

Country Activity Plan

Strategy Statement for Zambia 1997-1998

January 23, 1997



Partnerships
for Health
Reform

PHR

Abt Associates Inc. # 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 # Tel: 301/913-0500 # Fax: 301/652-3916

In collaboration with:

Development Associates, Inc. # Harvard School of Public Health #
Howard University International Affairs Center # University Research Corporation

Strategy Statement for Zambia 1997-1998

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Acronyms

CA	Cooperating Agency
CAP	Country Activity Plan
CBoH	Central Board of Health
CDC	Centers for Disease Control (U.S.)
CMAZ	Church Medical Association of Zambia
CSO	Central Statistical Office
DDM	Data for Decision Making Project
EU	European Commission
FAMS	Financing and Administrative Monitoring System
HMIS	Health Management Information System
HRIT	Health Reform Implementation Team
IMCI	Integrated Management of Childhood Illnesses
LCMS	Living Conditions Monitoring Survey
MOH	Ministry of Health
NGO	Non Governmental Organization
ODA	Overseas Development Agency (U.K.)
PCI	Project Concern International
PHN	Population, health and nutrition
PHR	Partnerships for Health Reform Project
PSI	Population Services International
PSMAS	Public service medical aid scheme
SIDA	Swedish International Development Agency
USAID	United States Agency for International Development
UTH	University Teaching Hospital
WHO	World Health Organization
ZCCM	Zambia Consolidated Copper Mines, Ltd.
ZCHP	Zambia Child Health Project

1.0 Executive Summary

This Country Activity Plan (CAP) proposes a series of activities to be carried out in Fiscal Year 1997 and 1998 by the Partnerships for Health Reform (PHR) Project with coordination provided by the BASICS Project. USAID/Zambia requested PHR to provide support to the Government of Zambia in two areas of the Mission's Results Framework which has been developed to support the Government's ambitious program of health sector reforms that are aimed at "providing equity of access to cost-effective quality health care as close to the family as possible." The two areas designated for PHR assistance are: 1) improving capacity for policy analysis, planning, and support for the delivery of population, health, and nutrition interventions -- specifically in the area of health care financing; and 2) improving access to population, health and nutrition interventions through public-private partnerships.

Reform efforts currently underway in Zambia related to the areas of PHR's assistance include:

- ▲ decentralizing the management of the public health system from the central and provincial levels to the district and hospital levels;
- ▲ developing an essential package of cost-effective health services to which all Zambians would be entitled;
- ▲ imposing user fees at government health facilities throughout the country as a means of cost sharing;
- ▲ introducing pre-payment schemes for primary health care and hospital care for the general public in the country's three central hospitals and districts where these hospitals are located;
- ▲ planning the development of a health insurance program for public sector employees (a public service medical aid scheme);
- ▲ developing plans for the start-up of a franchise or network of private, non-profit health clinics, based on the model of the Bolivian NGO, PROSALUD; and
- ▲ assessing the potential for increasing the role of the private sector and increasing collaboration between the public and private sectors in the delivery of health services.

To develop this CAP, PHR held discussions with the BASICS Project and other cooperating agencies (CAs) working in Zambia, met with World Bank personnel working on health reform in Zambia as well as with members of the team that recently conducted a policy review, and held discussions with the country's Chief Health Planner during a conference in South Africa. Two PHR staff members then traveled to Zambia from November 11 to 22 to hold a series of discussions with the Chief Health Planner of the Ministry of Health (MOH), other MOH officials, representatives of other donor agencies working in the areas of health financing and public-private collaboration (including SIDA and the European Commission), staff of USAID and BASICS, and representatives of a private physicians association. In addition, the Chief Health Planner suggested to the team that they visit some of the health districts experimenting with pre-payment schemes to identify their needs in the area of health care financing. The team accordingly met with district personnel in Kitwe (in the Copperbelt) and Lusaka to discuss these schemes in depth. The activities that are being proposed in this CAP are meant to respond directly to the needs identified by both central and district-level health personnel during this visit.

The proposed activities for PHR are:

Health Care Financing:

- 1) In collaboration with appropriate national institutions, such as the University of Zambia Economics Department, conduct assessments of district-level public sector pre-payment schemes that currently exist in *urban* areas, and assist in the design and implementation of *rural* pre-payment schemes to determine their impact on equity, access, efficiency, and quality of services in order to help districts improve the design, implementation, and monitoring of these schemes;
- 2) Work in partnership with MOH and WHO to develop strategies for the design of a public service medical aid scheme (PSMAS), and to implement these strategies, as requested;
- 3) In partnership with the University of Zambia Economics Department, analyze health demand data from the recent Living Conditions Monitoring Survey (LCMS 1), and disseminate results on health seeking behavior, household health expenditures, and ability and willingness to pay in order to inform and influence national policies and local programs related to health financing and public-private partnerships;

Public-Private Partnerships:

- 4) Take part in assessing the feasibility of adapting the franchising model of PROSALUD/Bolivia (a network of private, non-profit clinics) to Zambia and in designing the program (as requested); and
- 5) Collaborate with the MOH and other donors, as requested, in developing and implementing plans to develop partnerships between the public and private sectors in the delivery of health care services, following the MOH/European Commission (EU) assessment taking place in December 1996 to January 1997).

One of the major objectives of the proposed activities is to strengthen the capacities of local institutions, including universities and the Central Board of Health, to plan, implement, monitor, and evaluate policies and activities related to health financing and the development of public-private partnerships. The majority of the field work for the assessments of the district-level pre-payment schemes and the analysis of health demand data from the LCMS 1 will be conducted by local universities with oversight provided by appropriate MOH personnel. All activities will be carried out under the direction and coordination of the MOH Planning Unit. PHR has also incorporated into this plan coordination with other donors working on related activities, in order to avoid duplication of efforts.

The specific activities, objectives, performance indicators, target completion dates, and collaborators for each of these activities are summarized in the table that follows this page.

Proposed PHR Activities with Zambian MOH and Other Partners
Summary of Objectives, Results, Activities, Performance Indicators, and Target Dates

Activities	Performance Indicators	Target Date for Completion	Partners
<p><i>OBJECTIVE 1 - POLICY ANALYSIS, PLANNING AND SUPPORT</i> <i>Strengthen the national capacity to design, implement, monitor, and make necessary changes to health care financing policies in the context of decentralization reforms.</i></p>			
<p><i>Result 1.1 - Increased national capacity to design and implement equitable district-level cost sharing and pre-payment schemes.</i></p>			
<p>1. Conduct assessments of design, implementation and performance of cost-sharing schemes in 2 to 3 <i>urban</i> districts where they are currently being implemented (Lusaka, Kitwe, and maybe Ndola).</p> <p>2. Hold a workshop in each district on the findings of the assessment, indicators, and methodologies for data collection and analysis, and recommendations to improve the cost-sharing schemes.</p> <p>3. Assist in design, implementation, and monitoring of cost-sharing schemes in 2 <i>rural</i> districts.</p>	<p>1.1.1 Reports on cost-sharing performance in two urban districts produced jointly with national institutions.</p> <p>1.1.2 Workshops on results of assessments held in each district.</p> <p>1.1.3 Increased capacity of national institutions (e.g., universities) to assist districts in designing and assessing cost sharing and pre-payment schemes.</p> <p>1.1.4 Indicators and data collection and analysis methods developed to assist districts to monitor performance of cost-sharing schemes. (This will include use of FAMS data and recommendations for incorporation of certain data into FAMS.)</p> <p>1.1.5 Cost-sharing schemes designed and implemented in two rural districts with assistance from national institutions (e.g., universities).</p>	<p>Sept. 1997</p> <p>Sept. 1997</p> <p>Dec. 1997</p> <p>Dec. 1997</p> <p>June 1998</p>	<p>MOH Planning Unit, CBoH Directorate of Monitoring and Evaluation; Staff of Economics Department of University of Zambia (and other universities, as appropriate); DANIDA; PHR</p>
<p><i>Result 1.2 - Increased capacity to develop and implement a public service medical aid scheme.(PSMAS).</i></p>			
<p>1. Develop strategies for the design and implementation of a PSMAS (joint trip by PHR and WHO).</p> <p>2. PHR provides follow-up assistance with design and implementation of PSMAS, as requested.</p>	<p>1.2.1 Strategies for design and implementation of PSMAS developed.</p> <p>1.2.2 Implementation plan for PSMAS developed.</p>	<p>June 1997</p> <p>To be determined</p>	<p>MOH Planning Unit; WHO; PHR</p>
<p><i>Result 1.3 - Increased capacity of the Ministry of Health to make necessary policy changes in health care financing based on survey data on consumer demand for health services.</i></p>			

