

IV. Health

Introduction

The analysis which follows is structured over three main subsections. The first (A) provides an overview of health sector reform. A second subsection (B) considers evidence which suggests an increased denial of the right to health in Zambia. It encompasses an examination of expenditure and the use of maximum available resources; access of the poor to health care and the impact of user fees; prima facie denial of minimum standards of primary health care; and progress or regress in the control of communicable diseases. A final subsection (C) offers a limited review of the impact of AIDS in Zambia: the virus has particularly devastating consequences for the realisation of economic and social rights.

A. Reform of the health sector

Introduction: the National Policy on Health

Three system-wide biases characterised health service delivery in Zambia during the 1970s and 1980s.¹ First, there was a problem of over-sophistication. Too much money was spent on curative health - that is, doctors treating illnesses that had already occurred in high-cost clinics and hospitals - rather than on primary health care measures to help prevent many diseases and conditions from developing in the first place. Second, there was over-verticalisation and health interventions were organised in an inflexible way around donor-driven projects to fight specific diseases rather than to meet the health needs of the majority. Third, there was over-centralisation of decision-making and budgetary power in Lusaka, resulting in the isolation of the Ministry of Health from the network of health facilities around the country. Rural health provision was neglected in comparison to urban areas.² At the beginning of the 1990s, the resources which were being devoted to health care had declined significantly. At the same time, a collapse in institutional capacity and inefficiency was resulting in a lower standard of service than was to be expected for the given level of spending.³ The 1993 *World Development Report* showed Zambia to be in a group of countries whose life expectancy was five years lower than might have been expected for given levels of income and education.

The starting point for reform of the health sector was the completion in 1991 of the Government's National Health Policies and Strategies. The main objective of this policy document was 'to provide Zambians with equity of access to cost-effective, quality health care as close to the family as possible.'⁴ The intention was to raise the budget allocation to the health sector; to reassign resources internally to priority areas, to include primary health care; and to overcome institutional weaknesses and capacity constraints. In order to implement the National Health Policy, the Government produced a detailed National Strategic Health Plan (NSHP) in December 1993 to act as a blueprint for reform in the period 1995 - 1999.⁵ The most important reforms outlined were, first, the decentralisation of health care through District Health Boards with increasing devolution of responsibility for the planning, budgeting and management of local services. Second, the NSHP specified the improved coordination of donor and Government resources under a Health Sector Investment Program. Third, an essential packages of health care services was defined and costed. The fourth main area of reform concerned the opening up of the health sector to allow the participation of private providers. Finally, the intention to introduce user fees to share the costs of provision was given substance. The first three reforms are given further, immediate consideration. The issue of charges, which is highly pertinent to any discussion of the realisation of the right to health for those living in poverty, is discussed in due course.

a. Decentralisation

The way in which health care is organised in Zambia has been fundamentally altered and devolution of responsibility for the planning, budgeting and management of the delivery of health care has been achieved.⁶ District Health Boards were set up between 1994 and July 1996 and sixty-four were operational by the end of that year.⁷ A Central Board of Health (CBH) was established in November 1996.⁸

The CBH has taken over the operational functions of the Ministry of Health which now concentrates on policy formulation and the mobilisation of resources. The main task of the CBH is to contract districts and hospitals to deliver

health care. It reviews, approves, monitors and evaluates health plans which are developed at the local level by the District Health Boards and Hospital Management Boards.⁹

Unusually for Africa, Zambia has followed a model of reform which will eventually result in a split between the hospitals and clinics which provide health care and the purchasers of such services, that is the District Health Boards.¹⁰ Guided by the CBH, each DHB gradually takes over the management of all district resources; it makes decisions on the purchase of services from other health care providers in the district; and it purchases support services such as drugs, supplies and training from the centre. This autonomy to plan and use resources is contingent on the production of district plans and the required level of management and accounting capability.¹¹ District Health Management Teams implement programmes at the local level, under the ultimate control of the District Health Boards.¹²

The DHBs ought to have a better local knowledge when it comes to identifying needs and matching resource use accordingly.¹³ However, studies have shown considerable variation from region to region in the degree to which stakeholders are represented on the boards.¹⁴ On occasion, appointments from the centre have eroded local control and exposed the Boards to excessive political influence.¹⁵

A central tenet of reform has been to decentralise control of the budget.¹⁶ An increasing proportion of the health budget is allocated directly from the Ministry of Finance to each district or hospital board on the basis of each locally devised plan, as approved by the Ministry of Health.¹⁷ District allocations rose from 41.9 per cent in 1994 to 48.5 per cent in 1996.¹⁸ The increasing emphasis on the use of block grants allows the DHBs to maximise their autonomy in deciding how resources are spent. Decentralisation of budgeting to the district level ought to redistribute resources from urban areas to rural areas and simultaneously transfer funds from tertiary to primary care.¹⁹ This is because tertiary hospitals - including the major University Teaching Hospital in Lusaka - are located in a handful of Zambian cities whereas first referral hospitals, health clinics and health posts are more evenly distributed across the districts.²⁰

All districts have received direct funding to meet the recurrent costs of providing health services since late 1993, in advance of formal restructuring. It was not until September 1995 that the National Health Services Act was enacted to provide a legal framework for the establishment of the Central Board of Health, District Health Boards (DHBs) and Hospital Management Boards. The delay in passing the Act has created problems in this regard. In advance of legal recognition of the District Health Boards under the Act, the District Health Management Teams were not only formed first in 1993, but have also signed contracts for the receipt of decentralised funding in the interim. This has given them de facto control over district expenditure and leaves the relationship between the two bodies unclear.²¹

b. The integration of donor resources under the National Strategic Health Plan

The National Strategic Health Plan acts as the basis for coordinating donor action on health and ensuring that it integrates with Government policy. In the past, donors have tended to pump money into individual, piecemeal projects. The NSHP is updated annually by the Government in consultation with all partners, including the donors. The ultimate objective is to fully integrate donor and domestic resources into a single programme budget under the Ministry of Health out of which all recurrent and capital costs for the health sector are met.²² This would mark the end of individual donor health projects. Instead, all pooled funds would be used to deliver mutually agreed district health plans to provide the identified package of essential health services to all Zambians.

This vision remains to be achieved and current arrangements represent a halfway house. On the one hand, both bilateral and multilateral donors continue to fund specific projects and initiatives through distinct budget lines and thereby maintain control over their implementation. However, projects are now developed within the context of the NSHP.²³ On the other hand, certain donors are pooling resources in a common basket operated by the Ministry of Health out of which the District Health Boards and District Health Management Teams are funded.²⁴ Initial contributions have been low because of a lack of confidence in the degree of financial control and accountability within government.²⁵

The Bank approved its Health Sector Support Project in 1994 to dovetail with the NSHP. The total cost of the latter was estimated to total US\$537 million over the duration of the program.²⁶ The Bank's share of funding amounts to \$56 million, about ten per cent of the total, spread over six years from 1995 to 2000.²⁷ The Bank acts as a lender of last resort to finance elements of reform not covered by the Government or other donors.²⁸ Most Bank finance has been used for investment program support, that is to rehabilitate basic infrastructure and to provide drugs and other medical supplies.²⁹

Other multilateral donors - the European Community, UNICEF, WHO and UNFPA - have committed or earmarked a further \$34 million over a similar period while bilateral donors have either pledged or provided in the region of \$150 million between 1994 and 1999. According to the original estimates, the Government itself was to have provided

finance equivalent to US\$340 from its annual budget, representing around sixty per cent of the total program cost.³⁰ The MMD's record on health spending is examined in greater detail below. In 1997, total donor support for the health program was worth \$50 million which was matched by a similar level of Government expenditure.

c. The essential health care package

At the heart of health reform is the need to make the most effective use of limited resources by defining cost-effective, essential health care which is to be made available to all Zambians. Services falling outside of these parameters will not be publicly funded.³¹ Defining a package of health care not only requires detailing what inputs of trained staff, drugs, equipment and infrastructure are necessary for its delivery, but also demands that constraints imposed by resources and affordability are recognised.³² The Zambian Government has therefore assumed responsibility for financing the services that are public goods, such as chlorination of drinking water or health education, or those with positive externalities. The national package focuses on 'information, education and communication' on matters such as family planning, nutrition, AIDS, and hygiene; and upon support for some environmental health measures, for example, vector control, water supply, sanitation.³³ This national definition will provide a standard by which to develop and measure the proposed activities in the district health plans.

The package of essential health care services was finally identified and costed by Government in 1996.³⁴ The strengthening of primary health care is considered to be of key importance. A Basic Health Programme has been developed to be administered through the District Health Boards. A major component of this is the planning, implementation, management and monitoring of a Primary Health Care package. The aim is to tackle health problems at the household and community levels by focusing on the needs of vulnerable groups, such as those living in rural or peri-urban areas. An emphasis is placed upon preventive measures focusing on maternal and child care, family planning, nutrition, the control of communicable diseases, including the prevention of AIDS, the use of clean water, good hygiene, and sanitation.³⁵

The health centre is the key link for the delivery of primary health care services to the household.³⁶ It is to offer a package of services to include immunizations for young children, health education, and other outreach activities to support community health. Pre- and postnatal care for mothers and children, family planning, and nutritional rehabilitation are to be delivered through health centres which are also to play a role in the treatment of chronic illnesses, such as tuberculosis, respiratory infections, sexually transmitted diseases and AIDS.³⁷ There is an onus on the integration of services.³⁸

B. Evidence of the increased denial of the right to health

Introduction

'The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' [Article 12 (1)]

Reform of the health sector exhibits many elements that appear to be compatible with progressive realisation of the right to health: a recognition of the need for increased financing of the sector; an emphasis on primary care of benefit to the majority of poor people and vulnerable groups such as mothers and children; and an attempt to improve the level of coordination between international donors to advance their cooperation with the Government over health provision. While the caveat remains that the Committee does not favour one administrative or political system over another for the implementation of rights, decentralisation of budgetary control and decision-making, by allowing for improved local level participation, ought to result in better-targeted health care.

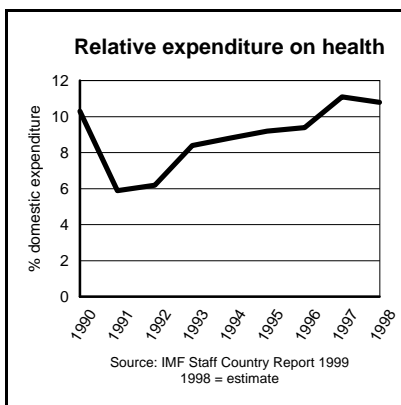
However, while many of the policies designed to bring about reform of the health sector have been broadly welcomed, the delivery of health care in Zambia has yet to improve significantly.³⁹ Now that the bulk of administrative reforms have been completed, the expectation is that there should be tangible improvements in health care. The World Bank warned at the outset that there was 'a risk that implementation of the Strategic Plan will be stalled on process issues, with little positive impact on the health care services nor for the targeted beneficiaries.'⁴⁰ Some donors are pressing for the use of indicators to monitor this impact, arguing that otherwise the reforms appear as an end in themselves.⁴¹

The reality of poor and declining health in Zambia is shocking. To cite one indicator, life expectancy in Zambia was 43 years in 1969, then 51 years in 1980, but has since fallen back to 45 years and 6 months in 1995.⁴² In comparison, average life expectancy in sub-Saharan Africa in 1995 was over 51 years.⁴³ It is estimated that the average life expectancy for a Zambian in 1998 had fallen to just 40 years and six months.⁴⁴

Juxtaposed to reform of the health sector are a number of other indicators which record a stark decline in the realisation of the right to health in Zambia. The focus here will be on the Zambian Government's obligation to use maximum available resources and on its core, minimum obligation to satisfy essential levels of the right to health through primary care. The issue of overall access to health care in Zambia will include a consideration of whether user fees have discouraged the poor from visiting clinics and hospitals. A final subsection reviews the increased incidence of disease, a situation exacerbated by the continuing failure to implement a national policy on drug supply.

1. Expenditure on health and the use of maximum available resources

The Covenant requires the use of maximum available resources in delivering progressive realisation of the rights it recognises. The MMD Government stated its intention to increase budgetary allocations to the health sector in its initial National Health Policies and Strategies document. It has only been partially successful in this.



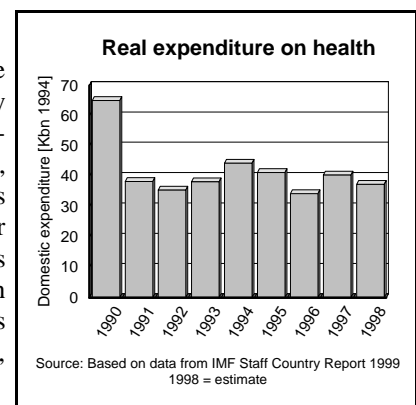
In 1996, Zambian households spent an estimated K65 to 70 billion (circa. \$56.25 million) on health care services. Public expenditure on health in 1996 was K67 billion (\$55.8 million). Hence a total of about K135 billion (\$112 million) was spent on health, shared equally between the Government and private households.

Two points of note arise from this level and distribution of expenditure. First, in a country where extreme poverty affects half of the population, private households are expected to meet half the total cost of health provision. Second, consultancy studies have concluded that 'the epidemiological profile or the performance on health indicators does not seem to correlate with such expenditures.'⁴⁵

To assess whether the Government is fulfilling its obligation to use maximum available resources in achieving the right to health requires a consideration of its funding of the health sector in both relative and real terms. During the last year of the prior UNIP administration, just over ten per cent of domestic expenditure was

allocated to the health sector. In contrast, the first three years of the MMD's term in office saw relative spending on health fall to between 5.9 per cent and 8.4 per cent. In 1995 and 1996, relative expenditure exceeded 9 per cent of domestic spending and peaked at 11 per cent in 1997 before falling again in 1998.

