Access to quality health care is a basic human right. Women and men have

the right to enjoy the highest attainable standard of physical and mental health.

The enjoyment of this right is vital to their life and well-being Women face

special needs in terms of reproductive health. Reproductive health refers to the

need for people to have a satisfying and safe sex life and that they have the

capability to reproduce and the freedom to decide if, when and how to do so

(UN. 1995b). Implicit in this is the right of women and men to be informed

and to have access to safe, effective, affordable and acceptable methods of

family planning, as well as other methods of their choice for regulation of

fertility which are legal, and the right of access to appropriate heath-care

services that would enable them to go safely through pregnancy and child -

birthing. Such services ought to provide parents with the best chance of having

a healthy infant.

96. Available data on health care, particularly pertaining to women’s reproductive

health, reveal a very depressing situation in Zambia. Zambia’s fertility rate of

5.9 births per woman remains one of the highest in Sub-Sahara Africa (SSA).

It ranks fifth among sixteen selected SSA countries with high total fertility

rates (TFR). The high rate of fertility is partly due to non-use of contraceptive

methods by the majority of women in Zambia. Sixty-six percent of married

women are reported not to be using any contraceptive methods by the latest

Zambia Demographic Health Survey (ZDHS) (CSO, 2002b). Only 34 percent

of women are using a contraceptive method (CSO, 2002b). Contraceptive use

is also very low among adolescents in Zambia. 25.5 percent of girls aged 15-

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19 years are using any method in 2002. A similar situation persists among

youths aged 20-24 years. Generally, few women use a contraceptive method

before having their first child (CSO, 2002b).

97. One of the main factors for limited contraceptive use is the low level of

education among women in Zambia. Studies conducted in Africa and other

parts of the world have established a positive relation between female

education and contraceptive use. These show that female education is a key

determinant of contraceptive use. By virtue of their greater decision-making

capabilities, educated women are in a better position than those who are less

educated to make decisions, while their ability to operate outside the home

enables them to access services better. Educated women also tend to have a

wider knowledge of contraceptive methods. This helps them to make better

informed decisions with fewer chances of subsequent discontinuation or

failure of the contraception method.

98. Available data from Zambia tend to prove these assumptions correct. More

educated women use contraception than those with little or no education. In

2002, 49.2 percent of women with secondary education were using a

contraceptive method compared to 30.9 percent of women with primary and

23.2 percent of those with no education. Fertility rates also tend to be lower

among educated than uneducated women. In 1996, the total fertility rate for

women with no education was 6.8 children per woman compared to 6.6 for

those with secondary education (CSO,1996). It is much lower for women with

tertiary education. Higher education is, therefore, an important determinant of

contraceptive use and low fertility rates, which enhance women’s health.

99. Zambia also has one of the highest maternal mortality ratios (MMR) in the

Southern African region. The MMR in Zambia has been pegged at 649 per

100,000 live births for almost a decade (CSO 2002). More recent data from

micro-studies indicate much higher ratios at district level. A survey that was

undertaken to establish accurate maternal mortality statistics in Kaputa

District, Luapula Province, in 1996, established an ala rmingly high MMR for

the area, at 1,549 maternal deaths per 100,000 live births, while there were

close to 900 deaths per 100,000 live births in Mongu District, Western

Province. Such micro numbers suggest an average that is possibly higher

than the currently estimated national one of 649.

100. Infant and under-five mortality has have remained above the 1980 level.

Currently in Zambia, 110 children per 1000 die before their first birthday

compared to 99 in 1980 (CSO, 2000a). The number of children that die before

their fifth-birthday also increased between 1990 and 2000 by about 7 percent.

Currently, 1 in 6 under-five children die before their fifth birthday compared

to 1 in 7 previously: about 162 children per 1000 die before their fifth birthday

compared to 121 in 1980 (CSO, 2002b). The ZDHS rate for 2001–2002 is

higher, at 168 children per 1000.

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**Table 5: Response to Maternal Health Services by education level**

**Education level**

% who received anti-natal

care from professional

% delivered by health

Professional

% delivered in a

health facility

No Education

Primary

Secondary

83.9

93.6

98.0

17.3

37.8

77.8

17.4

38.1

77.7

*Source: Compiled from CSO (2002), ZDHS 2001-2002 Preliminary Report*

101. Several factors contribute to the high materna l and child mortality rates despite

the relatively high number of women receiving maternity care in Zambia.