Activities	Performance Indicators	Target Date for Completion	Partners
<p>1. Analyze health-related data from the recent Living Conditions Monitoring Survey (LCMS).</p> <p>2. Disseminate major findings of the analyses and bring them to the attention of policy-makers and related research activities.</p>	<p>1.3.1 Report on health seeking behavior, household health expenditures, ability to pay for health care, etc. produced jointly with the University of Zambia.</p> <p>1.3.2 Packaged summary of results for policy-makers submitted to MOH and others, as appropriate.</p> <p>1.3.3 Presentation of plans for analyses and/or findings made at appropriate fora (e.g., SIDA-sponsored conferences on health care financing).</p>	<p>June 1997</p> <p>July 1997</p> <p>To be determined.</p>	<p>MOH Planning Unit; Central Statistical Office; University of Zambia Economics Department; PHR</p>
<p>OBJECTIVE 2 - PUBLIC-PRIVATE PARTNERSHIPS <i>To strengthen the partnership between the public and private sectors to support the Government's goal of increasing access to cost-effective, quality health care services.</i></p>			
<p><i>Result 2.1 - Increased knowledge on the feasibility of adapting the PROSALUD franchising model in Zambia.</i></p>			
<p>1. PHR contributes to feasibility assessment of adapting the PROSALUD franchising model to Zambia and in program design.</p>	<p>2.1.1 PHR reports on feasibility assessment and, if appropriate, program design completed.</p>	<p>To Be Determined</p>	<p>MOH; PHR; PSI</p>

Activities	Performance Indicators	Target Date for Completion	Partners
<i>Result 2.2 - Increased collaboration between the public and private sectors in the delivery of health services and increased provision by the private sector of public health services (e.g., primary health care, preventive care).</i>			
<ol style="list-style-type: none"> 1. PHR to follow up with the MOH to obtain results of the EU assessment and their plans for follow-up activities. 2. MOH and USAID jointly determine the role of USAID (and PHR) in promoting public-private partnerships in health care delivery. 3. Assist in development of plans and implementation for increased public-private partnership, as requested. 	<ol style="list-style-type: none"> 2.2.1 Agreement on the role of USAID on promoting public-private partnerships made between MOH and USAID. 2.2.2 Plans for technical assistance submitted to and approved by MOH. 2.2.3 Implementation of technical assistance plans begins. 	<p>TBD</p> <p>TBD</p> <p>TBD</p>	<p>MOH Planning Unit; USAID; European Commission; PHR</p>

2.0 Introduction and Methodology

Since 1991, the Government of the Republic of Zambia (GRZ) has embarked on an ambitious program of health sector reforms involving decentralization of the health system, hospital autonomy, the development of an essential package of health services to which all Zambians are entitled, cost-sharing strategies, and other efforts intended to provide Zambians with “equity of access to cost-effective, quality health care as close to the family as possible”. A large number of multilateral and bilateral donor agencies, including USAID, are providing financial and technical assistance to the MOH in support of the reform agenda. USAID finalized an agreement with the Government of Zambia in 1995 to implement the Zambia Child Health Project which is aimed at supporting the reforms by improving the technical quality of child health activities carried out by the restructured health care system. The BASICS Project is the lead CA implementing this eight-year project, with technical assistance from a number of other CAs, including the Quality Assurance Project, Data for Decision Making (DDM-CDC), MotherCare, OMNI, the Lactation Management Education (Wellstart) Project, the Rational Pharmaceutical Management (RPM) Project, and the Partnerships for Health Reform (PHR) Project.

USAID is in the process of developing a Results Framework covering all of its activities in child health, family planning, nutrition, and HIV/AIDS prevention and control, and which corresponds to the goals of the government’s reform agenda. The USAID Strategic Objective for health, population, and nutrition activities is “increased use of integrated child and reproductive health and HIV/AIDS interventions” as a means of achieving the goal of sustainable improvements in the health status of Zambians. All of the activities of the Zambia Child Health Project fall under five Results designed to support this Strategic Objective. These Results, and the strategies identified to achieve them are:

- 1) Increased demand for population, health, and nutrition (PHN) interventions among target groups through a strategy of information, education, and communications (IEC) activities;
- 2) Improved access to PHN interventions through community partnerships, which will involve training and technical assistance to strengthen partnerships between health centers and communities, a small grants program for NGOs and districts to implement integrated community-based child health prevention activities, and training for Community Health Workers and in other areas;
- 3) Improved access to PHN interventions through Public-Private Partnerships;
- 4) Improved Health Facility Worker Performance in Preventive and Curative Services and Management, through a series of pre- and in-service training activities in Integrated Management of Childhood Illnesses (IMCI), well-child care, and environmental health; and
- 5) Improved capacity for policy analysis, planning, and support for the delivery of PHN interventions, which will involve a large number of activities, including assistance to the MOH in policy development, assistance in analyzing and developing health care financing strategies, support for quality assurance activities, assistance to districts in developing annual health plans, operations research on various health interventions, development of a

new national health management information system, and development of a drug management information system.

USAID/Zambia has requested that the PHR Project provide assistance to the Government in two areas:

- 1) increasing public-private partnerships (Result #3); and
- 2) the analysis, development, and implementation of health care financing strategies and policies under Result #5 (improved capacity for policy analysis, planning and support for the delivery of PHN interventions).

This CAP proposes activities to be carried out in these two areas by PHR, in collaboration with local counterparts, the BASICS Project, and other donors, as appropriate. This CAP was developed during a visit to Zambia in November 1996 during which a two-person PHR team held a series of discussions with the government's Chief Health Planner, other Ministry of Health officials, health personnel from the Kitwe and Lusaka districts (during field visits), representatives of the private sector, personnel from the BASICS project, and representatives of other donor agencies, including SIDA, the World Bank, and the European Commission (EU). Prior to the visit to Zambia, PHR held discussions with World Bank representatives working in Zambia, members of the team that recently conducted a health policy review, BASICS and other CAs working in Zambia, and the Chief Health Planner, Vincent Musowe (during a conference in South Africa in June 1996). From the discussions with Zambian health officials from the central and district levels, needs were identified, as well as specific activities to meet these needs. This CAP presents detailed activities to be conducted during the first year of PHR assistance (October 1996 to September 1997), and outlines recommended follow-up activities for the following year, which will be further defined once first-year activities are underway.

3.0 Background

3.1 The Government's Health Reform Agenda

The evolving democratization in Zambia and the development of a new leadership since the early 1990s have enabled the initiation of radical reforms in the health sector. The overall framework of the health reforms is based on the promotion of effective leadership, accountability and partnership to sustain changes in the ways the health sector is managed. The reforms are aimed at moving the health sector from a centrally managed system based on hospital care to a decentralized system in order to meet the goal of “providing equity of access to cost-effective quality health care as close to the family as possible”.

