

PN ARH-774
71229

Zambia: 1987's Development Tragedy
A Look at the Human Dimension

Prepared by:
Hope Sukin
FVA/PPM
November 18, 1987

1

Zambia: 1987's Development Tragedy
A Look at the Human Dimension

Summary

Even as agricultural production has increased in Zambia over the past five years, household food security for a majority of Zambia's population has decreased dramatically. The Zambian economy has continued to deteriorate since the mid 1970's resulting in a declining GDP per capita a (decline of 38% between 1970 and 1986 in real terms), balance of payment deficit of SDR 502 million, external debts currently valued at 380% of the 1986 GDP. This situation coupled with a 3.4% population growth rate and 50% of the population located in urban areas has resulted in an expanding and worsening poverty problem. The magnitude and seriousness of the problem is already being seen in significant increases in childhood malnutrition and deaths due to malnutrition.

Background and Purpose

This paper examines a few very basic indicators of the level of well being of a population, or as the case is in Zambia, the degree of poverty and the seriousness of its effects. Emphasis is placed on indicators of household food security, the ability

of a household to obtain adequate food and nutritional standards as a critical indice of the population's state of well-being and/or the level of poverty.

This review is not meant to be an in-depth study of the Zambia situation but a concise update to several excellent studies including UNICEF and the GRZ's Situation Analysis of Children and Women in Zambia, June 1986, a World Bank draft report entitled: "Zambia, the Social Impact of Expenditure Reforms" and Paul Freund's "Health Care in a Declining Economy: The Case of Zambia". Recent studies by Zambia's Prices and Incomes Commission, using the 1985/86 Urban Household Survey and Dr. G.J. Bhatt (UTH)'s Statistical Analysis of Hospital Admissions provide important input for the following discussion.

A review of the relevant data leads directly to the following conclusions:

1. The poverty situation in Zambia and its potential effects on the health and nutritional status of the population is devastating.

2. There has been an apparent oversight of the seriousness of the poverty situation, its human and political consequences, on the part of the major donors in Zambia.
3. There is a critical need for the donors along with the GORZ to address these problems, as longer term solutions for economic restructuring are being negotiated and implemented.

Household Food Security

Income and food prices determine the ability of a household to obtain adequate food - particularly in urban areas.

Availability of mealie meal, the Zambian staple has not been a major problem however, shortages may become a problem this year due to marketing constraints and the drought in the south and West.

Review of Prices

The rate of domestic inflation averaged 20% during 1983/84. It rose to 30% in 1985 and over 60% in 1986. The Consumer Price Index for urban areas low income groups shows a 794.9% increase in all basic goods and services between 1975 and 1986. The

cost of food has increased even more - approximately 825.4% between 1975 and 1986. The price of mealie meal has increased four fold between 1980 and 1987. The cost of a minimum diet to meet the nutritional requirements of a family of six has gone from K50.45 in 1980 to K268 in 1987 - a five fold increase in costs. The cost per 1000 calories has risen from Ngwee 12.87 in 1980 to Ngwee 68.45 in 1987. The most economic sources of protein in the past for the lower income group has been milk, karpenta (dried fish) and groundnuts. The cost of basic protein sources, ground nuts and beans, has increased by five fold since 1980. Since 1980 milk powder has increased by over 2000 percent and the price of dried fish has increased fivefold - making these items unaffordable for a majority of the population. For the poor, corn is not only the major source of calories but also protein - contributing over seventy percent of the protein to the diet.

This has serious implications for weaning age children whose stomach capacity limits the amount of cereal that they can eat. With prices of oil, milk powder and dried fish (those foods which increase the nutrient density of the staple) so high, a young child is likely not to be getting adequate nutritional supplementation.

Wages and Employment

Unemployment and underemployment has been one of the most serious problems in the urban areas. The labor force in Zambia has grown from 1,761,000 in 1980 to 2,214,640 in 1986, an increase of 3.4%. During that time formal sector employment growth declined by 1.3%. By 1987, only about 17% of the labor force was employed in the formal sector - leaving 83% employed in the informal sector or unemployed. This means that a very large percentage of households are not receiving steady income with the market for informal sector goods and services receding with the overall decline in the economy.

