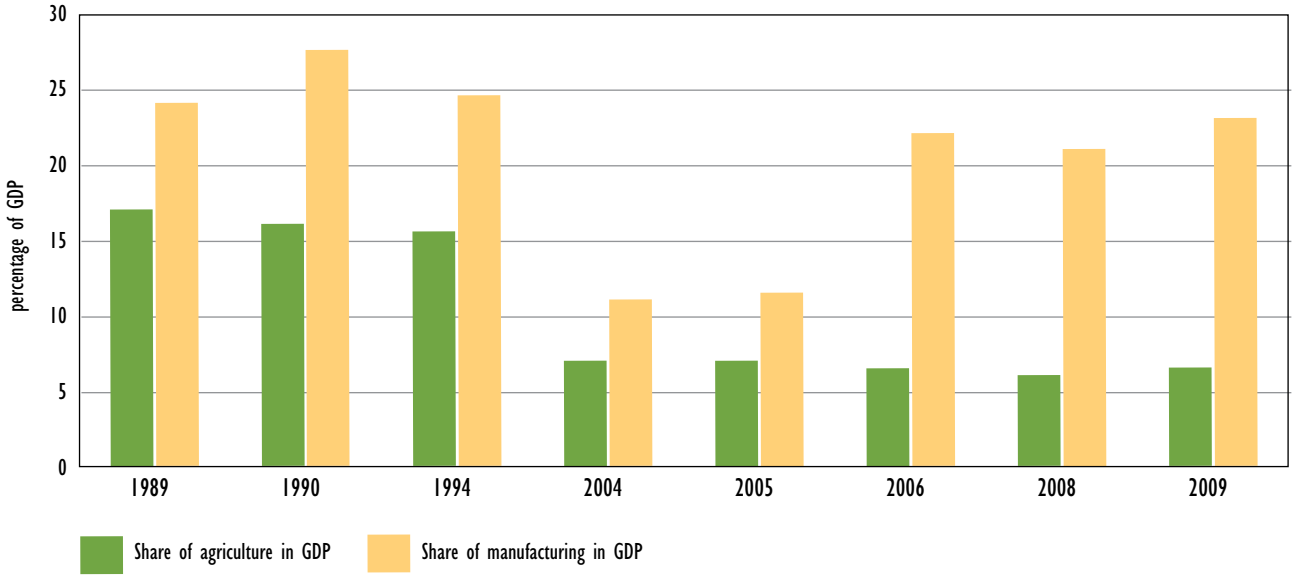
Source: MoFNP, 1994, 2009; World Bank, 2010

Figure 13b: Relative share of agricultural and industrial employment, 1990–2000



Source: MoFNP, 1994, 1998, 2000, 2002, 2005, 2010

Figure 13c: Agriculture, manufacturing – contribution to Gross Domestic Product, 1989–2009



Source: MoFNP, 1994, 1999, 2005, 2008, 2010

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CURRENT LEVEL: 2006-2010

- There was some recovery in urban employment in 2006, but the same did not happen in rural areas. While manufacturing's share of GDP rose over the period 2006–2009, the share of agriculture remained relatively constant (Figure 13c). Improvements in manufacturing jobs does not seem to have the same wide benefit as jobs in agriculture, as the latter is more labour intensive. As the latter comprised over 70 per cent of jobs in 2000, the stagnant improvement in that sector has constrained the translation of GDP into incomes. Further, the large population entering the labour force annually is a faster growing pool than the economy can absorb. Formal employment remains both urban biased and male dominated.

Progress

Formal sector employment appears to have been falling, during periods of both increased and falling shares of agriculture and manufacturing in GDP. Construction, mining and financial services have grown as sectors by about 10 per cent annually in contribution to GDP in the last two years (MoFNP, 2010). It is not yet clear how far this growth in GDP contribution has led to growth in employment, particularly given the lack of a clear association between GDP contribution and employment in manufacturing or agriculture.

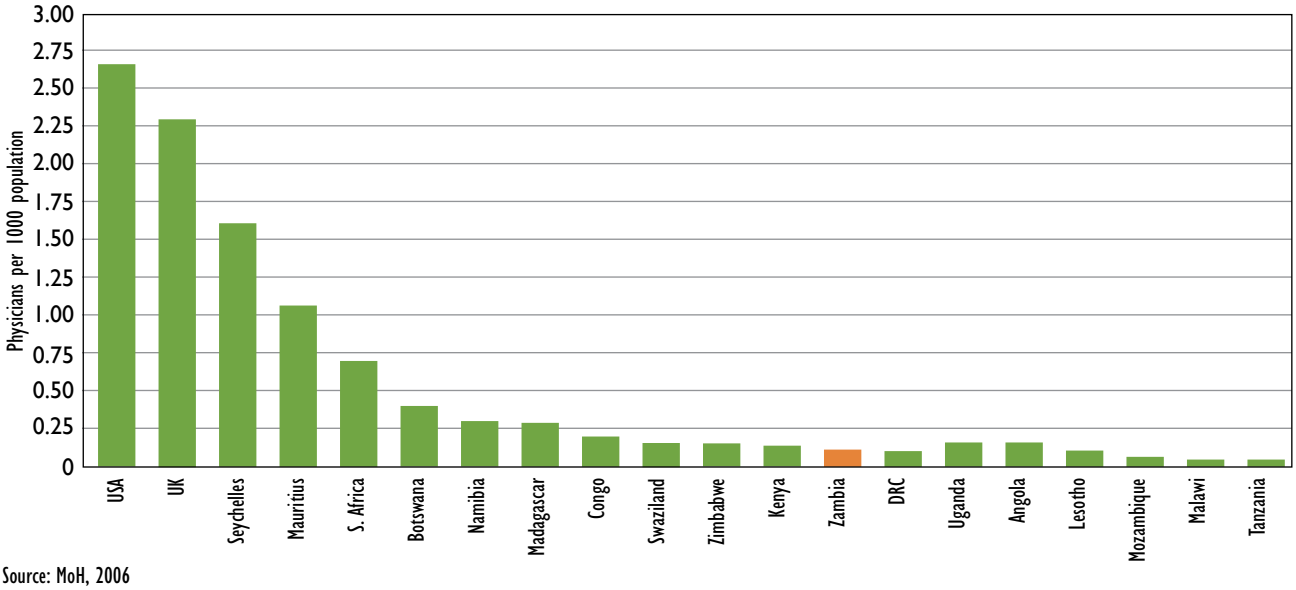
Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems

Health workers and pharmaceuticals between them account for over 80 per cent of health sector expenditure and are often cited as drivers of access, quality, cost and coverage of health care in Zambia (MoH, 2000, 2002, 2006, 2008).

PAST LEVELS: 1980-2005

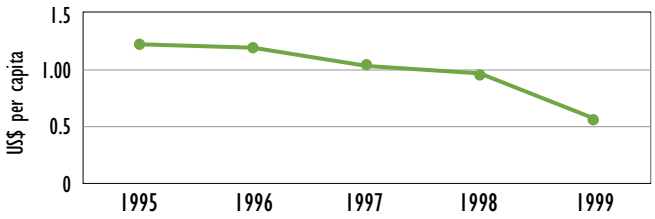
- There was a steady decline in available health workers between 1995 and 2005 (MoH, 2005). It has been noted that 'since the 1980s Zambia has been struggling to improve health outcomes with a decreasing human resource base … the population per physician ratio worsened from 1:7,900 in the early 1980s to 1 :11,100 in the mid-1990s and 1:14,500 in the early 2000s. The rural areas are particularly affected as there are significant disparities in the distribution of existing health workers' (World Bank, 2010).
- The low pay and incentive structure for health workers between 1980 and 2005 was further accentuated by the deterioration of the economy. This was a key factor in the out-migration of health workers from Zambia to countries in east and southern Africa, as well as to high income countries recruiting skilled health workers, such as United States, United Kingdom, New Zealand and Australia. In particular there has been high out-migration of medical doctors, pharmacists, radiographers and nurses, with doctors and nurses having lowest density per population level in terms of availability (MoH, 2001).
- During the latter part of the 1990s, health worker training was marginalized with, for example, one out of on average of two or three nursing schools per province closing. Further, in the latter part of the 1990s, the Ministry of Health introduced 'voluntary separation' in which health workers could if they wished take early retirement prior to normal retirement with full benefits if they had 21 years of service. This provided an incentive for workers to leave the health sector on full benefits and migrate from the country (Central Board of Health, 1999) and combined with HIV related mortality this contributed to the high attrition rate of health workers. It left health worker distribution skewed in favour of the urban areas and secondary and tertiary levels, particularly with respect to the nurses, pharmacists and doctors.
- Per capita drug expenditure declined from US$ 1.21 in 1995 to US$ 0.59 in 1999 (see Figure 15 on page 36). During this period, there were limited disbursements from Ministry of Finance and National Planning and inadequate allocations from the Ministry of Health to support drug procurement. It is difficult to reach firm conclusions on the implications of this reduction in expenditure on drugs and further investigation is needed to determine the extent of real decline in drug quantities versus efficiency gains from lower drug costs. External funding was used to fund 'health centre kits' which included essential medicines for this level. This meant that the essential drug stock position at the primary care level was slightly better than at the higher levels (CBoH, 1999, 2000).

