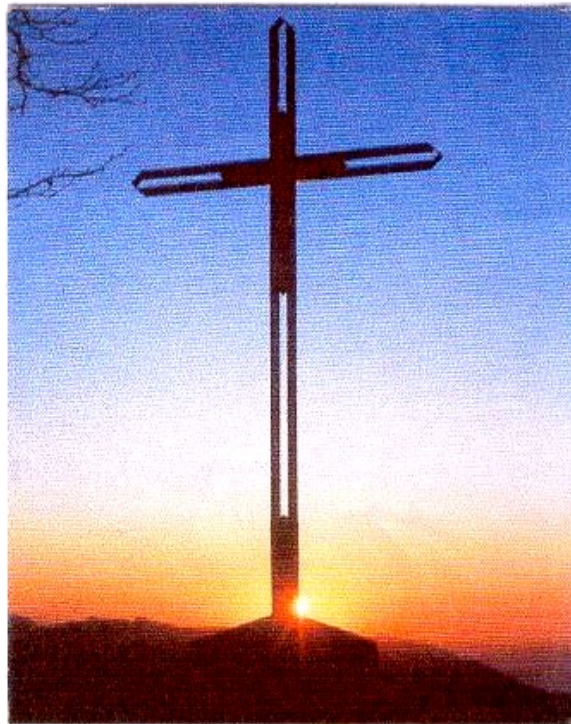


**Health Policy For the Catholic Church  
In Zambia**



CATHOLIC SECRETARIAT ZEC  
Health Department  
P O Box 31965  
Lusaka

## TABLE OF CONTENTS

<b>Foreword</b> .....	<b>i</b>
<b>Acknowledgement</b> .....	<b>ii</b>
<b>Definitions</b> .....	<b>iii</b>
<b>Acronyms</b> .....	<b>vi</b>
<b>1.0. Background and Introduction</b> .....	<b>1</b>
<b>2.0. Core Christian Values</b> .....	<b>4</b>
2.1. Beginning of Human Life .....	4
2.2. Caring for the Dying .....	4
2.3. Pastoral and Spiritual Care .....	4
<b>3.0. Situation Analysis</b> .....	<b>7</b>
<b>3.1. National Health Context</b> .....	<b>7</b>
3.1.1. Debt burden of Zambia .....	7
3.1.2. Institutional Capacity .....	8
3.1.2.1. Health Infrastructure, Drugs and Supplies .....	8
3.1.4. Human Resource Development .....	9
<b>3.2. Disease Burden</b> .....	<b>9</b>
3.2.1. HIV/AIDS .....	9
3.2.2. Malaria .....	11
3.2.3. Tuberculosis .....	11
3.2.4. Sexually Transmitted Illnesses (STIs) .....	12
<b>3.3. Gender Issues</b> .....	<b>12</b>
<b>3.4. Food Security and Nutrition</b> .....	<b>13</b>
<b>3.5. Community and Home-Based Care</b> .....	<b>13</b>
<b>3.6. Stakeholder Coordination</b> .....	<b>13</b>
<b>4.0. Vision, Mission Statement, Rationale and Guiding Principles</b> ..	<b>15</b>
<b>4.1. Vision</b> .....	<b>15</b>
<b>4.2. Mission Statement</b> .....	<b>15</b>
<b>4.3. Rationale</b> .....	<b>15</b>
<b>4.4. Guiding Principles</b> .....	<b>16</b>
<b>5.0. Policy Objectives and Measures</b> .....	<b>17</b>
<b>5.1. Institutional capacity</b> .....	<b>17</b>
5.1.1. Health Infrastructure, drugs and supplies .....	17
5.1.1.2. Human Resource Development .....	17
5.1.1.3. Resource Mobilization .....	17
<b>5.2. Community and Home Based Care Programmes</b> .....	<b>18</b>
<b>5.3. Voluntary Counselling and Testing (VCT)</b> .....	<b>19</b>
<b>5.4. HIV/AIDS and Behaviour Change Process</b> .....	<b>19</b>
<b>5.5. Hospices</b> .....	<b>20</b>
<b>5.6. HIV/AIDS and Workplace</b> .....	<b>20</b>
<b>5.7. Orphans and Vulnerable Children (OVC)</b> .....	<b>21</b>
<b>5.8. Gender and Health</b> .....	<b>21</b>
<b>5.9. Food Security and Nutrition</b> .....	<b>22</b>
<b>5.10. Stakeholder Coordination and partnership</b> .....	<b>23</b>
<b>5.11. Monitoring, evaluation and technical Support</b> .....	<b>23</b>

<b>6.0. Institutional Arrangements .....</b>	<b>25</b>
<b>6.1. The Zambia Episcopal Conference (ZEC) .....</b>	25
6.2. Catholic Secretariat – National Health Department .....	25
6.3. Diocesan Health Coordinator .....	25
6.4. Diocesan Health Boards/Commission .....	25
6.5. Health Institutions and Programmes .....	26
6.6. Managing Agencies and Staff Working in Hospitals .....	26

## **FOREWORD**

In the Gospels, we see Jesus’ compassion for the sick and His use of integral healing, the healing of both body and soul, as part of His Ministry. In keeping with the example set by Lord Jesus, the Church has, since the beginning of its mission, always shown solicitude for the sick through compassion and integral healing in her health care facilities.

Activities of Catholic Health care facilities in the country go back to the arrival of the first Missionaries. Alongside direct evangelisation, they established health care facilities and institutionalised health care programmes for the sick and dying. The Church has, however, been undertaking its healing mission without a policy framework to inform and guide its health personnel. This has led in some cases to duplication of effort and lack of coordination of scarce health resources. It is envisaged that the publication of this policy will help in creating an environment for improved health care delivery in Catholic Church health facilities and ensure that scarce resources are utilised in the most efficient manner. The policy is also expected to expedite strategic planning and coordination with a view to strengthening institutional capacities for effective and efficient health care delivery.

Being the first Catholic Church Health Policy, it poses challenges for all personnel in Church health facilities. Indeed, for the first time, Catholic Church health facilities are armed with a document that defines what motivates the Church in its interpretation of Jesus Christ’s teaching on care and healing of the sick. Consequently, I wish to commend the team that put the document together for its dedication and commitment to enhancing the Church’s role in health care delivery throughout Zambia. I wish to assure all personnel in Catholic Church health facilities of my support and admiration of their contribution to alleviating the pain and suffering of the sick and dying.

**+ Raymond Mpezele**  
**Bishop Director of Health**  
**Zambia Episcopal Conference (ZEC)**

## **Acknowledgement**

The preparation of this policy document was a collective effort of many people. We would particularly wish to express my sincere appreciation for the support of Bishop Director of Health, and Diocesan Health Coordinators from the ten Catholic Dioceses of Zambia and the National Health Department Staff. We also wish to thank the Zambian Government for its support to Catholic Church Health facilities. The Churches Health Association of Zambia (CHAZ) deserves commendation for its facilitative role in operations of Catholic Health Care facilities. We are grateful to the Zambia Integrated Health Programme (ZIHP) for all the technical backstopping that it provided in its formulation process.

