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Towards universal health coverage in Zambia: impediments and opportunities

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ABSTRACT

Universal health coverage has been given a prominent place in the post-2015 global development agenda, but there are concerns over its feasibility in low- and middle-income countries. This article assesses successive Zambian governments' efforts to achieve this agenda. We discuss the recent restructuring of health governance to support policies that re-emphasise the social determinants of health and health equity. This includes a new Ministry of Community Development and Mother and Child Health alongside the Ministry of Health. We argue that recent innovations in policy and practice need to be extended to include ministries which focus on economic development.

On prévoit que la couverture médicale universelle occupera une place importante à l'ordre du jour du développement mondial post-2015, mais il y a des inquiétudes concernant sa faisabilité dans les pays à revenu faible et intermédiaire. Cet article évalue les efforts de gouvernements zambiens successifs pour faire de cet ordre du jour une réalité. Nous discutons de la récente restructuration de la gouvernance de la santé afin de soutenir des politiques qui remettent l'accent sur les déterminants sociaux de la santé et de l'équité dans le domaine de cette dernière. Il s'agit entre autres d'un nouveau ministère du Développement communautaire et de la santé maternelle et infantile, parallèlement au ministère de la Santé. Nous soutenons que les récentes innovations en matière de politiques et de pratiques doivent être élargies de manière à englober les ministères qui se concentrent sur le développement économique.

En el marco de la agenda de desarrollo mundial pos-2015 se prevé que la cobertura de salud universal tenga un lugar destacado; sin embargo, existe preocupación en torno a su viabilidad en los países de ingresos bajos y medios. El presente artículo evalúa los esfuerzos encaminados a lograr este objetivo, realizados por sucesivos gobiernos zambianos. Al respecto, los autores examinan la reciente reestructuración implementada en el aparato gubernamental de salud para apoyar las políticas centradas, nuevamente, en los determinantes sociales de la salud y de la equidad sanitaria. Tal reestructuración incluye la creación del flamante Ministerio de Desarrollo Comunitario y Salud Infantil, que opera junto con el Ministerio de Salud. Los autores sostienen que las recientes innovaciones implementadas en las políticas y las prácticas deben extenderse a los ministerios que impulsan el desarrollo económico.

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Introduction

The concept of universal health coverage (UHC) has received a prominent place in the post-2015 global development agenda as the United Nations facilitated the revision of the Millennium

Development Goals (MDGs) (UN 2012). The concept combines both a technical agenda, the provision of all necessary services to serve health care demands in a national population, and a rights agenda – equity in the provision of health services among that population. Central to the concept of UHC are access to health services and financial risk protection. The goal of UHC is:

“to ensure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship”. (WHO 2010)

In 2005, World Health Organisation (WHO) member states committed to this goal via adoption of World Health Assembly resolution 58.33 (WHA 2005). The inclusion of UHC in the new Sustainable Development Goals is a reiteration of health as a fundamental human right, intending to renew the global commitment to closing the pervasive gaps in access to health care between the poor and the rich.

UHC is not a new concept. It has existed under various guises since the late 1970s and, most recently, as “universal coverage” summarising the goals of national anti-retroviral treatment programmes. The significance of the concept is that it represents a globally agreed goal, which also underpins health system strengthening in many African countries, and yet it has been elusive in those countries (Waage et al. 2010). This article considers the major impediments and opportunities for moving towards UHC, by means of a country case study. We analyse past and current efforts in Zambia in providing equitable health care since the country gained political independence in the 1960s and whose government, in 2013, implemented substantive changes in policy and health governance to help achieve this goal.

Methodology

In our analysis, we understand a country’s health sector as being one in a range of factors influencing progress toward UHC. We refer to the analytical framework by Solar and Irwin in which contextual factors, such as governance, societal values, macro-economic and public policies, are given substantial weight in determining health equity outcomes in any country (Solar and Irwin 2010). There is a body of literature which supports this perspective (Coburn 2000; London and Schneider 2012; McKee et al. 2013; Navarro et al. 2006; Savedoff et al. 2012).