In 1992, the Government of Zambia initiated an ambitious process of decentralization and organizational reforms. These reforms include the reorientation of the MOH and the devolution of key functions such as planning, management, service delivery, resource mobilization and allocation from the central to the district level. To support the implementation of these reforms, a Health Reform Implementation Team (HRIT) was put in place at the central level and has been instrumental in moving the reforms forward. The role of the MOH has been redirected from responsibilities for direct service provision to a focus on key strategic management functions such as policy formulation, resource mobilization and planning for the health sector. Technical management and the delivery of health services is now under the direction of a new national agency, the Central Board of Health (CBoH), which is based in Lusaka and has four regional offices. In addition, all central hospitals have been granted autonomy to manage their own funds, develop programs, and reassign staff, and are now managed by hospital boards and hospital management teams. At the district level, district health management teams were put in place to manage the decentralization process before district health boards could be formed. The districts now receive grants as well as “drug kits” from the central MOH, based on their population size, and are responsible for managing these resources. The district health boards are currently in the process of being formed.

Major changes in the delivery of health services are also taking place. The development of an essential health package, based on the measurement of the burden of disease in the country and on the cost-effectiveness of health interventions, is the principal means through which the public health sector will be guided to redirect its resources to the delivery of primary health care services. It is planned that the implementation of the essential health package will take place in eighteen districts in 1997.

The development of a health care financing policy consistent with the health reform agenda has lagged somewhat behind the organizational and programmatic reforms. The MOH released a new version of the National Strategic Health Plan in September 1996. In this new edition, the strategy for health care financing is to mobilize resources through appropriate and suitable means, and to ensure efficient use of these resources, in order to guarantee equity of access to cost-effective quality health care. More emphasis is now being placed on institutional sustainability and cost containment and reduction, as opposed to resource mobilization, due to the high level of poverty in the country. The goals of the health care financing strategy are: 1) the

promotion of health sector institutional sustainability, 2) improvements in cost containment, cost reduction and allocative efficiency, 3) increase in resources, and 4) the promotion of equity.

An important shift in the new strategy is the recognition that although the government is committed to making available a cost-effective essential health care package, it does not have sufficient resources to fully fund the package, even with donor support. Accordingly, the government's new orientation is to mobilize non-governmental resources to contribute to the funding of the package. Beyond mobilizing resources, however, the design of health care financing reforms will be linked to management and service delivery reforms designed to contain costs in order to improve the sustainability of the system.

The MOH is promoting different pre-payment schemes for different sectors (formal and informal) of the economy, given the differences between these sectors in the ability to collect contributions from potential members. In the formal public sector of the economy, the MOH is promoting the design and implementation of a public service medical aid scheme (PSMAS), to be paid for by employer contributions and deductions from employees' pay. In the formal private sector, increased employer financing of health services is being promoted in two ways: 1) through the expansion of existing employer pre-payment schemes with government-run health facilities (such as the University Teaching Hospital (UTH) in Lusaka, and the central hospitals in Kitwe and Ndola) and 2) through the expansion of contractual arrangements with private providers. In the urban informal sector, the MOH is promoting the development of pre-payment schemes for informal sector groups such as cooperatives, to be accompanied by measures for strengthening the referral system through financial incentives (i.e., patients going directly to hospitals instead of a primary care clinic first must pay a "bypass fee"). Local health care financing initiatives in rural areas are being promoted through the District Health Innovation Fund, set up by the MOH to finance experiments in alternative ways of organizing and financing health care service delivery. Finally, to guarantee access to quality health services to the poor, the MOH is promoting the Public Welfare Assistance Scheme, through which those who are identified as indigent by the Ministry of Social Welfare are exempt from paying for medical fees (either user fees or pre-payment fees).

The role of the private sector in the delivery of health services and the development of public-private partnerships are still to be defined in the government's health reform agenda. Some efforts in this area that have been made to date include a USAID-funded study of "Non-Governmental Health Care Provision" in Zambia, conducted by DDM/Harvard, and a national conference on Public/Private Sector Partnerships for Health held in Siavonga in June 1995, during which findings from the DDM study were presented and recommendations made. The government is also in the process of considering starting a pilot franchising project in Lusaka, based on the model of PROSALUD, a Bolivian private, non-profit network of primary care clinics that provide low-cost, high-quality health care to peri-urban populations (see *Section 4.2*). Plans are currently underway for PROSALUD and Population Services International (PSI) to assist in the establishment of this program. The latest edition of the National Strategic Health Plan reflects the MOH's interest in franchising, as well as in contracting out certain services currently provided by the government to the private sector. The Plan calls for: 1) the development of a legal framework to support franchising, 2) the development of an inventory of private providers who are interested in franchising, and 3) the development of contracts with private providers.

A further development in the area of public-private collaboration is a recent request from the Minister of Health to have the EU conduct an assessment of the potential for creating public-private partnerships. A team from the EU came to Zambia in late November to plan and conduct this assessment. Results from the assessment are expected in the second quarter of FY 97.

3.2 USAID's Support for Health Reforms in Zambia

USAID currently provides support to the Government of Zambia in the health sector through three multi-year projects: 1) the Zambia Child Health Project, 2) the Zambia Family Planning Project, and 3) the HIV/AIDS Prevention Project.

The Zambia Child Health Project (ZCHP), described briefly above, aims to contribute to a sustainable improvement in child health in Zambia through increased coverage and quality of promotive, preventive, and curative activities contributing to child health. The major activities of this \$26.5 million project include: training and supervisory activities to train health workers at various levels in Integrated Management of Childhood Illnesses (IMCI); strengthening partnerships between communities and the health system for the delivery of community-based child health services, working mainly through NGOs; strengthening partnerships between the public and private health sectors; providing technical assistance for policy formulation in a number of areas, including malaria treatment and prevention, health financing, immunization, and nutrition; assisting district health authorities with their annual action plans; providing training in quality assurance; and developing and testing a new national health management information system, as well as a drug management information system. A total of ten CAs are involved in implementing the ZCHP, with coordination provided by the BASICS Project. A joint work plan for FY 97 incorporating the plans of all CAs involved was developed in June-July 1996 and then revised and presented to senior MOH officials at a joint meeting in September. PHR's activities in Zambia will be funded under the umbrella of ZCHP; however, PHR has also been mandated by USAID to work with the CAs of its two other PHN projects in order to provide support to its family planning and AIDS objectives.

The Zambia Family Planning Project, a four-year, \$39 million project which began field activities in 1995, provides technical assistance in a broad range of areas to promote child spacing through the use of modern family planning methods. The project involves 12 CAs, coordinated by John Snow, Inc., which are providing support for: management training for family planning services; social marketing of contraceptives; information, education, and communications activities to promote awareness of and knowledge in family planning; the development of policy guidelines for family planning activities; and research.

The HIV/AIDS Prevention Project, implemented by Project Concern International (PCI) for a one-year bridging period, focuses on strengthening the capacity of selected districts and the central MOH to manage HIV/AIDS prevention and control activities. One of the main activities of the project is the development of training programs and training of trainers to strengthen the capacity of NGOs and other local institutions working in AIDS prevention in the area of information, education, and communications (IEC), counseling, and peer education. The project is currently working in five districts, including four urban and peri-urban districts and one rural district.

3.3 The Role of Other Donors in Supporting the Health Reforms

A large number of multi-national and bilateral donor agencies are providing technical and financial assistance to the government in a wide range of areas in support of its health reform efforts. Below we briefly describe the activities of these donors in the two areas in which PHR has been asked to provide assistance -- health care financing and the development of public-private partnerships. A summary of donor activities and financial support to the health sector can be found in *Annex 1*.

