Is there Health Equity in Zambia?

A CASE STUDY

EXECUTIVE SUMMARY OF
SOCIOECONOMIC STATUS, HEALTH STATUS AND HEALTH EQUITY: A CASE STUDY OF ZAMBIAN HOUSEHOLDS IN SELECTED AREAS

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The study involved extensive field work in four districts selected from Lusaka and Western Provinces carried out between October and December 2002. We acknowledge the good work of the eight research assistants who helped us gather the detailed information from a total of 396 households in the four selected districts. Entering and processing the collected data was also an arduous exercise and we acknowledge the efficient assistance provided by the two computer programmers in this respect.

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INTRODUCTION

If Zambia is ever to turn the corner on development – that is, move away from severe poverty conditions and advance toward sustainable livelihoods for all – there must be a marked improvement in the delivery of education and health services. No country develops without an educated and healthy population. Sometimes this fact is referred to as the "human capital" resource base for development. But it is more than simply that. It is the "human right" basis for a well-ordered society based on justice.

Because we at the Jesuit Centre for Theological Reflection (JCTR) believe in the basic human rights of every citizen for good education and good health care, we have done research, education and advocacy programmes touching on these topics. Our monthly *Basic Needs Basket* highlights the average cost of living for families, contrasting this with the take-home pay from average salaries. The findings of this survey show that very little money is available to meet family needs for education and health. In October 2001, in conjunction with OXFAM-Zambia, we released a major study on cost sharing in education in Zambia, entitled, *Will the Poor Go to School?* A policy-oriented study, this report urged that cost sharing in primary education should be discontinued because of its negative impact on the quantity and quality of education.

We are pleased now to have sponsored this current study on health care in Zambia, with the report's particular focus on *health equity.* Recent health reforms in Zambia have as their stated objective to provide to all Zambians equitable access to cost-effective and quality health care as close to the family as possible. The purpose of this study is to offer some concrete analytical evidence to evaluate the health reforms with a focus on health equity.

We consider this report a *policy* document, that is, a report aimed at advocacy for improved policies for Zambia. But as the recommendations growing out of our study show, these must not be merely sectoral policies touching on improved health but must be *holistic* policies relating to improvements in the overall socio-economic conditions in the country.

It is our hope that this study will contribute significantly to the priorities and politics that will make such improvements a reality in the near future.

Jesuit Centre for Theological Reflection
Lusaka, Zambia

IS THERE HEALTH EQUITY IN ZAMBIA?

A CASE STUDY

A. OVERVIEW OF THE SCOPE AND RATIONALE OF THE STUDY

Zambia has for long been experiencing high levels of poverty and inequality. This has been manifest in a number of ways, health poverty and inequality being one of them. The causes of the worsening poverty in Zambia have been clearly outlined by the Government in its Poverty Reduction Strategy Paper, PRSP. Over the years, the country has at best experienced marginal economic growth. With a population growth rate of almost 3% per year, the population has more than trebled over the last 40 years. While economic growth has been marginal, successive Governments have failed to follow pro-poor strategies. Lack of sustained economic growth and inadequate pro-poor strategies together with unfavorable land ownership laws and unsupportive land tenure systems as well as the fact that most of the population lead a subsistence existence without access to credit facilities has led to a continuous decline in productivity. Above all, due to poor governance, lack of transparency and accountability, drought, unfavorable international market relations and the huge debt burden, well over 73% of the population has been living below the poverty datum line. The situation has been compounded by the HIV/AIDS epidemic that has been impeding human capital formation necessary for sustainable growth.

One of the fundamental aims of policy is to reduce poverty and inequality. Within the wide array of reforms instituted by the Zambian Government over the past decade, health reforms constitute a prominent component. The express objective of the health reforms is to provide to all Zambians equitable access to cost-effective and quality health care as close to the family as possible.

In the light of the above objective, *have the health reforms been progressing in the right direction?* Comparative data from a series of Living Conditions Monitoring Surveys and Demographic and Health Surveys show that the incidence of diseases, morbidity and mortality has been persistently high.

In its 2001 *Economic Report,* the Government does indicate that even though the delivery of basic health care services has slightly improved, the disease burden has worsened. The incidence rates for malaria, HIV/AIDS, and TB for instance have worsened between 1999 and 2001.