This policy document is guided by Jesus Christ's compassion and mission of integral healing of the sick. It is expected to contribute to the improvement of the quality of health care delivery in Catholic Health facilities in Zambia. Consequently, We wish to commend it to all health personnel in our Catholic Health Institutions and Programmes

**Sr Theresa Nyoni**  
**National Health Co-ordinator**  
**Catholic Secretariat**  
**ZAMBIA EPISCOPAL CONFERENCE**

## Definitions

Term	Meaning
Adverse impact	Negative effect
Affliction	Suffering
Ailment	Sickness
Anti-retroviral drugs	Medicines used to treat HIV/AIDS
Catholic Social Teaching	According to the Catholic Church teaching is a collection of social wisdom that instructs us about the human person in society, and tells us about values, structures and practices that contribute to full human life. It is founded on the word of God and it develops the reading of the signs of the times
Collaboration	Teamwork or partnership
Commercial sex work	Prostitution
Complement	Match or go together
Conjugal	Matrimonial
Contraception	Any artificial method that inhibits conception
Deficit	Too little
Deteriorate	Worsen or decline
Diocese	The area ruled by a Bishop
Discordant couples	Where one partner is HIV-positive and the other is HIV-negative
Discrimination	Prejudice, unfairness or intolerance
Embryo	The earliest stage of human development
Empowering people	Enabling people to become more independent
Erratic	Unpredictable or irregular
Euthanasia	Any action or mission that itself or by intention causes death in order to alleviate pain and suffering
Explicit gender policy	Specific guidelines concerning sexual categories of male and female
Extra uterine pregnancy	Where the foetus develops outside the womb
Foetus	Unborn child after 28 weeks
Food security	Having sufficient food for a given period of time
Haemorrhage	Loss of blood
Health programmes	Set of health activities that are aimed at addressing specific concerns both in communities and health institutions
Hospice	Place of care for the terminally ill or dying
Human resources	Personnel
Human toll	Deaths
Hydration	Replacement of body fluids
Infertility	Inability to have children after one year of trying

Infirmaries	Centres to care for the sick
Health institution	Health care facility that is centred around a specific building or complex
Integral development	Essential growth
Legitimate	Lawful or valid
Liberation	Freedom
Limitations	Restrictions or limits
Material cooperation	Providing indirect assistance in material form so that an illegal task can be accomplished
Mute	A person who cannot speak
Obstetric	Concerning mothers in childbirth
Occupational safety	Safety issues within the working environment
Opportunistic infections	Infections occurring due to low immunity
Palliative care	Symptomatic care without the aim of curing
Pandemic	Disease pattern that remains constant in a given population worldwide
Pathology	Disease
Physician	Medical Doctor
Postnatal	After birth
Potential	Possibility or promise
Preferential option for the poor	Favouring the poor in a special way
Prenatal	Before birth
Prevalence	Occurrence of a disease per 1,000 population
Prioritise	Give greater importance to
Procreation	Reproduction
Provoked abortion	The directly intended termination of pregnancy before viability or the directly intended destruction of a viable foetus
Pronouncement	Statement or declaration
Rape	Sexual intercourse where one partner has not given consent
Rationalisation	The best use of limited resources
Reproductive technologies	Scientific studies, methods and equipment used in reproductive organs and systems
Sterilisation	Preventing conception by bilateral tubal ligation
Stewardship	Taking responsible care of what is entrusted to one
Stigma	Shame or disgrace
Subsidiarity	Making decisions at the appropriate levels
Supplementing	Adding to or enhancing something
Surplus	Too much or excess
Terminal illness	An irreversible disease process which ends in death
Therapeutic experiments	A trial aimed at healing or curing of disease or disability
Viaticum	A sacrament in the Catholic Church that is specifically for the sick and dying

Voluntary counselling and testing	Where people, in a freely chosen manner, seek to determine their HIV status through the approach of a trained counsellor
-----------------------------------	--

## Acronyms

AIDS	Acquired Immune deficiency Syndrome
CDR	Crude Death Rate
CHAZ	Churches and Health Association of Zambia
CHIP	Catholic Health Institutions and Programmes
DHMT	District Health Management Teams
DHS	Demographic Health Survey
HBC	Home Based Care
HBC	Home Based Care
HIPC	Heavily Indebted Poor Countries
HIV	Human immunodeficiency Virus
IGA	Income Generating Activities
ILO	International Labour Organisation
IMR	Infant Mortality Rate
ITNs	Insecticide-Treated mosquitoes Nets
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoU	Memorandum of Understanding
NHRs	National Health Reforms
NMCC	National Malaria Control Centre
OVC	Orphans and vulnerable children
PLWHA	People Living With HIV/AIDS
PLWHA	People living with HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
SP	Sulpha-Pyrimethamine
STI	Sexually transmitted Infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations programme on AIDS
UNAIDS	United Nations Programmes on HIV/AIDS
VCT	Voluntary counselling and testing
ZDHS	Zambia Demographic and Health Survey
ZEC	Zambia Episcopal conference

### 1.0 Background and Introduction

1. The Catholic Church's commitment to human dignity and the sanctity of life engenders an abiding concern for the sacredness of human life from conception. In this regard, the Church's health care ministry witnesses to the sacredness of life from the moment of conception until death. Its defence of life encompasses the care of women and their children during and after pregnancy. The Church has the deepest respect for the family, for the marriage covenant and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being. Marriage and conjugal love are by their nature ordained toward the begetting and

education of children. Children are really the supreme gift of marriage and contribute very substantially to the welfare of their parents. Parents should regard as their proper mission the task of transmitting human life and educating those to whom it has been transmitted. They are thereby co-operators with the love of God the Creator, and are, so to speak, the interpreters of that love.

2. For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. The Church cannot, however, approve contraceptive interventions that either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, has the purpose, whether as an end or a means, to render procreation impossible. With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While we rejoice in the potential good inherent in many of these technologies, we cannot assume that what is technically possible is always morally right. Reproductive technologies that substitute for the marriage act are not consistent with human dignity. Just as the marriage act is joined naturally to procreation, so procreation is joined naturally to the marriage act.

3. Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death. The Catholic Church health care ministry faces the reality of death with the confidence of faith. In the face of death (for many, a time when hope seems lost), the Church witnesses to her belief that God has created each person for eternal life. Above all, as a witness to its faith, Catholic health care is a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself; especially as it relates to dependency, helplessness and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is, therefore, critical in appropriate care of the sick and dying.

4. The truth that all life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, therefore, do not have absolute power over human lives. We have a duty to preserve life and to use it for the glory of God on earth as it is in heaven. The dignity of human life flows from its creation in the image of God (Gn. 1:26), from redemption by Jesus Christ (Eph 1:10 and 1 Tm. 2:4-6) and from our common destiny to share a life with God beyond all corruption (1 Cor. 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. Jesus Christ's words "I was ill and you cared for me" (Mt. 25:36) have provided inspiration for Catholic health care. Apart from its curative nature, Catholic health care assists those in need to experience their own dignity and value in the face of illness and/or imminent death.

5. Health care is provided on the basis of Gospel values. It is not limited to the treatment of diseases but also embraces the psychological, social, and spiritual dimensions of the human person. This is complemented by pastoral care that encompasses the full range of spiritual services such as listening presence, help in dealing with powerlessness, pain, and alienation, including assistance in recognising and responding to God's will with greater joy and peace.