Once more, it is only when considering expenditure in real terms that the true magnitude of the decline in health sector funding is apparent. Real spending fell by forty per cent from 1990 to 1991. It has not recovered since. The period 1994 - 1996 was characterised by a year on year decrease in real expenditure. By 1996, and adjusting to constant prices, the MMD Government was spending K30bn less on health than the K64 bn that was spent in 1990. To place this decline in its proper context, by 1990, real per capita expenditure on health had already declined to less than half the levels of the early 1980s.⁴⁶ Falling real term expenditures on health places a question mark over the sustainability of reform.⁴⁷ Expenditure in real terms in 1997 recovered slightly to be on a par with the level spent in 1996. However, estimates for 1998 suggest a reversal.



Given increases in the size of the Zambian population over the last decade, real expenditure on a per capita basis has been decimated to an even greater extent. The World Health Organisation noted in its 1999 World Health Report that Zambia allocated over 3 per cent of GDP to health, yet total per capita spending, taking into consideration external assistance and domestic expenditure, was only about half the \$12 suggested by the World Bank as necessary to fund the cost of a basic package of preventive and curative interventions. The WHO went on to conclude '[t]he reality is that allocating an inadequate share of resources to health, from both public and private sources, perpetuates the cycle of poverty.'⁴⁸

While reform of the way in which funds are allocated and controlled within the health sector has circumvented certain problems associated with the previous centralised system, other difficulties have arisen, often as a result of contradictory imperatives which are part of the wider agenda of reform. The implementation of cash budgeting in 1992, as part of the package of stabilisation measures insisted upon by the Bank/IMF, has had a detrimental effect on the actual delivery of

funds. The Treasury must have the financial resources available to release to each line ministry. There is an inevitable competition between ministries over the allocation of existing cash. In 1994 and 1995, for example, the Ministry of Health received 88 per cent and 66 per cent of funds approved under the budget.⁴⁹

Citing the requirement of strict cash budgeting as justification for the failure to deliver funds to the health sector causes some disquiet.⁵⁰ Notwithstanding the fact that certain ministries have seen an even greater shortfall between budgeted and realised funds, other powerful ministries receive finance *in excess* of the amount budgeted.⁵¹ For example, under the 1998 budget the approved estimate for the Ministry of Defence was K61.4 bn yet its authorised expenditure over the year was K94.9 bn.⁵² Moreover, it is apparent why Bank conditionality on the protection of overall health sector allocations is presented in relative rather than absolute terms: there is an appearance of social protection while actual spending is allowed to decline in line with the dictates of stabilisation.

In an article which is stark in its condemnation of World Bank/IMF structural adjustment and austerity measures and their devastating consequences for people's health in Zambia, a reporter describes his visit to the University Teaching Hospital.⁵³ The human cost is shocking. This is the reality of the violation of the right to health.

I went to UTH. It is Lusaka's biggest hospital, where those who can't afford private healthcare end up. In a packed ward near the main entrance a man writhed in bed. "I'm dying," he moaned, while his wife stood helplessly by his side. Emaciated figures shivered under sparse bedclothes. Families crowded around beds, many of them on the floor, bringing food to the sick to supplement the meagre hospital rations of beans and maize meal. In another ward a preacher harangued a dying woman, whose family stood round with heads bowed. As he waved his bible, she struggled to move her lips to acknowledge him.

Enter the children's ward and the smell hits you like a wall. A musty, medicinal odour - the smell of sickness, and of death. Rows of children lie on small beds, slowly passing away from preventable diseases like TB, malaria and pneumonia. On the other side of the building is a cleaner, neater ward, where half the beds stand empty. This is the fee-paying section, where families who can pay a 100,000 Kwacha (\$40) deposit can buy a slightly better chance of life. In World Bank language, this is 'user-responsive healthcare'.

In its supervision of the Covenant, the Committee seeks information on the role of international assistance in the full realisation of the right to health enshrined in article 12.⁵⁴ The austerity measures and economic adjustment insisted upon by the World Bank and IMF must be considered ill-advised under article 22 of the Covenant in the absence of an equally compelling and adequately resourced programme of social protection in the health sector.

2. Access to health care and the impact of user fees

'The steps to be taken by the State parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.' [Article 12(2)(d)]

This question of access to health care is of paramount importance to the Committee in its supervision of the Covenant, as demonstrated by the information sought in its guidelines for State reports and by other official statements it has issued.⁵⁵ It is possible to differentiate at least three aspects to the issue of access which are relevant in determining realisation of the right to health: access to facilities;⁵⁶ access to a certain standard of care - trained staff, common treatments, essential drugs;⁵⁷ and affordability.⁵⁸ In line with the principles of progressive realisation and non-discrimination, the Zambian Government is required to justify regression and any failures to protect or promote the right to health of vulnerable and disadvantaged groups.

a. Access to facilities

One definition of lack of medical access is a situation in which a person has to travel 16 km or more to the nearest health facility.⁵⁹ Data for 1996 records that the vast majority of people in cities and towns live within 5 km of the nearest health centre or clinic and that 98 per cent of them live within 15 km of such a facility. In rural areas, while almost 20 per cent of people live further than 15 km away from a clinic or health centre, the majority have reasonable access.

Distance to the nearest health facility is the most significant variable in determining access to the health service in Zambia. Analysis of national data shows that 53 per cent of sick persons living within 1 km of a health centre made use of the formal health service in Zambia. The corresponding figures for those living 5 - 9 km away and beyond 10 km from such a facility are 36 per cent and 29 per cent respectively.⁶⁰ The greater the distance from a health facility, the higher the transport costs and hence the lower the relative importance of user fees or exemptions in the decision to use the service. However, those living further from a health facility are much less likely to use it in the first place. This applies particularly in rural areas where transport links are poor.

In terms of patient outreach, access is problematic. As a direct result of low levels of expenditure, physical resources such as vehicles, equipment, materials for maintenance, even stationary, are lacking. In 1994, Bank staff drew attention to logistical problems posed by an ageing transport fleet and the inability of the Ministry of Health to address fundamental issues of regular vehicle maintenance and accountability for use.⁶¹ The daily work of Community Health Workers and the distribution of drugs is severely hampered by transport problems.⁶² Ambulance services are collapsing. Recent reports confirm that Kitwe Central Hospital does not have a working ambulance. Vehicles are standing idle in a state of disrepair because of a shortage of funds to maintain them.⁶³ The Health Sector Support Program, supported by the Bank and others, was supposed to deliver measures to address these deficiencies.⁶⁴ The problem is fundamental: Kitwe hospital received only 50 per cent of its allotted funding in 1998/9.

While the Zambian population appears to be relatively well served in terms of the number of health facilities, such indicators only have meaning if the infrastructure delivers a good standard of care to all Zambians.⁶⁵ Sample surveys for 1993 reveal that 11 per cent of all Zambians, including 9 per cent of those living in urban areas, visited a Government health institution in 1993.⁶⁶ By 1996, only 8 per cent of the population visited a Government health institution, with little difference between the proportion attending facilities in rural or urban areas.⁶⁷ This fall in attendance, despite persistently high levels of morbidity, most likely reflects the reality of a significant decline in the standard of service, for example, measured by medical staffing levels; an inadequate supply of essential drugs; and a denial of real access to care because of the introduction of user fees.

b. Access to a common standard of care from trained staff

The Committee, in its supervision of the right to health, demonstrates a concern with the quality of care on offer. Two indicators used are access to qualified staff and the regular supply of essential drugs.⁶⁸

i. Trained staff

In the first half of the 1980s, there were approximately 7,300 people to every doctor and a ratio of about 760 people per nurse.⁶⁹ In 1992, the number of people per doctor had risen dramatically to 11,905.⁷⁰ By 1995, in the midst of the health reforms, the ratio had worsened yet again to 14,286:1. Recent figures record a staggering decline of 33 per cent in the number of nurses from 10,378 in 1994 to 6,394 by the end of 1995.⁷¹ Furthermore, the World Bank's 1994 Poverty Assessment suggests that 80 per cent of doctors are concentrated in four provinces along the line of rail while, in contrast, many rural health centres do not have a single health worker.⁷² There is discrimination in the level of expertise on offer according to ability to pay: only 15 per cent of the extremely poor saw a doctor during their visit to a health facility as opposed to 36 per cent of the non-poor population.⁷³

ii. Essential drugs

The continued absence of a workable policy on the supply of essential drugs is a failure of obligation by omission. In 1994, the Bank concluded that while donor support helped to assure a reasonable supply of drugs to rural health centres and central urban hospitals, the supply to peri-urban areas and district hospitals was inadequately funded.⁷⁴ Yet estimates published in the 1994 Poverty Assessment suggest that, even in the case of rural health centres, 40 - 45 per cent of them did not have regular access to drugs as a result of transport problems.⁷⁵ The Bank noted the anachronism of a centralized supply-driven drug distribution system in the context of decentralisation of health care to the districts.⁷⁶ Problems included the irregular delivery of drugs, especially in the rainy season due to poor transport links, and the chronic shortage of imported drugs and their inappropriate or inefficient use.⁷⁷ The Bank outlined its intention to support a new national drug policy which would be reformulated by the first quarter of 1995, in keeping with the decentralised health care system and in accordance with the Strategic Plan.⁷⁸

Regrettably, and despite the promised action, the problem of inadequate drug supply persists. The Bank noted in 1996 that 'the present inefficiencies in the procurement, distribution and use of drugs in Zambia must be addressed quickly if the broader health sector reforms are to succeed.'⁷⁹ Likewise, a study of health reform in Zambia on behalf of UNICEF

in 1996 stated '[t]he National Drug Policy should be implemented expeditiously, as drug availability is critical to the public credibility of the reforms.'⁸⁰

As a condition of second tranche release of ESAC II, the Bank required the adoption of a comprehensive national drug policy.⁸¹ This was drawn up in 1996. The Government recognised procurement as the policy's most critical component and pledged to address the issue as a matter of urgency.⁸² However, implementation of the National Drug Policy has been less than fully effective.

Official figures to the third quarter of 1997 record that, at the primary level, no Community Health Worker Kits, each of which contains essential drugs, were distributed in seven out of the eight months assessed, despite an average monthly requirement of almost 4000 kits.⁸³ The supply of drugs and their distribution to urban and rural health centres is described as satisfactory and on target. Likewise, the distribution of drugs to hospitals appears effective. However, the figures must be treated with some caution. Firstly, it is conceded that the positive indicators cited do not apply to antibiotics, antiseptics and surgical items.⁸⁴ Secondly, the supply of emergency drugs 'was being made on demand and according to budgetary allocation per month for each institution.'⁸⁵ Finally, improved efficiency in distribution is irrelevant if sufficient quantities of the right drugs are not procured in the first place.

c. User fees as a barrier to access

i. Poverty, exclusion and discrimination in the right to health

The exclusion of people from access to health care on the grounds of their poverty and inability to pay must constitute discrimination. Article 2(2) of the Covenant specifically precludes discrimination on the grounds of social origin, property or other status.

Information is sought by the Committee on access by the vulnerable and disadvantaged to medical care.⁸⁶ Such groups include those living in poverty, for whom access is linked to the affordability of health care on offer. It is assumed that the Committee's endeavour to discover the impact of rising costs on the right to health realised by the elderly applies equally to other vulnerable groups.⁸⁷ The position of the Committee is unequivocal:

'If not supplemented by necessary safeguards, the introduction of user fees, or cost recovery policies, when applied to basic health and educational services for the poor can easily result in significantly reduced access to services which are essential for the enjoyment of the rights recognized in the Covenant.'⁸⁸

Of the sick population in Zambia in 1996, 34 per cent treated themselves and 42 per cent went to a health facility.⁸⁹ The remaining 23 per cent went without any treatment. When sick people seek medical care rather than treat themselves, three quarters do choose to use a government clinic, health centre or hospital as opposed to private or mission institutions.⁹⁰

Among the extremely poor, six out of ten persons, despite being sick, did not go for a consultation at a health facility.⁹¹ Instead, three out of ten treated themselves with self-administered medicine while a similar number went without treatment of any kind. On average in 1996, a Zambian household spent K3,300 (\$3.00) per month on health-related goods and services.⁹² The amount spent on health varies widely according to income. The poorest households in the lowest two income quintiles spent between K1,500 and K1,600 (circa. \$1.40) per month on health. The average budget for households in the highest income quintile was four times higher at K6,400 (\$5.82). In a recent survey in Lusaka, almost half of those who considered themselves ill did not seek health care because of lack of money.⁹³

The adverse consequences of poverty on the realisation of the right to health are all too readily apparent. Indicators used by the World Health Organisation to show equity of access to health care reveal that, on average, a poor person in Zambia is three times more likely to die between the ages of fifteen and fifty-nine than a non-poor person and over three and half times more likely to die between birth and five years of age.⁹⁴ The prevalence of tuberculosis was almost four times higher among the poor.

ii. The imposition of user fees

This is the context in which user fees in Zambia are currently implemented. Although certain, somewhat unsystematic, charges for health care in Zambia had been made in the past, a 1993 directive from the Ministry of Health authorised the universal introduction of medical fees in all districts.⁹⁵ This was done under the rubric of ‘cost-sharing’ as part of the National Health Policy, ostensibly to encourage appropriate use of health services and to generate local resources to finance improvements in the quality of care.

The fees were described as ‘symbolic’. The stated intention was to encourage individual responsibility, to promote ‘community ownership’ of health care, and to discourage frivolous use rather than to recoup recurrent costs. Over time, user fees are set to become a more important part of the overall health sector financing strategy.⁹⁶

A breakdown of expenditure on health in the average Zambia household in 1996 reveals that K1,600 (\$1.45) was spent on drugs compared to K450 (\$0.40) per month in fees to modern providers. Payments to traditional healers amounted to K430 (\$0.39) per month. This pattern of expenditure shows that user fees account for 14 per cent of the average household health budget in comparison to the cost of drugs which accounts for almost 50 per cent. Such figures give ostensible support to the policy line that user fees are set at a symbolic level and the lowest fees for consultations are charged by Government facilities.⁹⁷ Yet the way in which the imposition of charges on those using health services has been implemented in Zambia has attracted strong criticism. The World Bank, in its 1994 Poverty Assessment, viewed the premature introduction of charges as in danger of derailing the entire process of health reform and thereby destroying any positive signs of emerging change.⁹⁸ To draw the conclusion that the introduction of low user fees therefore has a minimal impact on access to health care is totally erroneous. There are a number of reasons why such a conclusion is misplaced.