In the area of health care financing, SIDA has conducted a number of research activities, including a recently completed health sector expenditure review and a study of the effects of initial cost sharing efforts in three districts. The agency, which has a long-term health program officer on the ground, is currently planning a national household health expenditure survey, a study of drug expenditures, and a comparative study of different types of providers (government, Mission, and mine-owned) to examine utilization, costs and resources, quality of care, and other areas. All of these activities are carried out in close collaboration with the Economics Department of the University of Zambia, as a means of capacity-building. SIDA also sponsors a series of training activities in health financing and economics, including in-country and regional (Southern Africa) short-term training courses for mid-level managers, development of a health economics undergraduate course at the University, and a course in health economics for MPH students at the University of Zambia Medical School.

UNICEF recently conducted a study in three districts of the costs of health care delivery, as well as an assessment of the effects of health sector reforms on the quality of health services in the Lusaka urban district. The British Overseas Development Agency (ODA) is currently designing a step-down costing study at five major hospitals, which will also examine the appropriateness of out-patient vs. inpatient care. Also relevant to PHR's work is a case study of decentralization of the health system carried out in 1995 with funding from WHO. Health Economist Joseph Kutzin of WHO also conducted a recent assessment of the government's plans for the establishment of a Public Service Medical Aid Scheme (PSMAS) and made recommendations on cost-sharing schemes in general, which were influential to the MOH in drafting its recent revisions to the National Strategic Health Plan (September 1996). Mr. Kutzin has been asked to make a return visit soon to advise the Ministry on health care financing policy and on strengthening the MOH's capacity to monitor and evaluate the reforms. WHO plans on providing on-going assistance to the MOH in these areas.

A number of donor agencies are also providing assistance to strengthen the management of the decentralized health care system -- working with the Health Reform Implementation Team (HRIT), the newly-created Central Health Board, and several District Health Boards. DANIDA is working on the development of the comprehensive financial and administrative management system (FAMS), which will be used as a budgeting, planning, accounting, management, and reporting tool. ODA is also implementing an innovative hospital management project at Ndola Hospital in the Copperbelt.

In the area of public-private partnerships in the delivery of health services, the EU has been requested by the MOH to conduct a study of options for the development of increased public-private collaboration and to assess the potential for private providers to assume some of the responsibilities currently provided by the public sector. The EU will presumably develop a project on public-private collaboration based on its assessment.

PHR's proposed work, as outlined in this CAP, will use the information gained from the above activities carried out by other donors as much as possible, and will complement, as opposed

to duplicate, what has already been done. In developing this CAP, PHR has met with a number of other donor agencies and has incorporated into the CAP collaboration with several of them for specific activities -- for instance, in assisting with the design and implementation of a public service medical aid scheme (PSMAS) with WHO, and in analyzing data on household health expenditures, pre-payment schemes and ability and willingness to pay from the 1996 Living Conditions Monitoring Survey in collaboration with the Swedish Institute of Health Economics and the Economics Department of the University of Zambia. In addition, to ensure complementarily with the work of the EU in the area of public-private sector partnership, PHR has not yet developed detailed plans for work in this area. PHR will wait until the EU's work has been completed and its recommendations made to the Ministry, at which point we will plan appropriate follow-up activities with the MOH and the EU.

4.0 Needs Assessment

A summary of basic data on health status, utilization, and resources is found in *Table 1*.

4.1 The Government's Health Care Financing Strategies and Policies

The most recent health expenditure review indicates that a relatively large share of health sector expenditures in Zambia is financed by a limited number of sources. In 1994, the major internal sources of funding of the health sector include government sources (44%), the Zambia Consolidated Copper Mines, Ltd (ZCCM) (17%) and households (13 %); donor funding accounts for 22 % of national health care expenditures (The Department of Economics, the University of Zambia, and The Swedish Institute for Health Economics, 1996). A review of the financial plans of the MOH indicates that if the government's resources to the health sector do not increase as fast as population growth, reforms in the financing of the health sector would be required in order to meet the growing needs resulting from population growth and emerging diseases, including AIDS, and from the decline in available funding to the health sector as a result of a stagnant economy. In that respect, the major health financing policy issue facing the MOH is how to ensure equitable access to quality health services to the majority of the Zambian population, given that nearly 70% of the population is classified as poor.

The MOH has begun efforts towards the formulation of a comprehensive health care financing policy to face that issue. It is expected that the development of the health financing policy will be completed by March 1997. Meanwhile, the MOH has drafted health care financing options and strategies which are incorporated in the third edition of the Strategic Plan, as described in *Section 3.1*.

4.1.1 Policy Issues and Constraints

The government's focus of the MOH on improving efficiency in the allocation and use of resources in the health sector rather than on mobilizing new resources, is consistent with the high level of poverty and the low level of economic performance in the country. The MOH is committed to continuing to use public financing as the major source of funding of the essential health care package to improve allocative efficiency in the health system. Additional measures to improve the efficiency of the health system, however, will be needed to ensure more rational use by consumers of different levels of health services, for, by example, improving referral mechanisms to minimize unnecessary use of hospital-based services.

While remaining the major source of funding of the health sector, the MOH is promoting greater partnerships between government, employers and households in sharing the costs of the essential health care package. As other health care financing mechanisms, such as pre-payment schemes and user fees paid by employers and households, are put in place to supplement government funding, however, greater differences in the availability of resources between districts may arise due to the differences between districts in the ability of households to pay for services and the relative size of the formal employment sector. In addition, given

Table 1: Selected Health-Related Statistics for Zambia

General:	
Population Size (1995 estimate) (a)	9,233,000
Population Growth Rate (a)	3.2%
GNP per capita (1994) (a)	US\$ 420
Health Status Indicators:	
Infant Mortality Rate per 1,000 live births (1992) (a)	113
Child (< five) Mortality Rate per 1,000 live births (1992) (a)	202
Life expectancy at birth (years) (1994) (a)	56
Total Fertility Rate (1992) (b)	6.5
Health Services Utilization Data:	
Percentage of births delivered in health facility (1992) (b)	50.7%
Percentage of pregnant women receiving any pre-natal care (1992) (b)	93.7%
Percentage of Children 12-23 months fully immunized (b):	
Overall	67%
Urban	74%
Rural	60%
Health Resources:	
Government per capita expenditure on health (1995) (c)	US\$6.05
Percent of central government budget allocated to health (1994) (c)	13%
Population per physician (1990) (d)	11,290
Population per nurse (1990) (d)	600
Hospital beds per 1,000 population (1993)	Not Available

Sources:

- a: Zambia Child Health Project Paper, April 1995, USAID/Zambia
- b: Zambia Demographic and Health Survey, 1992
- c: National Strategic Health Plan (1995-1999), Republic of Zambia Ministry of Health, March 1996
- d: World Development Report 1993, *Investing in Health*, World Bank

the differences in the ability to pay between the better-off and the poorest sectors of the population within districts, current policies that exempt all children under five and antenatal and delivery services for everyone may conflict with policies to extend access of quality health services to the poor. The MOH will therefore have to make difficult choices regarding the use of public funding to reduce inequities between districts and to implement appropriate exemption measures in order to increase resources available to the poorest sectors of the population within districts.

The current policy of promoting non-governmental sources of funding, such as pre-payment schemes, on a voluntary basis may increase the level of resources available in the health sector. However, in order to increase the acceptability and the participation of employers and households in such schemes, improved quality of health services in government and publicly-supported non-governmental facilities will need to be sustained. Appropriate pricing policies will also be needed to avoid the potential problem of the better-off, who are more likely to participate in employer-based or community-based pre-payment schemes, from capturing a disproportionate share of public subsidies channeled through government health facilities. The experience with employer and community pre-payment schemes is recent in Zambia. Therefore, in order to ensure that these cost-sharing strategies have the intended results, such as increased efficiency and equity, the capacity to monitor and evaluate their impact on these and other policy objectives will need to be increased.