6. The Catholic Church began its involvement in health care delivery in Zambia as soon as it embarked upon its mission in the country in the 1890s and the first established Mission Hospital was Lubwe in 1926 in the Luapula Province. Currently, the Catholic Church looks after 18 Mission Hospitals, 37 Rural Health Clinics, 8 Hospices and several Community Based Programmes mostly situated in rural areas. In all, the Catholic Church accounts for nearly 40 per cent of all health facilities in the country. This was in conformity with its evangelisation mission of ministering to both the body and the soul, which is the purpose of integral human development.<sup>1</sup> Initially, the Church began providing health care from small rural health facilities. Over the years, these developed and spread from their modest rural beginnings to medium-sized and major referral hospitals throughout the country. Currently, nearly 60 per cent of the health care provision in rural areas of Zambia is church-related. Given the increase and changes in disease burdens, and especially the onset of the HIV/AIDS pandemic in the early 1980s, the Church has been expanding the range of its health services to the communities through such initiatives as Community and Home Based Care Programmes.

7. Health care delivery by the Church in Zambia has, however, been undertaken in the absence of a policy and guidelines to inform operations of Church health facilities. This has resulted in inadequate coordination and dispersion of scarce health resources. In view of the challenges posed by severe health problems, more especially the HIV/AIDS pandemic and its effects on the health and socio-economic welfare of families, communities and the nation as a whole, the Catholic Church strongly believes that there is a need for a shared vision to guide health care delivery in Church health institutions.

8. Equally important is the need for harmonisation and coordination of the various health care interventions by the Church throughout the country. This is necessary for building synergies and maximising the impact of health care delivery by Church health institutions and for eradicating the current waste of scarce resources. Given this background, the Catholic Church is convinced

---

<sup>1</sup>John Paul II states that: "Christian wisdom, which the Church teaches by divine authority, continuously inspires the faithful of Christ zealously to endeavour to relate human affairs and activities with religious values in a single living synthesis. Under the direction of these values all things are mutually connected for the glory of God and the integral development of the human person, a development that includes both the corporal and spiritual well-being." *Apostolic Constitution Sapientia Christiana (On Ecclesiastical Universities and Faculties)*, 29 April 1979, *Foreword, section I*. See also his Encyclical *Evangelium Vitae (Gospel of Life)*, no. 81.

that significant benefits would accrue from a well articulated health policy to guide and inform operations of Church health institutions in the country. Specifically, it is anticipated that the policy would ensure that:

- Gospel values and the Catholic Social Teaching (CST) provide the framework in which the Church's health interventions are conceived and implemented;
- Guided planning and quality and effective health care service delivery form the basis for operations of all Catholic Church health institutions; and
- Monitoring and evaluation mechanisms are put in place for ensuring that health care delivery in Catholic Church health institutions is in line with Catholic Church's Vision of contributing to the creation of a healthy Zambian nation in which every citizen will enjoy the potential to live life to the full.

#### **4.0. Core Christian Values**

##### **2.1. Beginning of Human Life**

9. In conformity with Christian values and code of ethics, all personnel working in Catholic health facilities are supposed to be guided by the teaching of the Church. When the marital act of sexual intercourse, for instance, is not able to attain its procreative purpose, assistance that does not separate the unitive (promotion of love) and procreative ends of the act and does not substitute for the marital act itself, may be used to help married couples to conceive. On the contrary, all methods and techniques that do not respect the unitive and procreative ends of the marriage act and the unity of the spouses are prohibited.

10. Catholic Church health care facilities that provide treatment for infertility should offer not only technical assistance and counselling to infertile couples but also should help couples pursue other solutions such as adoption. They should also provide prenatal, obstetric, and postnatal services for mothers and their children in a manner that is consistent with the mission of the Church. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable foetus) is never permitted. Every procedure whose sole intent is the termination of pregnancy before viability is an abortion, which, in the moral context, includes the interval between conception and implantation of the embryo. In his regard, Catholic Church health care facilities are not supposed to provide abortion services even with material cooperation from requesting parties.

11. In case of rape, procedures to prevent fertilisation of the ovum are permitted. If time has elapsed and conception has taken place, measures to prevent implantation are abortifacient and forbidden. Catholic health care

providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion. Operations, treatments, and medications that have as their direct purpose the cure of a serious pathological condition of a pregnant woman are only permissible when they cannot be safely postponed until the unborn child is viable. Doing otherwise is tantamount to indirect abortion. Labour may, however, for a proportionate reason, be induced after the foetus is viable.

## **2.2. Caring for the Dying**

12. The Catholic Church attaches a lot of importance to the care of the afflicted, the sick and dying. People who are in danger of death from illness, accident, advanced age, or similar conditions should be provided with appropriate opportunities to prepare for death. Any person has a moral obligation to use proportionate means of preserving his or her life.

## **2.3. Pastoral and Spiritual Care**

13. In rendering pastoral and spiritual care, Catholic Church health facilities should have appropriate professional preparation and demonstrate the highest ethical standards. They should work in close collaboration with the clergy, parishes and communities. Appropriate pastoral services such as prayers, bible reflections and retreats, including referrals should be available to all the needy irrespective of religious belief, creed, origin, ethnicity, nationality or political affiliation. Small Christian community groups that offer spiritual and health care to the sick within the confines and administrative procedures of respective Church institutions and programmes are an essential part of pastoral care of the sick and should be encouraged.

14. In the case of Catholic patients or residents, provision of Sacraments is an especially important part of Catholic health care ministry. Every effort should, therefore, be made by Priests assigned to or working near hospitals and other health care facilities to celebrate the Eucharist and provide Sacraments to patients and staff. Properly prepared lay Catholics can be appointed to serve as extraordinary ministers of Holy Communion. However, this should be in accordance with the Canon Law and policies of the local Diocese. They should assist pastoral care personnel (clergy, religious and laity) by providing supportive visits, advising patients regarding the availability of Priests for the Sacrament of Penance and giving Holy Communion to the faithful.

15. All persons involved in pastoral care should facilitate the availability of Priests for the provision of the Sacrament of Anointing to the sick. This is in keeping with the fact that, through this sacrament, Christ provides grace and support to those who are seriously ill or weakened by advanced age.

Normally, the Sacrament of Anointing is celebrated when the sick person is fully conscious. However, it may be conferred upon the sick that have lost consciousness; or in the case of the deceased there is reasonable proof that he/she would have asked for the Sacrament while in control of his/her faculties. In order to forestall the latter case, it is recommended that all Catholics who are capable of receiving Communion should receive Viaticum while they are still in full possession and control of their faculties.

16. Except in cases of emergency such as danger of death, any request for Baptism by adults or for infants should be referred to the Chaplain of the institution or Parish Priest of the area. Newly born infants in danger of death, including those miscarried, should, if possible, be baptised. In case of emergency, and if a Priest or a Deacon is not available, anyone can validly baptise. When this happens, the Chaplain or Parish Priest should be notified. This is necessary to facilitate the entry of conferral of Baptism or Confirmation in the Parish Baptism/Confirmation Register.

17. Catholic discipline generally reserves the reception of the Sacraments to Catholics. With regard to other Christians who are not in full communion with the Catholic Church, when the danger of death or other grave necessity is present, the four conditions of Canon 844, §4 must apply. Canon Law stipulates that one:

- Cannot approach a Minister of ones community;
- Cannot ask for the Sacraments on their own; and
- Should manifest Catholic faith in the Sacraments and be properly disposed.

18. Lastly, the Diocesan Bishop has the responsibility to oversee this pastoral practice. In doing this, special attention should be given to the care of people living with HIV/AIDS (PLWHA) and their families, while networks of HIV-positive pastoral staff where they exist should be supported. Particular attention should also be paid to the special situation of HIV-discordant couples. These should be counselled to safeguard the life of their HIV-negative partners through abstinence, which is the hallmark of true sacrificial love for the other.