This article is based on results from a qualitative study conducted in Zambia between September 2012 and September 2014, which examined the development of public policy and strategy for the provision of chronic care services in the country. Methods included desk reviews, interviews, focus group discussions, and service observations. Our informants were officials from the Ministry of Health (e.g. policymakers, senior programme and tertiary level facility staff), the Ministry of Community Development, Mother and Child Health, the National AIDS Council and in-country technical assistance, funding, and United Nations agencies ($n = 18$); health care professionals operating at district, primary, and community level, such as physicians, nurses, counsellors, and programme staff of community based care programmes ($n = 17$); specialists involved with the country’s health management information system ($n = 19$); and community caregivers ($n = 36$). Interim results revealed substantive changes in policy and governance structures in 2013 which reflected both the government’s commitment to providing “equitable access to health care for all” alongside awareness of the threats to its health agenda, such as the emergence of chronic conditions. This led us to extend our study with an exploration of past and current reforms in the Zambian health sector. We undertook a desk review and conducted further interviews with directors and senior managers in Zambia’s health services, and with health system researchers and advisors ($n = 7$), in relation to the goal of equitable health care. Our selection included both local and international informants and was based on the informants’ experiential knowledge on recent developments and changes to the national health policy and on past periods of health sector reforms.

The study was approved by the biomedical research ethics committee of the University of Zambia (reference 013/02/11) and the medical ethics review committee of the VU University Medical Centre in Amsterdam, the Netherlands (reference 2011/180).

Findings

It should be noted that we discuss findings rather than results because, as indicated above, this article is the product of additional primary and secondary research to the core study, to investigate a particular set of issues and put them in historical context. The results of the core study have been published elsewhere (Aantjes, Quinlan, and Bunders 2014a, 2014b).

A history of aspiration, directed efforts, and profound challenges to equitable health care

From the 1960s to date, consecutive governments have aspired to: “equitable health care for all Zambians”. Here, we set the scene for our analysis by outlining the efforts and challenges associated with achieving this goal during the past five decades.

Inheriting a very inequitable, colonial health system in 1964 provided the impetus for that aspiration, not as an overt expression of human rights to health but from a conviction that all Zambians should be treated equally. There was no separate public policy on health at the time; health was included in the national development plan (GRZ 1966). The health sector was initially centrally governed by a Ministry of Health (MoH) with headquarters in the capital, with some allocation of administrative responsibilities to the provincial level and the larger hospitals. The sector’s focus was on undoing the inequitable divisions in health service delivery along racial and geographical lines and involved a significant, and necessary, expansion in health infrastructure. The emphasis was on provision of basic health services, disease prevention, and health education. Hospital and out-patient services were provided free of charge. The success of these efforts, evidenced by improvements in health indicators (Garenne and Gakusi 2006), was founded upon the fast growth of Zambia’s market economy during the 1960s. However, that momentum stalled by 1974 as the country experienced economic stagnation. Declining revenues from its main economic resource, copper minerals, and the effects of a global economic crisis, pushed Zambia from its middle-income country classification to a low-income country. By 1978, the country was heavily indebted and underwent a series of World Bank-led structural adjustment programmes (SAPs). A dramatic decline in the health expenditure per capita, and a “SAP ideology” in which health was regarded a consumer good and not a right, were the deathblow to the provision of equitable health care in Zambia. The net results were plummeting health indicators in a context of steeply rising poverty among the populace.

In 1991, a new government was elected. It criticised the former government for not having been able to address the unequal distribution of health care services, particularly between urban and rural areas (Kalumba 1997). This government developed Zambia’s first national health policy, and committed to reducing this disparity (MoH 1991). The new ruling party’s vision for the health sector was to provide equity of access to cost-effective, quality health care as close to the family as possible. It emphasised the need to return to the delivery of comprehensive primary health care (PHC) services, and acknowledged the significance of the social determinants of health (MoH 1991). According to informants, this included efforts to integrate disease programmes in primary health services, and environmental health (water and sanitation activities) was built into the definition of the basic health care package. Health care equity was sought via the delivery of PHC and the decentralisation of authority and finance to district health management teams. These teams as well as district health boards were established in 1993–94, with the objective to match planning and budgeting processes with the realities on the ground. Provisions were made, by earmarking 75% of the total budget, to secure sufficient budget for district health care. This was a conscious attempt to ‘right-size’ the budget which, after independence, had disproportionately been consumed by the larger hospitals.