Many women die due to hemorrhage and sepsis resulting from lack of medical

care at the time of delivery. Most deliveries are performed at home with the

assistance of untrained relatives. The number of women being delivered by

health professionals is very low. Education of women plays an important role

in the use of health facilities where these are available and accessible (Table 4

above). Less tha n 45 percent of women deliver in a health institution in

Zambia. According to the most recent ZDHS report, about 43.6 percent of

pregnant women deliver in a health facility. A similar number (43.4%) are

delivered by a health professional. The findings of the three Demographic

Health Surveys conducted in Zambia between 1992 and 2002 (CSO 1992;

1996a and 2002b) show declining trends in the percentage of medically

assisted deliveries. These fell from 51 percent of births in 1992 to 43 percent

in 2002. Earlier studies indicate much higher percentages for the pre-1991

period. Eighty-one percent of pregnant women were being attended to by

trained health personnel (including doctors, mid-wives and nurses) around

1990. A further 19 percent were being attended to by trained traditional birth

attendants (TBAs) (Central Bureau of Statistics, 1995).

102. Factors such as poor nutrition contribute to high levels of child mortality in

Zambia. Forty-seven percent of Zambian children are stunted due to poor

nutrition or malnutrition. About 22 percent of the affected children are

severely stunted. Stunting levels in Zambia do not vary greatly with the sex of

child or the mother’s age (CSO, 2002b). This implies that forces other than

gender are mainly at work. More children from rural than urban areas are

stunted. Stunting varies markedly from 36 percent in Lusaka to 59% in the

Eastern Provinces. It also varies according to the educational level of the

mother. Children of mothers with secondary or higher education tend to be

less stunted than children whose mothers achieved only the primary level or

never went to school. For example, 32.9 percent of children of mothers

without education, 28.7 percent of those whose mother have primary

education and 23.2 percent of children of mothers with secondary education

are severely under weight for their age (CSO, 2002b).

**Linkages among gender, health, education and poverty reduction**

103. Recent data persuasively demonstrate that there is a linkage between women’s

health and economic growth. Evidence indicates that investments in female

health can help to increase a country’s total economic output. This is

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particularly the case if there is also investment in both the education and health

of women. Education and health are closely linked. Healthy, educated women

are better able to engage in productive activities, find formal sector

employment and earn higher incomes and greater returns to schooling than

their counterparts who are uneducated or suffer from poor nutrition and health,

(Schultz 1998; World Bank 2001; World Bank 2002).

104. Further, education, particularly that of females, improves child nutrition and

children’s health and survival. It also lowers the rates of population growth. In

low -income countries, reduced population growth helps to increase savings

and investment rates and also lowers the stress on natural resources and the

environment (World Bank 2001, Chapter 2; World Bank 2002).

105. Available data on Zambia tend to prove some of these assumptions correct.

Fertility rates tend to be lower among educated than uneducated women, but

the difference is minimal. For example, in 1996, the total fertility rate for

women with no education was 6.8 children per woman compared to 6.6 for

those with secondary education (CSO, 1996). It tends to be much lower for

women with higher or tertiary education. As already noted, more educated

women use contraception methods than those with little or no education.

Higher educated women are delivered by medical professionals (79%) than

those with primary (38%) or no education (17.3%). Higher educated women

also tend to deliver in a health facility (78%) than those with primary (38%) or

no education (17%). Furthermore, women with secondary education (71%)

seek treatment from a health provider for their children than those with

primary (64%) or without education (56%) (CSO 2002b). A major reason for

these differences is that women with at least secondary school education are

able to make decisions about their own health and that of their children. They

are also likely to be less poor and thus able to be engaged in formal

employment or other viable income generating activities than their uneducated

counterparts. This enables them to pay for health services whenever necessary.

Education, therefore, is a key factor in improving women’s reproductive

health, poverty reduction and economic empowerment, all leading to enduring

development.

106. A recent United Nations Fund for Population Activities (UNFPA) report

indicates that better access to family and sexual health services for women, is

a key to fighting poverty across the world. The report further indicates that

some of the largest gaps between the world’s rich and poor are in reproductive

health. It also tries to show a relationship between low fertility rates and

economic growth. Since 1970, developing countries that have lowered their

fertility rates and slowed population growth have registered faster economic

growth, and demonstrate that allocating funds to health, education and

advancement of women and girls is a crucia l part for achieving that fall.

(UNFPA 2002 cited in Times of Zambia, November 2002).

**C. Gender and HIV/AIDS**

107. Acquired Immune Deficiency Syndrome (AIDS) is one of the most serious

public health and development challenges faced in Zambia today. The most

recent information put the HIV infection rate at 16 percent (CSO