4.1.2 Implementation Issues and Constraints

Thus far, pre-payment schemes have started only in the country's three central hospitals and the districts where they are located (Lusaka, Ndola, and Kitwe), which are primarily urban districts. Because the Ministry of Health has issued guidelines for cost-sharing schemes, all three pre-payment schemes share many common features. In all three, participant households pay a monthly membership fee (K500 - K800 for adults, depending on the district) to their community primary care clinic. These members are entitled to free treatment and drugs for all curative and preventive care at the clinics, as well as at the central hospital, if they are referred there by their clinic. To encourage people to join the pre-payment schemes, all three districts charge user fees (per visit or per-episode, and for drugs) to non-members. The poor are exempt from paying any fees and the Ministry of Social Welfare is supposed to reimburse the districts for their care. In addition, children under five years and adults over 65 are exempt from fees, as are women requiring pre-natal, delivery, and post-natal services, and people with certain chronic or communicable diseases, such as STDs, tuberculosis, and HIV/AIDS. Another common feature of these cost sharing schemes is that there is one fund-holding institution in the district, the District Health Management Team, is responsible for managing all of the funds collected from the health centers, along with grants that it receives from the Central Board of Health and from donors.

Since the pre-payment schemes were introduced, the management of utilization has become a major issue in both Kitwe and Lusaka -- the two districts visited by the PHR team. In Lusaka, the new scheme resulted in a substantial increase in the number of patients coming to the University Teaching Hospital (UTH) for outpatient and primary health care services, many of which could be handled adequately in community-based clinics. To solve this problem, the Lusaka district closed the Outpatient Department of UTH altogether, thereby requiring all patients to visit a primary health care clinic first. The district also upgraded 10 of its community clinics to 24-hour care centers so that they can handle emergencies. In Kitwe, utilization of the out-patient department of the Kitwe Central Hospital also increased sharply once the pre-payment scheme started, but, according to the district health authorities, has stabilized somewhat. The district is

considering imposing a large “bypass fee” for patients who bypass the primary care clinic and go directly to the central hospital, but has not yet done this.

Another issue facing the implementors of these schemes is the question of what proportion of medical fees (user fees and pre-payment membership fees) collected by the districts should be given to the central hospitals for cases that they refer. Both Lusaka and Kitwe districts have decided upon a fixed amount of 40% of the total revenues collected from medical fees. Lusaka has begun reimbursing UTH at this rate, while the Kitwe district is supposed to start reimbursing its central hospital in the coming year. It is not yet known if the 40% figure is an accurate reflection of the costs of hospital services provided to members of the pre-payment schemes (and others referred by the clinics to the hospital) or is considerably above or below the actual costs.

A further issue concerns reimbursements from the Ministry of Social Welfare to the health districts for the care of people identified as poor, who are exempt from paying fees. While the Lusaka district has thus far received one lump-sum payment as reimbursement for indigent care, the Kitwe district has yet to receive any reimbursement for its care of the poor. This obviously affects their cash flow and ability to supplement their drug supplies and otherwise improve the quality of their services.

It should be noted that, while the general design of the pre-payment schemes in the two districts visited by the PHR team are very similar, they differ significantly in some aspects. First, the user-fee structures are different; while the district of Lusaka uses a flat fee-per-episode, user fees in Kitwe are based on fee-for-service. The level of the membership fees for the voluntary pre-payment schemes also differs between districts. Exemptions for maternal health services also differ; while in Kitwe, all prenatal, delivery and post-natal services are exempt from fees, in Lusaka, only prenatal care services are free of charge.

MOH officials envision these cost sharing scheme experiments eventually being replicated throughout the country. However, the district personnel currently implementing these experiments feel that they lack critical information to be able to manage these schemes with confidence and to make sound decisions concerning the design and implementation of these schemes. Some of the questions concerning the performance of their schemes raised by district health managers include the following:

- ▲ What is the impact of the new cost-sharing schemes on quality (actual and perceived) of services? For instance, has the drug supply improved?
- ▲ Have the pre-payment schemes led to more appropriate and efficient use of the various levels of the health system (i.e., improved the referral system)?
- ▲ Are the schemes promoting equity? Are the poor joining or is the program benefiting mainly better-off people? Has utilization of formal health services (both in general and of specific key services) among the poor increased or decreased since the introduction of medical fees?
- ▲ What are the size and characteristics of the population that has joined the district prepayment schemes?
- ▲ What is the financial performance of the cost-sharing schemes? Are they improving sustainability by recovering a substantial proportion of revenues or are the costs to the

districts greater than the revenues they bring in because of increased over-utilization by members? What mechanisms can be put into place to improve the financial performance of these schemes?

- ▲ Of the total costs of services provided to beneficiaries, what proportion are for hospital services provided to patients referred by the districts? What should be the basis or rate for the districts reimbursing the hospitals for these services?
- ▲ What information do district health managers need on an on-going basis to manage the health care financing strategies that could be incorporated into existing information systems (e.g., the FAMS or HMIS)?

Information to answer these questions can be used to make informed decisions to improve the performance of these pre-payment schemes, including:

- ▲ the type of medical fees to introduce (e.g., prepayment schemes or user fees) for different types of services;
- ▲ the design of benefit packages for members of the pre-payment schemes;
- ▲ how to administer the schemes cost-effectively;
- ▲ the levels of membership contributions or user fees;
- ▲ measures to reduce adverse selection (in which many sick people join the schemes);
- ▲ strategies to extend the coverage of prepayment schemes;
- ▲ management of the utilization of services;
- ▲ policies and procedures to protect the poor;
- ▲ payment mechanisms for hospital services used by members of the schemes;
- ▲ how to management the exemptions; and
- ▲ what accounting systems to put in place.

4.1.3 Recommended Actions

Below we describe two priority areas where PHR can best contribute to the design and implementation of Zambia's new health care financing policies.

- 1) The implementation issues raised at the district level suggest that there is a need for increased capacity and appropriate tools at the district level to gather and analyze information on a regular basis to be able to develop sound financing strategies, to monitor their impact, and to make needed adjustments. Experience in Zambia and elsewhere has shown that cost-sharing strategies that are designed and implemented without sufficient information often do not meet expectations, resulting in negative attitudes on the part of the population towards these schemes. This has been the case with the initial cost-sharing experiences in certain parts of Zambia. Designing and implementing alternative health financing strategies in tandem with collecting relevant information can avoid many of these problems by anticipating them ahead of time and by modifying the strategies to address these problems. On-going monitoring of the impact of these strategies on utilization, financial performance, access of the poor to health services, and so forth will allow districts to make periodic modifications to respond to information showing a decrease in overall membership to the schemes, low membership rates among the poor, reductions in revenue due to cost inflation, continued inappropriate use of hospital services for primary health care, or other negative trends.

Now that the MOH is promoting the expansion and adaptation of cost sharing schemes to other districts of the country, the capacity at the national and regional level to provide support to the districts in the design of appropriate cost-sharing schemes and in developing indicators and methodologies to monitor these schemes should be enhanced. Since only three districts have thus far introduced pre-payment schemes, this is an opportune time to evaluate and develop monitoring tools for these schemes before they are put in place in other districts. The Directorate of Monitoring and Evaluation of the Central Board of Health, in fact, has plans to evaluate the performance of the three pilot pre-payment schemes before the schemes are implemented nation-wide. PHR is well placed to assist in this effort.

- 2) The process of developing a comprehensive health care financing policy consistent with the decentralization reforms underway in Zambia requires more information on the sources of funding of health services. The recent health sector expenditure review carried out by SIDA already provides an overview of current sources of funding and their use. Information on household health expenditures and willingness and ability to pay for health services, as well as on the costs of health services, is also needed to address in-depth health care financing policy options at the national level.