The incidence rate for malaria increased by 2%, while those for HIV/AIDS and TB increased by 8% and 19% respectively. Admittedly, there have been some improvements in some areas. Improvements have been recorded in, among others, health expenditures per capita, number of drug kits, and health center staff loads. The question that still remains unanswered is: how equitably have the achievements been distributed? To what extent have equity issues been addressed? Are the improvements only in average figures while conditions especially for the many in poverty have worsened?

The purpose of this study is to provide some concrete analytical evidence on the success or otherwise of the health reforms with a focus on health equity. This study examines the correlation that exists between socioeconomic status, health status and health equity. Measurable indicators of each of these concepts have been developed in the light of contemporary literature.

B. METHODOLOGY

On the basis of various indices and measures of correlation, the study verifies the extent to which equity exists (or does not exist) in respect of health. Specifically, do the poor or those belonging to low socioeconomic status have the same opportunities as the rich or those belonging to higher socioeconomic strata? These are the issues that are addressed in this study.

Four main indices have been developed:

1. Index of Socioeconomic Status
2. Index of Health Status
3. Index of Accessibility of health services
4. Index of Affordability of health services.

The *Index of Socioeconomic Status* was constructed by averaging the values of a number of sub-indices relating to: ownership of durable goods, ownership of agricultural implements, ownership of livestock, housing, water, sanitation, transport, education and employment.

The *Index of Health Status* was constructed by looking at the health condition of all the members of the sampled households to see to which of five types of health condition they belonged. These five types were: suffering ill-health beyond help, suffering fairly restrictive ability, suffering from a chronic health condition, suffering only occasional illness and being healthy.

The *Index of Accessibility* was constructed on the basis of three variables: the distance from the household to the nearest health facility, the average time taken to reach the health facility, and the means of transport used to commute between the household and the facility.

The *Index of Affordability* was calculated on the basis of cost estimates for a household to cover illness episodes and the financial strain these costs in the form of health expenditures place on the overall household expenditure.

Suitable boundary values were determined for each of the above indices and households were then placed in different categories as belonging to high, moderate or low values of each of these indices. Details of the calculation of these indices are shown in the Technical Annex to the main report.

One incidental aspect, not directly related to the main theme of the study, which was examined was the extent of *preventive health care* undertaken by households to keep the members healthy and minimize the probability of illness.

The study was carried out by collecting first-hand data using a comprehensive questionnaire that was administered to selected households in two selected districts in each of two selected provinces. The provinces selected were Lusaka and Western and the districts selected were Lusaka and Chongwe from the Lusaka Province and Mongu and Shangombo from the Western Province.

The provinces were selected on the basis of the fact that the Lusaka Province was the best faring and the Western Province the most ill faring province in the country in terms of the overall incidence of poverty and level of human development. This has been seen from data from successive Living Conditions Monitoring Surveys and their analysis in several reports such as the Zambia Human Development Reports.

The districts within each province were selected by taking the respective provincial capitals, namely, Lusaka and Mongu and the other two provinces were selected away from the provincial capitals. This was done in order to ascertain the impacts of centrality and centrifugal forces. The general hypothesis in this regard is that socioeconomic conditions deteriorate with increasing distance from the centre, i.e. from the capital.

In all, data were obtained from 396 households distributed among the four districts as follows: Lusaka: 101; Chongwe: 88; Mongu: 105; and Shangombo: 102. Care was taken to ensure that in each district, all income categories were covered as well as to ensure that workable sub-samples were obtained for various tabulations and classificatory analyses (e.g. rural - urban, male-headed – female-headed).

Two softwares were used for data analysis, SPSS and Excel.

C. RESULTS

The results are based on two kinds of analysis: *descriptive* and *correlation*. The descriptive analysis explains the various characteristics of the sample: demographic characteristics such as the sex and age distribution of the sample, status of children, morbidity and mortality, socioeconomic status, health status, affordability and accessibility to health care facilities, gender analysis, the impact of household size and the practice of preventive health care.

The correlation analysis that serves to portray further the equity situation in relation to health looks at the impact of the households' socioeconomic status on the health status, accessibility and affordability of health care by households. It also looks at the correlation of health status with affordability and accessibility and also the correlation between affordability and accessibility. Each correlation can provide insights into the kind of policy formulations that would be needed to address any issues that are seen to emerge.