## **5.0. Situation Analysis**

### **3.1. National Health Context**

19. The Zambian Government has, since 1992, been implementing National Health Reforms (NHRs) whose Vision is to "...provide Zambians with equity of access to cost effective, quality health care as close to the family as possible" (Government of the Republic of Zambia, National Health Strategic Plan: 2001-2005:4). A number of achievements have been recorded as a result of the implementation of the Reforms. Strides have, for instance, been made in institutional restructuring of the public health sector with a view to enhancing operational efficiency.

20. The major part of the national health system has, however, remained poorly served in terms of drug and supplies logistics. In the majority of cases, infrastructure and equipment have deteriorated to levels where they either require urgent replacement or repair. The consequence has been a prolonged deterioration in health care delivery and the situation has been worsened by the HIV/AIDS pandemic. Zambia is one of the countries hardest hit by the HIV/AIDS pandemic with a current prevalence rate of 16 per cent among 15 to 49 years olds (Demographic and Health Survey, 2002).

21. In addition, during the last decade, most health indicators have worsened due to the negative impact of HIV/AIDS. The crude death rate (CDR), for instance, had risen from 16.7 per 1,000 persons in 1980 to 20 in 2000, while the infant mortality rate (IMR) increased from 92 per 1,000 during 1982-86 to 109 during 1992-96 (United Nations, 1999). The pandemic has also worsened

maternal related deaths. Between 1990 and 1996, maternal mortality rate (MMR) was estimated at 649 per 100,000 live births.

22. Some of the causes for this decline in the health status include inability by Government to invest realistically in the health sector, ineffective health policies and generally poor management of health institutions. The Catholic Church has been supplementing the efforts of the Government through the provision of health care in mission health institutions mostly in rural areas. It is also involved in other areas that complement health, i.e. environment, literacy, social empowerment and refugee management.

### **3.1.1. Debt burden of Zambia**

23. Zambia's economy has been in decline for more a decade, mainly because of depressed world copper prices and declining production. Foreign Debt has grown steadily, and there is high inflation.

24. Zambia has a huge external debt of about US\$ 7 billion. Instead of allocating resources to readdress some of these socio-economic problems, the government has forced to spend money on debt repayment between 1990 and 1993. During the same period, Zambia spent US\$ 1.3 billion on debt repayments. It is this reason the Church has been in the forefront to fight for debt relief for Zambia. So far Zambia has started to access some of the funds from the debt relief.

25. The Government has continued pursuing negotiations, through the enhancement of heavily indebted poor countries (HIPC) initiative to which the country qualified in December 2000. After Zambia's accession to HIPC, the World Bank and other multilateral and bilateral institutions will suspend Zambia's external debt amounting to US\$ 213.1 million in 2001. It is expected that when each creditor delivers relief, Zambia will get refunds on debt services. While this is the case Aid flow to Zambia has continued to decrease in the past years. A total of US\$ 271 million was received in 2001 compared to US\$ 339 million in 2002, representing a decrease of 20 percent respectively

The World Bank has engineered a process that attempts to address the problems related to poverty and its reduction through the Poverty Reduction Strategy Paper (PRSP). Zambia has prepared the paper in order to develop and implement strategies that would target poverty and reduction and foster economic growth. However this dream has seen a lot of poverty to the many Zambians especially as we attempt to reach the HIPC completion point.

### **3.1.2. Institutional Capacity**

#### **3.1.2.1. Health Infrastructure, Drugs and Supplies**

26. Catholic Church health facilities, like other facilities in the country, are constrained in their service delivery by poor infrastructure and inadequate

transport and telecommunications. Due to prolonged economic hardships in the country, infrastructure such as hospitals, clinics and health centres have experienced delayed maintenance and repair, while some are hard to reach because of the poor state of access roads. Some hospitals and clinics do not even have ambulances and telephone facilities.

27. Public investments in health infrastructure such as maintenance of existing hospitals and health centres have not been in tandem with the growth in the national demand for health care. In the majority of cases, available health infrastructure has deteriorated to levels that require urgent repair in order to prevent them from totally collapsing. Funding for procurement of drugs and supplies has also been adversely affected as a consequence of deteriorating economic conditions. Indeed, in a number of cases, some grant-aided Catholic Church health facilities have gone for months on end without receiving their monthly allocations due to reduced and erratic Government funding.

28. Dioceses throughout the country face many constraints in their efforts to effectively participate in national health care delivery. The following are among the most serious ones:

- Inability to attract and retain suitably qualified and experienced health personnel, including inadequate systems for human resource development;
- Insufficient management capacity and lack of diocesan health budgets;
- Insufficient and erratic supply of drugs and supplies;
- Poor physical infrastructure and equipment;
- Inadequate maintenance and rehabilitation of health infrastructure and equipment;
- Poor transport and communications logistics and insufficient funding;
- Wide and unmanageable catchment areas, long distances to referral health facilities and poor road networks;
- Heavy dependence on external funding and support for drugs and supplies logistics;
- Inadequate community involvement in health programmes and activities;
- The traditional perception that Church health facilities offer free medical services; and are rich

#### **3.1.4. Human Resource Development**

29. Like in the case with all institutions, the Catholic Church can only manage to deliver quality health care to the needy on the back of a suitably trained and experienced pool of human resources. The converse of this will lead to waste of scarce health resources and frustration of the Church's vision of positively contributing to the creation of a healthy Zambian nation. Currently, Church health facilities face serious professional staff shortages and the few that are available are usually overworked and inadequately remunerated. This is due to a variety of reasons but the major one is the inadequate institutional

capacity of the Church to recruit and retain suitably trained and experienced personnel.

30. The Church, unfortunately, does not also have the requisite resource base to train and supply the required levels of health care providers either in its training institutions or others. The situation has been compounded by the general dilapidation of the national economy that has affected nearly all sectors. In the vent, the Church has to rely on its meagre resources to retain health care personnel that are still serving in its health facilities. Given its limited resource base, the Church has increasingly depended on volunteers who perform various tasks with little or no remuneration. Nevertheless, in light of the deepening levels of economic hardships and poverty, the number of people who are ready to volunteer their labour is becoming smaller.

## **3.2. Disease Burden**

### **3.2.1. HIV/AIDS**

31. Zambia now stands at 10.4 million with an annual growth rate of 2.9% (Census, 2000). More than 50% of the population is less than twenty years of age and constitutes the most vulnerable group of HIV infection. The prevalence and incidence of the HIV/AIDS pandemic has reached alarming proportions in Zambia with 16% of Zambians are estimated to be HIV infected among 15 to 49 years olds (Demographic and Health Survey, 2002). In urban areas, the prevalence rate among 15 to 49 year olds is 23% and about 11% in rural areas respectively. (National HIV/AIDS/STI/TB council, 2004)

32. The human toll of HIV/AIDS is a tragic reality being experienced by families, communities and the nation at large. There is no aspect of life that has not been negatively affected directly or indirectly, by the pandemic. The pandemic has become the major cause of death especially among those aged between 15 and 49 years of age. It continues to deprive households, communities and the nation of the critical human resource, as its victims comprise the young and economically active population. The result has been a reversal of nearly all the economic and social gains that were made after the attainment of political independence. Currently, nearly 80 per cent of the Zambian population is living on well below US \$1 per day!