There are two activities currently underway that will go a long way towards providing this information. First, the Swedish Institute of Health Economics (IHE) and the University of Zambia Economics Department are about to begin data collection for a national survey of 800 to 1,000 households, which will include information on the utilization of health services (both public and private), household health expenditures and overall income, pre-payment schemes, and other health-related data. However, in-depth analysis of people's utilization patterns of different types of providers, of household expenditure patterns, and of the population's ability and willingness to pay for health services, will be difficult, given the relatively small size of the sample. The second activity is the Living Conditions Monitoring Survey (LCMS), a large, multi-purpose national survey of 12,000 households being conducted by the government's Central Statistical Office in late 1996. This survey will provide a wealth of data on household income and household health expenditures (for medicines, fees for doctor and traditional healer, payments to hospital and health center, and pre-payment scheme), as well as considerable information on health care seeking behavior (including occurrence of illness, symptoms, self-medication and amount spent on self-medication, care from a health provider, type of health provider, mode of payment to the health provider -- including low and high-cost pre-payment schemes, payment by employer, paid directly, paid partly by self and partly by employer -- and amount of payment). Analysis of these data, which PHR is proposing as one of the activities in this plan, will provide valuable information on what people are currently paying for health care, who they're paying it to, whether or not they are seeking health care when needed, and other important issues that can be used to inform national health care financing policies.

4.2 Public-Private Partnerships for the Delivery of Health Care Services

The National Strategic Health Plan for 1995 - 1999 calls for the development of public/private sector partnerships as one of the principal means of improving access to cost-

effective, quality health services for all Zambians. The Chief Health Planner, Mr. Musowe, told the PHR team that he would like to see the formal private sector provide a much larger proportion of total health services than it is currently providing (up to something like 15 percent). A number of Zambian health professionals expressed the opinion that if more expensive, higher level curative care is provided by the private sector, this will free up more funds for the public health sector to provide more essential primary health care services for the less well-off. The upcoming assessment by the EU of the potential for increasing public-private partnerships in the delivery of health services, which was commissioned by the MOH, demonstrates the Ministry's interest in and commitment to increased collaboration between the two sectors. This assessment will presumably be followed by a MOH/EU project intended to create such a partnership.

The private health sector in Zambia includes: church-run organizations and other NGOs (most under the umbrella of the Churches Medical Association of Zambia (CMAZ)); health facilities operated by Zambia Consolidated Copper Mines (ZCCM) and other employee-based clinics; private, for-profit providers; traditional healers (including herbalists, spiritualists, and traditional birth attendants); and pharmacies, drug stores and other market vendors. As of 1994 there are thought to be around 150 private (non-mine) clinics in Zambia, mainly in the urban areas and along the line of rail, although the exact number is not known. Two small private hospitals in Lusaka (a 15-bed and a 35-bed facility) have also been established in the last eight years or so. The ZCCM runs 12 hospitals and 66 clinics, mainly in the Copperbelt, and the Missions in 1990 were running 29 hospitals and 53 health centers, primarily in the rural areas. An estimated 20,000 to 50,000 traditional healers are also active. Strict government regulations on private sector providers, which outlawed fees in hospitals from 1970 to 1990, and which set high standards for equipment and staffing in private clinics, helped to greatly limit the growth of the formal private sector in Zambia. Since some of the laws restricting private provision of health care were eliminated in the early 1990s, the private sector (mainly industrial-based clinics) has reportedly grown considerably.

The study of "Non-Governmental Health Care Provision" in Zambia conducted by the MOH and DDM/Harvard in 1994, as well as the national conference on Public-Private Sector Partnership for Health held in Siavonga in 1995 to present the study's findings and discuss recommendations, identified a number of issues and constraints that are considered to limit the provision of health care by the private sector in Zambia and thus increased collaboration between the two sectors. Interviews by the PHR team with formal private sector providers, including the executive director of a private physicians association and with other CAs, also identified additional issues and constraints. In addition to such "demand" factors as the high level of poverty in Zambia and the low population density outside of the urban areas, the following constraints affecting "supply" were identified:

- ▲ A lack of accurate information on the size of the private health sector in Zambia, what proportion of the population are using various types of private sector providers, what services they are providing (e.g., curative, preventive), and the quality of care available from these providers;
- ▲ Legal and regulatory constraints, which include high standards for equipment and services required for all private providers which makes starting up a clinic very expensive, the requirement that all private clinics have a full-time physician, and the ban on private health providers advertising;
- ▲ The difficulty providers may have in accessing formal credit to start up private facilities (which may or may not be a serious constraint), as well as the lack of insurance and

managed care programs in Zambia, which could provide a significant source of private clients;

- ▲ The low supply of physicians and other qualified health professionals in Zambia; and
- ▲ The lack of a formal mechanism, such as a coordinating body, for collaboration between the public and private sectors.

Recommendations from the DDM study, the Siavonga conference and interviews with private sector providers include: changing the laws to allow MOH practitioners to work on a part-time basis in the private sector; lowering the equipment standards of private clinics and allowing different levels of private health facilities (analogous to public sector health posts, health centers, etc.); having the MOH contract out certain services to private sector providers; offering tax or other incentives to private facilities to provide preventive care; offering low interest loans to private providers to establish clinics; improving communications between the two sectors; and establishing a private sector task force to oversee the development of private-public sector collaboration. The revised National Strategic Health Plan calls for conducting an inventory of private providers as preparation for franchising and contracting activities, establishing contracts with private providers, and revising the laws to permit and facilitate franchising.

The MOH has become increasingly interested in the concept of granting franchises through the government to general practitioners to establish a network of private low-cost, high-quality primary health care facilities, based on the model of the Bolivian NGO, PROSALUD. A group of Zambians representing the MOH, district health services, and private providers traveled to Bolivia in September with staff from USAID and Population Services International (PSI) to gather information and determine the feasibility of adapting such a model for Zambia. PSI is currently carrying out a feasibility study of adapting the PROSALUD model for Zambia. USAID has requested PHR to contribute to this feasibility assessment, particularly by reviewing the findings and assumptions of the PSI report. As part of this CAP, PHR will conduct this review and submit a report to USAID.

The MOH has requested that PHR delay the planning of other activities in this area until the EU has completed their initial assessment on the potential for increasing public-private partnerships in the delivery of health services. Once the MOH has developed plans following that assessment, PHR will work jointly with the MOH and the EU to plan specific activities.

4.3 Institutional and Personnel Capabilities

The health reform process is helping to strengthen the institutional and personnel capacities at all levels of the MOH. Strategic management capacities have been strengthened at the central level, and the Ministry is collaborating with Zambian institutions, such as the University of Zambia, to carry out much of the analytical work necessary to design and implement the reforms. As mentioned above, the Health Reform Implementation Team has increased the capacities of the MOH to move the reforms forward at the national level. The new Central Board of Health and restructured MOH are currently being put in place.

Management capacities have been strengthened at the district level; District Health Management Teams have been established in all districts and have received training in planning,

management and financial management. Management boards have been established in major hospitals and District Health Boards are in the process of being established. To support the planning, implementation and assessment of the reforms within the MOH, financial and administrative management systems (the Financial and Administrative Management System (FAMS) have been installed at the district level and their extension at the hospital level is underway. The Directorate of Monitoring and Evaluation of the Central Board of Health, responsible for data processing, documentation, research and quality assurance, has also been established.

A Health Care Financing Working Group has been formed to spearhead the development of health care financing policies. However, there is not yet someone designated within the MOH to concentrate solely on health care financing issues. In the area of public-private partnerships, the establishment of a private sector task force, as recommended at the Siavonga conference, has not yet taken place.

5.0 Proposed PHR Activities

5.1 Objectives

The overall objective of the PHR activities is to work with the MOH to improve the design and implementation of health care financing policies and to increase public-private partnerships in order to improve the Zambian population's access to health, nutrition, and population interventions. These activities support the new health care financing strategies outlined in the latest edition of the National Strategic Health Plan by providing assistance in the design and implementation of cost sharing and pre-payment schemes at the national and the district levels. They also support the government's goal of increasing the role of the private sector in the delivery of health services.