The governance of the health sector was restructured via the establishment of a semi-autonomous body, the Central Board of Health, which monitored the performance of the districts. The role of the MoH was confined to policy-making and sector regulation. The restructuring was based on a Swedish model (MoH 1991). The country was initially a frontrunner in the region (Cassels and Janovsky 1996) but the conditionalities attached to the SAPs and a deterioration in socio-economic circumstances for many Zambians proved major obstacles in the implementation of the health sector reforms.

Via the adjustment programme and other donor aid conditionalities, neo-liberal political influences percolated into public policy in Zambia. To illustrate, the national health policy stated that *"every abled bodied Zambian with an income should contribute to the cost of his or her health"* (MoH 1991). The reality was that only a small proportion of Zambians at the time were able to make such contributions. In 1991, 68.9% of the population fell below the poverty line (Thurlow and Wobst 2004; WB 1994). Poverty was particularly rampant in rural areas (88%) as a result of urban-biased government policies; in urban areas 46% of the population was below the poverty line (Thurlow and Wobst 2004). In pursuit of cost-recovery, user fees for health services were introduced in 1993. This intervention had a detrimental effect on the utilisation of health care by the poor (Blas and Limbambala 2001); a trend which was also witnessed elsewhere in the region (Makinen et al. 2000). Two years later, these fees were exempted for certain users and conditions (e.g. children under five and chronic conditions) but this had little effect as the public welfare assistance scheme which had to facilitate this policy decision failed to do so (Masiye, Chitah, and McIntyre 2010). The human development index, a composite measure for human development, consistently ranked Zambia in the lowest group globally; Zambia has not been able to migrate from there since (UNDP 2013).

These developments occurred as Zambians experienced the devastating effects of an HIV/AIDS epidemic. In the context of a severely constrained and underfunded health sector, civil society organisations led the response to the epidemic through pragmatic, community-oriented palliative care services and through invocation of existing, cultural values that emphasised mutual social support among community members. In the provision of services use was made of trained lay-persons, who lived in the villages and towns visited by mobile medical teams, to assist medical staff. It was a means to mitigate the costs of providing care and the limited human resources and infrastructure of Zambia's health sector. The government's health decentralisation programme of the 1990s promoted the use of community-based networks. Neighbourhood health and health centre committees were formed as a means to institutionalise the link between local communities and the health system. In effect, this policy provided the space for civil society to emerge as key agents in the provision of community-based health care and close part of the gap left by the state's inability to protect the most vulnerable in society.

It took well into the 2000s for substantive actions to redress the negative effects of the structural adjustment programmes on the health sector. The enablers for these actions were a recovery in national economic growth, debt relief to the country, and large-scale increases in donor aid for health, specifically for HIV/AIDS programmes (Cuesta, Kabaso, and Suarez-Becerra 2010; Rakner 2004). Ideologically, the government was influenced by the HIV strategies of international agencies such as UNAIDS and WHO, which advocated for people-centred services. In other words, the government could re-emphasise its commitment to equitable health care because of the exceptional foreign investment in health care and global political support for this aspiration. To illustrate, donor funding constituted 11% of the country's health budget in 1995, and 38% in 2004 (MoH 2008). Foreign aid outweighed the domestic allocation for health, which averaged 9% during 2006 to 2009 (Cuesta, Kabaso, and Suarez-Becerra 2010).

There were substantive changes in Zambian health strategies within a very short time period. For example, in 2004, the government introduced free anti-retroviral treatment (ART) for HIV patients in selected hospitals. In the same year, the Central Board of Health was disbanded and MoH regained authority to direct the country's health agenda. The MoH began to decentralise the ART programme