Firstly, and despite public statements to the contrary, there is strong evidence to suggest that cost recovery is a driving force behind the Government’s implementation of user fees. Although charges were not to be levied until exemption mechanisms were in place, field studies have confirmed that this instruction was disregarded in Zambia because of the pressure to collect revenue by minimising exemptions.⁹⁹ Local communities were neither consulted nor prepared for the introduction of user charges.¹⁰⁰ In an eight country review of health reform programmes by UNICEF, Zambia is singled out as failing to communicate the purpose of user fees, which resulted in a decline in utilisation.¹⁰¹ Oxfam believes that this policy was probably intentional since the welfare budget covered only a tiny fraction of legitimate claims in a country where 60 per cent of the population were living below the poverty line.¹⁰² Despite the drive to collect charges, all user fees generated K12 bn or less than 1.3 per cent of total Government revenue in 1996.¹⁰³ Put another way, the additional tax concessions worth K18 bn granted to the mining industry in 1998 would have more than allowed for the abandonment of all user fees, let alone those for the poorest.

Secondly, the proportion of money spent on user fees, though low in comparison to the amount spent on medicines, represents significant additional expenditure for a poor household. The fact that households spend a higher proportion of their resources on drugs serves only to highlight the burden of health care costs which falls on the poor. Inequity is increased by the fact that the exemptions which are in place apply only to user fees and not to the cost of expensive treatments and medicines.

People were recorded in the World Bank’s 1994 Poverty Assessment as having ‘expressed anguish’ at the fees they were expected to pay for the mediocre treatment they received.¹⁰⁴ In urban areas, the conclusion reached was that ‘user fees in the formal health care system appeared to be putting the mainstream health facilities out of reach of the poor.’¹⁰⁵ Medical fees were described as unaffordable.¹⁰⁶ In rural areas, escalating health care fees were singled out as the main concern. As a result, people were forced to use home treatments or turn to traditional healers who were increasingly seen as the only source of health care by the rural poor.¹⁰⁷ Contrary to the argument that user fees increases ownership, evidence from rural Zambia suggests that their introduction can be counterproductive as members of a community stop providing free labour and materials when they must also pay for a service.¹⁰⁸

Thirdly, and moreover, survey data confirms that the need for consultations is much greater than the actual number of visits which occur. The poorer a person is, the less likely he or she is to visit a health facility for a consultation.¹⁰⁹ Of the sick population in 1996, whereas almost half of those classified as moderately poor or non-poor went for a consultation, less than four out of every ten of those suffering an illness among the extremely poor did so. Furthermore, 27 per cent of sick persons living in extreme poverty went without any treatment at all, including self-administered medicine. In comparison, only 16 per cent of the non-poor were in the same position.

In other words people do not visit a health facility when they are sick because of the cost involved. It is therefore not surprising that the amount spent on user fees is lower than it otherwise might be if people were not so poor in the first place. While many Zambians have affirmed that they are willing to pay for health care, few have the ability to do so.

This explains the seeming paradox where only 4 per cent of Zambians in a survey conducted before the introduction of user fees stated that they were unable to afford the cost of health care.¹¹⁰ However, when fees were introduced, utilisation of health facilities plummeted. This is because people were too poor to translate their willingness to pay into an ability to pay due to competing demands on the household budget. This has prompted the conclusion in a recent UNICEF study on user fees that '[m]arkets by their nature express the level of purchasing power, rather than needs.'¹¹¹

Fourth, the Bank's participatory poverty assessment of 1994 identified access to quality health care as a critical issue. After the introduction of user fees, the picture that emerged was one of rising prices and a decline in the quality of service. Despite the official proviso that 'the quality of the [health] service will have to be improved before any of the cost sharing schemes are introduced', Government guidelines failed to detail how this improvement was to be measured or achieved.¹¹² The Government was berated in the Poverty Assessment for its 'uncoordinated implementation of user fees and prepayment schemes across the country' before the health service showed any sign of improvement with the result that people were being asked to pay for a service which was getting visibly worse.¹¹³

Finally, there is no stronger indication of the adverse impact of user fees on health care in Zambia than the dramatic declines in the attendance of people at Government health facilities. The United Nations has noted that the high level of charges excluded the poor, and especially children and women in most need of care.¹¹⁴ Studies are cited which confirm a decline in patient flows of between 60 to 80 per cent at urban health centres.¹¹⁵ Outpatient attendance at eleven clinics surveyed in Lusaka dropped, on average, by 64 per cent after the introduction of user fees.¹¹⁶ The poorest neighbourhoods showed the sharpest declines. A comprehensive review by UNICEF of the impact of user fees on basic service provision concluded, in the case of Zambia, that there is little evidence to suggest that the decline in the use of higher level services, such as hospitals, has been balanced by an increase in the use of primary services:¹¹⁷

Booth et al. [1995] reported that the utilization rates of both hospitals and clinics declined precipitously in Zambia. The number of outpatients dropped in all types of health facilities. In one of the children's hospitals, the monthly average number of outpatients declined by more than 50 per cent over the period 1989-1994. In another hospital, deliveries of babies fell by nearly half between 1991 and 1994, with a reported increase in maternal deaths in home deliveries. Outpatient consultations for malaria plummeted by two thirds between May 1993 and May 1994. In one hospital, total admissions fell by 49 per cent, with the largest declines in the children's ward (-65 per cent). Simultaneously, the authors observed a dramatic decline in attendance in clinics and rural health centres, suggesting that the decline in hospital use could not be interpreted as an increase in efficiency. On the contrary, if it is assumed that the poor had greater need of health services, efficiency actually declined. Booth et al. concluded that "the available evidence is not consistent with the idea that what we are witnessing is either a short-term response to the 'shock' caused by the new charge, or just an adjustment within the formal health care system to a more sensible set of relative prices. Rather, the evidence points to a fairly drastic, uncompensated and prolonged reduction in people's access to formal health care."

Subsequent surveys in Zambia confirm that the reduced use of facilities as a consequence of the introduction of user fees is a problem which persists in the longer term.¹¹⁸ The conclusion is that 'fee-induced dropouts are more permanent in nature and more severe than can be justified on the basis of efficiency gains.'¹¹⁹

iii. Help for the poorest

The right to health is universal and applies to everyone. The right to health of the poor and other vulnerable groups in society is unequivocal. Moreover, as has been noted several times within this report, the Committee has emphasised that programmes must be targeted to protect the rights of the vulnerable.¹²⁰ This obligation to accord disadvantaged groups a degree of priority consideration is reinforced by the Committee in its interpretation of the Covenant.¹²¹ Information is sought from State parties by the Committee on what measures are considered necessary by to improve the health situation of vulnerable and disadvantaged groups.¹²² The expectation is for a Government to take policy measures, to the maximum of available resources, to realise such improvements, as measured by time-related goals and benchmarks.¹²³ State parties are asked to provide information on the effects of policy measures on the health situation of vulnerable and disadvantaged groups and to report on problems and shortcomings, as well as successes, in this regard.¹²⁴ Hence the Zambian Government, in order to fulfil its obligation to achieve progressive realisation of the right to health, must not only justify the regressive nature of user fees, but must also satisfy the Committee that it has adopted measures to protect the poor and other vulnerable groups from their adverse consequences.

The health reforms were announced in 1992. Cost sharing, albeit at significantly below cost-recovery levels, was implemented in 1993. It was not, however, until 1994 that demographic and disease-based exemptions and prepayment schemes were introduced. The effectiveness and equity or otherwise of these measures must be examined.

1) Exemptions

Guidelines issued by the Government stipulate that the treatment of infectious diseases and immunisations should be free of charge. User fees are to be waived in the case of children under five, pregnant women seeking antenatal care, the disabled, those in chronic poverty, and persons aged 65 or older. The guidelines also require that acute and life-threatening conditions should be treated first and payment discussed later.

In practice, the exemption system has exhibited a number of failings. The poor targeting of vulnerable groups has resulted in inequity. There has been a significant degree of arbitrariness when deciding eligibility. Potential beneficiaries have been unaware of exemptions because of the failure to convey information. Overall, the system has been undermined by a lack of resources.¹²⁵

According to survey data for 1996, 43 per cent of Zambians did not pay a consultation fee when they last visited a health facility.¹²⁶ A majority are therefore charged user fees. During 1996, 55 per cent of the extremely poor paid for consultations, as did 61 per cent of the moderately poor and 60 per cent of the non-poor.¹²⁷ It is therefore apparent that the majority of those in extreme poverty are not exempt from charges and that the burden of user fees has not been shifted significantly from the poor to the non-poor.

Detailed studies by consultants in the Copperbelt and Lusaka show that those exempted from fees at government clinics and health centres were represented relatively evenly across all income groups.¹²⁸ The fact that the poorest do not benefit more from exemptions at these facilities is partly a reflection of the fact that the main criteria used relate to demography and disease. Moreover, the better-off and better educated are frequently better informed about their right to exemptions. At government hospitals, 56 per cent of the poorest patients do benefit from exemptions. This is above the exemption rate for relatively better off groups.¹²⁹ However, the corollary is that more than four out of every ten of the poorest patients are still required to pay a consultation fee at a government hospital. While acknowledging the 'relatively progressive' medical benefits of the demographic-based exemptions, the consultants conclude that '[t]hese exemptions neither address inequalities in the use of services related to income nor to distance to the nearest facility....'¹³⁰

The system has proved arbitrary in that, even in the same hospital or clinic, some patients are exempted while others are not. An example is cited when one researcher 'witnessed the arrival of a 14-year-old boy at a hospital suffering from acute malaria. His parents were unable to pay the registration fee of ZK300 (equivalent to US\$ 0.33), and the boy was turned away.'¹³¹ Within two hours the boy was brought back dead. Recent analysis suggests that 72 per cent of children under 5 years of age were correctly exempted from fees at government health facilities.¹³² In the category of patients over 65, the corresponding figure was 67 per cent. Overall, it has been calculated that about a quarter of patients are denied exemptions when they are entitled to them. At the same time, a significant number of those who are ineligible according to the official criteria are being granted waiver of payment.¹³³

At a prior stage many people may not use health facilities in the first place because they are unaware that they do not have to pay. A 1995 review of cost recovery mechanisms in Zambia concluded that both communication between policy makers and staff on the ground about the exemption scheme was poor and that an absence of advertising meant that most eligible patients did not know about the exemptions on offer and ceased to use health facilities.¹³⁴ A more recent study suggests that, while staff at clinics and health centres have now been instructed about exemptions, this information is still routinely denied to all potential beneficiaries.¹³⁵ This is corroborated by research on the care of the elderly, who have among the lowest probability of entering the modern health sector:¹³⁶

'many of the people who were over 65 years and were eligible for exemption based on age, expressed ignorance that they were supposed to benefit from this type of exemption. This means that the majority of such people, because they are unlikely to be in formal employment, are likely to simply give up on themselves and await death in their homes instead of rushing to the clinic or hospital with the full knowledge that the clinic will demand a charge which they do not possess.'¹³⁷

2) Prepayment schemes

To supplement the failing system of exemptions, a prepayment scheme, known as the Health Care Cost Scheme (HCCS), was introduced in nine pilot districts in August 1995 to assist the poor in meeting the cost of health care.¹³⁸ The scheme is run as a component of the Public Welfare Assistance Scheme. It is implemented by the Ministry of Community Development and Social Services in collaboration with the Ministry of Health. Those eligible receive support in the form of regular advanced contributions for the right of future use of Government run health institutions.

The aim of the HCCS is to ensure that no one is denied access to health services because of their inability to pay user fees, yet it has been criticised on three grounds, all of which relate to the issue of access. Firstly, the overall level of

finance for the scheme has been described as inadequate.¹³⁹ This is an understatement. As has been noted, expenditure in 1997 under the entire PWAS on assistance - support services and the health and education schemes - amounted to K517 million.¹⁴⁰ This equates to spending of 8 US cents for each of the five million Zambians living in extreme poverty. The HCCS is, of course, only one component of the budget and allocations are therefore further diminished. Secondly, and as a consequence, the scheme remains confined to nine districts in the Copperbelt and Lusaka, the two highest-income provinces, and is available to only 3 per cent of the rural population and 15 per cent of the urban population.¹⁴¹ There is a geographical concentration in line of rail provinces, leaving people living elsewhere with no access to the scheme. The intention was to extend the scheme to all districts in 1997, but this has not reached fruition.¹⁴² Nationally, only 13 per cent of patients in government hospitals benefit from voluntary prepayment schemes. At government health centres and clinics, only 6 per cent are similarly covered.

Finally, the prepayment schemes have benefited richer Zambians and not those living in the greatest poverty. The HCCS is meant to be targeted at the destitute:¹⁴³ given the widespread incidence of poverty, it is, perhaps, not surprising that the moderately poor have sought to benefit from the scheme. However, it is those living in the two highest income quintiles who have derived the most benefit.¹⁴⁴ The UNDP has criticised the HCCS as being seen 'to benefit more the non-poor and non-deserving sections of the community who have a larger command of the schemes' resources'.¹⁴⁵

Government data for 1996 confirms that, overall, only 8 per cent of consultations were prepaid, yet three times as many of the non-poor than the extremely poor took advantage of the low cost schemes available.¹⁴⁶ Analysis of those pilot prepayment schemes introduced in Lusaka and the Copperbelt reinforces this picture of inequity.¹⁴⁷ At Government clinics and health centres, almost half the patients in the highest income quintile participated in the prepayment scheme. In contrast, less than 12 per cent of the sick in the lowest income quintile participated. Hence the poor paid higher fees directly out of pocket much more frequently than the better off.

The picture for the take-up of prepayment schemes among those using Government hospitals was less polarised, with 60 per cent of the poorest participating. A possible explanation for the higher take-up among the poor is to hedge against the high cost of hospital treatment. In comparison, 57 per cent of those in the highest two income quintiles used the scheme.¹⁴⁸ Overall, therefore, there is no redistribution of resources from the better-off to the poor.