The proposed activities also fit into USAID/Zambia's Results Framework to support the Zambia health reforms through the expected outcomes of 1) improved access of population, health, and nutrition interventions through public-private partnerships, and 2) improved capacity for policy analysis, planning and support for the delivery of population, health, and nutrition interventions.

BASICS and PHR will collaborate with MOH policy makers, program managers, local institutions, and other donor agencies, to reach the following objectives:

1. To strengthen the national capacity to design, implement, monitor and make necessary changes to health care financing policies in the context of decentralization reforms; and
2. to strengthen the partnership between the public and private sectors to support the Government's goal of increasing access to cost-effective, high-quality health care services.

For each objective, we describe below the expected results, activities to accomplish these results, and performance indicators to monitor and evaluate these activities. We also outline proposed collaborating institutions and personnel, as well as level of effort to carry out these activities. A summary of these activities can be found in *Table 2*.

5.2 Objective 1

Strengthen the national capacity to design, implement, monitor, and make necessary changes to health care financing policies in the context of decentralization reforms.

Result 1.1

Increased national capacity to design and implement equitable district-level cost sharing and pre-payment schemes.

Table 2: Proposed PHR Activities with Zambian MOH and Other Partners
Summary of Objectives, Results, Activities, Performance Indicators, and Target Dates

Activities	Performance Indicators	Target Date for Completion	Partners
<p><i>OBJECTIVE 1 - POLICY ANALYSIS, PLANNING AND SUPPORT</i> <i>Strengthen the national capacity to design, implement, monitor, and make necessary changes to health care financing policies in the context of decentralization reforms.</i></p>			
<p><i>Result 1.1 - Increased national capacity to design and implement equitable district-level cost sharing and pre-payment schemes.</i></p>			
<p>1. Conduct assessments of design, implementation and performance of cost-sharing schemes in 2 to 3 <i>urban</i> districts where they are currently being implemented (Lusaka, Kitwe, and maybe Ndola).</p> <p>2. Hold a workshop in each district on the findings of the assessment, indicators, and methodologies for data collection and analysis, and recommendations to improve the cost-sharing schemes.</p> <p>3. Assist in design, implementation, and monitoring of cost-sharing schemes in 2 <i>rural</i> districts.</p>	<p>1.1.1 Reports on cost-sharing performance in two urban districts produced jointly with national institutions.</p> <p>1.1.2 Workshops on results of assessments held in each district.</p> <p>1.1.3 Increased capacity of national institutions (e.g., universities) to assist districts in designing and assessing cost sharing and pre-payment schemes.</p> <p>1.1.4 Indicators and data collection and analysis methods developed to assist districts to monitor performance of cost-sharing schemes. (This will include use of FAMS data and recommendations for incorporation of certain data into FAMS.)</p> <p>1.1.5 Cost-sharing schemes designed and implemented in two rural districts with assistance from national institutions (e.g., universities).</p>	<p>Sept. 1997</p> <p>Sept. 1997</p> <p>Dec. 1997</p> <p>Dec. 1997</p> <p>June 1998</p>	<p>MOH Planning Unit, CBoH Directorate of Monitoring and Evaluation; Staff of Economics Department of University of Zambia (and other universities, as appropriate); DANIDA; PHR</p>
<p><i>Result 1.2 - Increased capacity to develop and implement a public service medical aid scheme.(PSMAS).</i></p>			
<p>1. Develop strategies for the design and implementation of a PSMAS (joint trip by PHR and WHO).</p> <p>2. PHR provides follow-up assistance with design and implementation of PSMAS, as requested.</p>	<p>1.2.1 Strategies for design and implementation of PSMAS developed.</p> <p>1.2.2 Implementation plan for PSMAS developed.</p>	<p>June 1997</p> <p>To be determined</p>	<p>MOH Planning Unit; WHO; PHR</p>
<p><i>Result 1.3 - Increased capacity of the Ministry of Health to make necessary policy changes in health care financing based on survey data on consumer demand for health services.</i></p>			

Activities	Performance Indicators	Target Date for Completion	Partners
<p>1. Analyze health-related data from the recent Living Conditions Monitoring Survey (LCMS).</p> <p>2. Disseminate major findings of the analyses and bring them to the attention of policy-makers and related research activities.</p>	<p>1.3.1 Report on health seeking behavior, household health expenditures, ability to pay for health care, etc. produced jointly with the University of Zambia.</p> <p>1.3.2 Packaged summary of results for policy-makers submitted to MOH and others, as appropriate.</p> <p>1.3.3 Presentation of plans for analyses and/or findings made at appropriate fora (e.g., SIDA-sponsored conferences on health care financing).</p>	<p>June 1997</p> <p>July 1997</p> <p>To be determined.</p>	<p>MOH Planning Unit; Central Statistical Office; University of Zambia Economics Department; PHR</p>
<p>OBJECTIVE 2 - PUBLIC-PRIVATE PARTNERSHIPS <i>To strengthen the partnership between the public and private sectors to support the Government's goal of increasing access to cost-effective, quality health care services.</i></p>			
<p><i>Result 2.1 - Increased knowledge on the feasibility of adapting the PROSALUD franchising model in Zambia.</i></p>			
<p>1. PHR contributes to feasibility assessment of adapting the PROSALUD franchising model to Zambia and in program design.</p>	<p>2.1.1 PHR reports on feasibility assessment and, if appropriate, program design completed.</p>	<p>To Be Determined</p>	<p>MOH; PHR; PSI</p>

Activities	Performance Indicators	Target Date for Completion	Partners
<i>Result 2.2 - Increased collaboration between the public and private sectors in the delivery of health services and increased provision by the private sector of public health services (e.g., primary health care, preventive care).</i>			
<ol style="list-style-type: none"> 1. PHR to follow up with the MOH to obtain results of the EU assessment and their plans for follow-up activities. 2. MOH and USAID jointly determine the role of USAID (and PHR) in promoting public-private partnerships in health care delivery. 3. Assist in development of plans and implementation for increased public-private partnership, as requested. 	<ol style="list-style-type: none"> 2.2.1 Agreement on role of USAID on promoting public-private partnerships made between MOH and USAID. 2.2.2 Plans for technical assistance submitted to and approved by MOH. 2.2.3 Implementation of technical assistance plans begins. 	<p>TBD</p> <p>TBD</p> <p>TBD</p>	<p>MOH Planning Unit; USAID; European Commission; PHR</p>

Activities:

YEAR 1

1. This activity will provide information to MOH officials at the national, regional and district levels information to assist in the improvement of the design and implementation of current health care financing schemes at the district level and strategies for their expansion in other districts. This work will involve assessing the design, implementation and performance of current cost-sharing and pre-payment schemes in the districts of Kitwe and Lusaka (and eventually Ndola), in collaboration with the Directorate of Monitoring and Evaluation of the Central Board of Health, the MOH Planning Unit, and appropriate local universities. This activity will analyze whether and how these cost-sharing schemes promote equity and efficiency of the health system by examining enrollment rates in the test districts, the services currently being provided under the schemes, and the user fees being charged in each district. An assessment of current fees in relation to the population's willingness and ability to pay and an examination of exemption policies currently in place will be undertaken. This work will also involve assessing the financial performance of the schemes (and whether, for instance, they are resulting in increased utilization of costly hospital-based services); utilization management and use of the referral system; the current use of funds; performance of existing systems to control, account and manage revenues; the quality of services; the system of staff incentives; and current monitoring and evaluation systems.

The use of the district-level FAMS to obtain this information will be explored to the maximum extent possible to avoid duplication in data collection efforts. In addition to the FAMS, information will be gathered through reviewing district-level records and through interviews with district health staff, health center and hospital staff, and other key informants. Information on enrollment rates of different socio-economic groups, reasons people join or haven't joined the pre-payment programs, and are using or not using the services; and perceived quality of care will be obtained through small household surveys in this test districts. Additional data on service costs will be compiled from ODA costing studies of hospital services in UTH, Ndola and Kitwe. PHR proposes that most of the work in the field be carried out by staff and students of the Economics Department (or other appropriate department) of Zambian universities, such as the University of Zambia and the University of the Copperbelt.