The following sections provide a gist of the main findings of the study. For more detailed explanations and relevant tables, the reader is referred to the main report (available from the JCTR).

DATA DESCRIPTIONS

A description of the data obtained in the sample has been provided in terms of household demographic characteristics, morbidity and mortality, together with the socioeconomic status, overall heath status, health services affordability and accessibility and levels of preventive care adopted by the households.

Demographic characteristics
In the 396 sampled households, there were 1326 males and 1371 females, giving a total of 2697 members. Of the total number of 2697 members, 379 were children under five, 1042 were between the ages of 5 to 18 and the remaining 1276 were above 18 years of age. The age distribution is biased towards the adult population in the capital districts of Lusaka and Mongu and biased towards the lower age groups, especially the children under 5, in Chongwe and Shangombo.

Of a total of 1936 children in the entire surveyed population, 1257 were the own children of the parents while 679 were other children. One can thus see that there is a significant percentage (35%) of children who are not living with their own parents with possible psychological implications. And from the point of view of the households, there is an additional burden of having to support children other than one's own, with possible financial implications as well as implications for the overall living conditions of the households. The burden of dependence of additional children seems to be more or less evenly distributed in all the four districts with the exception of Chongwe where it seems to be much higher.

Orphanhood as well as economic conditions are the main reasons why the burden of supporting children other than one's own has been thrust upon households.

Incidence of mortality and illness
A larger percentage of households in Chongwe and Shangombo reported deaths than in the provincial capitals.

On the one hand, in Lusaka there were no patients who died that had not been admitted to a health facility. And except for one patient who was discharged and then died at home, the rest died at the facility. Of course, one does not know the exact reasons why the one patient was discharged or why the others died at the facility. The discharged patient may have been one who was suffering from an incurable terminal illness and it might have been felt better that he dies in the comfort of his home. Those who died at the facility might have been suffering from serious illnesses for which the facility might not have been able to provide adequate medical help. Be that as it may, the comforting fact is that they all have had access to the facility.

This is in sharp contrast to the other extreme situation in Shangombo where nearly 64% died at home, with some not having visited a health facility at all and a large majority of them dying after having been discharged from the facility. The latter fact may have in all probability been due to the fact that health facilities in Shangombo hardly have any of the needed medical personnel or perquisites. Although there are many clinics in Shangombo, there are virtually no registered doctors or nurses and drugs are acutely scarce.

In Chongwe too, well over 50% of the patients died at home, with 17% of the patients not having been admitted to a health facility at all.

The above is one illustration of the impact of *centrality*. Lusaka is the best-faring district and Shangombo the worst. But more pointedly, Mongu, the capital of a more deprived province, fares much better than Chongwe that lies in the best-faring province.

It can be noted that in all the four districts, a very large majority who died had received some treatment but were not cured. This clearly suggests that, for whatever reason, the treatment of cases was not adequate / effective. Field observations indicate for instance that drugs were not available in the health facilities, patients consequently resorted to buying cheap and expired drugs from ordinary shops or going to traditional healers for help. While the study did not seek to establish the different sources of drugs, one of the questions in the research instrument was "If you did seek medical help, which health facility did you visit ?". 90% said they sought help from Government health facilities, 6% from private health facilities and 4% from traditional / spiritual healers.

Socioeconomic status

A very large majority of the households in Shangombo fall in the low socioeconomic (SES) category. Shangombo is followed by Chongwe, Mongu and Lusaka in that ascending order of SES.

Two things are noteworthy. One, there are no households belonging to the high SES category in any district except Lusaka. Two, the percentage of households in Chongwe belonging to the low SES category is significantly higher than in Mongu. Both these facts testify to the impact of centrality. Lusaka has very few households belonging to the low SES category and even has some in the high SES category. This is obviously because Lusaka Province as a whole is the best-faring province and Lusaka district is also the provincial capital.

A more striking proof of the impact of centrality is the fact that households in Mongu, the provincial capital of Western Province, on the whole seem better off than in Chongwe.