33. The first cases of HIV/AIDS in Zambia were reported in the 1980's. Since that time, the epidemic has spread throughout the country and has affected all social groups. It is estimated that currently, around 920,000 people in Zambia are living with HIV, with about 94,000 deaths as a result of AIDS each year. Given the rate at which HIV infection is spreading, it is estimated that nearly 1.6 million people are likely to die of AIDS related illnesses by 2014 if nothing is done to arrest the pandemic (UNAIDS 2004).

34. Illness and death negatively affect the working population with the result that the quantity and quality of labour and overall production are adversely affected. In rural areas when HIV/AIDS eventually leads to death, there is a permanent loss of labour for the farm. In some cases, children are removed from school to save money and to increase household labour. As a result of this, families have become even more vulnerable to food insecurity and malnutrition. Food insecurity is made worse by the fact that, quite often, it is women and girl-children that are more likely to tend sick relatives.

35. Zambia's epidemic of HIV/AIDS has created many orphans. The situation analysis shows that the orphan crisis had grown steadily since 1992 and has shown no sign of slowing down; in 1996, 13% of Zambian children were orphans. 13% of orphans were double orphans; in 1995, there were 218,000 orphans aged 10-14. By 2000, this had increased to 326,000. The Proportion of children who are orphaned increased with age; by 2002, 15% of Zambia children were orphans and 19% of orphans were double orphans. (Orphans and Vulnerable Children in Zambia 2004 Situation analysis). According to Brink 2004, by 2003, 19% of Zambian children under the age of 18 had been orphaned, totaling 1,100,000 children. This suggests that Zambia has amongst the very highest proportion of orphans in Sub-Sahara, much higher than any country in Asia, Latin America or the Caribbean. (Children on the Brink, 2004). Many of the Zambian's orphans have been orphaned by HIV/AIDS, usually meaning that they lose one parent, and later the other.

36. Zambia response to this crisis stretches from families and communities, to churches and NGOs, and to Government and the international community. However, the scale of these responses is inadequate to meet the needs. For most orphans, there is no help beyond what little their grandparents or close relatives may have to offer. With 73% of Zambia's population living below the poverty line, most households are quite unable to provide adequately for their own children, let alone the needs of orphaned and dependent relatives. (Orphans and Vulnerable Children in Zambia 2004 Situation analysis).

### **3.2.2. Malaria**

37. Malaria is endemic throughout Zambia and continues to be a major public health concern. It is the leading cause of morbidity and the second highest cause of mortality, especially among pregnant women and children under the age of five. The Ministry of Health estimates that there are more than 3.5 Million cases and 50,000 deaths per year. Malaria accounts for 37% of all out patient attendance in Zambia.

38. The efforts to control malaria to ensure at least 60% of those that are at risk of malaria, particularly women and children under five benefit, the MoH/National Malaria Control Centre (NMCC) has adopted presumptive treatment of fever with sulpha-pyrimethamine (SP) and Cortem which is the latest introduction in the country and the use of Insecticide-treated mosquitoes nets (ITNs) through the Roll Back Malaria initiative. However, the

initiatives to treatment of malaria have not gone without challenges, which are dependant on the levels of education, urban and rural attitudes in the use of ITNs and drugs. It is likely that some women are not sure of the type of drug they take during pregnancy or gave to their children. Alternatively the use of mosquito nets is more common among urban than rural women, although rural women are almost as likely to use ITNs as urban women (ZDHS, 2001-2002)

### **3.2.3. Tuberculosis**

39. The arrival of the HIV/AIDS pandemic has caused a re-emergence of TB epidemics throughout the country. Two-thirds of TB patients may be HIV positive. Many adults carry a latent TB infection, which is suppressed by a healthy immune system. When HIV weakens the immune system, overt TB disease.

40. The average TB cases rate between 1964 and 1984 remained constant at 100 per 100 000 population. Since the advent of HIV/AIDS epidemic the TB case rate in Zambia increased nearly five-fold to over 500 per 100 000 population in 1996.

41. There are now in excess of 40,000 new TB cases reported every year. This figure is expected to rise by 10% annually in the next few years. The TB co-infection has also resulted in an increased mortality rate of TB patients on treatment by 15%

### **3.2.4. Sexually Transmitted Illnesses (STIs)**

42. Sexually Transmitted Infections (STIs) are common infections in Zambia and have been identified as co-factors in HIV transmission. However quantification of the morbidity attributed to STIs are difficulty for the following reasons; poor documentation and reporting of STIs at health institutions; STIs patients may seek treatment from providers (e.g. traditional healers of private clinic) who do not normally report STIs; Lack of technical and material resources to conduct community STI morbidity surveys; Social stigma and cultural barriers which can impede access to STIs services participation in community surveys. Even where data is available, the extent to which it reflects the frequency of STIs depends on factors such as; health seeking behaviour in the community; case –finding efforts by people in charge of STIs control; variations in reporting practices, that is: who reports, what is reported, to whom and for what; prevalence of asymptomatic infections.

43. Notwithstanding these limitations, available data from Zambia suggests STIs are among the top six conditions for which adults attend outpatient clinics and account to 6 percent of women and 8 percent of men. The peak age for having STI symptoms is 20-24 for both women and men. After this peak, the percentage declines with age for both women and men.

### **3.3. Gender Issues**

44. Within the Church in Zambia there have been no explicit gender policies at both national and diocesan levels as well as in practices at institutional and programme levels. The practice has been to include women in various programmes and activities and to move them into positions of authority in a token manner without allowing them space to fully exercise their responsibilities. In March 2000, the Government finally published the National Gender Policy. The Policy seeks, among others; to empower women, do away with gender disparities between them and their male counterparts. Specifically, the Policy recognises the "...need for equal and full participation of women and men at all levels of national development (Government of the Republic of Zambia, National gender Policy, March 2000: i). This policy commitment is, however, fully noticeable on the ground as gender imbalances continue at nearly all levels of society.

45. In family planning and child rearing, for instance, men have traditionally played a lesser role than women as these are considered to belong to the female domain. Women are also disproportionately responsible for the care of sick family members with the result that, at times, they even tend to neglect their own health needs. The social and economic vulnerability of women is greater than that of men primarily because of power imbalances in relationships. Power imbalances have made women to be unable to negotiate meaningfully where sexual relationships are concerned and consequently, the majority of women are vulnerable to infections such as STIs and HIV.

46. The Gender imbalance promoted by culture and tradition puts women in vulnerable position of early sexual relationships and marriages in which risk contracting STIs and the HIV virus. Many women are raped, abused or subjected to traditional ritual practices that further make them more susceptible to STIs and HIV. Similarly, due to their poor economic circumstances, women and girls often find themselves involved in commercial sex. Wife beating and abuse is equally prevalent and perpetrated by traditional beliefs that presuppose that a woman and girls should be subservient to the husband.

### **3.4. Food Security and Nutrition**

47. Nutritional levels are generally low for the majority of Zambians with the result that immunity levels are also low. Despite occasional crop surpluses due to good rains, the country's food situation is generally poor. The major cause of food insecurity at household level is the inability to produce enough food largely due to inadequate agricultural service support and technical services, inefficient markets and transport systems, including periodic droughts. Others include inadequate household incomes and lack of knowledge for preparation of balanced diets. The negative impact of HIV/AIDS has exacerbated the problem of household food insecurity and

worsened the nutritional status of the majority of the Zambian population. UNAIDS has concluded that poor agricultural policies, climatic fluctuations, and HIV/AIDS all contribute to the food crisis

### **3.5. Community and Home-Based Care**

48. In caring for the sick and dying, the Catholic Church employs various methods and strategies. Among them is community and home-based care that is usually used to tend the sick that are not hospitalised in any of its health facilities or those run by the Government or other health providers.