For those in the formal sector, real wages have declined significantly. In 1983 government basic starting salaries in real terms were less than 50% of what they were in 1975, according to the Zambia National Employment Survey. In mining the basic starting salary wage rate for unskilled workmen in 1983 were 50% of their 1970 level and a little less for skilled workers. Based on the Lusaka 1985 employment survey, the average monthly gross earning for paid employees was K246, only a three Kwacha increase since 1983. Seventy percent of the wage earners received less than K200. And when you compare

average salaries between 1983 and 1985 for five out of seven employment categories, nominal salaries had actually decreased. Inclusion of informal employment in the 1985 survey influenced this decline - but the level is significant. Female wage earners across all categories received significantly less income than males.

Table - shows average salaries for Zambia and Lusaka. An unpublished 1987 labor force survey may show that a majority of the employed are still earning less than K200 a month.

Purchasing Power

When you look at the increases in consumer prices - particularly food prices, the large unemployment rates, and stagnant wages - there can be no doubt that serious purchasing power problems exist. The Prices and Income Commission has determined a Poverty Datum Line based on a minimum level of income that would permit households to use no more than 60% of their income on food. If a household must spend more than 60% of their income to purchase a least-cost adequate diet, they would fall below the poverty line. In 1987, the proportion of households living below the poverty line increased to 55%.

As mentioned previously, diets are changing to reflect the restricted purchasing power - with more calories and protein coming from corn. At the same time that corn is becoming even a more important source of nutrients effective demand for corn from the poorest households may be declining due to the higher costs of all the other necessities.

During my visit in September 1987, health center personnel in one of the largest and poorest compounds reported that many families were eating one meal a day.

Nutrition and Health Indications

The level of malnutrition in any country is generally influenced by the interaction of a variety of factors disease, food availability, household purchasing power. In all countries malnutrition is directly associated with poverty and therefore it is one of the most critical indicators of the effects of changes in economic conditions, on a population's well-being. Changes in the level of malnutrition is an excellent indicator of the stress that a society may be experiencing.

Between 1975 and 1987, data from the University Teaching Hospital as well as aggregate clinics and hospital data for all Zambia shows significant increases in serious malnutrition and deaths due to malnutrition. This trend is alarming since it signifies a growing and bigger problem in the community.

Country wide data shows that malnourished admissions rose from 5.7% of all hospitals admission in 1976 to 6.4% in 1980 and to 9.0% in 1984. Between 1980 and 1984 there has been an average annual increase of 6.6 percent of malnutrition hospital clinic admissions compared to a 3.4 percent natural rate of growth. Hospital deaths associated with malnutrition increased even more significantly from 13.1% in 1976 to 18.1 in 1980 and further to 25.6% in 1984. UTH data is available through the first quarter 1987.

Malnutrition admissions as a percent of all pediatric admissions rose from 15.6% in 1985 to 17.4% in 1986 and 19.9% for the first quarter 1987. Case fatality rates also rose from 341(per 1000) in 1985 to 376 in 1986 and 392 in 1987 (first quarter). These case fatality rates are extraordinarily high and need to be carefully assessed. One possible explanation may be that with the reduction of expenditures on health

services, drug shortages and staffing vacancies at many clinics, the poor are bringing their critically ill children, who have had little or no previous medical attention, to UTH at the eleventh hour. Graph I shows that case fatality rates for PEM have been rising while rates for other diseases have stabilized or are actually decreasing. If this is the case, then the increase in malnutrition and its seriousness may be directly associated with the poverty situation.

Note on Health Infrastructure

Zambia has always shown a strong commitment to supporting the health sector. But because of the economic situation and declining value of the Kwacha, health expenditures per capita have declined by 37% from 1970 to 1985. Capital expenditures in the health sector have declined by 97% between 1970 and 1985. The UNICEF "Situation Analysis states that" the consequences of such serious financial constraints affect both existing and new resources. New capital building projects have virtually stopped, maintenance back logs have become more acute...." As of January 1987 a total of 59% of physicians posts throughout Zambia were vacant. It is obvious that the health sector situation is contributing to the seriousness of

the nutritional problems in the country. During times of economic hardship, outreach services and nutrition education are typically the first activities to be cut out. Growth monitoring is being promoted at clinics but participation drops markedly after the child's first birthday and completion of immunization. Lack of drugs and doctors at the clinics effect both the quality of services and the demand for needed services.