across the country. User service fees were abolished at rural health facilities in 2006 and, in 2007, at peri-urban health facilities. The MoH also increased the wages of medical professionals in an attempt to halt their exodus from the country, which had started in the early 1990s and had a profound effect on service capacity. The government formulated a long-term development plan with the vision to become a middle-income country by 2030 (GRZ 2006). In this plan, equitable health care provision was once more affirmed. The policy and programmatic emphasis was on development of community-level services which by then were founded largely upon CSO-led community programmes. Around 2007–08, the MoH was exploring avenues to engage with these (mostly HIV-focused) programmes and commenced with preparations for a national community health worker strategy and a community-based health management information system. In 2008, the MoH signed the Ouagadougou declaration, together with other African countries, which committed it to the “revitalisation of PHC”. The goal of the declaration was to re-entrench the principles to achieving health for all from the 1978 Conference in Alma Ata. Actions by the government included plans to construct an additional 650 health centres, to recruit more nurses to staff these centres, and a training programme to establish cadres of state-paid community health assistants (CHAs). These efforts provided the basis for a strategy to integrate CSO-led community programmes into the ambit of MoH PHC facilities. In 2012, the MoH deployed its first cadre of CHAs into rural communities and in that same year, Zambia reached universal coverage for ART (covering 450,000 of the 520,000 of people in need of treatment; UNAIDS 2013) after having successfully decentralised this treatment to PHC clinics. Practical innovations in the ART programme have included experiments with introducing electronic patient files, establishing mobile treatment clinics in rural areas, and delegation of treatment-related tasks to nurses and counsellors.

During this time, in 2011, a new government came to power and quickly emphasised its commitment to the aspiration of equitable health care. It abolished the user fees for PHC in urban health facilities and promulgated a new national health policy (GRZ 2012b). The vision in the policy is to “provide equitable access to cost effective quality health services, as close to the family as possible”, with an explicit commitment to address the social as well as biomedical determinants of health by aligning future health strategies with the country’s socio-economic development plans. In brief, the government prioritised health and well-being from the perspective that investments in public health are necessary for sustainable development. The vision was supported by the necessary financial injections as well as a restructuring process in social sector ministries. In 2011, Zambia was one of six African countries which were spending 15% of their national budget on health care, a goal agreed upon by all members of the African Union in 2001. The government has maintained this level of spending; for example, in 2014 it increased the 2013 domestic allocation to the health budget by 16% (KPMG 2014). Similar increases are witnessed in the social welfare budget. One director in this Ministry explained that for 2014:

“... the social welfare programme budget line has increased to 199 million [Kwacha; local currency]. They have been given an extra 150 million. Before they used to be as low as 30 or 40 something. So the government allocation is very high, it is the highest I think has happened.”

The government made substantive changes to the governance of health and social welfare services by creating a new ministry, the Ministry of Community Development, Mother and Child Health (MCDMCH). This ministry was given the responsibility of managing the delivery of PHC services, as part of its mission “to effectively and efficiently facilitate the provision of equitable social protection and quality PHC services to communities in order to contribute to sustainable human development” (MCDMCH 2013). The MoH retained authority to manage implementation of the health policy, research, and delivery of “curative care” (i.e. the management of secondary and tertiary level health care). The expectation is that the alignment of PHC with the departments of social welfare and community development under one ministry will create greater opportunities for addressing the social determinants of health, via a pool of civil servants who actively liaise with each other and with existing groups of volunteers in the delivery of services at community level.

In summary, in the past five decades, a multitude of factors have influenced the provision of equitable health care. Many of these, such as macro-economic policies, fell outside the jurisdiction of the sector but had a profound impact on the aspired outcome. In the last six years, better economic prospects as well as a range of innovative policies and strategies have brought the country closer to the longstanding ideal of equitable health care. Now, as Zambia continues this quest under the guise of achieving UHC, new impediments arise. These are discussed in the next section.

Current impediments and opportunities

The economic foundation for Zambia to sustain its commitment to equitable health care is the country's successive, substantive annual economic growth rates during the last 15 years (WB 2013a). The pursuit of equitable health care is underpinned by an explicit attention on the social determinants of health in the current government's agenda: expressed in the promotion of inter-sectoral interventions and epitomised in the creation of the MCDMCH. This is not a new agenda in Zambia, as shown in the previous section; the difference today is the evidence that the trickle-down effect of economic growth to the poor population – as once promoted by the “Washington consensus” (Williamson 1990) – has unfortunately been negligible in the country. In 2010, 60.5% of the Zambian population still lived below the poverty line, with a continuation of the strong rural–urban disparity (77.9% versus 27.5%) (GRZ 2012a). Furthermore, income inequality has risen consistently since 2003: in 2010 the Gini coefficient for Zambia was worse than it was in 1993 and the latter was a time when SAPs were in place (WB 2010). This situation is not unique to Zambia. For example, the African Development Bank has reported that during the last decade, six out of the world's ten fastest growing economies were in Africa but there was insignificant redistribution of wealth within these economies (ADB 2012).