### **3.6. Stakeholder Coordination**

49. There are several care providers in the health sector. These include the Government itself, Churches, the private sector, non-governmental organisations and international bilateral and multilateral agencies. The Churches Health Association of Zambia (CHAZ), the coordinating body for Church health institutions and programmes, is the major stakeholder for Church health interventions in Zambia. Efforts of these stakeholders in providing quality health care are compromised by inadequate coordination of programmes and resources. This causes mistrust, lack of knowledge sharing and synergies, including unjustified competition for limited resources and health commodities.

## **4.0. Vision, Mission Statement, Rationale and Guiding Principles**

### **4.1. Vision**

50. A healthy Zambian nation in which each person has the capacity to live life to the full.

### **4.2. Mission Statement**

51. To contribute to the holistic development of people in dioceses and communities through provision of health services inspired by the Gospel values and the Social Teaching of the Church.

### **4.3. Rationale**

52. The Church has always sought to embody Christ's concern for the sick. In the Gospels, there are accounts of the acts of healing by Jesus Christ. For example, He cleansed a man with leprosy (Mt. 8:1-4 and Mk. 1:40-42), gave sight to two people who were blind (Mt. 20:29-34 and Mk. 10:46-52), enabled one who was mute to speak (Lk. 11:14), cured a woman who was haemorrhaging (Mt. 9:20-22 and Mk 5:25-34) and brought a young girl back to life (Mt. 9:18, 23-25 and Mk. 5:35-42). Our Lord cured every kind of ailment and disease (Mt. 9:35). Consequently, the Gospel of Matthew states our Lord's mission as the fulfillment of the prophecy of Isaiah that says, "He took away our infirmities and bore our diseases" (Mt 8:17 and. Is. 53:4).

53. Jesus' healing mission went beyond curing physical afflictions to embrace

mental and spiritual healing (Jn. 6:35 and 11:25-27). Indeed, He "came so that they might have life and have it more abundantly" (Jn 10:10). The mystery of Christ's teaching and healing mission informs and guides every facet of Catholic Church health care, which is to use Christian love as the animating principle for all health care. It also helps the Catholic Church to see its health care interventions and compassion as a continuation of Christ's mission.

54. An encounter with suffering and death can, for a Christian, take on a positive and distinctive meaning through the redemptive power of the suffering and death of Jesus Christ. Indeed, as St. Paul says, we are "... always carrying about in the body the dying of Jesus so that the life of Jesus may also be manifested in our body" (2 Cor. 4:10). This does not lessen the pain and fear but gives confidence and grace for bearing suffering rather than being overwhelmed by it. The Catholic health care ministry bears witness to the truth that, for those who are in Christ, suffering and death are the birth pangs of the new creation. "God himself will always be with them [as their God]. He will wipe every tear from their eyes, and there shall be no more death or mourning, wailing or pain, [for] the old order has passed away" (Rev. 21:3-4).

55. In keeping with the examples set by Jesus Christ in His suffering and death, the Church has served the sick, suffering and dying in various ways throughout its history. It has been doing this through elaborate infrastructure that comprises infirmaries, hospices, hospitals and clinics. Health care professionals working in these and other health facilities are motivated by their willingness to share in carrying forth God's life-giving and healing work. The delivery of health care services is based on an integrated approach that sees spiritual and socio-economic development as making people more fully human and dignified. The integrated approach emphasises individual and collective material improvement, spiritual enrichment, cultural promotion, ecological harmony, including community solidarity and intellectual growth.

56. It is in the spirit of this vision and mission that this Health Policy document for Catholic Church health facilities should be seen. It is hoped that the document will reach all Catholic health facilities in the country and that it will form a sound moral basis for health personnel in their daily dispensation of health care to needy populations.

#### **4.4. Guiding Principles**

57. The principles that guide the work of personnel in Catholic Church health facilities include the following:

- Provision of person centred and equitable health care;
- All development endeavours should aim at empowering people and building communities and community partnerships;
- Health care should be delivered in a holistic and integrated manner;

- There should be preferential option for the poor in the provision of health care;
- Complement to Government the provision of health services;
- Health care delivery should emphasise participatory decision-making at all levels;
- Available health resources should prudently be managed in line with prioritised health concerns;
- All personnel in Catholic Church health facilities should be guided by Christian morals and ethical codes; and that
- Personal sacrifice, justice and fairness should be the motivating factors for affording health care to those who need it.

## **5.0. Policy Objectives and Measures**

### **5.1. Institutional capacity**

#### **5.1.1. Health Infrastructure, drugs and supplies**

**5.1.1.1. Objective:** To maintain, repair and expand Health infrastructure, in order to prolong the lifetime of the infrastructure and advocate accessibility and availability of drugs and supplies to meet the growing national demand for health care services to the people, especially the poor and vulnerable groups

#### **5.1.1.2. Measures**

58. The church upholding the right to health of every human person and in conformity with its evangelisation mission of ministering to both the body and soul, which is the integral human development shall;

- Promote equality and non discrimination, fairness and justice in governance and operations of all Catholic health institutions and programmes
- Advocate increased capital expenditure on health for all capital and infrastructure development in the spirit of true partnership and collaboration, in consultation with GRZ/MOH/CBOH/CHAZ
- Facilitate and Support initiatives on all capital and infrastructure development with cooperating partners and donors
- Advocate and support accessibility and availability of drugs and supplies at all hospitals and clinics to GRZ/MOH/CBOH/CHAZ

### **5.1.1.2. Human Resource Development**

**5.1.1.2.1. Objective:** To support the development of Human resources in order to positively contribute and enhance quality health care services and increase motivation

#### **5.1.1.2.2. Measures**

59. The church recognises the need to recruit and retain suitably trained and experienced pool of human resources in order to contribute positively to the creation of a healthy Zambian nation and therefore shall:

- Facilitate on-going training in order to build capacity of Catholic health institutions and programmes human resource through CHAZ, Ministry of Health Human Resource Strategic Plan and stakeholders to enhance knowledge and skills.
- Support the development of human resource in formal or basic training in various fields according to the needs of Catholic health institutions and programmes
- Encourage and attract volunteers in our Health institutions and programmes in order to supplement the labour force

### **5.1.1.3. Resource Mobilization**

**5.1.1.3.1. Objective:** To facilitate mobilization of both internal and external resources that is financial, material, human resources, technical assistance, capacity building, research etc to support and enhance efficient administration of Health institutions and programmes

#### **5.1.1.3.2. Measures**

60. The church while strengthening local sustainability and ownership acknowledges the need to continue to mobilize internal and external resources and therefore shall;

- Facilitate collaboration, harmonization of efforts and build local institutional, human and financial capacities of financial resource management
- Support efforts towards more effective donor coordination and optimization of resource inflows
- Continue to promote and abide to principles of accountability, good management, social justice and transparency
- Work towards ensuring improved reporting of internal and external resources

## **5.2. Community and Home Based Care Programmes**

**5.2.1. Objective:** To enhance contribution of community organisations and individuals to the care of the sick and dying.