While exemptions and prepayment schemes apply to user fees, it is apparent that they do not provide relief to the poor for the purchase of drugs which represents over half their health spending.¹⁴⁹ The consultants who undertook the analysis of the household expenditure data have concluded: 'if fees or benefit packages under prepayment schemes do not cover drugs, the willingness of the population to pay for fees or to participate in prepayment schemes could stay relatively low.'¹⁵⁰

iv. The World Bank's position on user fees

While never advocating a deregulated market in health care, the Bank has been at the forefront in promoting market-orientated mechanisms in provision, to include cost recovery and the introduction of user fees.¹⁵¹ It is important to note that the World Bank has no objection, in principle, to the poor paying for health services as long as they get value for money and good quality care. However, critics of Bank policy maintain that the imperatives of cost recovery and equity are contradictory when, as is the case in Zambia, the majority of the population is so poor as to require exemption.¹⁵² A strategy to raise the maximum revenue will create inequity, while applying exemptions will increase administration costs and cut revenue.

The Bank's own position *vis-à-vis* user fees in Zambia appears ambiguous. Contrary to the stark condemnation of user fees presented in its Poverty Assessment, in other public documents the Bank justifies its support for the strategic health plan which has introduced 'nominal fees' on the grounds that such costs 'foster ownership at the community level' and discourage people from by-passing primary care facilities.¹⁵³ The authors of a Bank discussion paper on cost-sharing, citing the example of Zambia where user fees were implemented before exemption mechanisms and safety nets were in place, recommended that the Bank should pay more attention in its lending portfolio to the detail of such policies.¹⁵⁴

There is strong evidence in the Staff Appraisal Report for the Health Sector Support Project to suggest that the Bank was aware of the Government's actions and intentions on the issue of user fees when formulating its own assistance measures. A number of critical observations can be made. First, the report records 'the revenue-generating potential of cost-sharing through different mechanisms,' thereby confirming cost recovery as the Government's prime consideration behind the imposition of user fees.¹⁵⁵ The advantages of introducing such charges listed by the Bank - few of which relate to social justice - can only be interpreted as an affirmation of its support for their use in Zambia.¹⁵⁶ Second, the Bank's judgement over the Government's ability or intent to improve services in conjunction with the imposition of fees is at best confused and at worse contradictory. At one point, the Staff Appraisal Report confirms '[b]efore any nation-wide mechanism is implemented....they [the Government] are committed to improving the quality of services

provided through the basic package of care.¹⁵⁷ However, the Bank concedes that ad hoc monitoring of the impact of health financing policy implementation suggests a dramatic fall in outpatient attendance following the introduction of user fees in Lusaka and a denial of access to health care by vulnerable groups.¹⁵⁸ In a final section on perceived project risks it is stated that:

Within the Strategic Plan, the precipitated introduction of cost recovery could potentially derail health reforms. Sustainability of the reforms could be put at risk by ad-hoc implementation of cost recovery schemes, in isolation from quality improvements in health services, as perceived by Zambian clients. Resentment of new financial burdens without commensurate exchange of service value could undermine public support for the entire reform process.¹⁵⁹

A final criticism therefore centres on the failure of the Bank and other donors to act to counter this fundamental risk, despite being in a position to do so. The close involvement of the Bank and other donors in shaping and monitoring health reform through the Health Sector Support Program is apparent from the care taken in specifying supervision. Agreements secured by the Bank under the Health Support Project require the Government to implement the reform and investment program according to the Strategic Plan.¹⁶⁰ There is a requirement that this Plan will be updated annually by government and discussed with donors no later than 1 November of each calendar year.¹⁶¹ 'Cost recovery potential and affordability' is one area specified for such annual review. The Government is required to present annual progress reports on implementation and to adopt project reporting, auditing and monitoring procedures acceptable to the Bank.¹⁶² Two annexes to the Bank's Staff Appraisal Report are devoted to laying down a program for annual consultation and a supervision schedule.¹⁶³ Moreover, at the outset, an assurance is given in the Staff Appraisal Report that an acceptable health financing plan, as an integral part of the Strategic Plan, had indeed been agreed to minimise the risk posed by user charges.

In the light of the subsequent and highly adverse impact of user fees on access to care by the poor and the denial of their right to health, either the Bank badly misjudged the effectiveness of safeguards within the Strategic Plan, or else it implicitly supported the proposals on cost recovery as outlined.

The World Bank has responded by advocating that exemptions from costs in primary services and health care for the poor need to be enforced at the present time. Under ESAC II (FY96), the budget allocation for the Public Welfare Assistance Scheme was protected in absolute terms at K760 million, to include finance for the HCCS component.¹⁶⁴ Similarly, under the PSREPC (FY99), spending on the PWAS component is to be monitored to ensure the Government allocates K1.2 billion from public expenditure.¹⁶⁵ In its Letter of Development Policy accompanying ESAC II, the Government outlined its plans to develop targeting guidelines and implementation mechanisms to extend health prepayment schemes from nine to eighteen districts.¹⁶⁶ A Vulnerability Profile, developed under the Public Welfare Assistance Scheme, was to be used as the basis for targeting scarce resources.¹⁶⁷ However, it must be noted that this action was not the subject of a specific loan agreement and has not been delivered. The same undertaking to initiate implementation of the revamped PWAS is repeated in the Bank's follow-on PSREPC, approved over two years later in early 1999.¹⁶⁸ Furthermore, while it is necessary to ensure that assistance reaches the poorest, if vulnerability profiles are too narrowly defined, given the prevalence of mass poverty in Zambia, they will result in the exclusion of other deserving groups from much needed support and denial of their right to health.

Moreover, as documented in final part of this report, the Bank-backed privatisation programme has set the scene for certain hospitals and clinics to move into the private sector where they will be run for profit. This will reinforce the 'two-tier' system in Zambia where the better off purchase good quality care while the vast majority live and die increasingly excluded even from the failing Government run health service. A consultancy study on the scope for franchised health care services in Zambia contrasts the health care offered to staff by firms prior to privatisation with the current attitudes of private businesses: 'They have begun to modify the health care benefit to reduce its cost, by limiting the services covered, capping the amounts of money paid out per employee, negotiating lower charges with providers, paying the pre-payment fee for access to government services, or cutting out the benefit entirely.'¹⁶⁹

3. Primary health care and prima facie violation of the right to health

One specific element of the right to health which the Zambian Government has a core, minimum obligation to satisfy is the provision of essential primary care. As part of its health reforms, the Government has defined a Primary Health Care package which places an emphasis upon maternal and child care, family planning, nutrition, the control of communicable diseases, immunisation and sanitation.¹⁷⁰ The Zambian Government has set a number of goals and has adopted other commitments in this regard. This accords with the Committee's view that national benchmarks can

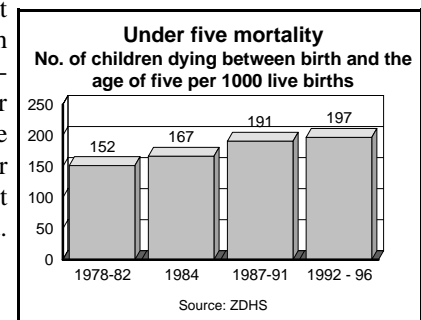
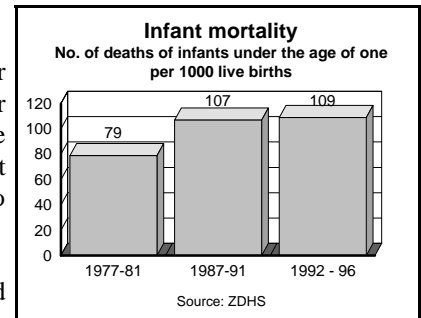
provide an extremely valuable basis upon which the obligation of progressive achievement can be assessed.¹⁷¹ These are reviewed alongside corresponding aspects to the right to health as codified in the Covenant.

a. Maternal and child care

i. *Infant and child mortality*

The Zambian Government is required under the Covenant to take steps necessary for 'the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.'¹⁷² As one measure of progressive achievement, Zambia has committed itself to attaining a reduction in the infant mortality rate to 65 deaths per 1000 live births and the under five mortality rate to 100 deaths per 1000 live births by the year 2000.¹⁷³

The number of children dying before their first birthday in Zambia has increased dramatically in recent years. Infant mortality of 109 deaths per 1000 live births was recorded over the period 1992 - 1996.¹⁷⁴ Fifteen years previously, the rate stood at 79 per 1000.¹⁷⁵ The number of children who die between birth and their fifth birthday has increased to an alarming extent. Across Zambia for the period 1992 - 1996, for every 1000 live births, 197 children or almost a fifth are dead by their fifth birthday.¹⁷⁶ Ten years ago, the under five mortality rate for Zambia as a whole was 167 per 1000.¹⁷⁷ In some provinces under five mortality has reached 250 per 1000 during the last decade.¹⁷⁸ UNICEF's 1997 *State of the World's Children* report records that Zambia has the twelfth highest under five mortality rate in the World. Most of those countries with a worse rate are riven by war and internal strife.



ii. *Infant and child morbidity*

Over a two-week sample period in 1992, 13 per cent of children under five had symptoms of acute respiratory infections, and 23 per cent had diarrhoea.¹⁷⁹ Fever is the primary symptom of malaria, although it is also a symptom of other diseases, and was reported in 44 per cent per cent of children under five. In the equivalent survey in 1996, the prevalence of all three diseases remained broadly the same, reflecting a situation of stasis in child morbidity.¹⁸⁰ There is evidence to suggest the reduction in the use of health facilities caused by the introduction of user fees has been disproportionately higher for infants and children than for their parents.¹⁸¹

iii. *Immunisation*

In conjunction with the obligation on State parties to take steps to reduce infant mortality, the Committee requires information on immunisation in order to assess compliance with the Covenant.¹⁸² Yet Government action to ensure universal immunisation coverage in Zambia has proved retrogressive. The introduction of user fees caused a significant reduction in the hospital deliveries. As a result, fewer babies were registered at birth and therefore did not receive a free vaccination.¹⁸³ This has contributed to a severe fall in immunisation rates. The UNDP concludes that low levels of immunisation in the first years of the MMD Government 'could not but have contributed to the rising mortality rates of children witnessed subsequently'.¹⁸⁴ In 1992, just 67 per cent of Zambian children had been vaccinated against tuberculosis, polio, measles, diphtheria, pertussis, and tetanus by their second birthday owing to the fact that vaccination coverage fell to 20 per cent over the year.¹⁸⁵ A period of improvement followed and, by 1996, 78 per cent of children under two were similarly covered.¹⁸⁶ However, during 1997, immunisation coverage for three out of the four main vaccinations fell to an average of just 54 per cent.¹⁸⁷ This situation must constitute a prima facie denial of the right to health.

iv. *Maternal mortality*

'The State Parties to the present Covenant recognize that: (2) Special protection should be accorded to mothers during a reasonable period before and after childbirth.' [Article 10(2)]

One stated goal of the Primary Health Care programme is 'to improve the quality of, access to and utilisation of maternal and child health services in order to reduce maternal deaths and complications.'¹⁸⁸ A specific commitment made in 1994 was to reduce the maternal mortality to 101 deaths per 100,000 live births by 2000.¹⁸⁹ In its human

development report for Zambia, the UNDP describes the maternal mortality ratio as presenting ‘one of the most disturbing pictures of Zambia’s health scene.’¹⁹⁰ Based on reports for the six years prior to 1996, the MMR was recently estimated at 649 deaths per 100,000 live births.¹⁹¹ One probable factor contributing to high maternal mortality is the number of home births taking place in the absence of trained health personnel.¹⁹² Data presented in 1996 records that the majority, or 53 per cent, of births take place at home.¹⁹³ Once more, the indicators reveal a deterioration in health care: data gathered for 1992 showed that less than half or 49 per cent of births were taking place at home.¹⁹⁴ The 1996 health survey confirms that less than half or 46.5 per cent of all births were attended by a nurse, trained midwife or doctor.¹⁹⁵ In rural areas, trained health professionals were in attendance at just one birth in four.¹⁹⁶ More than three quarters of deliveries to mothers in the poorest 40 per cent of households take place at home compared to less than one quarter of deliveries in the highest income quintile.¹⁹⁷

It is apparent that the Committee considers access to such professional care during both pregnancy and delivery as essential for full realisation of the right to health.¹⁹⁸ Such provision is encompassed within the definition of essential primary health care: the prevailing situation in Zambia constitutes a *prima facie* contravention of the Covenant.

v. Nutrition

Nutrition and health are interconnected and ensuring that people, and especially children, are adequately fed is a recognised component of primary health care. In terms of the Covenant, both the right to health and the right to food are violated if a person does not receive the necessary nutrition they require.¹⁹⁹ In respect of the latter right, ‘[e]very State is obliged to ensure for everyone under its jurisdiction access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure their freedom from hunger.’²⁰⁰

The obligations to protect, respect and fulfil apply. Attention is drawn here to the latter two undertakings. The obligation to respect existing access to adequate food requires the Zambian Government, as a State party to the Covenant, not to take any measures that result in preventing such access.²⁰¹ Violations of the right to food can occur through the direct action of a State when it adopts policies ‘which are manifestly incompatible with pre-existing legal obligations relating to the right to food’.²⁰² The Committee recognises two elements - to facilitate and to provide - under the obligation to fulfil. Facilitation ‘means the State must pro-actively engage in activities intended to strengthen people’s access to and utilization of resources and means to ensure their livelihood, including food security.’²⁰³ Provision requires direct intervention by the State to fulfil the right to food whenever an individual or group is unable, for reasons beyond their control, to enjoy the right by the means at their disposal.²⁰⁴

In its 1997 and 1998 annual human rights reports on Zambia, Afronet records widespread denial of the right to food. In urban areas, and in the wake of the abolition of food subsidies, continued double-figure inflation, capped, low wages and massive unemployment are blamed for poor nutrition and food insecurity.²⁰⁵ The Committee has determined that a Government, as part of its strategy to realise the right to food, should adopt measures to respect and protect self-employment and work which provides a remuneration ensuring a decent living for wage earners and their families.²⁰⁶ In rural areas, the flooding caused by El Niño in early 1998 prompted the Government to declare 34 out of 72 districts, in seven of Zambia’s nine provinces, as disaster areas. However, beyond natural events, economic liberalisation to encourage cash crops is blamed for a fall in the production of maize as a staple and for creating dependency on expensive inputs.²⁰⁷ Seasonal household food insecurity among subsistence farmers is exacerbated by the lack of on-farm storage facilities, forcing the sale of crops at low prices during a time of abundance. In the months prior to the next harvest, households are forced to buy in commodities at high prices in order to feed themselves. Many cannot afford to do so.