Economic growth coupled with widespread poverty has also generated new demands on the country's health system. Notably, changes in the composition and concentrations of the national population have led to the increase in chronic non-communicable diseases (Aantjes, Quinlan, and Bunders 2014a). The manager of one of the largest hospitals in the country made the point aptly:

“You see the costs for health care, for sure, has gone up. Because mainly the dynamics in the community, there has been in shift in health dynamics that will require more money on certain disease conditions. The demographics also you see, Lusaka is rapidly expanding, lots of poor shifting to the city, so impact on health services is much more.”

Furthermore, even though recent consecutive Zambian governments have increased, and continue to increase domestic funding for the country's health services, the health system as a whole is subsidised by foreign donor funds and that funding has been decreasing since 2010 following the global financial crisis. Precise figures on the funding reductions for Zambia's health sector do not yet exist in the public domain, but World Bank data (WB 2013b) indicate a decrease during 2010–2012 and less financial support than was received during the previous decade. There is some indication that Zambia is managing to maintain the momentum of its broad health system strengthening agenda partly by securing loans and investments from India and the People's Republic of China (Kragelund 2011). Senior Zambian government officials also reported that social health insurance and further taxation are being considered as options; these being mechanisms which have previously been advocated by WHO as means to achieve UHC (WHO 2010). However, it should be noted that there is a body of research which shows that these measures do not necessarily work in contexts of widespread poverty (Basaza, Criel, and van der Stuyft 2008; Ekman 2004; Jütting 2004).

This leaves Zambian policymakers, for now, with the option to either spread the available resources thinly or to prioritise a number of diseases. Both options affect the equity agenda. If resources are spread too thinly, the quality and quantity of services are inevitably affected. As one advisor to the MoH stated: “*equity to services does not mean equity to poor services*”. As a result, those who can afford better services opt for the private health sector. This point was made succinctly

by a director of health programmes in a large umbrella organisation representing the private not-for-profit health sector in Zambia:

“... you have equipment, even state of the art equipment, you have a specialist but it is congested, and nobody would like to wait for six months to be seen by a doctor. But if I go into the private sector, the same doctor will see me within a day.”

If certain services are prioritised over others, inequity also creeps into the system. The strain of decision-making is already evident as voiced by a MoH director: *“the difficulty I have is ... I can buy a CAT-lab at such an amount of money and then drive just 15km from here, what is confronting a child is just malaria and diarrhoea”*.

In sum, health officials are grappling with the challenges associated with sustaining improvements to the country's PHC services and developing the capacity of secondary and tertiary level health care services, in the face of changing burden of disease and health care demands in the country. In practice, at present, the programmatic focus at the level of primary health facilities is on maternal and child health, the integration of CSO-managed community and home-based care (CHBC) programmes with MoH PHC facility operations, and on the provision of health care for communicable diseases at these facilities. MoH officials highlighted plans to address the rise of non-communicable diseases (NCDs) in the country; for example, via establishment of specialist clinics at each provincial hospital, expansion of the cancer hospital, purchase of necessary technologies such as MRI, CT, and CAT scan machines, building a heart catheterisation laboratory, and investment in overseas medical specialisation training for Zambian doctors. However, there was little evidence of development of NCD care services at primary level facilities, despite comments from doctors that secondary and tertiary level facilities were overburdened with treating complications in NCD cases that could have been prevented through appropriate patient monitoring and treatment in PHC facilities. For instance, at present, NCD care skills are not part of the training curriculum for community health workers; there are no NCD care refresher courses for nurses and doctors; and there are no standardised protocols for simple screening activities such as blood pressure measurement in health centres. This is the context behind the frustrations voiced by a MoH director:

“... if you do not fix things at PHC, you will change the secondary level hospitals into first level hospitals and then you will have the whole system again bending towards, responding to where there is a challenge. That is what we are seeing, that is what we were discussing now ...”