Figure 14: Availability of physicians compared to other countries, 2004



Source: MoH, 2006

Figure 15: Per capita expenditure on medicines, 1995–1999

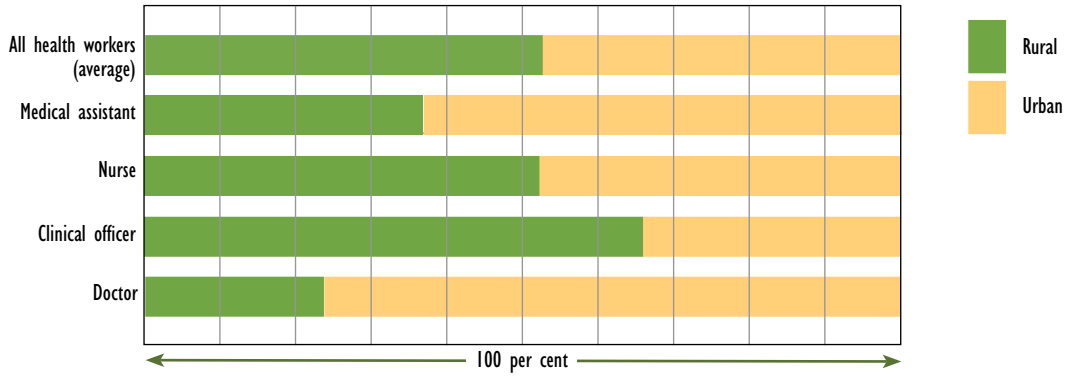


Source: P. Fulilwa, 1999

CURRENT LEVEL:2006-2010

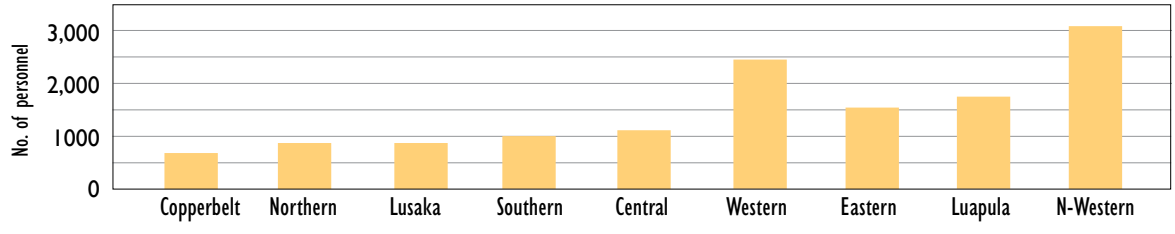
- The negative trends described earlier meant that by 2006 Zambia fared poorly when compared against the internationally recommended norms on health worker:population ratios (see, for example, Figure 14). WHO suggests a minimum of 2.5 nurses, midwives and doctors per 1,000 population and Zambia had about 1.01 of these cadres per 1,000 population in 2005 (MoH, CBoH ,2005; JLI, 2004). As one response, government significantly increased budget allocations for personnel. In 2006/7, government permitted the Ministry of Health (and the Ministry of Education) to employ more staff than other sectors. By 2010 the ministry was allowed to recruit in excess of 1,200 clinical staff, while the 2011 budget gave the ministry leeway to recruit up to 1,700 new staff. However, an attrition rate of up to 10 per cent or 1,800 staff leaving the sector annually reverses this gain (MoH, 2001; MoH 2005). The maldistribution of personnel has also been addressed in recent years. Poor incentives fuelling rural to urban migration were partly addressed from 2002 through the provision of allowances for health workers working in rural areas. This was part of the Zambian Health Worker Rural Retention Scheme, although initially this was limited to medical doctors. In addition, training and other non-financial incentives were provided, for example, by constructing staff housing. By 2008, the number of rural health workers was higher for nurses and clinical officers and the overall share of health personnel, excluding medical doctors, was relatively higher in rural areas (See Figure 16a). When these numbers are however weighed against facility and population numbers, the urban areas remain clearly better staffed.
- These rural–urban disparities in staffing persist when taking provincial population numbers into account. Staff densities are higher in the Copperbelt and Lusaka provinces, both more urbanized, and lowest in Luapula and North-Western Provinces, with over tenfold differentials (see Figure 16b).

Figure 16a: Health workers by residence, 2008



Source: World Bank, 2010

Figure 16b: Staff densities by province, 2009



Source: MoH, 2011

- As Table 6 shows, the shortfalls on personnel in 2010 were most profound with respect to midwives. This is important for equity given the high demand for midwives for safe deliveries, and the wealth, education and other social disparities in access to assisted deliveries noted earlier.
- The per capita drug budget in 2011 was estimated at US$1.39 (MoFNP, 2010). However, disbursements have not necessarily tallied with procurement and availability of drugs. In 2009 stock outs of essential drugs were found to be more likely at health centre level than at district pharmacy level across a range of essential drugs (see Table 7). This is partly attributable to the logistical and support systems, including reliable and timely transport between Medical Stores Limited in Lusaka and the districts and health centres, given that transport from the district health management team is often unavailable or over-committed. This 'secondary distribution' has been identified as the main bottleneck in medicines distribution (World Bank, 2010: 98). In 2003, the Ministry of Health contracted in the Central Medical Stores Limited to store and distribute drugs and other pharmaceuticals to try to address this.

Table 6: Staff availability, 2010

Professional category	2005		2010	
	Number	People per health worker	Staff requirement: using 2005 Staff- pop ratio	Number of staff: 2010
Clinical officer	1,161	9,700	1,388	1,535
Medical doctor	646	17,433	772	911
Nurses	65			
Pharmacists	108	104,276	129	371
Midwives	2,273	4,955	2,717	2,671
*EHTs	803	14,025	960	1,203
Total clinical staff	12,173	925	14,549	16,256
Overall total	23,176	486	27,700	30,713

*EHT = environmental health technologists

Source: MoH, 2011

Table 7: Stock outs of selected essential drugs, health centre, district pharmacies, 2009

	Probability of stock out at health centre	Probability of stock out at district store
AL 4x6 (strip of 24 tabs)	0.34	0.11
Amoxicillin suspension (bottle of 100ml)	0.72	0.33
Benzyl penicillin Inj. (5MU 10ml vials)	0.23	0.39
Malaria RDTs (box of 25 tests)	0.46	0.33
Male condoms (box of 100/144)	0.18	0.56
Metronidazole 200mg tabs (bottle of 1000)	0.61	0.33
OralconF (Levonorgestrel/Ethinylestradio)	0.41	0.33
Quinine injection (2ml ampoules)	0.34	0.17

Source: World Bank, 2010

Progress

Health worker availability and retention has improved in recent years and so has drug availability, distribution and procurement. Government has taken measures to improve the recruitment, deployment and retention of personnel and to capacitate drug distribution, making it demand driven to avoid expiry and waste and to strengthen transport for monthly deliveries. There is still need to further address inequalities between rural and urban areas in personnel availability, the shortfall on midwives and the greater likelihood of stock outs at primary care level.

Abolishing user fees from health systems backed up by measures to resource services

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
*Out of pocket spending as a percentage of total health expenditure	34	1995	27	2006
	34	1996		
	31	1997		
	32	1998		
	40	2000		
	29	2002		
	28	2004		
	27	2005		

*Out of pocket spending covers health-related household spending, including for health facilities, drugs, medical consultations and diagnostic services, estimated from public and private sector health facility revenue.

Source: MoH, , 1999, 2002, 2004, 2008

PAST LEVELS: 1980-2005

- Government policy following the post-independence period was that all health services for all facilities would be provided free of charge. This led to the abolition of fees charged at rural primary care level facilities. When the autonomous hospital management boards were set up in the mid-1980s, tertiary facilities re-introduced fees and physicians were allowed to run their own clinics at public health facilities and to charge for these services. This practice was introduced, albeit on a limited scale, as a retention incentive in the public sector but was then discontinued due to difficulties with regulating the time spent between private and public practice and the negative impact it had on other personnel as it was only available to senior medical staff, such as consultants and specialists (MoH, 1996). Health accounts studies suggest that out of pocket spending was about a third of total health expenditure in the 1990s, rising to 40 per cent in 2000 and then falling relatively sharply to below 30 per cent in the early 2000s (see summary table).

CURRENT LEVEL: 2006-2010

- User fees were abolished in all rural-based primary health care facilities (health centres and district hospitals) in January 2006. This measure affected the 57 districts considered to be rural out of the total of 72 districts in the country (Masiye and Chitah, 2010; MoH, 2006). The initial phase focused on the most disadvantaged districts with the ultimate aim of abolishing fees across primary care facilities in all districts, and later, to some degree, in secondary and tertiary facilities (MoH, 2006). Fee abolition in rural, primary level public health facilities was followed up with an increase in the grant allocated to affected districts, as a means to replace the estimated revenue previously realized from user fees (MoH, 2006). As shown in later progress markers, after 2006 government improved the share of health in the government budget (from 6.8 to 9.75). Evidence on post-2006 allocations to district and clinic level was not available.

Progress

The removal of user fees resulted in increased drug consumption, increased staff–patient contact time as well as increased health facility use (Masiye and Chitah, 2008). There is some evidence of improved public financing to facilities to replace resources lost. However, the removal of fees has remained limited to primary care level facilities.

Overcoming the barriers that disadvantaged communities face in access to and use of essential health services

PAST LEVELS: 1980-2005

- Some of the barriers that disadvantaged communities face in accessing health care services and using essential health care services have been identified as being socio-cultural and economic. These barriers include gender inequalities, a high incidence of deprivation and poverty, lack of information and awareness about the rights to health services and poor education levels, especially of women. These elements all limit uptake of health services. Other factors relate to poor access to facilities due to distance, limited staffing and inadequate drugs undermining confidence in services, weak infrastructure, lack of training and technology (machinery and equipment) for services as well as high costs due to poor financing. Weaknesses in the organization of communities and community structures, that facilitate access to and interaction with health care services, heighten the impact of these factors (MoH, 1992, 2000). These barriers have impacted on access to services and the system's responsiveness to the needs of the population.

CURRENT LEVEL: 2006-2010

- In more recent years, the barriers that have been documented include systems barriers, such as distance to health facilities, costs of transport, food and medication (when clinics do not have drugs) and lack of qualified health workers, which all reduce the quality and use of health services. Some community level barriers have persisted, including the knowledge and acceptability of health care services and cultural and traditional barriers that affect health-seeking behaviours (CSO, MoH, Macro International, 2001; 2007). Household surveys show that barriers are highest for the poorest people who, for instance, face the longest distances to health facilities and for whom the costs of health care and transport have been most difficult to meet (CSO, MoH, Macro International, 2001, 2007). The Ministry of Health has begun to address access barriers through a plan to construct an additional 400 health posts between 2006 and 2011. However, only 18 such posts had been constructed by 2010 due to logistical and budget constraints (MoFNP, 2010). Having an accessible health post, as a first point of entry in the health system, would enhance access to and uptake of services. The recruitment of additional health workers discussed in earlier progress markers and improved retention incentives for skilled health personnel working in rural areas will also enhance availability of and confidence in services, although it does not cover all cadres (MoH, 2005). Attempts have also been made to provide all districts with reliable transport both to improve the referral system and to ensure that facilities are supplied with resources like drugs on a timely basis.