> "Life is not fair with me and my family. On most occasions we go without food and do not even know where our next meal would come from as no household member works. This makes it very hard for us to have access to health facilities and services, and in the long run we resort to buying cheap and maybe expired drugs from ordinary shops". - A female head of household, Sibanga Village, Katongo area, Mongu.

The fact that out of a total of 396 randomly sampled households, only 8 households belong to the high SES category is indicative of the overall poor socioeconomic situation in the country. Zambia has not experienced any meaningful growth in more than a decade and the overall level of development as measured by the Human Development Index has been consistently declining over the years. Consequently, one can hardly expect many households in the country to belong to the high SES category especially when the SES is defined in terms of a very large number of development-related variables.

Notwithstanding the above, however, one would have probably expected a higher percentage of households to belong to the high SES category in Lusaka. Given that a lot of income and infrastructure is concentrated in Lusaka, there must be a much higher percentage of households in the high SES category than just 8. This must be due to the problems faced in data collection. Enumerators have faced a considerable level of reluctance by affluent households in Lusaka to grant interviews. This would have obviously introduced some bias in terms of the representativeness of the sample for Lusaka that was beyond redress in this research.

Health status

In the entire sample from all four districts, a little over 13% of the households enjoy low health status, nearly 37% enjoy moderate health status and over 50% of the households belong to the high health status category. This result is somewhat *contra-intuitive*. For so much has been said about the generally poor state of health services in the country that one would have expected a majority of the households to belong to the low health status category.

However, the above is no reason for too much cheer since the distribution of health status is not very equal. While over 90% of the households in Lusaka enjoy high health status, the corresponding percentage for Shangombo is only about 21%. And while only 1% of the households in Lusaka enjoy low health status, corresponding percentage for Shangombo is over 25%.

Again, one can note the manifestation of centrality. Households in Mongu enjoy a better health status than those in Chongwe.

Accessibility to health facilities and services
A large majority of the households in the entire sample as well as in each of the four districts has a moderate degree of accessibility. However, once again the distribution is a problem. And yet again, the most extreme contrast is provided by the situation in Lusaka and in Shangombo. While only 1% of the households in Lusaka has a low level of accessibility, nearly half the households have low accessibility in Shangombo. And while nearly half the households in Lusaka have easy or high access to the health facilities, none of the households have easy access in Shangombo.

"We mainly go to private health institutions because government health institutions do not have drugs on most occasions when we visit them and they offer inadequate services". – A head of household, Boma Area, Mongu Township

A very important distinction that needs to be made, however, is between access to health *facilities* and access to health *services*. Easy access to health facilities simply means that the health facility is located at a relatively short distance from the household, that it can be reached at a relatively short space of time, and at a relatively low cost. But this does not necessarily mean or guarantee access to health services if the health facility does not have the needed medical personnel, medical equipment and drugs and other medical supplies. The lack of any these things can result in lack of prompt and proper medical attention and in diagnostic and curative failure. A conclusive demonstration of the reasons for the "ineffectual treatment" can only be reached after more research.

The statistics depicting a high percentage of households enjoying moderate or easy accessibility to health services are, therefore, not of much consolation since the crux of the problem seems to lie with the provision of services. In Shangombo, for example, there is no dearth of health centres – there are nearly three dozen of them - *but there is no single registered doctor, nurse or midwife in the entire district!* The supply of drugs too is sporadic and inadequate.

Affordability of health services

The affordability of health services is influenced by location much in the same manner in which the other variables that we have discussed. There is a high level of easy affordability among households in Lusaka and a high level of low affordability among households in Shangombo. Again, Mongu is better off than Chongwe in respect of affordability too.

Gender analysis

Gender has a notable impact on health status as well as on the affordability of health services. The study shows clearly that the health status in the female-headed households is distinctly lower than in the male-headed households. The results are the same for each of the four districts.

The impact of gender on affordability is also clear. A much larger percentage of male-headed households can easily afford health services as compared to female headed households. This pattern of relationship holds for each of the districts.

Impact of household size in terms of number of children

The affordability of health care by a household seems to vary directly with the number of children in the households, i.e. more the children, better the affordability! For example, while only 37% of the households with one to three children have easy affordability, this percentage increases to over 64% for households with four to seven children and further to nearly 70% for households with more than 7 children. And while 42% of the households with one to three children cannot easily afford health care, this percentage goes down to 39 for households with four to seven children and still further down to 14.5% for larger households!