The fact that the Committee views the incidence of malnutrition as fundamental to deciding whether the right to food is being denied is apparent by the attention paid to this issue in the reporting guidelines it issues to State parties.²⁰⁸ A State party has a clear obligation to protect the right to food of vulnerable groups.²⁰⁹ This obligation is of especial significance in times of severe resource constraints, whether caused by economic adjustment or climatic conditions.²¹⁰ In the Reporting Guidelines, attention focuses on the right to food of, *inter alia*, the landless and unemployed in rural areas, the urban poor, and children.²¹¹

The poor in Zambia are finding it more difficult to get good food and achieve a balanced diet. At a time when trends in nutritional status have been improving on a world-wide basis, they have worsened in Zambia. Even by 1990, and not accounting for a recent deterioration, the rates of under-nutrition and stunting among the under fives in Zambia was already twice the levels in Botswana, Lesotho and Zimbabwe.²¹² The Government’s goal of reducing moderate and severe malnutrition among children to 25 per cent by the year 2000 appears to be unattainable as the downward trend in the nutritional status of Zambia’s children continues.²¹³ In 1996, 50 per cent of children between 3 months and five years, or double the year 2000 target, were stunted, indicating chronic malnourishment; and 5 per cent showed signs of wasting, indicating acute malnourishment. The figures for a previous survey in 1991 record 39 per cent of children as

stunted and 6 per cent as wasted.²¹⁴ On balance, therefore, the nutritional status of Zambia's children has worsened since 1991. In 1992, a primary health care target was framed to reduce the percentage of underweight children under five from 23 to 18 per cent.²¹⁵ Yet even the starting assumptions have shifted: the 1996 survey recorded that 25 per cent of children were underweight as a result of a combination of both chronic and acute malnutrition.²¹⁶

While disease and inadequate dietary intake are the immediate causes of malnutrition, the underlying causes are food insecurity, the inadequate care of children and support for their mothers, insufficient health services, and an unhealthy environment.²¹⁷ Ultimately, these underlying causes are themselves linked to low levels of education and prevailing economic conditions. A positive correlation between malnutrition and low socio-economic grouping has been established in Zambia in the midst of the period of structural adjustment.²¹⁸ Malnutrition has also been associated with low household income, although the level of maternal education must be taken into consideration.²¹⁹

The Committee has established that '[v]iolations of the Covenant occur when a State fails to ensure the satisfaction of, at the very least, the minimum essential level required to be free from hunger.'²²⁰ Considerable remedial action is required if Zambia is to reverse this deterioration in nutrition. To claim that it is unable to carry out its obligation to satisfy freedom from hunger for reasons beyond its control, the Zambian Government has the burden of proving that this is the case.²²¹

A State party must take the necessary steps to the maximum of its available resources.²²² One necessary step specified by the Committee in respect of a State party's obligation to realise the right to food is the adoption of a national strategy to ensure food and nutrition security for all.²²³ In its 1996 Letter of Development Policy to the Bank, the Government conceded that 'support for nutrition is characterised by institutional fragmentation, weak and grossly under-funded institutions, and lack of a clear national policy.'²²⁴ It promised to study the role, funding and management of the National Nutrition Commission. The Bank made completion of this study and the adoption of suitable policy recommendations a condition of second tranche release of ESAC II (FY96).²²⁵ It is therefore disappointing to note that three years later, the results of this study had still not been applied. Arrangements reflecting the development of the detailed policies and the institutional framework necessary to deal effectively with nutrition issues once again feature in the Bank's follow-on PSREPC (FY99).²²⁶ However, these stipulations are not the subject of a specific loan agreement tied to the release of funds and it remains to be seen whether they are implemented. The lack of progress to date is reflected in the fact that a policy document on nutrition, characterised as a basis for institutional reform and legislative review, was only completed for a planned presentation to the Cabinet in July 1999.²²⁷

Attention is drawn by the Committee to the obligation of State parties to the Covenant to realise the right to food in other countries.²²⁸ As a specific requirement under General Comment 12 on the right to food, 'international financial institutions, notably the International Monetary Fund (IMF) and the World Bank, should pay greater attention to the protection of the right to food in their lending policies and credit agreements and in international measures to deal with the debt crisis. Care should be taken, in line with the Committee's General Comment No. 2, paragraph 9, in any structural adjustment programme to ensure that the right to food is protected.'²²⁹ The evidence presented within this submission suggests that the World Bank and IMF have been negligent in this regard.

4. The control and treatment of communicable diseases

In respect of the right to health as codified in the Covenant, the Zambian Government is required to take the necessary steps for 'the prevention, treatment and control of epidemic, endemic occupational and other diseases'.²³⁰ The control of communicable diseases, including those which are sexually transmitted, is an integral part of the Zambian Government's Primary Health Care Programme.²³¹ While such primary care places an emphasis upon disease prevention, it also encompasses basic treatment. Certain diseases will, of course, require hospital care if they are to be treated successfully.

Overall, Zambia has a high level of morbidity.²³² Extrapolating from health survey data, a quarter of the population or about 2.4 million people are reporting illnesses or injuries at any given time.²³³ In respect of the prevention of disease, Zambia's incomplete record on immunisation has already been noted. There has been a failure to control other diseases, notably malaria, cholera, diarrhoea, tuberculosis and AIDS. Such debilitating diseases, and the cost of caring for sick relatives, continually pushes individual households into poverty.

In its 1994 Poverty Assessment, the World Bank noted 'a general increase in case fatality rates at hospitals.'²³⁴ This includes a sharp rise in hospital case fatality rates for major child illnesses. Data for the period 1982 to 1992 confirms that pneumonia, diarrhoea and malaria case fatality rates have all doubled.²³⁵ Increased fatality rates reflect the declining standard of hospital treatment. They also reflect increased poverty, malnutrition and a decline in resistance to disease. People suffering from AIDS are more likely to die from infections which could otherwise be cured or controlled. The impact of AIDS is considered in its own right in a final subsection.

a. Malaria

Malaria is endemic and its incidence doubled in Zambia between 1982 and 1992 from almost 170 cases to just over 350 cases per 1,000 persons.²³⁶ Malaria was the major cause of hospital admissions and the number one killer in all age groups in 1996.²³⁷ The rise in malarial cases is accounted for by the abandonment of vector control programmes by local councils because of inadequate resources, the general decline in health services, the inability of the poor to afford preventative drugs, and an increase in malaria strains resistant to prophylactics.²³⁸ The first three factors relate directly to the policy sphere.

b. Water borne diseases

An increase in the incidence of water borne diseases in Zambia has been described by the World Bank as one of the 'most glaring outcomes of the decay in urban infrastructure'.²³⁹ Whereas there were less than 2000 cholera cases each year from 1988 - 1990, a sudden flare-up of the disease in 1991 resulted in over 12,000 cases.²⁴⁰ The underlying poor state of water provision and insanitary conditions in poor urban areas has resulted in further serious cholera outbreaks with over 10,000 cases in 1992, 7,000 cases in 1993, and over 2000 cases in 1996.²⁴¹ While the number of reported cases fell to less than 200 in 1998, by June 1999 the number of cases rose to 11,327, the majority of which were in Lusaka district.²⁴²

The high prevalence of diarrhoea is associated with unsanitary conditions and a lack of access to safe water. Its high persistence is linked to malnutrition. Survey data for 1992 records that twenty-three per cent of children under five years had diarrhoea.²⁴³ A specialised survey conducted in the same year found a prevalence rate of 28 - 29 per cent in both rural and urban areas. The proportion of children with persistent diarrhoea exceeding two weeks in duration was exceptionally high: 23 per cent in urban areas and 15 per cent in rural areas.²⁴⁴ By 1996, the situation had not improved. Over 23 per cent of children under five were suffering from diarrhoea in the two weeks preceding the survey.²⁴⁵

A goal of the Primary Health Care programme is to increase the percentage of the population having adequate sanitation from 66 to 75 per cent in urban areas and from 37 to 57 per cent in rural areas.²⁴⁶ This differs somewhat from other stated aims of providing access to clean water and sanitation for 50 per cent of rural and 100 per cent of urban households.²⁴⁷ To achieve full realisation of the right to health, the Covenant requires State parties to take necessary steps for 'the improvement of all aspects of environmental...hygiene...'.²⁴⁸ It must be noted that the Committee specifically requires information from State parties on access to safe water and sanitation. The implication is that the full realisation of the right to health is denied in their absence.²⁴⁹

According to the United Nations, poor access to safe water and sanitation has contributed significantly to the decline in public health in Zambia.²⁵⁰ A specific criticism of the health sector reforms is that there has been a lack of coordination between the Ministry of Health and other departments with the responsibility for water and sanitation.²⁵¹ Government figures for 1996 suggest that 82 per cent of urban households and a mere 28 per cent of rural households have access to safe water.²⁵² Indeed, the figure for urban areas may be overstated when a breakdown in council water treatment and provision, itself a reflection of the collapse in local government finance, further erodes access to safe water.²⁵³ Overall, at least five million Zambians lacked access to safe water in 1996.²⁵⁴

Government figures for 1997 indicate that 12 per cent of urban residents, 30 per cent of those living in peri-urban areas and 88 per cent of those in rural areas do not have access to adequate, safe, convenient sanitation.²⁵⁵ In other terms, 65 per cent of the total population do not have access to safe and convenient sanitation.²⁵⁶ The implications of the privatisation of water supply and sanitation, especially in the highly urbanised provinces of Lusaka and the Copperbelt, have been examined in Section 2(IV) of this report. It is sufficient to recall that planning for the takeover of water and sewerage services formerly provided by the mines in many Copperbelt towns has been entirely inadequate.

In urban shanty compounds, where there is a concentration of poor residents, knowledge of real levels of access to safe water and sanitation is incomplete. This notwithstanding, Government data for low cost urban areas in 1996 suggests that 17 per cent of residents were obtaining water from unsafe sources and just over a third used public taps.²⁵⁷ For sanitation, 60 per cent used their own or communal pit latrines.²⁵⁸ In an area like Chawama - a poor but legal residential area of Lusaka - the World Bank indicated in 1994 that 95 per cent of residents used latrines or buckets for sanitation.²⁵⁹ In densely populated areas during the rainy season, the use of unlined pit latrines creates a health hazard as clean water supplies are threatened by the seepage of effluent.²⁶⁰

c. Tuberculosis

The number of notified tuberculosis cases has increased from 35,134 in 1996 to in the region of 40,000 cases in 1997.²⁶¹ In comparison, in 1985 there were 8,500 registered cases.²⁶² While tuberculosis is a disease which is associated with poverty, it is also associated with the spread of AIDS as HIV is a potent activator of dormant TB infection. Many people harbour the TB bacillus and, should they be infected by HIV, are at high risk of developing tuberculosis. It is estimated that 30 per cent of all AIDS deaths result directly from tuberculosis. WHO/UNAIDS have described the potential for growth of co-infection in developing countries as vast 'given the crushing prevalence of TB carriers in the general population (some 30 per cent) and the almost 6 million new HIV infections a year.'²⁶³

C. The impact of AIDS on social and economic rights

Introduction

AIDS is disease which, by its very nature, represents a grave problem for any country, especially when that country is poor. The onus must be upon other State parties to the Covenant and international organisations to take steps through international assistance and cooperation, to include economic and technical assistance, to achieve full realisation of the right to health.²⁶⁴ The World Bank and IMF must ensure, in line with article 22, that the other measures they adopt are compatible with the realisation of all rights under the Covenant, including the right to health. The principle recognised by the Committee that all State parties to the Covenant, and international agencies, should protect basic rights by promoting adjustment with a human face has a powerful resonance given the suffering caused by the AIDS crisis in Zambia.²⁶⁵ The Zambian Government is obliged to use maximum available resources to combat the threat AIDS poses to the realisation of the right to health and other rights recognised in the Covenant; it must also take appropriate policy measures and target assistance at the vulnerable.

While it is beyond the scope of this report to review the Zambian Government's programme to combat AIDS and its effects in its entirety, it is possible to make observations in three areas. First, to provide basic information on the incidence of HIV infection and AIDS in Zambia and to indicate its truly devastating impact upon the economic and social rights of many Zambians. The expectation is that the Committee, in consultation with other specialised UN agencies such as UNAIDS, UNICEF, WHO, UNDP, and the World Bank, will pursue some of the matters raised in a constructive dialogue with the Zambian Government.²⁶⁶ Second, attention is drawn to the adverse impact of specific measures, such as the imposition of user fees, on the prevention and treatment of HIV/AIDS. Finally, State parties to the Covenant are obliged to take measures to ensure equal protection of the rights of women, and special protection for mothers and children and all those who are vulnerable and disadvantaged.²⁶⁷ In Zambia, the plight of certain groups of girls and women, who suffer disproportionately either from a high rate of HIV/AIDS infection or from the burden of care the disease brings, is cause for serious concern. Likewise, many orphans of the virus are faced by a desperate situation.

1. The incidence of HIV infection and AIDS

According to estimates for 1999, more than 95 per cent of all HIV-infected people now live in the developing world which accounts for 95 per cent of all deaths to date from AIDS. Africa, and in particular sub-Saharan Africa, is the epicentre. The region accounts for 83 per cent of all AIDS deaths to 1999. Four-fifths of all AIDS deaths in 1998 occurred in sub-Saharan Africa and 70 per cent of those that became infected with HIV in the same year lived in the sub-region. A recent WHO/UNAIDS update portrays a shocking picture:²⁶⁸

The sheer number of Africans affected by the epidemic is overwhelming. Since HIV began spreading, an estimated 34 million people living in sub-Saharan Africa have been infected with the virus. Some 11.5 million of those people have already died, a quarter of them children. In the course of 1998, AIDS will have been responsible for an estimated 2 million African deaths - 5500 funerals a day. And despite the scale of death, today there are more Africans living with HIV than ever before: 21.5 million adults and a further 1 million children.