Progress

There has been a policy effort to reduce barriers, raise awareness, promote equity and improve the quality of service provision in the health system. During 2009, for example, cabinet approved, launched and disseminated the National Child Health and National Reproductive Health policies to enhance uptake in these specific areas. Cabinet also evaluated the drug and laboratory policies to improve the performance of the system (MoFNP, 2010). The Ministry of Health has just concluded the Community Health Workers' Strategy which outlines the development and strengthening of community health workers as frontline staff. These policies aim to strengthen the resources and services at the first point of entry into the health system. It will be important to continue to track the resource support for and the operational implementation of these policies, given the limited roll out of the policy on health posts to date.

EQUITY WATCH

Resourcing redistributive health systems

Progress markers

- Achieving the Abuja commitment of 15 per cent government spending on health
- Achieving US$60 per capita public sector health expenditure
- Increasing progressive tax funding to health and reducing out of pocket financing in health
- Harmonizing the various health financing schemes into one framework for universal coverage
- Establishing and ensuring a clear set of comprehensive health care entitlements for the population
- Allocating at least 50 per cent of government spending on health to district health systems (including level 1 hospitals) and 25 per cent of government spending to primary health care
- Implementing a mix of non–financial incentives for health workers
- Formal recognition of and support for mechanisms for direct public participation in all levels of health systems

EQUITY WATCH

Resourcing redistributive health systems

For health systems to promote health equity they need to work with other sectors to improve household access to the resources for health (for example, safe water and education), discussed in the previous section. Health systems also need to 'get their own house in order', to promote the features that enhance health equity. This section presents selected parameters of progress in this direction, for example: in the benefits, entitlements and framework for achieving universal coverage; in mobilizing adequate resources through fair, progressive funding; in allocating resources fairly on the basis of health need; and in investing in the central role of health workers, people and social action in health systems.

Achieving the Abuja commitment of 15 per cent government spending on health

INDICATOR	PAST LEVELS		CURRENT LEVEL	
	Level	Year	Level	Year
Government spending on health including external funding as a percent of total government expenditure	6.5	1995	6.8	2006
	7.2	1996	9.7	2008
	7.7	1997	9.8	2009
	6.5	1998		
	6.7	1999		
	5.0	2000		
	7.0	2001		
	6.9	2002		
	5.2	2003		
	4.7	2004		

PAST LEVELS: 1980-2005

- In 2001, the Zambian government, like other African governments, committed itself to the Abuja commitment of increasing the share of government domestic spending on health to 15 per cent. The commitment aimed to prioritise health in the budget and in allocating domestic public resources. Strengthening public spending has been found crucial in low income countries in achieving a healthy population and protecting the poorest (WHO, 2005; Ogbu and Gallagher, 1992). Public spending can provide cost-effective interventions that protect poor people from financial shocks since poorly regulated private health care has an incentive to prescribe more expensive care (Gauri, 2001). Government health spending in Zambia before 2001 ranged from 5 to 7.7 per cent as a share of total spending. After 2001 it ranged from 4.7 to 7 per cent (MoH, 1999, 2004), indicating no improvement after the Abuja commitment was made.

CURRENT LEVEL: 2006-2010

- Zambia is far from achieving the Abuja commitment but has begun to make improvements. From a share of 6.8 per cent government spending on health in 2006, the level had risen to 9.8 per cent by 2009.

Progress

Between 1998 and 2006 Zambia did not spend more than 7 per cent of its total public budget on health with no consistent increase in government spending, in line with the Abuja commitment. However, the 6 per cent growth in the Zambian economy over the last seven years suggests that the government could improve its share of public spending on health (Bank of Zambia, 2010). The positive sign of a marked increase to 9.7 and 9.8 per cent spending on health in 2008 and 2009 needs to be sustained.

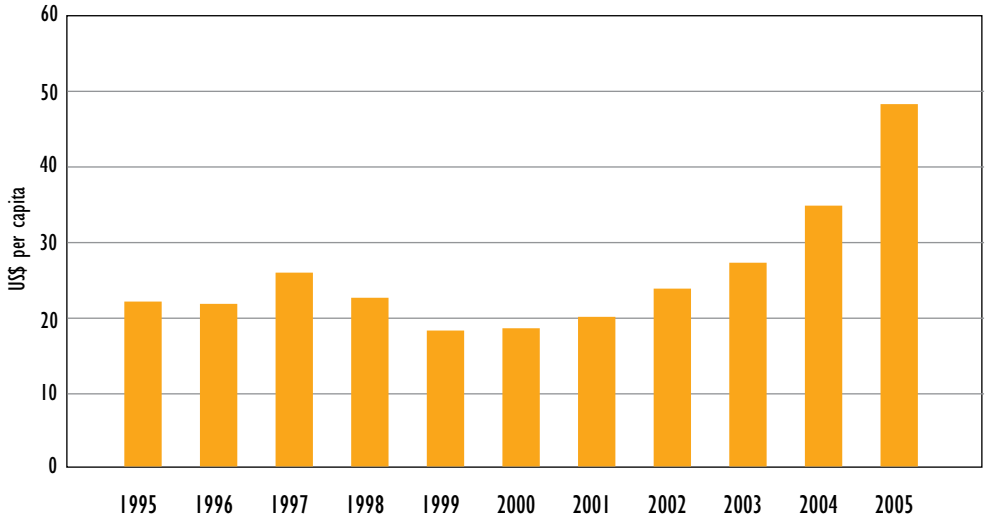
Achieving US$60 per capita public sector health expenditure

In addition to increasing the share of public spending devoted to heath, total health spending should reach a minimum level of about US$60 per capita to achieve the level of health service coverage needed to improve population health. In 2000/01, the WHO costed a package of priority health interventions for sub-Saharan Africa at US$34 per capita, excluding the wider systems costs, and US$60 per capita including these costs (WHO, 2001).

PAST LEVELS: 1980-2005

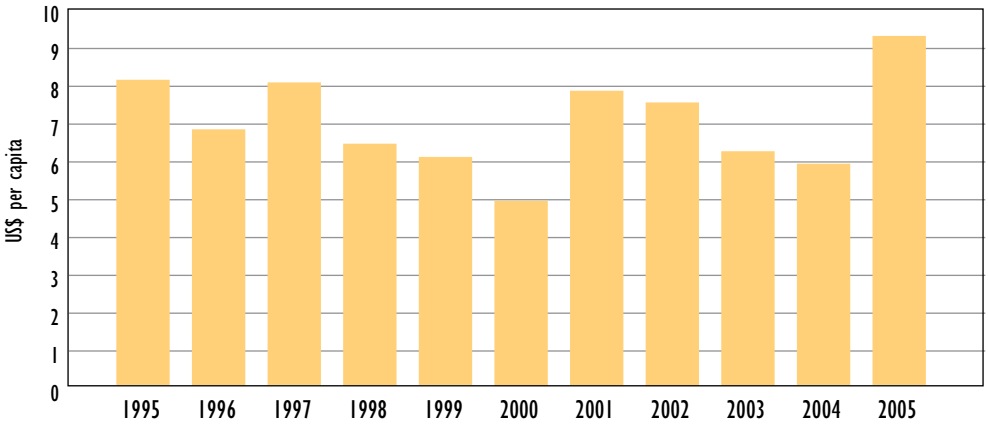
- Total per capita health expenditure fell from 1995 to 2000 with deteriorating economic conditions. It increased thereafter to US$47 in 2005 (see Figure 17a), rising towards but still below US$60. Government spending also fell from US$8.10 per capita in 1995 to US$4.90 in 2005, rising to US$9.30 by 2005 or to about a quarter of total health expenditure. Figures 17a and 17b show that while total health spending per capita was rising towards the US$60 indicated, government spending only reached about 15 per cent of this level.