Urban vs. Rural Nutrition/Health Problems

It appears that the urban areas are being considered by many Zambian officials the worst off-most nutritionally vulnerable to any further increases in food prices and reduction in purchasing power. And that the rural areas, particularly with the increases in producer prices for maize, are doing fairly well. The urban focus for any targeted food or nutrition program is certainly well justified given the unemployment and purchasing power problems; however, the situation in the rural areas needs to be carefully monitored. Recent studies by the Zambia Food and Nutrition Commission show high rates of malnutrition in the Eastern and Northern Provinces. In three districts - Serenje, Mpyika and Chinsuli, a sample survey showed that 46-52 percent of the children under five were

underweight. In another study in nine districts in the Eastern Province, 28.7 percent of the under fives were malnourished including 56.8 percent of children in their second year of life. What is most alarming in both these studies is the doubling of malnutrition in the hungry months from January to March. Another longitudinal community survey in the Western provinces has found increases in the number of malnourished children as well as increases in morbidity from malaria, diarrhea and respiratory infections.

Per capita health expenditures are considerably less in the rural areas and access to health services is limited. Therefore the rural areas cannot be dismissed as "relatively well off since all information indicates that there are serious health and nutrition problems existing - even with increases in income from maize production. This may suggest that the increased income farmers are receiving from maize is still inadequate to cover the increasing costs of the other necessities of life.

Implications for Structural Adjustment in Zambia

First, the objective of this paper is not to point blame at the

adjustment program in Zambia for the serious poverty problems and human deprivation existing today. But rather the objective is to point out strongly that the poverty situation and human dimension must be taken into consideration in designing and implementing structural reform programs.

There is still considerable debate in Zambia and in the donor community about why K kaunda finally broke off relations with the IMF. Many point to the November 1986 food riots as the straw that broke the camel's back. The events behind the food riots are also muddy. Some people feel that failure to plan properly for the reduction in food subsidies was the chief cause - not enough attention to implementation details. Not only did the price of breakfast meal dramatically increase overnight, but because the millers weren't certain about how they would be paid for the still subsidized roller meal, production of this basic staple stopped. Others feel that the riots were a political demonstration by the opposition who had just been waiting for an opportunity to speak out.

Whatever the reasons it is clear that the economy in Zambia in the early 1980's was fragile and had already deteriorated significantly since 1975. By 1983, unemployment, inflation,

real cutbacks in government expenditures were already taking their toll. Although the political situation in Zambia has been extremely stable with KK in power since 196_, the continued and spiraling inflation, price increases for basic goods and services and stagnant wages were just too much to expect a country to endure if political stability was to be maintained.

The donors should have more carefully assessed the level of stress the people and ultimately the country were already under before setting out the time schedule for reforms. It is not the reforms themselves, per se that are under question, but rather the timetable for implementation and the implementation strategies.

Elimination of food subsidies is an excellent example. If the poverty and human stress factors had been considered, then an appropriate implementation strategy could have been designed (as is being done in Zambia today) which would have combined a gradual reduction of the subsidies on breakfast meal, an agreed-upon mechanism for reimbursing millers and ensuring a supply of roller meal and a targeted food distribution program (possibly using donated food) that would assist the neediest.

The plan that is being discussed in Zambia today is a targeted food subsidy program based on ration shops. Calculations indicate that food subsidies could be reduced by fifty per cent with the introduction of the scheme and that the poorest urban populations would still have access to subsidized food. Great care needs to be taken with design of such a program which would include safeguards to protect the system from corruption and escalating costs. The author feels that if more attention had been given originally to developing a workable food subsidy reduction strategy with a compensatory program for the poor, that the market-place scheme could have worked.

Conclusions

In summary, the Zambia experiences illustrates several major lessons:

1. In developing a major economic reform program, donors must take into consideration the level of stress of a society reflected by such indicators as household food security and malnutrition rates. The degree of human oppression will invariably effect a country's political stability, willingness and ability to carry out the reforms.

2. More attention must be paid to implementation of each reform. Donors must be aware of the strategic options that are available for implementing each reform and help a country select the preferred strategy, given a country's political stability, economic and poverty situation. Implementation strategies then should be developed and realistic time frames set and agreed to for carrying out the implementation. More long term technical assistance than has been used to date may be needed for assisting countries to actually implement specific reform strategies.