Countries in southern Africa have been particularly hard-hit by the epidemic.²⁶⁹ This includes Zambia. It is estimated that, by the end of 1997, the prevalence rate of HIV/AIDS among the adult population aged 15 - 49 years in Zambia was

19 per cent. Although not strictly comparable, the adult prevalence rate for sub-Saharan Africa was recently estimated to be 8 per cent.²⁷⁰ In total, 770,000 adults and children in Zambia were believed to be infected with HIV/AIDS at the end of 1997. There have already been almost 600,000 deaths in Zambia attributed to AIDS since the epidemic began in the early 1980s, including 97,000 deaths in 1997 alone.

HIV/AIDS in Zambia	
Estimated number of adults and children living with HIV/AIDS in Zambia (to end 1997):²⁷¹	
Adults (15-49)	730,000
Adult rate (%)	19.07
Women (15-49)	370,000
Children (0-15)	41,000
Estimated number of AIDS cases in adults and children that have occurred since the beginning of the epidemic:	630,000
Estimated number of adults and children who have died of AIDS:	
Since the beginning of the epidemic:	590,000
During 1997:	97,000
Estimated number of orphans:²⁷²	
Since the beginning of the epidemic:	470,000
At the end of 1997:	360,000

Zambia is a country with a mature AIDS epidemic. As a consequence, the damage caused by the disease is becoming increasingly visible.²⁷³ It had been calculated that AIDS will reduce life expectancy in Zambia by eleven years to an average of 43 years by 2005 when compared to the lifespan of fifty-four years otherwise predicted in the absence of the disease.²⁷⁴ By 1995, life expectancy had already fallen to less than 46 years. The decline to this date is explained by high maternal mortality and the high incidence of other fatal childhood diseases and does not capture the impact of AIDS.²⁷⁵ By as early as 1998 the predicted nadir of 43 years had already been undercut, with life expectancy reduced to just 40 years and six months. Studies in nine African countries, including Zambia, have calculated that life expectancy will be reduced by an average of seventeen years due to AIDS when compared with the increased lifespan which had been predicted.²⁷⁶

2. Selected impacts of AIDS

a. Productivity

The vast majority of those engaging in behaviour which puts them at substantial risk are in the age range 15 - 49. It is precisely this group which makes up the productive core of a population and upon whom the elderly and children are dependant. The final implications for economic development are unclear, the more so given a context of continued structural adjustment and uncertainty about HIV projection scenarios. However, the loss of labour and skills in the informal and formal economies is already being felt. The example is cited in the UNAIDS/WHO 1998 global AIDS update of large Zambian companies who have reported that AIDS illness and death cost more than their total profits for the year. Models have predicted that, by 2000, the impact of AIDS, in the absence of external assistance to cover medical and other transitional employment and retraining costs, would account for a 9 per cent reduction in GDP below the non-AIDS projection.²⁷⁷ A fall in GDP of 5 per cent was predicted solely on the basis of losses in the workforce.

b. The impact of AIDS on education

As discussed in Section 3(II), AIDS is having a significant adverse impact on education which will have repercussions for development in the longer term. HIV/AIDS prevalence among the teaching profession is high and mortality and sickness are depriving the system of experienced teachers, while simultaneously requiring that scarce resources are spent on recruitment and retraining. The learning ability of pupils in families affected by AIDS is being impaired by anxiety and disruption. Many of those who die leave a surviving partner who is often infected with the virus and in need of care. This burden of care all too frequently falls upon children and young adults who are withdrawn from school in order to tend to a sick relative or to generate household income. Girl pupils suffer more than boys in this respect.

c. AIDS, the health care system and user fees

Zambia's already overstretched and depleted health care system is being placed under increasing strain by the AIDS epidemic. The United Nations cites figures for 1992 which record that HIV/AIDS related illnesses accounted for 43 per cent of in-patient days in the hospitals surveyed.²⁷⁸ The current situation is undoubtedly even more acute, and the human suffering must not be lost sight of amid the statistics:

‘Two-thirds of the patients at the main hospital in Ndola, in the copper-mining region of northern Zambia, are dying of AIDS. Some have lost so much weight that their arms look like broken broom handles and their tattoos are shrivelled and illegible. Their immediate wish is not for costly antibiotics, but for food. In theory, the state-run hospital provides meals for all patients, but several complain that they have not eaten all day, and beg for 100 kwacha (four American cents) for breakfast.’²⁷⁹

The consequence of user fees in reducing the access of poor people with HIV/AIDS to health care is highlighted by the UN agencies as a particular concern in Zambia. Sexually transmitted diseases often go undetected and untreated because of the poor state of the health service.²⁸⁰ Attendance by people at clinics for the treatment of sexually transmitted diseases declined in Zambia after the introduction of user charges.²⁸¹ This is a serious outcome given the prevalence and consequences of such diseases: sufferers have a drastically increased risk of HIV infection.²⁸²

According to the 1996 Zambia Demographic and Health Survey, 27 per cent of women and 55 per cent of men claim to have used a condom during sexual intercourse over the preceding twelve months.²⁸³ However, the fact that less than 5 per cent of women and just over 6 per cent of men used a condom during their last sexual encounter is cause for serious concern.

3. AIDS/HIV and vulnerable groups

a. Orphans of the virus

The number of children orphaned by AIDS is shocking in its extent and consequences. By the end of 1997, 360,000 children under fifteen living in Zambia had lost one or both parents to the disease.²⁸⁴ To personalise the impact of this situation, a recent article cites the case of Faides Zulu, a grandmother from a shanty compound near Ndola.²⁸⁵ The old lady was supported by her daughter and her husband until they both died of AIDS. Now she must look after five grandchildren, using a small plot to grow vegetables which she then carries to the market in town, despite her frailty and advanced years.

Double orphans of the virus are particularly vulnerable. Commonly, they do not receive adequate care, are at greater risk of being abused, and are liable to slide into streetism.²⁸⁶ Article 10 of the Covenant requires, *inter alia*, that ‘Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation.’²⁸⁷

The Zambian Government has closed most state-run orphanages. While the care offered in such institutions may have been inadequate, in its absence it is incumbent upon the authorities to make alternative provision. The reliance on relatives to provide a home when half the population live in extreme poverty, and when welfare payments reach less than 2 per cent of all Zambians, must represent a failure to target the vulnerable. The result is an estimated 90,000 homeless children living on the streets or in the bush.

b. HIV/AIDS and young women

Not only does an unequal burden of care fall on women and girls, but young women are particularly vulnerable to contracting the disease. HIV infection rates for girls 15 -19 years has been shown to be seven times the rate for males of the same age.²⁸⁸ In the main, this is because young girls, with little knowledge of contraception or the power to refuse sex, are being infected by older men.²⁸⁹ The use of condoms among teenage girls is low. Half of all teenage girls in Zambia are sexually active by the time they are 16, yet less than 12 per cent of all women aged 15 - 19 have ever used a condom.²⁹⁰ Less than 5 per cent of women in this age group used a condom the last time they had sexual intercourse.²⁹¹ Teenage pregnancy rates are high. Survey results for 1996 record that three out of ten girls aged 15 - 19 were either already mothers or were pregnant with their first child.²⁹² Poverty and low levels of education are factors which exacerbate this situation. Women with at least secondary education are four times more likely to use a condom than those with no education.²⁹³

HIV prevalence of 27 per cent was recorded among pregnant women less than twenty years of age visiting antenatal clinics in the major urban areas in 1993.²⁹⁴ Neonatal HIV infection rates are correspondingly high and analysis suggests that AIDS is contributing to rising child mortality rates in Zambia.²⁹⁵

Notes

¹ PSHDZ, p.64; also PA, paras. 8.53 and 8.63 ff.

² PSHDZ, p.64.

³ PA, para. 8.53.

⁴ Ministry of Health (1992a), *National Health Policies and Strategies (Health Reforms)*. The other two central objectives are to create environments conducive to better health and to disseminate knowledge on the art of being well.

⁵ Ministry of Health (1994), *National Strategic Health Plan 1995-1999: From Vision to Reality*. See also HSSP SAR, para. 1.14 ff., for an account of health reform and the Strategic Plan.

⁶ Oxford Policy Management (1996), 'Zambia Health Reform Programme,' para. 12. For an account of progress on decentralisation, see also HSSP SAR, paras. 1.25 ff and paras. 2.10 ff.

⁷ ER 1996, p.106.

⁸ Oxford Policy Management (1996), table 1, p. A4.5.

⁹ Ibid., para. 8.

¹⁰ UNICEF (1998), *Implementing health sector reforms in Africa: a review of eight country experiences*, p.2.

¹¹ HSSP PID, para. 2.

¹² Below the level of the DHBs, Neighbourhood Health Management Committees have also been created to encourage community-level participation in the health sector. Representatives are either elected or appointed by elders.

¹³ Each DHB appoints a District Health Management Team which plans health services to match local needs. However, some of the DHMTs have been established in advance of the District Health Boards.

¹⁴ Oxford Policy Management (1996), para. 18.

¹⁵ UNICEF (1998), p.39.

¹⁶ Prior to reform, the Ministry of Health received its budget allocation from the Treasury. Decisions were made centrally over the distribution of funds to each Provincial Permanent Secretary who controlled the flow of funds to the district and local levels. The result was often inflexibility and a mismatch of resources with the consequence that managers and health professionals on the ground did not receive their proper allocation.

Bureaucracy caused the system to fail. For example, voucher schemes for supplies often required the direct authorisation of the Provincial Permanent Secretary so that a special journey had to be made to obtain a signature. See PA, para. 8.13.

¹⁷ PFP (1995 - 1998), para. 146; also PSHDZ, p.66.

¹⁸ Oxford Policy Management (1996), para. 12.

¹⁹ *Idem*; also PFP (1995 - 1998), para. 147.

²⁰ PFP (1995 - 1998), para. 147.

²¹ UNICEF (1998), p.39.

²² Oxford Policy Management (1996), para. 40.

²³ Ibid., para. 41. On the subject of donor coordination, see also the HSSP SAR, paras. 1.52 ff; and the Joint Donor Statement, reproduced in *idem*, Annex 5 - Zambia: Health Sector Support Project.

²⁴ The common basket represents a unitary mechanism by which funds from the central Government budget for health are channelled to each district according to set planning, budgeting, disbursement, accounting and auditing criteria. Donor contributions are used to make up any shortfall between planned expenditure and the actual resources which are allocated to the Ministry of Health. See Oxford Policy Management (1996), para. 43.

²⁵ In 1996, only three agencies - DANIDA, SIDA, and UNICEF - committed funds totalling \$3.4 million. See *ibid.*, paras. 44 and 46; also 48 (iii).

²⁶ HSSP SAR, para. 3.1. At the time (i.e., 1994), this figure was based on the part of the Government's program for which there was agreed domestic and donor funding. The total was expected to be revised to reflect 'on-going implementation experience'.

²⁷ HSSP SAR, para. 3.3; see also para. 3.17.

²⁸ Ibid., paras. 2.5 and 3.5. See also Oxford Policy Management (1996), para. 21.

²⁹ *Idem*; also HSSP SAR, paras. 2.5 and para. 2.7. The remainder of Bank finance - that is, around 5 per cent - was earmarked for expenditure on recurrent budget support, policy development and external monitoring and evaluation.

³⁰ Ibid., para. 3.3.

³¹ also Oxford Policy Management (1996), para. 7.