Figure 17a: Total per capita health expenditure in US$, 1995–2005



Sources: MoH, 1999, 2004, 2008

Figure 17b: Per capita government health expenditure (US$), 1995–2005

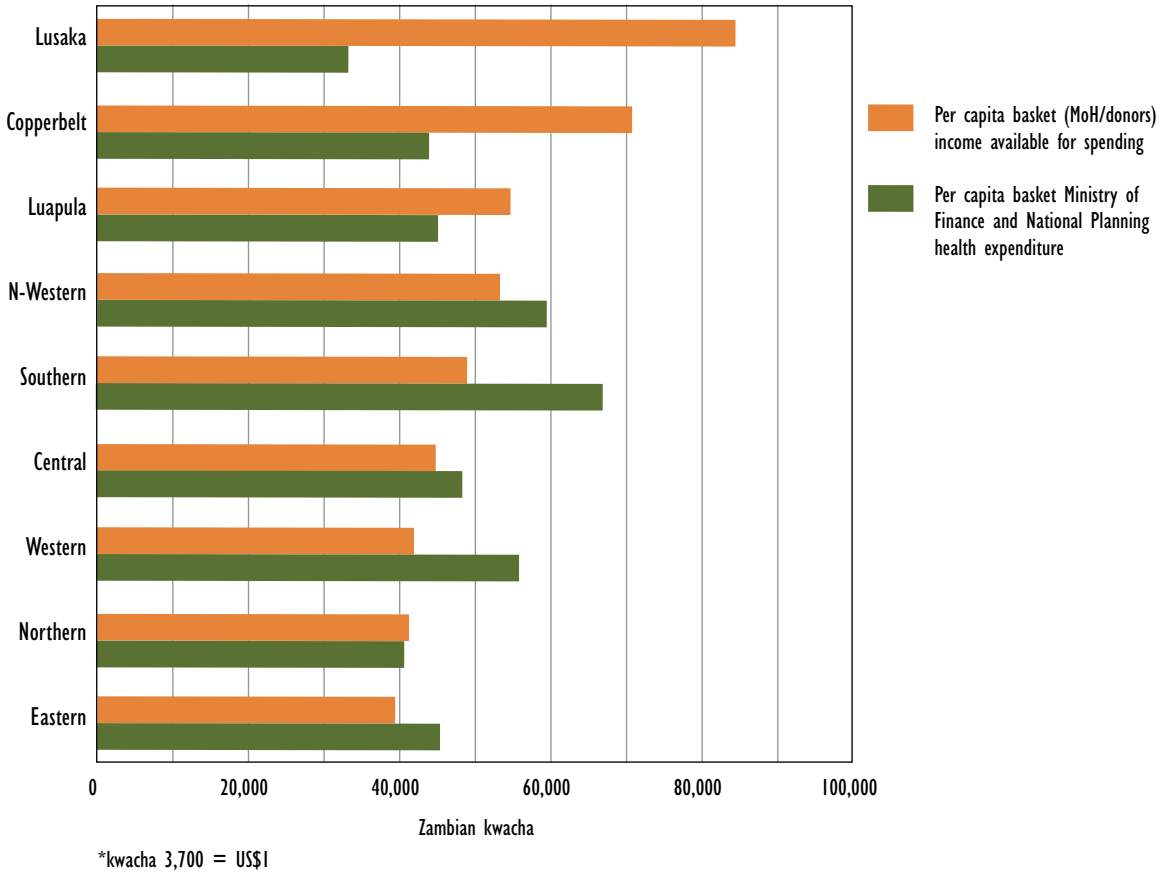


Sources: MoH, 1999, 2004, 2008

CURRENT LEVEL: 2006-2010

- According to the most recent national health accounts report covering the period 2003–2006, Zambia recorded an increase in real total health spending during that period (MoH, 2010). In 2006, total spending reached US$56 per capita, above the US$34 per capita identified by the WHO Macroeconomic Commission on Health as a minimum for AIDS, tuberculosis and malaria interventions and close to the US$60 per capita minimum for health systems to meet the Millennium Development Goal targets in health. One contributor has been external funding. While this has increased in recent years it has been erratic and not necessarily long-term funding so it is difficult to predict its sustainability (NAC, 2007).
- The improvement in public and overall health funding opens opportunities for increased equity in the allocation of resources. There are wide differentials in the distribution of the public sector recurrent health budget across Zambia's provinces, with relatively well served, higher income provinces like Lusaka and Copperbelt better funded than others with higher health need (see Figure 18). Higher allocations to these provinces are a product of combined government and external funder allocations. This suggests that reaching equitable per capita allocations across provinces needs to factor in both sources of funding.

Figure 18: Per capita government allocations of recurrent budget by province in *kwacha, 2008



*kwacha 3,700 = US$1

Source: MoFNP, 2009; MoH, 2009

Progress

Spending on health has increased in Zambia in this decade, with larger increases in external funder and domestic private spending (employer medical schemes) than in public spending. A large share of the increase in total spending may be attributed to external funder spending on HIV/AIDS, tuberculosis and malaria, which is not always predictable or consistent. Reaching adequate, predictable levels of spending, especially in the public sector, and improved equity in the distribution of aggregate spending remains a challenge.

Increasing progressive tax funding to health and reducing out of pocket financing in health

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
% of total health expenditure that is government spending on health	51.7	2000	57.7	2007
Private spending on health	48.7	2000	42.3	2007
Social health insurance	0	2000	0	2007
Out of pocket spending as a % of private spending	80.5	2000	67.6	2007
External resources as % of total health expenditure	17.8	2000	33.3	2007

Source: WHO, 2010

PAST LEVELS: 1980-2005

- Between 1985 and 1993, the public health sector was dominant with a small private sector and the majority of health financing from government spending through general tax revenue. General tax revenue is largely progressive as contributions increase with income or wealth. The health financing landscape changed dramatically after the introduction of user fees in 1993, partly to reduce the cost burden on the treasury. By 2000, private spending was almost as large as public spending (see summary table) despite being largely regressive and increasing the financial burden on the poorest.

CURRENT LEVEL: 2006-2010

- The abolition of user fees in April 2006 at public primary health care facilities and increased public (tax) funding to the affected districts brought a shift from regressive to progressive financing, to mitigate the impoverishing impact of user fees on the poorest section of the population. Some externally funded programmes also exempted users from paying high fees, including for ARV treatment, HIV diagnostic services, prevention of mother to child transmission, tuberculosis drugs, malaria treatment and reproductive health services. These are now offered either free of charge or at a reduced price of about K40,000 (US$8) at all public health facilities, in both rural and urban areas – significantly lower fees than those charged in the private sector. User fee revenue accounted for less than 5 per cent of total revenue and the summary table shows the significant fall in this area of spending, with substantial positive impact on individuals.

- The current round of the national health accounts will more accurately measure these trends. Lifting user fees at public facilities will not relieve all out of pocket spending as a large share is for drugs, consultations and treatments at private clinics. Social health insurance is absent in Zambia. However the share of external health spending nearly doubled between 2000 and 2007.

Progress

Zambia has made some strides in increasing progressive funding through replacement of user fees with public funding. This has improved the level of progressive funding and the share of out of pocket funding has fallen since 2000. The Ministry of Health is proposing to introduce social health insurance to increase pooled funding, as a further option for increased progressive health financing.

Harmonizing the various health financing schemes into one framework for universal coverage

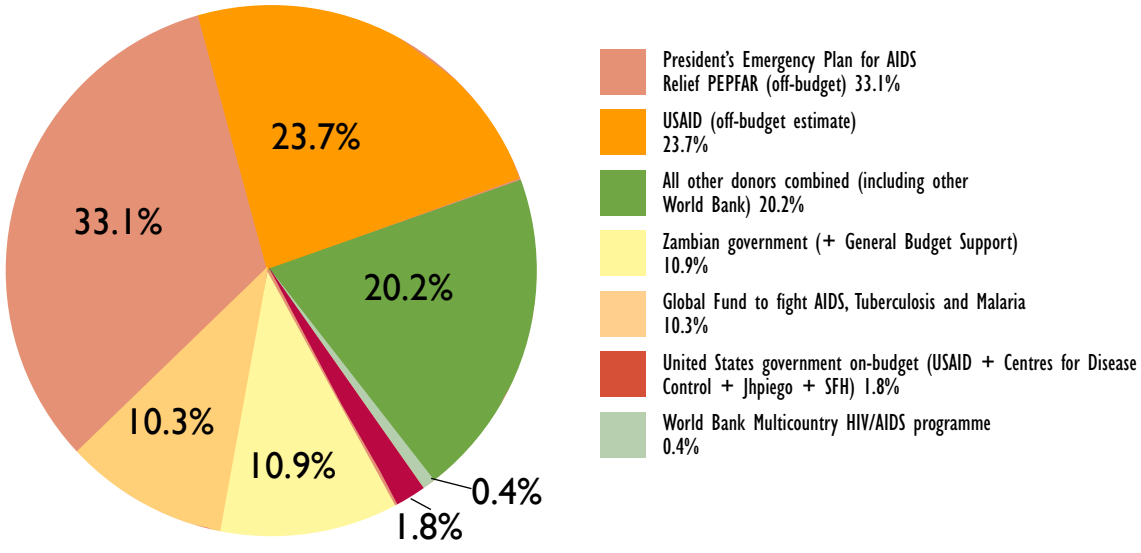
PAST LEVELS: 1980-2005

- Achieving a unified health financing framework has been a challenge. National accounting exercises and expenditure tracking surveys show health financing in Zambia as complex and fragmented (MoH, 2008), making it more difficult for policy makers to assess the resources available, direct them to where they are needed most and avoid duplication. The health sector is funded through basket funding, earmarked on-budget funding, general budget support, sector budget support and off-budget funding. The basket fund and sector budget support contribution are the only funds that can be appropriately classified as fully aligned and harmonized with government systems (MoH, 2008).
- In 1999, the Zambian government and its major health cooperating partners (external funders) agreed a framework for harmonizing health financing through the establishment of the health sector-wide approach (SWAp). Zambia was one of the pioneer countries of the SWAp and its basket funding. The SWAp approach brought external funders into a single pool fund, initially for district and primary health care funding according to the agreed health sector operational plan. However, despite the SWAp approach the flow of funds in the health sector in this period remained fragmented as major donors such as USAID did not disburse their funds through the basket.

CURRENT LEVEL: 2006-2010

- As noted in the prior progress marker, the share of external funding in total health funding rose markedly in Zambia after 2000. In the absence of any progress on new resource pools, such as through social health insurance, this external funding has implications for harmonizing health funding, particularly if these resources flow parallel to government funding. Much of the external funding to health in Zambia is targeted at specific diseases, with major funders, such as the Global Fund, USAID, targeting malaria, HIV and AIDS, tuberculosis and other diseases. The National Health Account reports for 2003 and 2005 showed that a large share of external funds were channelled through non-government agencies and other international agencies, rather than through the state, with 63 per cent of external funds in 2003 channelled through the Ministry of Health (MoH, 2004; MoH, 2008). This figure dropped further to 43 per cent in 2005 and 29 per cent in 2006 (Cheelo *et al,*. 2008,2010; see Figure 19).

Figure 19: On and off budget funding for HIV and AIDS to the health sector, 2009



Source: Goldsborough and Cheelo, 2010

CURRENT LEVEL continued

- Government made efforts to harmonize health funding by extending the basket concept to include hospitals and, in 2006, to cover financing for health workers, to help mobilize resources for this area. By 2007, all areas of the health budget were covered in the health sector basket. However, as Table 8 shows, basket funding has not risen above 14 per cent of total external funding in the period up to 2010. One reason for this limited growth in the basket funding was because DFID, the largest bilateral donor to the basket at the time, restructured from direct health sector support to direct budget support through the Ministry of Finance in 2005. While, in principle, this supports harmonization, with external funds channelled through the national treasury allocated to the Ministry of Health, there was concern that the Ministry of Health may receive less funding overall.
- As a further measure taken to strengthen harmonization, in 2007, Zambia joined the global campaign on Health Millennium Development Goals. It also signed 'A Global Compact' for achieving the goals under the International Health Partnership, an initiative that aims to strengthen health systems towards the attainment of the Millennium Development Goals based on the principles of the Paris Declaration of ownership, alignment, harmonization, managing results and mutual accountability (High level Forum on AID Effectiveness, 2005). However, in early 2009, after officials at the Ministry of Health were accused of embezzling 32 billion kwacha (equivalent of US$7 million) of pooled donor funds from the basket, all external funders suspended their support to the health sector and diverted their funds through channels outside the Ministry of Health. This development undermined the efforts made in prior years to overcome fragmentation in the financing architecture in the health sector.