3. As part of, or complementary to, strategies for implementing those reforms which would significantly reduce real income purchasing power or access to health services; donors should be prepared to help design and support targeted feeding, nutrition, health activities which would help reduce the hardships felt by the poor. Donor investments in employment programs, which would have both short term and longer term effects on earning opportunities for poorer population groups, should also be considered. Specialized technical expertise for analyses of the social impact of proposed economic reform programs and for compensatory project development should accompany reform design teams.

In summary, the international donor community - including the multilaterals, bilaterals and NGOs will all need to understand better the psychology and dynamics of a society that has lived under severe economic stress for the past decade and are being asked to tighten their belts even more. The current situation in many countries requires cooperation of the entire international community in helping countries develop and implement reform programs that address both the long term problems of economic stability and growth and also the short term acute living condition problems. Without addressing the latter, governments and societies may not be able to honor their commitments to both private and multilateral lending institutions or follow the required course for longer term economic recovery. Zambia has shown this premise to be all too true.

Zambia
Socio-Economic Indicators

| | 1975 | 1980 | 1984 | 1985 | (July) 1986 | 1987 |
|---------------------------------------------------------------------|-------------------------|-------------------------|--------------------------|-------------|------------------------|-------------------|
| <u>GDP Per Capita (1970 Kwacha)</u> | 298.0 | 241.2 | | | 187.5 | |
| <u>% Change</u> | -4.2% | -4.2% | | | -3.0% | |
| <u>Population Growth Rate (5 yrs)</u> | 2.9% | 3.3% | | | 3.4% | |
| <u>Population % urban</u> | 36.5% | 43.0% | | | 47.0% | |
| <u>CPI</u> | | | | | | |
| 1. All Items | 100.0 | 202.9 | 373.5 | 513.3 | 794.9 | |
| 2. Food | 100.0 | 211.1 | 395.8 | 540.0 | 825.4 | |
| 3. Breakfast Meal (K) (50kg) | | 9.0 | 24.94 | 37.32 | 37.32 | |
| 4. Roller Meal (k) (50kg) | | 7.90 | 20.64 | 28.77 | 28.77 | |
| <u>Cost of Least-Cost Adequate Diet</u> | k | 50.4 | 84.69 | 131.79 | 204.82 | 268.29 (April) |
| <u>Wages</u> | | | | | | |
| | <u>1981</u> | <u>1982</u> | <u>1983</u> | <u>1985</u> | | |
| 1. Zambia - average | 199.3 | 213. | 220.5 | | | |
| 2, Lusaka - urban | | | 243. | 246 | | |
| 3. Wages have decreased in real terms by 50% between 1975 and 1987. | | | | | | |
| <u>Employment</u> | | | | | | |
| 1. Labor Force | 1,479,000 | 1,761,000 | | | 2,214,640 | |
| 2. Labor Force Growth | $\frac{70/75}{3.5\%}$ | $\frac{75/80}{3.2\%}$ | | | $\frac{80/86}{3.4\%}$ | |
| 3. % employed in formal sector | 26.6% | 21.6% | | | 17% | |
| 4. Formal Sector Growth | $\frac{1970/75}{2.7\%}$ | $\frac{1975/80}{-.2\%}$ | $\frac{1980/86}{-1.3\%}$ | | $\frac{1970/86}{.3\%}$ | |
| 5. % in informal sector employment and unemployment | 73.8% | 77.9% | | | 83% | |

| <u>Malnutrition</u> | <u>1975</u> | <u>1980</u> | <u>1984</u> | 85 | 86 | 87 |
|---------------------------------|-------------|-------------|-------------|-----------------|------|------|
| 1. Total Malnutrition Admission | 7566 | 11,582 | 18,155 | | | |
| 2. Case Fatality Rate | 159.1 | 187.4 | 207.2 | | | |
| 3. UTH | | 1700(1982) | | 2796 | 2441 | 2460 |
| Deaths % total | | | | 46.6 | 41.8 | 43.4 |
| 4. Rural Areas | | | | 37%* | | |
| | | | | malnourished | | |
| | | | | 38.6%** | | |
| | | | | 77% subsistence | | |
| | | | | 59%*** | | |

* Kawanbua District
 ** Nchitenge District
 *** Serenje - Chensuti

3002E

PEM & OTHER RELATED DISEASES
MORTALITY RATES (PER 1,000)