These challenges reiterate challenges that Zambia's health sector has experienced since the 1960s; and which have been well described in the literature (Marquez and Farrington 2012; Rice 1966; Shiffman, Berlan, and Hafner 2009), namely how to balance investment between curative and preventive care services, whether to opt for comprehensive or selective health care, and how to prevent inequities that inevitably arise with the growth of private health services. Currently, Zambia seems to be trying to expand gradually from a narrow set of services to comprehensive services which focus on maternal and child health, communicable and non-communicable diseases, as also suggested in the literature on UHC (O'Connell, Rasanathan, and Chopra 2014; Sachs 2012; WHO 2014). This is complemented by an acceleration in the delivery of social welfare services. Notably, according to two informants, one director in the MoH and another in the MCDMCH, the intention in 2015 was to use conditional social cash transfers to reach the very poor with basic social services. For example, pregnant women enrolled into the cash transfer programme will need to use ante-natal and post-natal services. A related planned intervention, informed currently by strong advocacy among women parliamentarians to reduce the practice of child marriages (girls married at a young age according to customary norms and values), is to provide the cash transfers on condition that parents ensure their daughters attend secondary schools.

The alignment between Zambia's health, community development, and social welfare departments is a significant step as it re-emphasises commitment to the social determinants of health¹. However, as our historical analysis shows, this collaboration may still fall short of overcoming the

structural impediment of poverty. The observation is supported by the work of other scholars who argue that health and social protection programmes are not sufficient to address ill health in contexts of poverty (De Janvry and Sadoulet 2009; Marmot et al. 2008). This implies that inter-sectoral action needs to be extended further in Zambia. There are precedents; for example, promotion of agricultural production in China has helped to improve the economic and social conditions of the rural poor (De Janvry and Sadoulet 2009; Montalvo and Ravallion 2010). It should be noted that there are limited references in literature on how to design and implement effective inter-sectoral policies (Shankardass et al. 2012). In the case of Zambia, efforts to achieve UHC need to be accompanied by investigation of what combination of policies and actions could effectively reduce economic inequities and contribute to improving the health status of the poor.

Conclusion

UHC, under different guises, is a long-standing aspiration in Zambia. It is an aspiration which made important strides in the last six to eight years via innovative strategies in the health sector. Notably, substantive changes in health policy and governance in the last two to three years re-emphasise the social determinants of health. This is an important but, of itself, not sufficient step to address the underlying inequities in Zambian society which help aggravate the burden of disease. The crux of the matter is that the MCDMCH and the MoH may be seen to be driving innovative, effective interventions but these confront only the symptoms of inequitable economic development in the country. Consequently, it is predictable that the goal of UHC, which has seemed achievable in the last five to six years, will once again elude Zambian policymakers. The caveat to this conclusion is that much depends on whether the alignment between the MCDMCH and MoH will be followed by a further elaboration of Zambia's inter-sectoral policies and which include ministries that focus on economic development.

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No potential conflict of interest was reported by the authors.

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Note

1. It has to be noted that the decision to place the responsibility for PHC under the MCDMCH was reversed and brought back to the Ministry of Health. This decision occurred during the time this paper was accepted for publication.