### **5.2.2. Measures**

61. The Church recognises the strategic role of community and home-based care in providing support and health and spiritual care for the sick. In line with this acknowledgement, the Church shall:

- Encourage the formation and strengthening of community and home-based care programmes in health care institutions (rural health centres and Mission Hospitals) and parishes in each Diocese in the country;
- Ensure that community and home-based care programmes are a high priority in the allocation of resources (human, financial and material);
- Strengthen linkages between community and home-based care and formal health institutions (health centres and hospitals) so as to foster an efficient and effective two-way referral system;
- Ensure that all registered community and home-based care clients are exempted from paying any medical fees;
- Involve communities in all areas of planning and management in order to foster ownership of the programmes; and
- Encourage networking with all key stakeholders involved either directly or indirectly in the provision of health care to the sick and dying.

### **5.3. Voluntary Counselling and Testing (VCT)**

**5.3.1. Objective:** To sensitise the public to the importance of VCT as a means of knowing ones status and arresting the spread of the HIV/AIDS pandemic.

#### **5.3.2. Measures**

62. The Church recognises the significance of VCT as a tool in HIV/AIDS prevention. In this context, the Church shall:

- Sensitise the community to the value of VCT;
- Open a VCT centre;
- Ensure that the voluntary and confidential nature of counselling and testing is maintained;
- Encourage clients to share confidentially with someone they trust;
- Enhance the capacity of counsellors through training for improved coverage and quality of counselling;
- Train community care-givers in counselling skills;
- Promote the formation of post-test clubs and other support groups; and
- Promote strong linkages among VCT, community and home-based care.

### **5.4. HIV/AIDS and Behaviour Change Process**

**5.4.1. Objective:** To encourage behavioural and attitude change as a way of preventing HIV infections in the country.

## **5.4.2. Measures**

63. HIV/AIDS is fundamentally a behavioural issue and as such there should be more investments in interventions and capacities targeted at changing attitudes and behaviour. The Church shall, therefore,:

- Encourage programmes that create awareness and support human, moral and Christian values about abstinence and faithfulness;
- Ensure that, in keeping with the Catholic Moral Teaching, condoms are not kept and/or distributed at Catholic health institutions or by Catholic Church programmes;
- Promote alternatives/options for the provision of employment and recreation. This will especially be in favour of the youth;
- Seek current information on HIV/AIDS and develop systems for ensuring that it is widely available;
- Encourage greater involvement of PLWHA in prevention of HIV infections;
- Teach that stigma and discrimination are harmful and that people living with HIV/AIDS, including those affected by the disease, are invited and welcomed in Churches and communities; and
- Continue to fulfill a teaching role on sex and sexuality in conformity with its Moral values and work to break the silence created by discomfort and tradition. In doing this, it will emphasise gender issues, empowerment of women and girls, including the necessity for men to change their behaviour and for all to take responsibility for containing the spread of HIV.

## **5.5. Hospices**

**5.5.1. Objective:** To utilise redundant hospital space with a view to expanding the Church's capacity to care for the sick and dying.

### **5.5.2. Measures**

64. In view of GRZ policy of right-sizing some Catholic hospitals in the country and given the high demand for hospice capacities due to HIV/AIDS, the Church shall:

- Encourage the creation of hospice capacities out of redundant hospital wards/beds;
- Strengthen the bed and staffing capacities of existing hospices; and
- Rationalise the use of hospice resources with a view to targeting the needy and most vulnerable.

## **5.6. HIV/AIDS and Workplace**

**5.6.1. Objective:** To promote HIV/AIDS awareness in workplaces as a way of prevention and fighting stigma.

### **5.6.2. Measures**

65. Currently, there is inadequate awareness of the economic and social impact of HIV/AIDS in the majority of workplaces. In order to contribute to raising awareness of the pandemic among the work force, the Church shall:

- Require medical examination for employment as per existing regulation/legislation but shall in no circumstances demand compulsory HIV testing as among the criteria for employment;
- Turn stigma and discrimination into care and counselling for people living with and affected by HIV/AIDS;
- Support employees who are tested HIV-positive to live a full and quality life;
- Advocate for access to health care and to drugs to treat opportunistic infections, relieve pain and distress through palliative care and to prevent mother to child transmission;
- Support the effort of those who are campaigning for access to anti-retroviral drugs (ARVs);
- Strengthen Church related hospitals and clinics that are providing ARVs;
- Explore and promote the contribution that traditional medicine and wisdom can offer as a therapeutic resource;
- Work out mechanisms for the facilitation of sick leave, medical insurance or financing of medical fees, funeral and burial benefits/support, time taken off to attend funerals or visit the sick;
- Ensure that occupational safety measures/regulations are strengthened and adhered to in all Church health institutions and programmes;
- Put in place effective measures to minimise occupational safety risks of volunteers (even though these are not a direct responsibility of Church health institutions/programmes). This would include providing training to volunteer and care-givers on occupational safety as well as the requisite protective material tools and skills; and
- Develop minimum standards for health care delivery by volunteers and caregivers.

### **5.7. Orphans and Vulnerable Children (OVC)**

**5.7.1. Objective:** To contribute to the care of orphaned and vulnerable children.

#### **5.7.2. Measures**

66. The problem of OVC is slowly turning into a national calamity and might spin out of control if it not urgently addressed by responsible sections of the Zambian society. Mindful of the need to avert this danger, the Church shall:

- Promote and support programmes aimed at providing care and support to OVC;
- Facilitate coordination of OVC activities with special emphasis on health, education and psychosocial needs; and

- Promote requisite family values and use role models where significant adults are absent.

## **5.8. Gender and Health**

**5.8.1. Objective:** To challenge traditional beliefs and customs that disadvantage and undermine the position of women and the girl-child in society.

### **5.8.2. Measures**

67. Women in Zambia, like elsewhere in poor countries, suffer discrimination in areas such as decision-making, land and asset ownership, including sexual relations. This exposes them to the risk of HIV infections, as they are most of the time not given the opportunity to negotiate sexual relations with men. The Church is committed to empowering women and the girl-child in all facets of human endeavour and shall, therefore,:

- Continue to respect the dignity of both sexes and allocate responsibilities and positions according to ability rather than gender;
- Encourage men to get involved in caring for the sick and dying in their families and communities;
- Encourage men to participate in pre- and post-natal activities such as in promoting breastfeeding and other under-five programmes;
- Encourage men to treat their wives or partners with respect and not place them in positions that are harmful to them either psychologically or physiologically;
- Combat sexual or gender-based violence, abuse and rape in homes, communities and schools;
- Support organisations that are providing refuge, counselling and legal assistance to victims of abuse and gender violence;
- Support the work by women and men in community and home-based care programmes;
- Support various HIV/AIDS prevention programmes and education-for-life programmes so that couples are encouraged to discuss sexual relationships and are empowered to relate in a meaningful and life-giving way; and
- Challenge cultural and traditional values and systems that keep women oppressed and undervalued.