The only possible explanation for the above results is that households with larger number of children would also have more number of older children who probably work and thereby increase the household income. But this would also suggest that these children would be deprived of schooling.

In other words, more children in households with larger number of children are likely to be out of school than in households with fewer children.

The practice of preventive health care

In general, there is very little preventive care practised by households. Only Lusaka has about 20% of the households practising moderate levels of care. Two households in Chongwe are seen to practise a high level of preventive care but this is not indicative of any trend. Again, the result that no households practise high levels of preventive care may be due to the fact mentioned earlier on that households that would have come in the category of high socioeconomic status especially in Lusaka were not willing to be interviewed. Casual empirical evidence shows that there are individuals who are members of physical fitness centres and sports clubs in major urban centres such as Lusaka whose membership fees are such that they can be afforded only by the well-to-do.

CORRELATION ANALYSIS

In the following sub-sections, we analyze the relation-ships between the key index variables of our study on the basis of cross tabulations. Chi-square tests have been conducted to gauge the statistical significance of the relationships. However, Chi-square tests cannot be used when the expected cell frequency in any cross-tabulation is less than 5. Modifications to the tables through techniques such as Yates Correction can help only to a marginal extent. Hence, the results of the Chi-square tests have been used only in cases where they can be validly interpreted. In particular, Chi-square values have been ignored in respect of those tables where there are several empty cells.

Socioeconomic status and health status

The health status of the sampled households is disproportionately better than the socioeconomic status. For example while 165 out of the total of 396 households (48%) belong to the low SES category, only 52 households (13%) belong to the low Health Status category. Over 50% of the households belonging to the low SES category enjoy moderate health status while 29% of them enjoy even high health status. While 56% of the households belong to the medium SES category, 87% of the households enjoy moderate or high health status. And all the households belonging to the high SES category enjoy high health status. There are only 18 households (less than 5% of the total sample) that enjoy a lower health status than their SES status.

The above results are encouraging to the extent that, in general, a household's health status is not too adversely affected by its socioeconomic status. Although this result seems to hold for all the individual districts as well, there is some noticeable difference in the case of Shangombo where 50% of the households belonging to moderate SES category enjoy low health status.

Socioeconomic status and accessibility to health care facilities
The socioeconomic status does not adversely affect the accessibility of households to health services.

Socioeconomic status and affordability
There is a significant association between socioeconomic status and affordability of health services. Lower the SES status, lower the level of affordability. However, there is no inequity revealed in the relationship per se. This holds true both at the aggregate level as well as at the level of individual districts.

Health status and accessibility to health care facilities
There is a high level of association between access to health care facilities and health status. The Chi-square value of 56.288 is highly significant. This means that, in general, easier the access, better the health status. However, lack of accessibility does not commensurately tell on the health status. For example, while 86 households of the total of 396 households do not have easy accessibility to health care facilities, only 52 households enjoy low health status. And while only 51 households have easy access to facilities, 207 households enjoy high health status.

Health status and affordability of health care
There is a positive relationship between affordability of health care and health status. The Chi-square value of 28.522 for the relevant degrees of freedom is again statistically significant at the 1% level of significance.

The heartening result once again is that the lack of affordability does not have a commensurate impact on health status. While 115 households out of the 396 households cannot easily afford health care services, only 52 households suffer low health status. But at the other end, while 216 households can easily afford health care services, a slightly lower number (207) enjoy high health status.

Affordability of health care services and accessibility to health care facilities
Financial affordability of health care services and physical accessibility to health care facilities are conceptually independent variables by and large.

From the data collected, there are 115 households who cannot easily afford health care services while there are 86 households who cannot easily access health care facilities. But on the other hand, there are 216 households who can easily afford health services but only 57 households who can easily access health facilities! Hence a categorical inference as to which is a greater constraining factor cannot be drawn.

The fact, however, is that, as has already been seen from the earlier analysis of affordability and accessibility, the broad picture in respect of neither of these factors is bad. But there are marked inter-district variations. For example, 48 households out of the 86 households (56%) who cannot easily access facilities are in Shangombo. Again, Shangombo also has 46 households out of the total of 115 households (40%) in the sample who cannot easily afford health care services. Some 14% of the entire sample of households (55 out of 396) suffer from lack of both accessibility and affordability.