References

- Aantjes, C. J., K. Quinlan, and J. Bunders. 2014a. "Practicalities and challenges in re-orienting the health system in Zambia for treating chronic conditions." *BMC Health Services Research*, 14: 295.
- Aantjes, C. J., K. C. Quinlan, and J. F. G. Bunders. 2014b. "Integration of community home based care programmes within national primary health care revitalisation strategies in Ethiopia, Malawi, South-Africa and Zambia: a comparative assessment." *Globalization and Health* 2014, 10: 85.
- ADB (African Development Bank). 2012. "Income Inequality in Africa." Briefing Note 5. Tunis: African Development Bank Group.
- Basaza, R., B. Criel, and P. van der Stuyft. 2008. "Community Health Insurance in Uganda: Why does Enrolment Remain Low? A View from Beneath." *Health Policy* 87 (2): 172–184.
- Blas, E., and M. Limbambala. 2001. "User-payment, Decentralization and Health Service Utilization in Zambia." *Health Policy and Planning* 16 (suppl 2): 19–28.
- Cassels, A., and K. Janovsky. 1996. "Reform of the Health Sector in Ghana and Zambia: Commonalities and Contrasts." Geneva: World Health Organisation.
- Coburn, D. 2000. "Income Inequality, Social Cohesion and the Health Status of Populations: The Role of Neo-liberalism." *Social Science & Medicine* 51 (1): 135–146.
- Cuesta, J., P. Kabaso, and P. Suarez-Becerra. 2010. "How Pro-poor and Progressive Is Social Spending in Zambia?" Policy Research Working Paper 6052. Washington D.C.: The World Bank Poverty Reduction and Economic Management Network. Poverty Reduction and Equity Unit.
- De Janvry, A., and E. Sadoulet. 2009. "Agricultural Growth and Poverty Reduction: Additional Evidence." *The World Bank Research Observer* Ikp015.
- Ekman, B. 2004. "Community-based Health Insurance in Low-income Countries: A Systematic Review of the Evidence." *Health Policy and Planning* 19 (5): 249–270.
- Garenne, M., and A. E. Gakusi. 2006. "Vulnerability and Resilience: Determinants of Under-five Mortality Changes in Zambia." *World Development* 34 (10): 1765–1787.
- GRZ (Government Republic of Zambia). 1966. "First National Development Plan 1966-1970." Lusaka: Office of National Development and Planning.
- GRZ (Government Republic of Zambia). 2006. "Vision 2030: A Prosperous Middle-income Nation by 2030." Lusaka: Government Republic of Zambia.
- GRZ (Government Republic of Zambia). 2012a. "Living Conditions Monitoring Survey Report 2006 & 2010." Lusaka: Central Statistics Office.
- GRZ (Government Republic of Zambia). 2012b. "National Health Policy." Lusaka: Ministry of Health.
- Jütting, J. P. 2004. "Do Community-based Health Insurance Schemes Improve Poor People's Access to Health Care? Evidence from Rural Senegal." *World Development* 32 (2): 273–288.
- Kalumba, K. 1997. "Towards an Equity-Oriented policy of Decentralization in Health Systems Under Conditions of Turbulence: The Case of Zambia." Discussion paper. Geneva: Forum on Health Sector Reform, Secretariat, Division of Analysis, Research and Assessment, World Health Organisation.
- KPMG (Klynveld Peat Marwick Goerdeler). 2014. "2014 Government Budget Highlights." Lusaka: KPMG Zambia Ltd.
- Kragelund, P. 2011. "Back to BASICS? The Rejuvenation of Non-traditional Donors' Development Cooperation with Africa." *Development and Change* 42 (2): 585–607.
- London, L., and H. Schneider. 2012. "Globalisation and Health Inequalities: Can a Human Rights Paradigm Create Space for Civil Society Action?" *Social Science & Medicine* 74 (1): 6–13.
- Makinen, M., H. Waters, M. Rauch, N. Almagambetova, R. Bitran, L. Gilson, D. McIntyre et al. 2000. "Inequalities in Health Care Use and Expenditures: Empirical Data from Eight Developing Countries and Countries in Transition." *Bulletin of the World Health Organisation* 78 (1): 55–65.
- Marmot, M., S. Friel, R. Bell, T. A. Houweling, and S. Taylor. 2008. "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health." *The Lancet* 372 (9650): 1661–1669.
- Marquez, P. V., and J. L. Farrington. 2012. "No more Disease Silos for Sub-Saharan Africa." *British Medical Journal* 345, e5812–e5812.
- Masiye, F., B. M. Chitah and D. McIntyre. 2010. "From Targeted Exemptions to User Fee Abolition in Health Care: Experience from Rural Zambia." *Social Science & Medicine* 71 (4): 743–750.
- MCDMCH (Ministry of Community Development, Mother and Child Health). 2013. "Strategic Plan 2013-2016." Lusaka: Ministry of Community Development, Mother and Child Health.
- McKee, M., D. Balabanova, S. Basu, W. Ricciardi and D. Stuckler. 2013. "Universal Health Coverage: A Quest for All Countries but Under Threat in Some." *Value in Health* 16 (1): S39–S45.
- MoH (Ministry of Health). 1991. "Health Policy Framework. Managing for Quality: A Healthy People Policy Framework." Lusaka: Ministry of Health.
- MoH (Ministry of Health). 2008. "National AIDS Spending Assessment (NASA 2005-2006)." Lusaka: Ministry of Health, National HIV and AIDS/STI/TB Council.
- Montalvo, J. G., and M. Ravallion. 2010. "The Pattern of Growth and Poverty Reduction in China." *Journal of Comparative Economics* 38 (1): 2–16.