Table 8: Total external funds to health by mechanism (kwacha billions), 2005–2010

Funds to the health sector	2005	2006	2007	2008	2009	2010
SWAp	28.20	43.94	51.18	43.72	35.00	35.00
Projects and loans	70.55	229.60	292.60	275.21	252.04	214.11
Total external funding	98.75	273.54	343.78	318.93	287.04	249.11
Basket funding as % of total	29%	16%	15%	14%	12%	14%

Source: MoH, 2010

Progress

Despite efforts made in the last decade, the health financing landscape in Zambia continues to present a picture of segregated government, external and private funding, with policy makers not yet capturing information on or harmonizing the various funding sources into one framework. This weakens planning for and public information on the various sources and their spending on health. Efforts to coordinate external funders yielded positive results in the establishment and involvement of some funders in the health sector basket or the national treasury and the cooperation on the International Health Partnership. Many external resources are, however, still channelled through parallel mechanisms, with potential for duplication and inequities in allocation. Efforts were also badly affected by the corruption scandal in 2009. As noted earlier, the Ministry of Health has commenced work on the development of social health insurance to improve resource mobilization and strengthen financing within a framework of universal coverage, but this is still at early stages. The next section also discusses the progress on defining a universal benefit package, which would support the harmonization of health financing.

Establishing and ensuring a clear set of comprehensive health care entitlements for the population

PAST LEVELS: 1980-2005

- This progress marker explores how resources are guided to achieve an agreed set of benefits and interventions with high impact on health. In 1996, the Ministry of Health developed a basic health care package as an instrument for rationing and prioritising health services. The package responds to the scarcity of resources by identifying the health problems that make the greatest contribution to the burden of disability and lost years of life, and then identifying interventions that address these health problems in the most cost-effective manner for their health impact. The basic health care package outlines the package of interventions to be provided on this basis (MoH, 2004), both to guide the allocation of resources and to make clear to Zambians what health benefits government prioritises and would seek to provide free of charge.

CURRENT LEVEL: 2006-2010

- Progress in implementing the basic health care package has been slow. The 1996 package was revised in 2008, with new interventions such as ART, radiotherapy and other new technologies added (MoH, 2009). As shown earlier and from the costing estimates shown in Table 8 below, the national health accounts estimates show that total health spending in Zambia has exceeded the US$32–US$34 per capita costed as necessary to provide the comprehensive basic package for the Zambian population (Goldsborough and Cheelo, 2007). Although the basic package thus provides well defined interventions for all levels of care and costing studies have indicated its feasibility, it has not been approved by the Ministry of Health to date, and it has not been used to operationalize priority setting or resource allocation.

Table 9: Health care system costs to meet health related Millennium Development Goals, 2005

	Total cost 2005-2015 US$ million	Average annual cost US$ million	Per capita annual cost US$	% of Annual GDP:FNDP projection
CBOH (2004) and Kombe & Smith (2003) costing (b)+(h)	4,444.9	404	31.1	2.9
Mphuka (2005) costing	4,403.6	400.3	30.8	2.9
CBOH (2004) and National AIDS Council (2006) costing	5,369.1	488	37.5	3.5
Fifth National Development Plan core costs	4,578.8	416.2	32.0	3.0

CBOH = Central Board of Health

Source: Goldsborough and Cheelo, 2007

Progress

While progress has been made in setting and costing health entitlements in Zambia in the basic health care package and although the national health strategic plan states a vision to provide equity of access to cost-effective quality health care as close to the family as possible, the entitlements are not yet guaranteed for all. The basic health care package is yet to be formally adopted and instruments for ensuring equitable access to its elements are yet to be fully implemented.

Allocating at least 50 per cent of government spending on health to district health systems (including level 1 hospitals) and 25 per cent of government spending on primary health care

PAST LEVELS: 1980-2005

- One of the goals of the health reforms of the early 1990s in the Zambian health care system was to direct more resources from secondary and tertiary hospitals towards the district level (MoH, 1996). The data show that Zambia has made progress in devoting health resources to the primary care level (Bossert *et al.*, 2003). The national health accounts reports show evidence of increased resources allocated to the district and primary care level between 2003 and 2005, with the total to the district and primary care level combined rising above 50 per cent in 2005 (see Table 10).

Table 10: Ministry of Health expenditure by level of care, 2003–2006, Zambian kwacha (ZK)

	2003		2005		2006	
	ZK million	%	ZK million	%	ZK million	%
Tertiary	88,197	14.3	98,506	10.9	97,665	10.8
Secondary (district)	45,320	7.3	95,408	10.5	71,578	7.9
Primary health care	261,531	42.4	438,278	48.4	397,235	43.8
Mission facilities	0	0	4,788	0.5	7,534	0.8
Central administration	159,087	25.8	106,072	11.7	152,696	16.8
Other *	62,883	10.2	167,355	18.5	187,323	20.7
Total	617,018	100	905,618	100	906,497	100

*Providers not specified by kind, for example, traditional healers, rehabilitation services

Source: MoH, 2009

CURRENT LEVEL: 2006-2010

- Between 2005 and 2006 there were some reversals to the improvements that had been made in allocations to the primary care and district levels in the 2003–2005 period. Allocations to both secondary and primary care level fell by 2.6–4.6 percentage points between 2005 and 2006, with an increase in allocation to central administration. Allocations to the primary care level are higher than the 25 per cent aimed for and to the district and primary care level combined they are over the 50 per cent target.

Progress

Zambia has made efforts to reallocate resources from better resourced urban areas and curative functions towards primary health care and less well served rural services, through shifting resources by function and geographical areas. There have been efforts to improve resource allocation based on deprivation within the allocations for primary health care by revising the criteria for resource allocation at these levels. A reversal on progress made in the 2003–2005 period was evident in the 2005–2006 period. This implies that this trend needs to be further tracked in the next national health accounts exercise to ensure that progress in this respect is sustained.

Implementing a mix of non–financial incentives for health workers

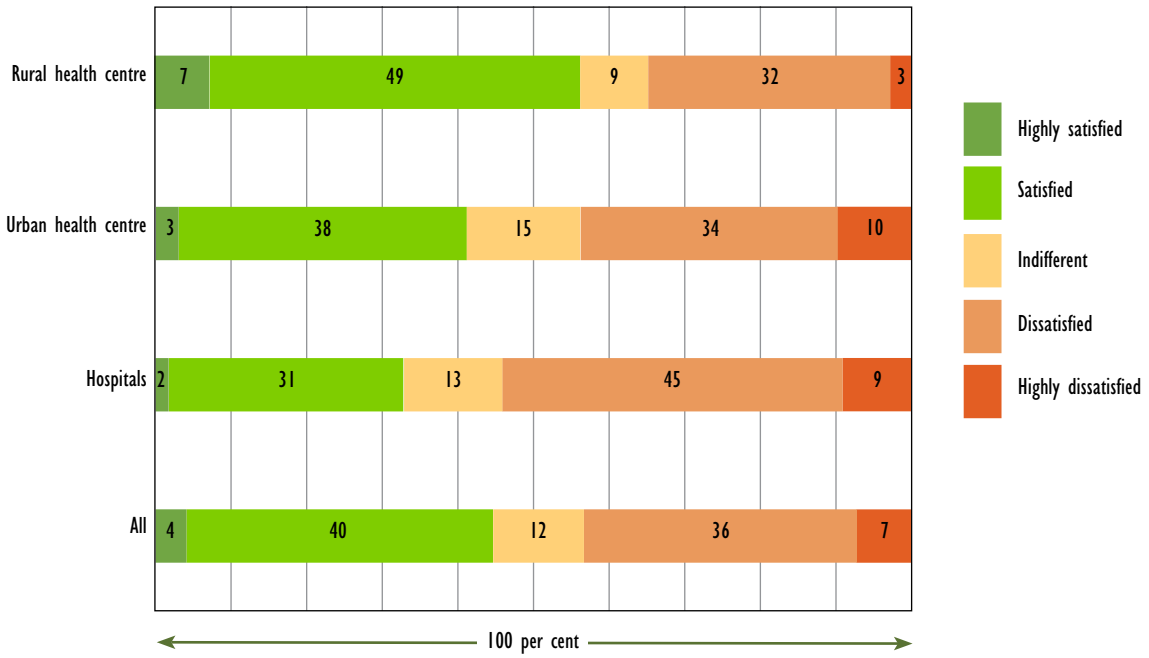
PAST LEVELS: 1980-2005

- Health worker retention generally depends on improved pay levels and improved conditions of service. Allowances help attract and retain health workers in remote or underserved areas but further non-financial incentives are needed to ensure that health workers access housing, training, education for their children and other needs. There is limited evidence of government efforts to apply incentives to retain health workers in the early part of this period. In contrast, economic decline between 1985 and 1992, falling real incomes and poor incentives were associated with strikes by medical doctors and other health professionals. A 1999 strike led to 200 medical doctors being fired. Striking doctors complained of poor working conditions and lack of equipment and working tools in the hospitals (Khabir, 2000). As noted earlier, this fuelled out-migration with, for example, 461 Zambian nurses migrating to the United Kingdom between 1998 and 2003 (Amin and Aaditya, 2007).
- In 2003, in partnership with the Dutch Development Cooperation, the Ministry of Health set up a pilot retention scheme, the Zambia Health Workers Retention Scheme, that aimed to place and retain local doctors in rural and remote districts. The scheme was initially targeted at encouraging medical doctors to move to remote rural facilities and 88 doctors (in a country with an estimated total of 600 medical doctors in 2003) were retained for the three year contract period and 65 per cent renewed for a second three year term (HSSP, 2006). A mid-term review of this scheme in 2005 assessed that it had retained 516 health workers in 41 districts of the country (MoH, 2005b).