- ³² *HSSP SAR*, para. 1.23.
- ³³ *Ibid.*
- ³⁴ *Ibid.*, para. 12.
- ³⁵ *ZDHS* (1996), para. 1.4; see also *HSSP SAR*, para. 1.17.
- ³⁶ The health centre is viewed as the first formal point of interface between the community and the health system: the 'client' will be screened, diagnosed and either treated with basic curative care or referred to the general hospital. See *HSSP SAR*, para. 1.18.
- ³⁷ *Idem.*
- ³⁸ For example, preventing future illness while providing curative care; advising on good nutrition practices when providing oral rehydration solution (for diarrhoea), and counselling in family planning and/or contraceptives. See *HSSP SAR*, para. 1.22.
- ³⁹ Oxford Policy Management (1996), para. 13. A recent review by UNICEF concluded that, in the case of Zambia, 'the impact of the reforms on health service delivery has been partial.' (UNICEF (1998), p.32).
- ⁴⁰ *HSSP SAR*, para. 4.5.
- ⁴¹ Oxford Policy Management (1996), para. 39.
- ⁴² The figures for 1969 and 1980, averaged for men and women, are from census results summarised in *ZDHS* (1996), table 1.1, p.3. The figure for 1995 is cited in the *ZHDR 1997*, p.16.
- ⁴³ World Bank (1997), *1997 World Development Indicators*, 'Mortality,' table 2.14, p.88.
- ⁴⁴ WHO (1999b), *World Health Report*, Statistical Appendix, Table 1.
- ⁴⁵ Diop, Seshamani & Mulenga (1998), 'Household Health Seeking Behaviour in Zambia,' p. xv.
- ⁴⁶ *PSHDZ*, p.63.
- ⁴⁷ In 1996, the Government calculated a funding gap of \$13 million for the period 1995 - 1999 based on a total health sector budget of \$132 million, to include domestic and donor finance. To arrive at the figure of \$132 million, the Government was to contribute \$60 million and donors \$56 million. Cost sharing - that is, user fees - were to contribute the remaining \$3 million. See Oxford Policy Management (1996), para. 31 and table 2.48 (ii).
- ⁴⁸ WHO (1999), *World Health Report*, p.34.
- ⁴⁹ Oxford Policy Management (1996), para. 33.
- ⁵⁰ For a discussion of the negative impact of cash budgeting and other management practices on social spending, see *PA*, paras. 4.16 and 4.76 ff.
- ⁵¹ For example, the reduction in real expenditure on health has not been as disproportionate as the budget cuts on education. See *intra*, Section 3(II), pp. 236 ff.
- ⁵² Catholic Commission for Justice and Peace (1999), 'Visions, Priorities and Parliamentary Responsibilities,' Post-Budget Statement.
- ⁵³ Mark Lynas (1999), 'Just what happens in hospitals' .
- ⁵⁴ See *Reporting Guidelines*, Article 12 of the Covenant, para. 9.
- ⁵⁵ *Ibid.*, paras. 4(f)-(h) and para. 5(h).
- ⁵⁶ Information is sought on 'the measures taken by your Government to assure to all medical service and medical attention in the event of sickness.' (*Reporting Guidelines*, Article 12 of the Covenant, para. 5(h)). Reference is also made to the proportion of the population having access for treatment 'within one hour's walk or travel.' (*Idem.*, para. 4(f)).
- ⁵⁷ The Committee seeks information on access of the general population to treatment by trained personnel for the treatment of common diseases and injuries, including data on the regular supply of essential drugs. Specific information is also required on the access of pregnant women and infants to trained personnel. See *Reporting Guidelines*, Article 12 of the Covenant, paras. 4(f) - (h).
- ⁵⁸ Derived from *ibid.*, paras. 5(h) and 5(i): the poor are a vulnerable group whose access to health care is diminished by their poverty. See also the Committee's Statement on Globalisation, para. 3, on user fees and reduced access of the poor to health care (reproduced in E/1999/22, Chapter VI).
- ⁵⁹ Definition adopted by UNDP, *ZHDR 1997*, p. 17.
- ⁶⁰ Diop, Seshamani & Mulenga (1998), section 4.1.3.
- ⁶¹ *HSSP SAR*, para. 1.42.
- ⁶² *Ibid.*, para. 8.14.
- ⁶³ George Aligiah, BBC News, 1999.
- ⁶⁴ *HSSP SAR*, para. 2.27.
- ⁶⁵ The Bank states this succinctly: 'a short distance to [a] health center should not be thought [of] as automatic access to health care.' (*PA*, para. 3.94).
- ⁶⁶ Calculated from Central Statistical Office (1994), *Priority Survey II 1993*, table 5.2.
- ⁶⁷ *LCMS* (1996), table 8.7. While the overall proportion of the population making such visits is shown to have declined, of those attending health facilities, about 6 per cent more were visiting Government run institutions. One possible explanation for the drop in the overall number of people visiting is that people increasingly only do so when they feel it is absolutely necessary. When they must make an essential visit, they seek the least cost option which, despite user charges, remains Government run institutions.
- ⁶⁸ See *Reporting Guidelines*, Article 12 of the Covenant, para. 4(f).
- ⁶⁹ Cited in *ESAC II R&R*, Annex A, 'Zambia - Social Indicators of Development,' p.28.
- ⁷⁰ Calculated from ratios of the number of doctors/100,000 population, cited by the UNDP in its *ZHDR 1997*, p. 18.
- ⁷¹ *Idem.*
- ⁷² *PA*, para. 8.16.
- ⁷³ *LCMS* (1996), table 8.8.
- ⁷⁴ *HSSP SAR*, para. 1.39.
- ⁷⁵ *PA*, para. 8.14.
- ⁷⁶ *HSSP SAR*, para. 1.41.
- ⁷⁷ *Idem.*
- ⁷⁸ *HSSP SAR*, para. 2.25.
- ⁷⁹ *ESAC II R&R*, para. 51.
- ⁸⁰ UNICEF (1998), Appendix H, p.81.
- ⁸¹ *ESAC II R&R*, para. 57 (i)(i).
- ⁸² *ESAC II R&R*, Annex J, Letter of Development Policy, para. 69.
- ⁸³ *ER 1997*, table 3.29.
- ⁸⁴ *Ibid.*, para. 208.
- ⁸⁵ *Ibid.*, para. 209.
- ⁸⁶ See *Reporting Guidelines*, Article 12 of the Covenant, para. 5(h) in conjunction with para. 5(i).
- ⁸⁷ Cf. *Reporting Guidelines*, Article 12 of the Covenant, para. 6.
- ⁸⁸ See Statement on Globalisation, op. cit., para. 3.
- ⁸⁹ *LCMS* (1996), table 8.5.
- ⁹⁰ Of the 11 per cent of the population who sought care at a health facility in 1996, 76 per cent chose a government clinic, health centre or hospital; 8

per cent a mission institution; 6 per cent an industrial or company institution; and 4 per cent, a private institution. See *ibid.*, table 8.7.

⁹¹ *Ibid.*, table 8.6.

⁹² See Diop, Seshamani & Mulenga (1998), section 6.1. The analysis is based on *LCMS* (1996) survey data.

⁹³ Fiedler, Levin, & Mulikelela, 'A Feasibility Analysis of Franchising the PROSALUD/Bolivia Primary Health Care Service Delivery Strategy in Lusaka, Zambia,' table 21.

⁹⁴ WHO (1999), *World Health Report*, Statistical Appendix, Table 7. Data is based on the period 1990 - 1995 and the poor:non-poor probability ratios have been averaged for men and women.

⁹⁵ User fees were initially introduced in Zambia in 1989. They were set at a rate of K4 (\$0.32) for registration and K50 (\$4.00) for a medical examination. There was little incentive to collect fees at the facility level as the fees were to be forwarded on to the district and provincial levels under the control of the Permanent Secretary of the Ministry of Health. See *HSSP SAR*, para. 1.49.

⁹⁶ UNICEF (1998), p.23.

⁹⁷ The average cost of consultation at a Government institution in 1996 was K804, although in urban areas this rose to K1828 or four times the amount charged in rural areas. (*LCMS* (1996), table 8.10). The average cost of consultations at a private health centre (K12,363) or with a traditional healer (K8,463) were significantly higher. However, the caveat still applies that the recorded figures do not reveal the total cost of treatment - payment for medicine, prescription charges, admission fees.

⁹⁸ *PA*, para. 8.72.

⁹⁹ Booth et al. (1995), 'Coping with Cost Recovery'; also *PA*, para. 8.72.

¹⁰⁰ Oxford Policy Management (1996), para. 32.

¹⁰¹ UNICEF (1998), p.48.

¹⁰² Watkins (1997), 'Cost-recovery and equity in the health sector: issues for developing countries,' subsection entitled 'Problems in exemption systems'.

¹⁰³ *SCR* (1997), Statistical Appendix, table 12.

¹⁰⁴ See *PA*, para. 3.94.

¹⁰⁵ *Idem.*

¹⁰⁶ The apparent average cost of each visit to a Government health institution in 1993 was K113, much less than the charges for traditional or private consultations (Central Statistical Office (1994), *Priority Survey II 1993*, table 5.3). However, the figure quoted for fees at Government institutions differs significantly from a breakdown of charges cited by the World Bank for urban health services: registration K100; consultation K500; prescription; admission K1500; mortuary costs of K1000 (see *PA*, para. 3.94). The difference is probably accounted for by two factors: the average cost of a consultation in rural areas is significantly less, lowering the average cost and masking high charges in urban areas; and the official statistics reflect the cost of consultation, not the total cost of consultation and treatment. The average cost of consultation at a Government institution in 1996 was K804, although in urban areas this rose to K1828 or four times the amount charged in rural areas (*LCMS* (1996), table 8.10). Once more, the cost of consultations at a private health centre or with a traditional healer were significantly higher. However the caveat still applies that the recorded figures do not reveal the cost of treatment - payment for medicine, prescription charges, admission fees. While fees charged by traditional healers are seldom less than at a Government clinic or hospital, payment can often be made on credit.

¹⁰⁷ *PA*, para. 3.59. When people living in rural areas are ill, official survey data suggests that they use traditional healers just 4 per cent of the time. However, detailed analysis of data from the same survey suggests that spending on traditional care among rural households averaged 20 per cent of the domestic health budget. See, respectively, *LCMS* (1996), table 8.7; and Diop, Seshamani & Mulenga (1998), table 4.1.2. The consultants conclude that formal surveys are not the best way to obtain information on the use of traditional medicine.

¹⁰⁸ Booth et al. (1995), 'Coping with Cost Recovery'.

¹⁰⁹ *LCMS* (1996), table 8.6.

¹¹⁰ The survey data and associated paradox is cited in Watkins (1997), 'Cost-recovery and equity in the health sector: issues for developing countries,' subsection entitled 'Willingness and ability to pay'.

¹¹¹ Reddy & Vandemoortele (1996), 'User financing of basic social services,' p.9.

¹¹² *Ibid.*, p. 16.

¹¹³ *PA*, para. 8.72.

¹¹⁴ *PSHDZ*, p.67.

¹¹⁵ See, for example, Booth et al. (1995), 'Coping with Cost Recovery'; Lake (1994), *User Charges in the Health Sector: Some Observations on the Zambian Experience*; also Foster (1993), *Cost and Burden of AIDS on the Zambian Health Care System: Policies to Mitigate the Impact on Health Services*. The latter study is cited in *PSHDZ*, p.67.

¹¹⁶ Kahenya & Lake (1994), 'User Fees and Their Impact on Utilisation of Key Health Services'.

¹¹⁷ Reddy & Vandemoortele (1996), p.15.

¹¹⁸ For example, the monthly attendance in a clinic located in a poor area in Lusaka declined sharply immediately after the introduction of user fees and still had not recovered a year later. See Lake (1994).

¹¹⁹ Reddy & Vandemoortele (1996), p.16.

¹²⁰ *GC* 3, para. 12.

¹²¹ In respect of the right to housing, see *GC* 4, para. 8(e); in respect of realisation of the right to education, see *GC* 13 para. 6(b)(i). *GC* 5 recognises the obligation to take positive action to reduce structural disadvantages and to give appropriate preferential treatment in the case of the disabled as a vulnerable and disadvantaged group (para. 9). The duty of the state to protect those old people who are vulnerable in times of recession and restructuring, notwithstanding resource constraints, is recognised by the Committee in *GC* 6, para. 17. *GC* 8 on economic sanctions and respect for economic, social and cultural rights pays particular attention to the obligation of the affected State to protect vulnerable groups and the obligation of those States applying sanctions to respond to any disproportionate suffering experienced by vulnerable groups (paras. 10 and 14; see also paras. 4 - 6 and para. 8).

¹²² *Reporting Guidelines*, Article 12, para. 5(b).

¹²³ *Ibid.*, Article 13, para. 5(c).

¹²⁴ *Ibid.*, Article 13, para. 5(d).

¹²⁵ Booth et al. (1995), 'Coping with Cost Recovery'.

¹²⁶ *LCMS* (1996), table 8.9.

¹²⁷ *Idem.*

¹²⁸ 35 per cent of the next-to-lowest reported not paying. The range is 42 to 48 per cent not paying for the other quintiles, including the highest and lowest. See Diop, Seshamani & Mulenga (1998), section 5.3.

¹²⁹ In the other four income quintiles the range is 29 - 49 per cent of patients who are exempted from fees at government hospitals. See *ibid.*, section 5.3.

¹³⁰ *Ibid.*, section 5.4. Somewhat paradoxically, recognition is given elsewhere in the report to the contribution of such exemptions in mitigating inequities of access, while their potential to do so 'is not fully realized because of significant errors in the administration of exemptions.' See *idem*, section 7. Conclusions.

¹³¹ The researcher was conducting a survey for the study by Booth et al. (1995). The citation is from Reddy & Vandemoortele (1996), p.51.