- Navarro, V., C. Muntaner, C. Borrell, J. Benach, Á. Quiroga, M. Rodríguez-Sanz, and N. Vergés. 2006. "Politics and Health Outcomes." *The Lancet* 368 (9540): 1033–1037.
- O'Connell, T., K. Rasanathan, and M. Chopra. 2014. "What does Universal Health Coverage Mean?" *The Lancet* 383 (9913): 277–279.
- Rakner, L. 2004. *Economic and Political Liberalization in Zambia, 1991-2001*. Uppsala: Nordic Africa Institute.
- Rice, D. 1966. "Three Paradoxes in Health Development." *Public Health Reports (1896-1970)* 81 (10): 885.
- Sachs, J. D. 2012. "Achieving Universal Health Coverage in Low-income Settings." *The Lancet* 380 (9845): 944–947.
- Savedoff, W. D., D. de Ferranti, A. L. Smith and V. Fan. 2012. "Political and Economic Aspects of the Transition to Universal Health Coverage." *The Lancet* 380 (9845): 924–932.
- Shankardass, K., O. Solar, K. Murphy, L. Greaves, and P. O'Campo. 2012. "A Scoping Review of Intersectoral Action for Health Equity Involving governments." *International Journal of Public Health* 57 (1): 25–33.
- Shiffman, J., D. Berlan, and T. Hafner. 2009. "Has Aid for AIDS Raised all Health Funding Boats?" *JAIDS Journal of Acquired Immune Deficiency Syndromes* 52: S45–S48.
- Solar, O., and A. Irwin. 2010. "A Conceptual Framework for Action on the Social Determinants of Health, Social Determinants of Health Discussion paper 2." Geneva: World Health Organisation.
- Thurlow, J., and P. Wobst. 2004. *The Road to Pro-poor Growth in Zambia: Past Lessons and Future Challenges*. International Food Policy Research Institute.
- UN (United Nations). 2012. "United Nations General Assembly Resolution 66th Session: The Future we Want A/RES/66/288." New York: United Nations.
- UNAIDS (Joint United Nations Programme on HIV/AIDS). 2013. "Global Report. UNAIDS Report on the Global AIDS Epidemic 2013." Geneva: Joint United Nations Programme on HIV/AIDS.
- UNDP (United Nations Development Programme). 2013. "Human Development Report. The Rise of the South. Human Progress in a Diverse World." Geneva: United Nations Development Programme.
- Waage, J., R. Banerji, O. Campbell, E. Chirwa, G. Collender, V. Dieltiens, A. Dorward et al. 2010. "The Millennium Development Goals: A Cross-sectoral Analysis and Principles for Goal Setting after 2015." *The Lancet* 376 (9745): 991–1023.
- WB (World Bank). 1994. "Zambia Poverty assessment. Volume five." Washington D.C.: The World Bank.
- WB (World Bank). 2010. "Gini Index. Accessed 2 December 2014. <http://data.worldbank.org/indicator/SI.POV.GINI>.
- WB (World Bank). 2013a. "GDP Growth (annual %)." Accessed 6 January 2015. <http://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG>.
- WB (World Bank). 2013b. "Net Official Development Assistance and Official aid Received." Accessed 9 October 2014. <http://data.worldbank.org/indicator/DT.ODA.ALLD.CD>.
- WHA (World Health Assembly). 2005. "Sustainable Health Financing, Universal Coverage and Social Health Insurance [WHA Resolution 58.33]." 58th World Health Assembly. Geneva: World Health Assembly.
- WHO (World Health Organisation). 2010. "The World Health Report - Health Systems Financing: The Path to Universal Coverage." Geneva: World Health Organisation.
- WHO (World Health Organisation). 2014. "Making Fair Choices on the Path to Universal Health Coverage. Final Report of the WHO Consultative Group on Equity and Universal Health Coverage." Geneva: World Health Organisation.
- Williamson, J., ed. 1990. *What Washington Means by Policy Reform*. Washington, D.C.: Institute for International Economics.