CURRENT LEVEL: 2006-2010

- Zambia's policy commitment to address the health worker crisis is expressed in its Fifth National Development Plan 2006–2010, the 2006-2010 National Health Strategic Plan and the 2006–2010 Human Resources for Health Strategic Plan (MoH, 2005a; MoH, 2005b). The five year Human Resources for Health Strategic Plan has been costed and seeks to ensure an adequate and equitable distribution of an appropriately skilled and motivated health workforce through effective planning, increased health workforce production, improved health workforce productivity and stronger management and governance structures (MoH, 2005b).

Figure 20: Percentage of health worker satisfaction by level of care, 2006



Source: Picazo and Kagulula, 2008

CURRENT LEVEL: 2006-2010 continued

- By 2006, there was evidence that health worker dissatisfaction was higher at hospital level and in urban health centres (see Figure 20 on page 51). Prior data in this report suggest that working conditions and resources were lower in rural services and at primary care level but also that investments were being made at these levels.
- In this period, the government of Zambia and several external funders have supported initiatives to provide non-financial incentives to cadres of health workers in Zambia (HSSP, 2006, MoH, 2006). For example, the United States Agency for International Development (USAID) funded a project to construct and renovate housing for staff in Luapula province, one of the Zambia's poorest rural provinces, and government granted import duty exemptions for medical doctors importing motor vehicles. An expanded health worker retention scheme in the Ministry of Health funded by a consortium of donors under the Sector Wide Approach (SWAp) provided for various incentives, including health staff training, housing and transportation services to medical personnel, as well as upgrading health facilities and facility equipment (HSSP, 2006). The Zambia Health Workers Retention Scheme was expanded to include tutors, lecturers, Zambia enrolled nurses (ZEN), Zambia enrolled midwives (ZEM), environmental health technologists and clinical officers. Table 11 shows the target figures and those attained in 2008, suggesting persistent gaps with respect to most cadres. Despite these interventions low staff morale remains a significant problem, with problems of absenteeism, and tardiness (Picazo and Kagulula, 2006).

Table 11: Targets and employment figures for the retention scheme, April 2008

Cadre	Targets for 2008	Employed April 2008
Doctors	150	84
Medical licentiate	150	12
Nurse and other health tutors	200	130
Clinical officers	400	10
Nurses and midwives	400	200
Environmental health technicians	250	80
Total	1,650	516

Source: MoH, 2011

Progress

Since 2005 Zambia has scored some success in retaining health cadres within the country and in attracting cadres to remote rural settings. Various schemes have been introduced with support from external partners, and extended after 2006 to a wide range of key health personnel. There is some evidence that these schemes have been effective. Shortfalls and inequalities in geographical distribution persist, however, and low staff morale remains a significant problem. Many facilities, particularly in rural areas, still lack the clean water, reliable source of electricity, vehicles, drugs and working equipment that health workers need to perform their jobs (World Bank, 2008). Beyond the specific incentives, continued efforts are needed to improve health services and retain health workers. Budget support for incentives and the integration of incentives within the SWAp facilitates linkages across health worker incentives and these wider investments.

Formal recognition of and support for mechanisms for direct public participation in all levels of health systems

PAST LEVELS: 1980-2005

- There was limited space for participation in the Zambian health system in the early 1980s. One element of the health sector reform in 1992 was to address this and autonomous hospital management boards were piloted at the university teaching hospital. Board representatives were drawn from the public as well as from bureaucrats, technocrats and policy makers (MoH, 1992). The 1992 health policy widened the design and implementation of reforms to facilitate community organization in health and to enable people to take an active role in health care planning and decision making (NHPS, 1992). The decentralization policy included in the revised National Health Services Act (1995) ushered in the district and hospital management boards and the neighbourhood health committees. A National Health Council was proposed at the national level which would have a key responsibility in the design of national health policies. Neighbourhood health committees were developed to enhance accountability and community participation in planning, budgeting and implementation of health activities. Capacity development programmes were initiated and guidelines developed to orient them in their expected roles.
- Survey evidence in 2006 suggested that most communities were involved in planning and budgeting for health activities on an annual basis but that there was little or no incorporation and implementation of these community plans by health centres. Communities were not well informed of the available resources or their disbursement and use at health centre and community levels, leading to tensions and misunderstandings between health workers and the local communities they served (Lusaka Health Board, Equity Gauge Zambia, 2006). Clear guidance, support, communication and information exchange were identified as essential but sometimes absent contributors to partnership (Macwan'gi and Ngwengwe, 2004).

CURRENT LEVEL: 2006-2010

- In 2006, the Ministry of Health abolished all autonomous structures in the sector that were charged with responsibilities for health care provision and support – the district health and health management boards and the Ventram Board of Health – with the exception of the neighbourhood health committees. This subsequently affected community representation at all levels. The 2006 Health Services (Repeal) Act moved to dissolve the district health boards, hospital management boards and the Central Board of Health. The role of the neighbourhood health committees were reconstituted into the neighbourhood advisory committees. Their roles were redefined as 'advisory'. There has been no evaluation on the changed roles and responsibilities of these institutional structures in the district governance system.

Progress

Progress was made in the early 2000s in formally recognizing and strengthening public participation in the health system, although there were implementation gaps. After the 2006 Health Services (Repeal) Act, these structures for participation were either removed or, in the case of the neighbourhood health committees, had their roles scaled back to advisory functions. The formal provisions for mechanisms for participation thus still need to be addressed. Beyond these mechanisms, experiences from the 2000s in Zambia suggest that 'representative' mechanisms need explicit additional investments to reach and capacitate marginalized groups.

EQUITY WATCH

A more just return from the global economy

Progress markers

- Reducing debt as a burden on health
- Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers
- Ensuring health goals in trade agreements, with no new health service commitments to GATTS and inclusion of TRIPS flexibilities in national laws
- Bilateral and multilateral agreements to fund health worker training and retention
- Health officials included in trade negotiations

EQUITY WATCH

A more just return from the global economy

Household access to the resources for health and the promotion of equitable health systems are both increasingly influenced by policies, institutions and resources at the global level. The final section examines selected parameters of the policy space and support for health equity at global level. These include the debt burden on health, the use of flexibilities in world trade agreements, the support from international institutions for health worker incentives, protecting women smallholders' food production in trade policies and including health officials and health protection in trade negotiations and agreements.

Reducing debt as a burden on health

PAST LEVELS: 1980-2005

- Before the Highly Indebted Poor Countries (HIPC) initiative for debt cancellation, Zambian debt exceeded US$7 billion, falling from US$7,08 billion in 2004 to US$4,53 billion in 2005. Once the initiative was applied in Zambia, the national debt was reduced by nearly 70 per cent to US1,57 billion. This HIPC concession assumed that the savings generated from repayments foregone would be redirected to the social sectors, including education, health, water, sanitation and agriculture. Reducing debt servicing has been a key issue to free resources for health. Prior to the 2006 debt cancellation, debt servicing alone accounted for in excess of US$400 million or up to 60 per cent of the national budget (MoFNP, 2006).

CURRENT LEVEL: 2006-2010

- When the major part of the external debt was cancelled in 2006, debt and debt servicing were reduced, as shown in Table 12. Resources which would have otherwise gone to debt serving could be prioritised for the social sectors (World Bank, 2010, MoFNP, 2006). However as shown in Table 12, there was not an automatic relationship between reduced debt servicing and increased health budgets.

Table 12 Debt servicing levels, 1980–2008

	1980	1985	1990	1995	2000	2005	2006	2007	2008
Debt service on external debt (US$'000 000)	409,9	136,4	200,7	2 612,6	185,4	281,5	158,9	121,1	169,8
Per capita Budget allocation to health (US$)	n/a	n/a	n/a	8.1	4.9	9.3	n/a	n/a	n/a

Sources: MOH 1999, 2004, 2008; World Bank, 2010

Progress

The country has experienced a significant decline in multilateral debt and debt servicing with the Highly Indebted Poor Countries initiative. There is limited evidence that this has benefited allocations to the health sector. There is also concern over generating new debt, as the 2010 national budget projects US$400 million in new debt for projects in the country.

Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL Level	Year
Government spending on agriculture as a % of total government expenditure	2	1995	5.7	2006
	4	2002	8.8	2007
			5.8	2008
			7.1	2009
			6.8	2010

Source: MoFNP,, 1996, 2003, 2007, 2008, 2009, 2010, 2011

PAST LEVELS: 1980-2005

- Agriculture has been the main source of livelihood for the majority of the population. Employment in agriculture grew between 1990 and 2000 (see Figure 19 on page 51), even though its share of contribution to the GDP fell relative to manufacturing (see Figure 20; World Bank, 2010). As for other African states, the manner in which the agricultural and rural economies develop is closely linked to the reduction of poverty, discussed in an earlier progress marker. As noted earlier, poverty differentials between rural and urban areas widened from 2.52 in 1996 to 5.10 a decade later in 2006 (see Table 4).

CURRENT LEVEL: 2006-2010

- After stalling mid-way through the 2000s, the agricultural sector has shown positive improvements in performance since 2006, leading to increased output in key crops such as maize, groundnuts and tobacco (MoFNP, 2002, 2004, 2010). There have also been policy changes leading to the split and creation of a separate Ministry of Livestock and Fisheries to reorganize the sector more effectively. The sector however continues to lack medium to long term financing sources (MoFNP, 2010). The summary table shows that the allocation to the agriculture sector has fluctuated below the 10 per cent committed by the SADC health ministers.

Progress

Allocations to the agriculture sector have shown an unpredictable trend and have been fluctuating over time. The highest allocation to agriculture appears to have been in 2007, at 8.8 per cent, and it has subsequently fallen. Yet in spite of this decline in allocations, the production of key crops such as cotton, maize and groundnuts has increased resulting in the country producing surpluses in the last few years. There is inadequate evidence of how the budget resources have benefited women, smallholder and food producing farmers, with consequent benefit to family food security, and this needs to be further assessed.