SUMMARY OF THE RESULTS

The analysis of the data collected for this study provides some interesting findings. Some of them may even run counter to popular assertions based on sporadic or casual empirical observations. Indeed, the value of such rigorous research and analysis is to disprove some of the stylized notions based on shallow evidence and establish conclusions based on firmer data and analytical grounds.

The general socioeconomic status, gauged from a large number of variables related to the living conditions of households, does not present a healthy picture. But, on the face of it, the picture is not as bleak as the one that emerges from poverty data that are based on money-metric measures alone. While nearly three quarters of Zambian households are known to be poor (based on money-metric measures) from the last Living Conditions Monitoring Survey, only 42% of the households in our study sample belong to the low SES category – the equivalent of poverty. A larger percentage (56) of households belong to the moderate SES category.

The above differences may be on account of two reasons. One, socioeconomic status as defined in this study is a much broader measure of living conditions than one based solely on monetary variables. The latter, for example, do not take into account ownership of a variety of assets that households possess. Two, the results of this study are based only on 4 out of the 72 districts in the country, chosen purposively, and hence may not be fully representative of the situation in the country as a whole. For instance, poverty is known to obtain more in the rural areas than in the urban areas and a large majority of the districts in the country are rural; whereas our study is based on two urban and two rural districts. This factor alone could be responsible for an underestimate of the general situation of deprivation at the national level.

All the same, even 42% based on a comprehensive SES index is a pretty high figure. Moreover, the positively skewed distribution (i.e., a distribution where there are more values below the mean value than values above it) is indicative of the inequity that exists in the society.

The more striking result, however, is that the inequity in socioeconomic status does not seem to be transmitted commensurately to the main health-related factors of this study, namely, health status, accessibility to health care facilities and affordability of health care services. The picture that emerges in respect of these factors is somewhat more sanguine than the one in respect of socioeconomic status. There is on the whole less positive skewness in their distributions than in the case of SES status. This is undoubtedly a sanguine result.

However, the overall picture is marred by significant geographical and gender differences. Levels of health status and of affordability of health care services are lower for female-headed households and for areas removed from administrative centres. In other words, within a given socioeconomic status category, female-headed households experience a lower health status and a lower level of affordability than male-headed households. And likewise, centrality too has a significant impact. The contrasting situations in respect of health-related factors in this study can be seen not only in respect of Lusaka and Western provinces but also between Chongwe and Mongu.

We see a peculiar result in respect of the impact of household size (in terms of the number of children) on the affordability of health care. As we have stated, the positive impact of larger number of children on households' affordability of health care services is probably at the cost of a negative impact on schooling.

"The Government may get the information based on your questionnaire but it may not act at all. The Government has decided to neglect us to die from hunger and disease. I have children who have qualified to secondary school, but due to lack of financial support, they are now roaming the streets of Chongwe. I have a daughter who is quite sick but we have no money to buy the prescribed medicine." – A female head of household, Chikela Village, Chongwe.

SOME QUALITATIVE INSIGHTS

In the course of conducting the interviews with households to elicit information based on the questionnaire, some qualitative information was also collected which provides some critical insights into the mindsets of the households and the coping strategies that they adopt in difficult situations especially in respect of health-related issues.

Households in some areas displayed unwillingness to cooperate with the enumerators. The reasons for this were twofold. One, they have been subjected to interviews by several previous researchers and have not seen any subsequent tangible results for themselves. Two, even if the research outputs come up with policy prescriptions for their benefit, they do not seem to have adequate faith in the Government's commitment to adopt them and ameliorate their lot. *Some felt that only God, not any Government, could help them out of their misery!*

In many instances where the interviewed households had used institutional health facilities, they were just given prescriptions for drugs that they were required to buy from outside. In such cases, either these drugs were purchased from the shops (with the risk of obtaining expired drugs) or they were obtained free from friends and relatives (again with no guarantee of drug quality). Many households also resorted to traditional medicines that could only have a fortuitous curative effect on the patients.

Households also tend to use medicines without any institutional prescriptions. For example, chloroquine is often used for malaria without any formal medical advice. This could entail indiscriminate use of drugs resulting in resistance of the disease to the drugs over time.