## **5.9. Food Security and Nutrition**

**5.9.1. Objective:** To contribute to enhancing household food security and to link good nutrition with good health.

### **5.9.2. Measures**

68. There is a proven correlation between good nutrition and good health. Indeed, it has been there as evidence that good nutrition prolongs the life of the sick. In cognisance of this fact, the Church shall:

- Demonstrate a commitment to complementing medical care with good nutrition;
- Establish and support nutrition programmes in its health facilities;
- Create awareness of the benefits of prevention of illness and the use of locally available nutritious foods as part of the process of healing;
- Strongly encourage initiatives that target national and household level food security and the long-term production of food by training people in income generating activities to reduce dependence on food relief;
- Support the work done by community groups such as home based care in the provision of food to the chronically ill, especially those living with HIV/AIDS;
- Give assistance in the storage and distribution of food where necessary; and
- Work in conjunction with food agencies that supply food to clinics, health centres, community and home based programmes.

## **5.10. Stakeholder Coordination and partnership**

**5.10.1. Objective:** To enhance true partnership through dialogue, coordination, harmonization and information sharing takes place at all levels of implementation with stakeholders and partners.

### **5.10.2. Measures**

69. The Church recognises that the importance of impartial, transparent, effective, well coordinated efforts and pledges a multi-sectoral implementation of initiatives in supplementing the Health care service delivery in Zambia and therefore shall;

- Ensure result oriented coordination of activities takes place at different levels of implementation with stakeholders and partners
- Facilitate more harmonized approach of Health institutions and programmes operations
- Foster and strengthen the relationship between Government, CHAZ, DHMTs, Donors and other stakeholders at all levels.
- Ensure Health priorities, strategies, plans are identified and developed in conjunction with guidelines of the Catholic Church teachings, MOH. CHAZ and other partners and stakeholders
- Support and conduct resource mobilization meetings/efforts
- Support partnership initiatives
- Carryout advocacy role for legal reform and policy changes etc

Support exchange information and visits on best practices and standards at different levels for Health institutions and programmes development

## **5.11. Monitoring, evaluation and technical Support**

**5.11.1. Objective:** To maintain and improve Health institutions and programmes operational and implementation procedures and processes to assure timely and effective management decision-making

### **5.11.2. Measures**

70. The Church acknowledges the importance to monitor, evaluate and provide technical support on Health institutions and programmes interventions as they provide essential data and information that is important for drawing important lessons and secure the confidence of all stakeholders and funding agencies that resources are prudently being utilised. The church therefore shall;
- Generate and disseminate quality information which feeds back into the policy process for informed decisions
  - Develop and strengthen the reporting and monitoring systems
  - Develop a supportive and effective management information system that should be able to provide accurate, reliable and timely data
  - Support research and surveillance on Health institutions and programmes interventions
  - Support the establishment of information and research bureaus or centres at National, Diocese and institutional levels
  - Monitor Health institutions and programmes interventions regularly
  - Facilitate the provision of technical and material support to Health institutions and programmes
  - Work towards improvements in the transparency and availability of monitoring information

## **6.0. Institutional Arrangements**

### **6.1. The Zambia Episcopal Conference (ZEC)**

71. The Zambia Episcopal Conference, under the Bishop Director of Health, is responsible for the overall pastoral vision as well as the framework for the implementation of the Catholic Church Health Policy.

### **6.2. Catholic Secretariat – National Health Department**

72. The Catholic Secretariat is responsible for coordinating and providing overall logistical support in developing, implementing, monitoring and review of the Catholic Church Health Policy. The National Health Department will be responsible for linking up Dioceses in regard to coordination, policy issues, development of community and home-based care and many other health and HIV/AIDS related issues. The need for collaboration comes out of a shared vision and understanding of the Church's mission and its pastoral role in society. Collaboration will require strong support of the National Health Department, the Local Ordinary at the Diocesan level continue strong links with CHAZ and MOH

### **6.3. Diocesan Health Coordinator**

73. The Diocesan Health Coordinator shall be responsible for the coordination of all Diocesan Health institutions and programmes. The Diocesan Health coordinator shall specifically be responsible for:

- Ensuring the implementation of the Catholic Church Health Policy and developing strategic plans in conjunction with Diocese health institutions and programmes;
- Coordination of Church health institutions and programme activities in the respective Dioceses;
- Advocating and lobbying for improved health institutions and quality service delivery, including forging strategic partnerships with relevant stakeholders;
- Managing networks between and among the National Health Department, CHAZ, DHMTs, Non-governmental Organisations, donors and other stakeholders; and
- Building sustainable human resource capacities in Church health institutions.

#### **6.4. Diocesan Health Boards/Commission**

74. Diocesan Health Boards and Commission are responsible for developing and instituting mechanisms for coordinating health providers in their areas. The implementation of provisions of the Catholic Church Health Policy will be the responsibility of Dioceses and community programmes. They will specifically be responsible for:

- Approving project proposals as a way of improving coordination and avoiding duplication of efforts in Church health interventions;
- Ensuring that a system for harmonised incentives (allowances, fees, salaries) is put in place for all Catholic Church health institutions, programmes and activities; and
- Reporting to the Catholic Secretariat's Health Department of all proposals, steps and nature of donor funding on an annual basis.

#### **6.5. Health Institutions and Programmes**

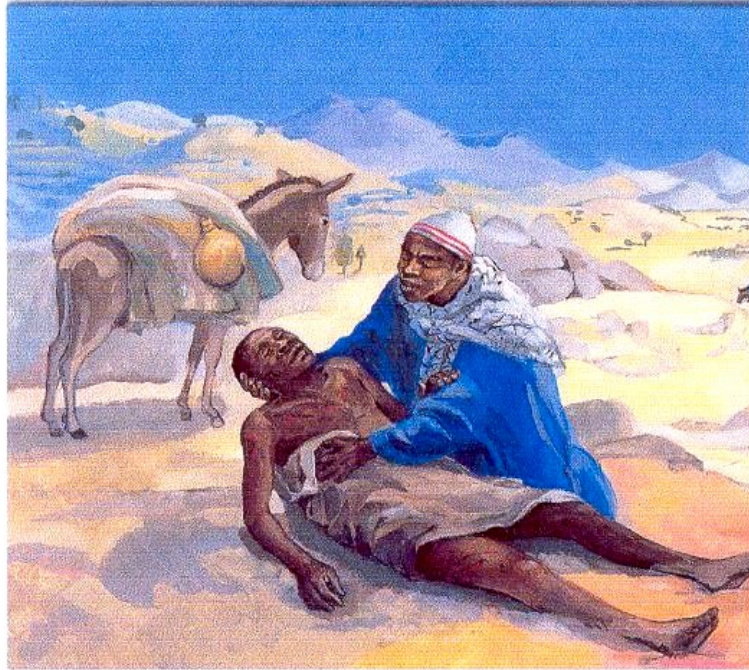
75. Health institutions and programmes shall be responsible for the day-to-day operations of health interventions in respective hospitals, centres and report their activities to CHAZ, DHMTs, National Health Department, National Health Coordinator, Diocesan Health Coordinator, Rural Health Clinic

#### **6.6. Managing Agencies and Staff Working in Hospitals**

76. In order to provide guidance on the roles of Managing Agencies and Medical Officers-In-Charge, Dioceses shall ensure that Managing Agencies are specifically responsible for overall administration and policy framework where as Medical Officers-In-Charge shall be responsible for the technical (medical) aspect. In order to attain this functional distinction, clear job descriptions and functions of Managing Agencies and Medical Officers-In-Charge will be formulated.

There will be a Memorandum of Understanding (MoU) between Catholic Mission Hospitals and Clinics and District Health Management Teams on the issue of attachment

---



But a Samaritan Traveller who came on him was moved with compassion when he saw him. He went up to him and bandaged his wounds.....

**LK. 10:33**