Ensuring health goals in trade agreements, with no new health service commitments to GATS and inclusion of TRIPS flexibilities in national laws

PAST LEVELS: 1980-2005

- Zambia, as a World Trade Organization member, is a signatory to various trade instruments including the Trade Related Aspects of Intellectual Property Rights (TRIPs) and the General Agreement on Trade in Services (GATS). As of 1995, Zambia had least developed country status at the World Trade Organization, giving it certain latitudes on trade law in relation to health and development issues. In the interest of public health, the TRIPS agreement includes a number of flexibilities. It allows transition periods for laws to become TRIPS-compliant. On compulsory licensing, it accepts that governments may allow someone else to produce the patented product or process without the consent of the patent owner. It allows parallel importation – importing products patented in one country from another country where the price is lower – as well as exceptions from patentability and limits on data protection. It also includes the Bolar Provision on early working which allows generic producers to conduct tests and obtain health authority approvals before a patent expires, thereby making cheaper generic drugs available more quickly at that time. Member states have the authority to use these flexibilities when this is necessary to protect public health and to promote access to medicines. Zambia amended its 1958 Patents Act in 1980 and 1987 and the amendments cover the TRIPS flexibilities. Section 37 of the Act permits the granting of compulsory licences on grounds of insufficient use or abuse of patent rights and section 42 permits the government to make use of an invention on grounds of a state of emergency. In 2004, the Zambian government issued a compulsory licence for the manufacture of antiretrovirals to a local producer (Munyuki and Machemedze, 2010).
- Under GATS, the Zambian government committed itself to liberalize business services, construction and related engineering services, health and related social services and tourism and travel related services. It is one of few countries in the region that have made commitments under GATS in health services. This makes the market in the health sector more attractive for foreign service suppliers by not placing any national treatment or market access limitations but may limit government's ability to regulate the market or to subsidize or give preference to national suppliers in the interests of heath equity. Current law provides for the regulated operation of licensed private hospitals and sets the minimum level of facilities they must provide (GoZambia, 1975, 1990, 1995) and the law's relationship with the GATS commitment made remained largely untested in the period due to low foreign private investment in the health sector.

CURRENT LEVEL: 2006-2010

- Zambia's laws continue to include TRIPS flexibilities and the country endorsed the public health related aspects of the TRIPS flexibilities at the World Trade Organization level in August 2009. There is no available evidence on the issues faced in implementing the TRIPS flexibilities and any conflicts between the GATS commitment made and the efforts to manage private investment in health in the interests of health equity.

Progress

While Zambia's laws include TRIPS flexibilities there is need to assess and address barriers to their implementation. The effect of Zambia's health services commitment in GATS still remains to be tested.

Bilateral and multilateral agreements to fund health worker training and retention

PAST LEVELS: 1980-2005

- There were no bilateral or multilateral agreements in this period for funding health worker training and retention schemes until the advent of the health reforms in 1992. Previously, government funding was used to train doctors, nurses, and laboratory and other clinical personnel. During the 1995–2002 period, the Zambia Central Board of Health, the DANIDA Health Sector and the Royal Netherlands Embassy agreed to fund training in nursing schools and for accounting staff. District health officials had the opportunity to undertake a specially designed management course lasting 10 months (key Informant interview, 2010).

CURRENT LEVEL: 2006-2010

- After the phasing out of the 1995–2002 programmes, various agreements were negotiated to support the funding of health worker incentives, payments and retention schemes with the Government of the Netherlands and the Global Fund to Fight HIV/Aids and Malaria. These have been limited to specific cadres such as medical doctors working in rural areas. There is a question of how far these policies are aligned with policies of the Ministry of Health. One problem is, for example, the extent to which the non-state sector applies incentives for its own workers rather than those in the public sector (MoH, 2005b).

Progress

The limited application of negotiated resources to incentives for specific cadres or to specific and sometimes non-state workers suggests that there is scope to further align policies and resources from international funding to the health worker policies of the Ministry of Health. The WHO Code on the International Recruitment of Health Workers raises the role of bilateral and multilateral agreements to manage health worker retention and training, opening up the possibility of greater use of such instruments for policy and resource alignment.

Health officials included in trade negotiations

PAST LEVELS: 1980-2005

- Health officials were not included in the teams for trade negotiations.

CURRENT LEVEL: 2006-2010

- Health officials have not been included in the teams for trade negotiations, although there may be some consultation across sectors on health related issues. However Zambia has appointed a health attaché for its embassy in Geneva to provide specific health input to diplomacy at United Nations level, giving it a stronger capacity in this regard.

Progress

Given the increasing overlap between trade and health issues it is important for health officials to be included in the teams for trade negotiations. Making a link between the health attaché at the embassy in Geneva and officials in the capital will strengthen coherence between national and global policy dialogue on trade matters.

PROGRESS MARKERS	STATUS AND TRENDS	PRIORITY AREAS FOR ACTION
EQUITY IN HEALTH		
Formal recognition of equity and health rights	There has been policy recognition of the right to health and to access health care for several decades and international treaties containing these rights. Continued gap in the inclusion of health rights in the constitution.	Within and beyond the national constitutional process further debate on how the right to health should be included in law and progressively realized.
Halve the number of people living on less than a dollar per day	Overall poverty declined between 1998 and 2006 although with high rural–urban differentials. After 2006, extreme poverty declined in both the rural and urban areas but the rural–urban differentials widened.	While GDP growth rates suggest that halving extreme poverty is possible, there is need to achieve this within all areas and communities, particularly among rural, marginalized groups.
Reduce the Gini-coefficient	Relatively high income inequality throughout the past three decades, higher in rural than in urban areas. There has been some limited improvement and some evidence of closing of the rural-urban gap as rural inequalities have fallen.	Increase attention towards reducing inequality, particularly given the need to ensure access to benefits of growth for wider poverty reduction.
Eliminate differentials in child, infant and maternal mortality and under-nutrition rates	After 2002, the under 5 mortality, infant and maternal mortality rates declined. Rural–urban differentials have closed markedly in under 5 mortality. Nutrition has improved. Rising differentials between rural and urban areas in 1996-2002 fell up to 2007, although stunting continues to show differentials by wealth and education.	Track and assess reasons for the different rates of improvement in different socio-economic groups in child mortality to sustain progress made in closing rural–urban differentials and address socio-economic differentials in mortality rates. Collect evidence on differentials in maternal moratlity.
Eliminate differentials in access to immunization, ANC, skilled deliveries	Improvement up to 2007 in immunization and ANC coverage and in closing rural–urban differences. Wealth differentials remain wide. Limited improvements in maternal health service coverage and area and wealth differentials.	Falling coverage in maternal health services and wide inequalities in access threaten gains in MMR for poorer groups and need to be addressed, given wider effects on economic and social inequalities and for maternal and child mortality.
Universal access to PMTCT, ART, condom uptake	Significant progress in PMTCT and ART coverage with support from external funders. Overall coverage of VCT and HIV testing improved, but urban–rural differentials in access have widened. Condom use has declined.	Address disparity in access in favour of wealthier groups. Uptake of prevention interventions still needs to be improved.
HOUSEHOLD ACCESS TO RESOURCES FOR HEALTH		
Close gender differential in education	Marked improvement with increased public investments and abolition of primary school fees. Gender parity is high but inequalities greater in the higher grades.	Ensure female children stay in school and make the transition to and complete high school.
Halve the proportion of people without safe drinking water and sanitation	There has been a deterioration in urban access to safe water and sanitation while rural access has improved, narrowing differentials.	Proposals to improve resources to this area need to be monitored to ensure improved population coverage.
Increase ratio of wages to GDP	Formal sector employment appears to have been falling, during periods of both increased and falling shares of agriculture and manufacturing in GDP.	Clarify links between growth in GDP and growth in employment, particularly in manufacturing and agriculture.
Provide adequate health workers and drugs at primary levels	Improved health worker availability, retention and drug availability, distribution and procurement in recent years, with measures taken to improve the recruitment, deployment and retention of personnel and more effective drug procurement and management.	There is still need to further address inequalities between rural and urban areas in personnel availability, the shortfall on midwives and the greater likelihood of stockouts at primary care level.
Abolish user fees	The removal of user fees and additional resources allocated to primary care levels in affected districts has improved uptake of services.	Broaden the depth and or widen the abolition of user fees wholly or partially for selected services across other districts..
Overcome barriers to use of services	There has been a policy effort to reduce barriers, raise awareness, promote equity and quality of service provision and to introduce a Community Health Workers' Strategy.	It will be important to continue to track the resource support for and the operational implementation of these policies, given the limited roll out of the policy on 'health posts' to date.