Not infrequently, patients are taken to clinics only after the illness has assumed serious proportions, thereby lowering the probability of its cure.

D. CONCLUSIONS AND RECOMMENDATIONS

The main conclusions emerging from the study and the recommendations that can be derived therefrom are summarized below. The conclusions are obtained from both the quantitative and qualitative analyses that have been carried out. It will be noted that although this study is centred on health, the conclusions relate not only to health but to broader concerns regarding the overall poverty situation in the country as well as thematic issues such as centrality, governance and the efficacy and value of the conduct of empirical research, that go beyond the issues of health. Also, health being highly inter-related to several other variables, a *holistic* rather than just a *sector* approach is needed in order to improve the efficiency and equity in the delivery of health services.

Conclusion 1: The chronic poverty of many households and communities seems to have greatly eroded their confidence in the Government and its sincerity to ameliorate their lot. "Governments may come and Governments may go, but we go on for ever in the same plight" seems to be their plaintive theme song.

Recommendation: *Government needs to establish its credibility by producing results on the ground in terms of poverty alleviation and reduction. Now that the PRSP document exists, the projects and programmes contained therein need to be implemented as per schedule with impacts demonstrated on the basis of monitorable indicators. People will have faith in their Government only when they see a concrete improvement in their lives.*

Conclusion 2: The growing impoverishment of households and the incidence of orphanhood due to death of parents from disease, in high probability from HIV/AIDS, have been generating growing numbers of children dependent on other households to take care of them. This in turn leads to deterioration in the living conditions of these latter households.

The burden of supporting additional children seems to be an ubiquitous phenomenon and not something peculiar to the rural or urban households.

Recommendation: *As has been suggested in some earlier studies (e.g. Republic of Zambia, 1999, Serpell, 2000), poverty reduction programmes should use, for greater effectiveness, "Poverty + Health, notably HIV/AIDS" (the latter being the main cause of orphans), for targeting beneficiary groups.*

Conclusion 3: The study confirms the centrality thesis and the consequent inequity that emerges in terms of the distribution of development. As has been noted, as a prominent result of this study, Mongu, being the provincial capital albeit of the worst-faring Western Province fares better than Chongwe in the best-faring province of Lusaka owing to it being removed from the capital of Lusaka.

Recommendation: *Poverty reduction and development programmes should not be concentrated in and around the vicinity of major towns, cities and capitals. This results in an "out of sight, out of mind" approach to development! They need to be evenly spread over the entire country. Indeed, given the higher levels of deprivation already obtaining in the more remote areas in the country as a whole as well as within each province and district, there is need to focus development efforts more on these areas than on those that are already empowered to some extent in respect of various dimensions of development such as social services, employment, infrastructure, etc.*

Conclusion 4: The health status of Zambian households is not as bad as their socioeconomic status. However, there is geographical inequality in the distribution of health status. Remote areas like Shangombo enjoy poor health status.

Recommendation: *The recommendation under Conclusion 3 needs to be implemented specifically in respect of health.*

Conclusion 5: There is a big cleft between accessibility to health facilities and accessibility to health services. While the situation in regard to health facilities is not too bad, the fundamental problem is in respect of adequate provision of health services.

Recommendation: *There is no point in building more health centres or clinics even in areas where there is a shortage of such facilities if you cannot equip them properly. Existing health facilities should be adequately equipped with adequate personnel and supplies before more facilities are created. Failure to follow this principle will result in wastage of resources and inefficiency.*

An expeditious and efficient way of improving the health services especially in the remote areas of the country would be to introduce mobile medical facilities equipped with a complement of staff and medical supplies. In India and South Africa they have mobile medical trains that go from village to village. This may not be feasible in Zambia. However, there could be mobile vans that could move within a given district with known time schedules. For example, in Shangombo there could be a van that would be stationed at a given clinic on a given day and this information should be known to all residents of the district. The scheduling could be done in such a way that the mobile van would be stationed at every clinic once in say two weeks. On any given day, a patient with a fairly serious illness could then go to the clinic where the mobile facility is stationed even if that clinic is not the one nearest to his house. And if the illness is not too serious, he could wait for the mobile facility to arrive at his nearest clinic.