- ¹³²The estimates exclude patients exempt on the grounds of chronic disease. See Diop, Seshamani & Mulenga (1998), section 5.4.
- ¹³³Those not paying at government health facilities include 30 per cent among children between 5 and 15 years of age; 16 per cent among young adults between 15 and 25 years of age; 22 per cent among adults between 25 and 45 years of age; and 28 per cent among adults between 45 and 65 years of age. See *ibid.*, section 5.4.
- ¹³⁴Booth et al. (1995).
- ¹³⁵See Diop, Seshamani & Mulenga (1998), section 7. Conclusions.
- ¹³⁶Survey results suggest that only 2 per cent of those seeking health care at government facilities in 1996 were over 65. See *ibid.*, section 5.4.
- ¹³⁷Sumaili & Milimo (1996), *Health Sector Reform Review*, p.17.
- ¹³⁸*ZHDR 1997*, p. 57.
- ¹³⁹See Kakuwa (1997), 'Ensuring Accessibility of Health Care and Health Facilities by the Destitutes in Zambia'.
- ¹⁴⁰*ER 1997*, para. 228.
- ¹⁴¹*ZHDR 1997*, p. 20. By September 1995, the HCCS assisted 17,703 people, by August 1996, 25,150 people and by the end of 1997 it had assisted 40,000. For a brief review of the assistance offered each year, see *ER 1996*, para. 250; and *ER 1997*, para. 230.
- ¹⁴²*ER 1996*, para. 220.
- ¹⁴³On the issue of targeting see Kakuwa (1997).
- ¹⁴⁴*ZHDR 1997*, p. 20.
- ¹⁴⁵*Idem.*
- ¹⁴⁶*LCMS* (1996), table 8.9.
- ¹⁴⁷Diop, Seshamani & Mulenga (1998), section 5.3.
- ¹⁴⁸The lowest take-up at 37 per cent was for the next to lowest and middle income quintiles. See *ibid.*, section 5.3.
- ¹⁴⁹Makinen & Leighton (1997), 'Summary of Market Analysis for a Franchise Network of Primary Health Care in Lusaka, Zambia,' section 5.3.
- ¹⁵⁰See Diop, Seshamani & Mulenga (1998), section 6.1.
- ¹⁵¹For a critical review of Bank policy in this area, see Watkins (1997).
- ¹⁵²*Ibid.*, under the subsection entitled 'Problems in exemption systems'.
- ¹⁵³*HSSP PID*, para. 7.
- ¹⁵⁴World Bank (1996), 'Cost Sharing in the Social Sectors of Sub-Saharan Africa: Impact on the Poor,' pp. 28 - 29.
- ¹⁵⁵*HSSP SAR*, para. 2.32; see also para. 1.48.
- ¹⁵⁶The advantages of user fees listed by the Bank include strengthening the position of the Ministry of Health in its annual 'budget battle' with Ministry of Finance; providing incentives to health service managers to enhance both revenue collections and service quality by allowing retention of fees at the point of collection; the promotion of equity by requiring patients from higher income households to pay for the health care they receive; and their usefulness as a proxy measure of quality care, based on willingness of middle and low-income households to pay for services. (See *HSSP SAR*, para. 2.32 (a).
- ¹⁵⁷*Idem.*
- ¹⁵⁸*HSSP SAR*, para. 1.49.
- ¹⁵⁹*Ibid.*, para. 4.4.
- ¹⁶⁰*Ibid.*, 'B. Other Agreements,' especially para. 5.4 (a).
- ¹⁶¹*Ibid.*, para. 2.37. See also *idem*, 'B. Other Agreements,' especially para. 5.4 (d).
- ¹⁶²*Ibid.*, 'B. Other Agreements,' respectively paras. 5.4 (e) and (f).
- ¹⁶³Respectively, *HSSP SAR*, Annex 4 - Proposed program for annual consultations between donor agencies and the ministry of health, Zambia; and Annex 6 - Supervision Schedule.
- ¹⁶⁴*ESAC II R&R*, Annex J, Sub-sectoral budget allocations, p.26.
- ¹⁶⁵*PSREPC R&R*, Annex A, Social Spending in 1999, pp. 56 - 57.
- ¹⁶⁶*ESAC II R&R*, Annex J, Letter of Development Policy, para. 73.
- ¹⁶⁷*ESAC II R&R*, para. 52.
- ¹⁶⁸*PSREPC R&R*, para. 49.
- ¹⁶⁹Makinen & Leighton (1997), section 3.2.
- ¹⁷⁰*ZDHS* (1996), para. 1.4.
- ¹⁷¹*GC 1*, para. 6.
- ¹⁷²ICESCR, article 12(2)(a).
- ¹⁷³These targets are specified in Zambia's 1994 *National Programme of Action for Children* which arises from commitments made at the World Summit for Children.
- ¹⁷⁴*ZDHS* (1996), table 7.1.
- ¹⁷⁵The IMR of 79 deaths per 1000 live births for the period 1977 - 81 is cited in the World Bank's *PA*, p.18, which itself draws on data from the *Zambia Demographic and Health Survey*.
- ¹⁷⁶*ZDHS* (1996), table 7.1.
- ¹⁷⁷The 1990 census, for the reference period 1984, records under five mortality of 167 per 1000. See *ZDHS* (1996), table 7.2.
- ¹⁷⁸In Luapula Province under-five mortality over the last ten years to 1996 stood at 254 deaths per 1000 live births (*ZDHS* (1996), table 7.3).
- ¹⁷⁹*ZDHS* (1992).
- ¹⁸⁰*ZDHS* (1996), tables 8.10 and 8.11. The incidence of malarial type fever was 40.1 per cent, of Acute Respiratory Infections was 12.7 per cent and of diarrhoea was 23.5 per cent.
- ¹⁸¹Booth et al. (1995).
- ¹⁸²*Reporting Guidelines*, Article 12 of the Covenant, para. 4(d).
- ¹⁸³Reddy & Vandemoortele (1996), p.33.
- ¹⁸⁴*ZHDR 1997*, p. 17.
- ¹⁸⁵To be fully vaccinated, the WHO specifies BCG, measles and three doses each of DPT and polio vaccines. BCG protects against tuberculosis. DPT protects against diphtheria, pertussis and tetanus. The 1992 immunisation coverage figure of 67 per cent is reported in *ZDHS* (1996), p.113. However, the UNDP cites coverage of just 20 per cent in the same year, suggesting that the majority of children born in 1992, and therefore under 12 months, were not vaccinated. See UNDP, *ZHDR 1997*, p. 17.
- ¹⁸⁶*ZDHS* (1996), table 8.7.
- ¹⁸⁷BCG coverage declined from 100 per cent in 1996 to 59 per cent in 1997; DPT coverage fell from 83 per cent to 52 per cent; immunisation coverage against measles was 50 per cent in 1997 compared with 92 per cent in 1996. Figures for the other main vaccination against polio are ambiguous. While coverage for the oral polio vaccination fell from 81 per cent to 51 per cent, an increase in overall polio vaccination is recorded. See *ER 1997*, 'Immunisation,' para. 212.
- ¹⁸⁸*ZDHS* (1996), p.6.
- ¹⁸⁹Government of Zambia (1994), *National Program of Action for Children*.
- ¹⁹⁰*ZHDR 1997*, p. 17.

- ¹⁹¹ZDHS (1996), p.136.
- ¹⁹²ZHDR 1997, p. 17.
- ¹⁹³ZDHS (1996), table 8.4. The data is compiled from births in the survey during the preceding five years to 1996.
- ¹⁹⁴ZHDR 1997, p. 17, based on ZDHS (1992).
- ¹⁹⁵ZDHS (1996), table 8.5.
- ¹⁹⁶*Idem.*
- ¹⁹⁷Diop, Seshamani & Mulenga (1998), section 4.20.
- ¹⁹⁸The Committee requests information on professional care before and during childbirth and on the maternal mortality rate. The implication is that such maternal care is an important aspect of the right to health. See *Reporting Guidelines*, Article 12 of the Covenant, para. 4(g).
- ¹⁹⁹ICESCR, respectively, article 12, and article 11 on the right to an adequate standard of living, including adequate food.
- ²⁰⁰GC 12, para. 14.
- ²⁰¹*Ibid.*, para. 15.
- ²⁰²*Ibid.*, para. 19.
- ²⁰³*Ibid.*, para. 15.
- ²⁰⁴*Idem.*
- ²⁰⁵Afronet (1997) and (1998), *The Zambian Human Rights Report*, respectively Chapters 4 and 5 on Economic and Social Rights.
- ²⁰⁶GC 12, para. 26, drawing on ICESCR, article 7(a)(ii).
- ²⁰⁷Cf. the requirement within the Covenant to take measures, including specific programmes, 'to improve methods of production, conservation and distribution of food by making full use of technical and scientific knowledge of the principles of nutrition....' (ICESCR, article 11(2)(a)).
- ²⁰⁸*Reporting Guidelines*, Article 11 of the Covenant, para. 2(b)(i-iii).
- ²⁰⁹GC 12, para. 13.
- ²¹⁰*Ibid.*, para. 28.
- ²¹¹*Reporting Guidelines*, Article 11 of the Covenant, para. 2(b)(i). Within GC 12, para. 13, reference is made to the vulnerability of landless persons and other particularly impoverished segments of the population, indigenous population groups whose access to their ancestral lands may be threatened, physically vulnerable individuals, such as infants and young children, elderly people, the physically disabled, the terminally ill and persons with persistent medical problems, including the mentally ill. It is also recognised that victims of natural disasters people living in disaster-prone areas and other specially disadvantaged groups may need special attention and sometimes priority consideration with respect to accessibility of food.
- ²¹²PSHDZ, p.38.
- ²¹³Government of Zambia (1994), *National Programme of Action for Children*.
- ²¹⁴*Priority Survey 1991*, as cited in ZHDR 1997, p. 17. The LCMS figure of 46 per cent for the incidence of stunting in the UNDP report appears to be erroneously quoted. Direct reference to the LCMS (1996) gives a figure of 50 per cent.
- ²¹⁵ZDHS (1996), p.6.
- ²¹⁶LCMS (1996), table 16.12.
- ²¹⁷PSHDZ, p.39.
- ²¹⁸Central Statistical Office (1994), *Priority survey II 1993*, p.147.
- ²¹⁹*Ibid.*, pp.146 -147; also PA, para. 2.45.
- ²²⁰GC 12, para. 17.
- ²²¹*Idem*, drawing on GC 3, para. 10.
- ²²²ICESCR, article 2(1).
- ²²³GC 12, para. 21.
- ²²⁴ESAC II R&R, Annex J, Letter of Development Policy, para. 70.
- ²²⁵ESAC II R&R, para. 57(i)(ii).
- ²²⁶PSREPC R&R, para. 49.
- ²²⁷PSREPC R&R, Annex I, Letter of Development Policy, para. 43.
- ²²⁸GC 12, paras. 36 ff.
- ²²⁹GC 12, para. 41.
- ²³⁰ICESCR, article 12(2)(c).
- ²³¹ZDHS (1996), p.5.
- ²³²ZHDR 1997, p. 18.
- ²³³As part of the LCMS (1996), people were asked to report illness or injury which occurred in the previous two weeks. The survey took place from September to November and it should be noted that morbidity rates vary depending upon seasonal environmental conditions.
- ²³⁴PA, para. 8.57.
- ²³⁵PSHDZ, p.63 and figure 5.6.
- ²³⁶WHO figures, cited in *ibid.*, p.37, figure 4.5.
- ²³⁷ZDHS (1996), para. 8.4.
- ²³⁸PSHDZ, p.36 and p.63.
- ²³⁹PA, para. 3.80.
- ²⁴⁰PSHDZ, p.76. See also the World Bank's PA, para. 8.55.
- ²⁴¹PSHDZ, p.76; WHO (1997), *Weekly Epidemiological Record*, 72nd Year, 1 August 1997.
- ²⁴²WHO (1998), *Global Cholera Update 1998*; WHO (1999a), *Outbreak News*, 16 June 1999.
- ²⁴³ZDHS, 1992.
- ²⁴⁴Ministry of Health (1992b), *Diarrhoeal Diseases Household Case Management Survey: Zambia*. (Cited in PSHDZ, p.36).
- ²⁴⁵ZDHS (1996), table 8.11.
- ²⁴⁶*Ibid.*, p.6.
- ²⁴⁷Government of Zambia (1994), *National Programme of Action for Children*.
- ²⁴⁸ICESCR, article 12(2)(b).
- ²⁴⁹*Reporting Guidelines*, Article 12 of the Covenant, para. 4(b) and (c).
- ²⁵⁰PSHDZ, p.76.
- ²⁵¹Oxford Policy Management (1996), para. 15; 48 (i).
- ²⁵²LCMS (1996), para. 14.7.
- ²⁵³PSHDZ, p.76.
- ²⁵⁴ZHDR 1997, p. 17.
- ²⁵⁵ER 1997, para. 2.15.
- ²⁵⁶ZHDR 1997, p. 17.
- ²⁵⁷LCMS (1996), table 14.7.

²⁵⁸Ibid., table 14.12.

²⁵⁹PA, para. 6.30.

²⁶⁰PSHDZ, p.77.

²⁶¹ER 1997, para. 210.

²⁶²ER 1996, para. 233.

²⁶³UNAIDS & WHO (1998b), *AIDS epidemic update: December 1998*, p.3.

²⁶⁴ICESCR, article 2(1).

²⁶⁵See GC 2, para. 9.

²⁶⁶The basis for such consultation is provided in ICESCR, article 18. See also the Committee's *Rules of Procedure*, Rules 66 - 68.

²⁶⁷See, respectively, ICESCR article 3 and article 10. On the obligation to target measures to realise the rights of vulnerable groups, see GC 3, para. 12.

²⁶⁸UNAIDS & WHO (1998b), *AIDS epidemic update: December 1998*, p.3.

²⁶⁹For example, in Botswana, Namibia, Swaziland and Zimbabwe, current estimates show that between 20 per cent and 26 per cent of people aged 15-49 are living with HIV or AIDS. (Ibid., p.3).

²⁷⁰The adult prevalence rate for sub-Saharan Africa is also provided by UNAIDS/WHO and is an estimate of the proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1998, using 1997 population numbers. The global average of adult prevalence is 1.1 per cent, although this figure is itself skewed by the high incidence of the disease in sub-Saharan Africa. Although the regional prevalence rate is based on earlier estimates using 1998 country models, the figures cited are provisional and reflect adjustments. They are not directly comparable with earlier or later series. See UNAIDS & WHO (1998b), *AIDS epidemic update: December 1998*.

²⁷¹These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1997.

²⁷²Children who have lost their mother or both parents to AIDS (while they were under age 15).

²⁷³UNAIDS & WHO (1998b), *AIDS epidemic update: December 1998*, p.7.

²⁷⁴Fylkesnes, Brunborg & Msiska (1995), 'An update on the current HIV situation and future demographic impact, Zambia 1995' (cited in PSHDZ, p.60).

²⁷⁵The UNDP specifically rejects the explanation that this decline in life expectancy as officially reported is due to the increased probability of death in middle age because of AIDS since the mortality rates for older cohorts are not directly measured. See ZHDR 1997, p.16.

²⁷⁶The countries are Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia and Zimbabwe. All have an adult HIV prevalence rate of 10 per cent or more. See UNAIDS & WHO (1998b), *AIDS epidemic update: December 1998*, p.7.

²⁷⁷L. Forgy and A. Mwanza (1994), *The Economic Impact of AIDS in Zambia* (cited in ZHDR 1997, pp. 18 - 19).

²⁷⁸PSHDZ, p. 62.

²⁷⁹'Children of the virus,' *The Economist*, 14 August 1999, p.47.

²⁸⁰PSHDZ, p.60.

²⁸¹Booth et al. (1995).

²⁸²In 1991, 60 per cent of male STD patients tested in Lusaka were HIV positive. Outside of Lusaka, prevalence was 38 per cent in the same group. See UNAIDS & WHO (1998a), *Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted diseases: Zambia*.

²⁸³ZDHS (1996), table 11.13.1.

²⁸⁴UNAIDS & WHO (1998a), *Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted diseases: Zambia*.

²⁸⁵'Children of the virus,' *The Economist*, 14 August 1999, p.47.

²⁸⁶PSHDZ, p. 61.

²⁸⁷ICESCR, article 10(3).

²⁸⁸Webb (1996), 'The socioeconomic impact of HIV/AIDS in Zambia' (cited in UNDP, Zambia Human Development Report, p. 18).

²⁸⁹PSHDZ, p.61.

²⁹⁰The median age for sexual intercourse among women in Zambia is 16.4 years. See ZDHS (1996), table 5.5. The survey results on condom use is given in *idem*, table 4.3.1.

²⁹¹ZDHS (1996), table 11.13.1.

²⁹²Ibid., table 3.10.

²⁹³Ibid., table 11.13.1.

²⁹⁴11 per cent of antenatal clinic women less than 20 years of age who were tested outside of the major urban areas were HIV positive. See UNAIDS & WHO (1998a), *Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted diseases: Zambia*.

²⁹⁵Analysis by the Ministry of Health, cited in PSHDZ, p.60.