PROGRESS MARKERS	STATUS AND TRENDS	PRIORITY AREAS FOR ACTION
REDISTRIBUTIVE HEALTH SYSTEMS		
Achieving the Abuja commitment of 15% govt spending on health	Between 1998 and 2006 Zambia did not spend above 7 per cent of its total public budget on health. A marked increase to 9.7 and 9.8 per cent spending on health in 2008 and 2009.	A 6 per cent growth in the economy over the last seven years suggests that Zambia could sustain improvements in the share of public spending on health.
Achieving US$60 per capita health funding	Spending on health has increased to $56 per capita total, with larger increases in external funder and domestic private spending than in public spending.	Improve adequate, predictable levels of spending in the public sector, and improved equity in the distribution of aggregate spending.
Improve tax funding and reduce out of pocket funding for health	Some strides in increasing progressive funding by replacing user fees with public funding, reducing the share of out of pocket funding after 2000. Social Health Insurance being considered.	Design of the comprehensive financing modalities has to maintain a focus on the urban and rural poor and indigent.
Harmonize health financing into a framework for universal access	Limited progress in harmonising finance sources. Efforts made to coordinate external funders through SWAp and national treasury or the cooperation on the IHP+ but many external resources still outside this.	Restore confidence in public funding mechanisms and align external funds within a framework of universal coverage.
Establish and ensure clear health care entitlements	While progress has been made in setting and costing health entitlements in Zambia in the basic health care package, the package is yet to be formally adopted or fully implemented.	Formally adopt the basic health care package and develop and apply measures to ensure equitable access to its elements.
Allocate at least 50% of public finances to districts, 25% to primary health care	There have been efforts to improve resource allocation based on deprivation within the allocations for primary care and to allocate increased resources to rural areas and primary health care.	The reversal on progress in 2005-2006 implies further tracking needed in the next national health accounts exercise, to ensure that progress is sustained.
Implement non-financial incentives for health human resources	Shortfalls and inequalities in geographical distribution persist, however, and low staff morale remains a significant problem.	Continued efforts needed to improve health services and retain health workers. Incentive schemes need aligning within budget support and SWAp.
Formal recognition of and support for mechanisms for public participation	Progress was made in the early 2000s in formally recognizing and strengthening public participation in the health system, although with implementation gaps. Repeal of the law in 2006 removed or scaled back these mechanisms	The formal provisions for mechanisms for participation still thus need to be addressed. Representative mechanisms also need investments for their functioning and capacities.
A JUST RETURN FROM THE GLOBAL ECONOMY		
Reducing the debt burden	Multilateral debt and debt servicing addressed with the HIPC initiative. Unclear benefit in allocations to the health sector.	Avoid new debt for projects in the country and ensure debt relief benefits the health sector
Allocate resources to agriculture and women small holders	Allocations to the agriculture sector have shown an unpredictable trend and have been fluctuating over time. The highest allocation to agriculture appears to have been in 2007 at 8.8 per cent, and it has subsequently fallen.	Track how far budget resources and agricultural growth has benefited women, smallholder and food producing farmers, with consequent benefit to family food security.
Bilateral and multi lateral health worker agreements	Bilateral agreements and budget support negotiated for retention schemes.	There is scope to further align policies and resources from international funding to the health worker policies of the Ministry of Health.
Ensure health goals met in World Trade Organization agreements	While Zambia's laws include TRIPS flexibilities there is need to assess and address barriers to their implementation. The effect of Zambia's health services commitment in GATS still remains to be tested.	Assess and address barriers to implementation of TRIPS flexibilities. Ensure legal safeguards to regulate private health services in the interests of equity despite health services commitment in GATS.
Health workers included in trade agreements	Health officials have not been included in the teams for trade negotiations, although there may be some consultation across sectors on health related issues. However Zambia has appointed a health attaché for its embassy in Geneva.	Include health officials in relevant trade negotiations. Identify focal point in ministry for health diplomacy. Strengthen links between embassy in Geneva and officials in the capital.

KEY  Improving  Static, mixed or uncertain  Worsening NOTE: In two cases green or red colours are blended with yellow as the picture has a general direction of improving or worsening but with some mixed results.

Conclusions

In this report we monitor the progress made in addressing unfair and avoidable inequalities in health and in ensuring access to the resources for health, within the health sector and in relation to the social determinants of health, based on need. This has been done for indicators that are relevant to major health burdens, to policy commitments at global, regional and national level and to measures that have known positive impact on improving health equity.

Between 1980 and 2000, Zambia experienced significant decline in its socio-economic indicators, including in life expectancy, poverty, child, maternal and adult mortality, employment, water and sanitation and access to health care. After the harsh decline in health and health care from the period of structural adjustment reforms and the AIDS epidemic, we describe the post-2000 period as one of economic growth, political stability and falling HIV prevalence.

Progress is evident in the post-2000 period. At national level, there was a decline in poverty, child and maternal mortality, HIV prevalence and child stunting. School enrolment and completion improved, as did the coverage of antenatal care, immunization and antiretroviral therapy for adults and children. This was supported by increases in the share of government spending in total health expenditure, in the share of the budget to health, in the supply of health workers and medicines and in the removal of user fees at health facilities.

However, aggregate improvements do not tell the whole story. Inequality in wealth in Zambia remains high and is reflected in rural–urban, wealth, gender and regional differentials in health and in the social determinants of health. The report shows that these differences affect the opportunities for health in a number of ways:

- Rural areas and poor households have the highest levels of child mortality and stunting and although gaps have narrowed, they still persist;
- The same differentials exist in key social determinants, such as water and sanitation, and in primary health services like antenatal care, immunization, maternal health services, voluntary counselling and testing and HIV testing. This suggests that the health system has not yet managed to overcome wider social differentials in ensuring access, despite the positive measures taken.

Aggregate improvements cannot thus be assumed to be taking place for all and that health and health care resources may not reach everyone. Rural–urban gaps were recognized and responded to and have been closed for numerous health indicators. Gender gaps in education were similarly closed by specific measures to enhance girls' enrolment. Such areas indicate that progress is possible with specific measures to address inequalities, particularly if they are sustained over time. The evidence calls for similar recognition of the inequalities in health within areas that disadvantage the poorest and most marginalised households, so that additional measures can be designed and implemented to ensure that these households access the social determinants of health and heath care.

The health sector plays an important role in this. The steps underway to organize and distribute funds, heath workers and medicines towards primary and district level services are fundamental for achieving this role. This demands adequate public sector resources and we highlight the still faltering progress in meeting the Abuja commitment of 15 per cent government spending on health, the limited improvement in per capita domestic public sector funding and the increasing reliance on external funding in the heath sector. The report provides evidence that while external resources play a significant role, there is scope to better align the policies and resources from international funding with public sector policies aimed at enhancing equity. Formally adopting the costed basic health care package, identifying and taking steps to implement the options for progressive tax and pooled domestic funding, allocating resources in line with health needs of different population groups and ensuring capacities to use these resources are priorities in building a framework for universal coverage in Zambia. At the same time, some services need urgent attention, for example trained midwives need to be available in all communities and uptake of maternal health services needs to be enhanced in the poorest groups.

Government recognizes that improving availability is necessary but not sufficient to overcome inequalities. The abolition of user fee charges at health centres and district levels is an important step in addressing barriers to uptake. However, greater focus needs to be given to the role of community participation in health. The unclear situation on the right to health in the constitution and the legal vacuum created by the repeal of the Health Services Act of 1995 creates an uncertain framework for participation. Further assessment and policy dialogue with civil society representatives and communities is needed as well as legal provisions, mechanisms and capacities for public and social roles in health planning and implementation.

Neither economic growth nor aggregate poverty reduction necessarily lead to equitable improvements in health. Additional measures are required. The report shows that when such measures are taken, by closing rural–urban inequalities in primary health care, reducing cost barriers by removing user fees or stimulating female uptake of schooling, for example, they can overcome inherited and unfair opportunities for health. For the health and other sectors to motivate and secure resources for these measures, they need to organize the evidence to show both the problem of inequity and the impact of interventions. The Equity Watch is a first step and analyzing equity is linked to monitoring implementation of the National Health Strategic Plan and annual plans. More options for relevant disaggregations can be explored in routine surveys like the demographic and health survey and the national health accounts, and in planning and reviewing funding arrangements through the SWAp. A strong group convened from the Ministry of Health, line ministries, local government, civil society and other stakeholders in health could monitor and review progress and galvanize concerted action from across key sectors involved in health, housing, clean water and sanitation, food security and employment.

We hope that the report will be widely disseminated and used as a resource. The parameters are not exhaustive and a review meeting on the report suggested that future equity watch reports should analyze evidence on the distribution of other heath burdens, such as malaria, diarrhoea and respiratory diseases, and other determinants of health, within and beyond the health sector. The report uses available data but also notes limitations in data quality for equity analysis. The authors and government, academic and civil society stakeholders reviewing the report suggested that the equity watch should be carried out regularly for continued use and to build awareness and understanding of how to strengthen equity in health.

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Key informant interviews

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EQUITY WATCH

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. It is achieved through the distribution of societal resources for health, including but not only through the actions of the health sector. All countries in East and Southern Africa have policy commitments to health equity, as do the regional organizations, the Southern African Development Community and the East Central and Southern African Health Community. In February 2010, the ECSA Regional Health Ministers resolved to track and report on evidence on health equity and progress in addressing inequalities in health. EQUINET is working with countries and the regional organizations to implement the Equity Watch, to monitor progress on health equity, through gathering, organizing, analysing, reporting and discussing evidence on equity in health at national and regional level.

This report of the Zambia Equity Watch has been produced by the University of Zambia and Ministry of Health Zambia working with EQUINET through TARSC and with peer review input from HNC. The summary table below shows the progress markers that were assessed, the trends, with green for improving progress, red for worsening trends and yellow for uncertain or mixed trends. The report provides the evidence on these trends and proposes areas for action.

PROGRESS MARKER	TREND
EQUITY IN HEALTH	
Formal recognition of equity and health rights	
Halving the number of people living on US$1 per day	
Reducing the Gini coefficient of inequality	
Eliminating differentials in child, infant and maternal mortality and under nutrition	
Eliminating differentials in access to immunization, ante-natal care, skilled deliveries	
Universal access to prevention of vertical transmission, antiretroviral therapy and condoms	
HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH	
Closing gender differentials in access to education	
Halving the proportion of people with no safe drinking water and sanitation	
Increased ratio of wages to gross domestic product	
Provide adequate health workers and drugs at primary, district levels	
Abolish user fees	
Overcoming barriers to access and use of services	
REDISTRIBUTIVE HEALTH SYSTEMS	
Achieving the Abuja commitment	
Achieving US$60 per capita funding for health	
Improve tax funding and reduce out of pocket spending to health	
Harmonize health financing into a framework for universal coverage	
Establish and ensure clear health care entitlements	
Allocate at least 50% public funding to districts and 25% to primary health care	
Implement non-financial incentives for health workers	
Formal recognition of and support for mechanisms for public participation in health systems	
A JUST RETURN FROM THE GLOBAL ECONOMY	
Reducing the debt burden	
Allocate resources to agriculture and women smallholder farmers	
Ensure health goals in World Trade Organization (TRIPS, GATS) agreements	
Health worker training and retention	
Health officials included in trade negotiations	