Such mobile facilities could of course initially provide only outpatient facilities but over time their capabilities can be developed to handle more serious cases of illness. These facilities could also perform the function of gathering epidemiological statistics in the district and use the data to cater to patient needs better over a period of time.

Conclusion 6: The people do not see much benefit from the health facilities that are not adequately equipped with competent medical personnel and supplies. Respondents were concerned, in particular, with the continued lack of drugs at health facilities. This forced them to use drugs whose quality they were not sure of. They obtained drugs from relatives and friends or purchased from drug stores. They are also not aware of the right dosages of the drugs resulting often in over-consumption and consequent enfeeblement of immunity to drugs over a period of time.

It may be added in passing that a systematic supply of drugs through approved heath facilities also serves to enhance the credibility of the health system. For instance, recently the CEO of a noted pharmaceutical company, Smith, Kline and French stated that they would be willing to supply African countries with the anti-retroviral drugs (ARVs) for AIDS that are otherwise very expensive,

at cost price on one condition.

The condition was that the drugs should be supplied only through clinics and must be accessible to the poor. Their fear is that otherwise the drugs supplied to these countries at low cost will be sold to private traders who then may re-export them to make huge profits.

Recommendation: *Adequate and continuous provision of drugs and medical supplies at the health facilities, even at a cost, will reduce the use of expired drugs and the costs of searching for drugs. Since households are already purchasing drugs, they might as well purchase them from the health facilities where they will be assured of proper quality and dosages of the drugs. They will also be able to buy the drugs at much lower prices than what are charged in other sources.*

Conclusion 7: Qualitative data suggest that there may be significant substitution impacts between the consumption of health and other goods and services. For example, if there are many sick members in a household or members who are chronically ill, even if they are receiving treatment for which households are spending money, it does not imply that households can afford such expenditures. Often, this expenditure may be incurred by saving on food and children's education. Household may consume less food or pull children out of school so that the resultant savings may be used to treat sick members.

Recommendation: *The problem of health has to be addressed from a holistic perspective because of the inter-linkage of health with other dimensions such as food, nutrition, education, etc. Spending to cure the illness of the sick members of the household by reducing food and nutritional intake of other healthy members, for example, would increase the probability of the latter too falling ill and thereby warrant further future spending on curative health. Thus the affordability of health services must be gauged not by the actual spending by households on the services but in relation to the overall basic needs of the households.*

Conclusion 8: Gender inequity exists in respect of health status and affordability of health care. This study serves to reinforce the broader findings from numerous researches that gender differentials constitute a serious development issue that needs to be addressed.

Recommendation: *Health programmes and more broadly poverty reduction and development programmes must target female-headed households.*

Conclusion 9: There is very little preventive health care practised by households. This warrants a much higher level of expenditure on curative care.

Recommendation: *There is need to encourage households to undertake preventive health care measures such as abstinence from smoking and excessive consumption of alcohol, boiling water before drinking and other such cost-less measures. The efforts under the Roll-Back Malaria Campaign mentioned in recent budgets by which there could be greater and inexpensive access to mosquito nets need to be sustained.*

Conclusion 10: It is clear from the study that a broader measure of living conditions than one based solely on monetary variables gives a slightly different picture of poverty levels.

Recommendation: *In working out exemption mechanisms account should be taken of other variables other than monetary ones only. Given the scarcity of resources, use of broader variables, like the ones used in this study to construct indices, will ensure that only the needy benefit from the well intended exemption mechanisms.*

Conclusion 11: It is clear from most of the respondents that they don't see much value from the research conducted. Researchers too, like Government, seem to come and go while their plight of poverty goes on unchanged. Consequently, over time they become less willing to cooperate with researchers in the latter's data collection exercises.

Recommendation: While it should be acknowledged that not all research does result in visible change, and that even when it sometimes does it is only after a while, efforts should be made by researchers to make this very clear to the respondents. Just as there are no quick fixes to many serious problems, there can also be no quick results from research even if they are development oriented. Researchers should also only resort to primary data collection in instances where secondary data are not available. In such instances, when feasible, use could be made of the Central Statistical Office in data collection by inputting in the process at earlier stages of formulating research instruments. Also, a modest monetary incentive to the sampling units may help in getting the needed cooperation in furnishing information.

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