In the process of conducting these assessments, indicators will be developed to monitor the pre-payment schemes on an on-going basis. Recommendations on how the required information can be incorporated into the FAMS or the HMIS will be made to avoid duplication in monitoring systems as much as possible. Any information not obtainable from the FAMS or HMIS may require simple data collection and monitoring systems or methodologies, which will be developed during this process.

2. A workshop will be organized with the two (or three) districts to assess the performance of the cost sharing schemes and to discuss the indicators and data collection methods to monitor these schemes (including recommendations for incorporating certain data into the FAMS). Participants may include representatives of district health management teams, representatives of the regional health offices of the Central Board of Health, representatives of the Central Board of Health and the MOH, and collaborating institutions (such as Zambian universities). An output of the workshop will be

recommendations to improve the design and implementation of these cost-sharing strategies.

YEAR 2

1. PHR and its collaborators will work with two rural districts to design, implement, and monitor new pre-payment schemes in these areas. This work will be similar to that for the urban districts, except that the rural schemes will likely be still in the design phase (and not yet implemented) when this collaboration begins.

Performance Indicators:

- 1.1.1 Reports on assessment of pre-payment schemes in two urban districts produced jointly with national institutions by the end of the fourth quarter of FY97.
- 1.1.2 Workshops on results of assessments held in each of the urban districts by the end of the fourth quarter of FY 97.
- 1.1.3 Increased capacity of national institutions (e.g., universities) to assist district health management teams in designing and assessing cost sharing and pre-payment schemes.
- 1.1.4 Indicators and data collection and analysis methods developed by the first quarter of FY98 to assist districts to monitor the performance of their cost-sharing schemes. This will include use of FAMS data and recommendations for incorporation of certain data into the FAMS.
- 1.1.5 Cost-sharing schemes designed and implemented in two rural districts with assistance from national institutions (e.g., universities) by the third quarter of FY98.

Personnel and Collaborating Institutions:

PHR will work in collaboration with the MOH Planning Unit, the Central Board of Health Directorate of Monitoring and Evaluation, Zambian universities and district health management teams of Kitwe and Lusaka (and eventually Ndola) to implement this activity. The MOH Planning Unit will coordinate this activity with support from the CBoH Directorate of Monitoring and Evaluation. Data collection and analysis will be conducted by staff of the Department of Economics of local universities (the University of Zambia and perhaps the University of the Copperbelt, with assistance from students in the health economics program (in the case of the University of Zambia). A Health Planner/Financing Specialist from PHR will oversee this process.

Timing & Level of Effort:

Pending approval by the MOH, this activity will begin the second quarter of FY 1997 (January to March 1997). Data collection and analysis, as well as the development and refinement of the indicators and data collection methodologies, will take place over the following six to eight months, after which the workshops will take place. This work will require two three-week trips by the Health Financing Specialist from PHR in Year 1, and three 3-week trips in Year 2. Local costs, covered by BASICS, will include the salaries for 12 weeks of university staff in each of the two districts, plus salaries or stipends for three students in each district for six weeks each to collect and analyze the data, develop indicators and data collection methodologies, and participate in the workshop. Additional local costs will be incurred for the workshop, transportation and per diem for those working in the field, the production of data collection instruments, and other related costs.

Result 1.2: Increased capacity to develop and implement a public service medical aid scheme

Activities:*Year 1:*

1. PHR proposes to conduct a joint trip with Health Economist Joseph Kutzin of the World Health Organization to jointly develop strategies with the MOH for the design and implementation of the PSMAS, as well as technical assistance activities.
2. Upon request from the MOH, PHR will collaborate on the design and implementation of the program. The design phase may involve conducting employer and provider surveys (or analyzing information available on employer health benefit packages and arrangements with providers); designing a package of health services for beneficiaries (benefits, contributions and membership, identifying health providers, cost containment measures); and developing financial plans and a management information system for the program. This activity can also involve collaboration on the development of an implementation plan for the PSMAS, which may include developing a legal and organizational structure, finalizing arrangements with providers contracts, developing procedures for recruiting and accrediting providers, and designing and installing administrative and operating systems and procedures.

Year 2:

1. Continual assistance in implementation and monitoring of the PSMAS will be provided, as requested by the MOH.

Performance Indicators:

- 1.1 Strategies for design and implementation of PSMAS developed jointly with MOH and WHO.
- 1.2 Implementation plan for PSMAS developed.

Personnel and Institutions:

PHR will provide an expert experienced in the design, implementation, and evaluation of health insurance and pre-payment schemes in developing countries and a health financing specialist for this activity. This work will involve close coordination with the MOH and WHO.

Timing & Level of Effort:

It is estimated that this work will require two trips in Year 1 by the Insurance Specialist and three trips in Year 2 by the Insurance Specialist and a health financing specialist.

Result 1.3

Increased capacity of the MOH to make necessary policy changes in health care financing based on survey data on consumer demand for health services.

Activities:

YEAR 1

1. PHR will work with the Department of Economics at the University of Zambia and the Central Statistical Office (CSO) to analyze health-related data from the large, national Living Conditions Monitoring Survey (LCMS), which is being carried out by the CSO in late 1996. (See *Annex 2* for a summary of the LCMS.) These analyses will supplement data that will be obtained from the smaller (800 - 1,000 household) health expenditure and consumer behavior survey that is currently being conducted by the University of Zambia and the Swedish Institute of Health Economics.

Data on health care seeking behavior, utilization of different types of providers and services, household health expenditures, ability and willingness to pay for health care, and other important information will be analyzed and compared for various socio-economic groups and areas of the country. A report will be produced that will provide valuable information to the central MOH authorities on the current level of utilization of health services by the population, the unmet need, the ability of households to pay for health services, and possibly, the level of participation in the existing pre-payment schemes in the Copperbelt and Lusaka. This information will also be packaged for a wider audience to include policy-makers, political leaders, and health program managers.

If possible, PHR and its collaborators in this activity will present the analyses at appropriate conferences and seminars in Zambia. One possible venue is the upcoming conference sponsored by SIDA and tentatively scheduled for April 1997 on the results of their health care financing research work, including the health sector expenditure review and the household health expenditure survey currently underway. Depending on the timing of the conferences and the data analysis work, PHR will present the plans for the data analysis or preliminary results of the analyses. The information obtained from the LCMS survey will add to the discussions during this and other conferences and to the knowledge base on the demand for health services in Zambia.

Performance Indicators:

- 1.3.1 Report on health seeking behavior, household health expenditures, and ability and willingness to pay for services produced jointly with the University of Zambia by the end of the third quarter of FY97.
- 1.3.2 Packaged summary of results for policy-makers submitted to the MOH and others, as appropriate, by the fourth quarter of FY97.
- 1.3.3 Presentation of plan for analyses and/or findings made at appropriate fora (e.g., SIDA-sponsored conferences on health care financing).

Personnel and Collaborating Institutions:

This activity will be implemented in collaboration with the Department of Economics of the University of Zambia, the Central Statistical Office, the MOH Planning Unit, and the CBoH Directorate of Monitoring and Evaluation. The activity will involve inputs from a PHR health economist who will work with a CSO statistician, and an economist and two students from the University.

Timing and Level of Effort:

The CSO plans to enter and clean the LCMS data during the second quarter of FY97 (January to March 1997). Data analysis can therefore take place during the third quarter of FY97, and a report produced and packaged summary produced by June or July 1997. This task will require three weeks of the PHR health economist and eight weeks of University staff and students.

5.3 Objective 2

To strengthen the partnership between the public and private sectors to support the Government's goal of increasing access to cost-effective, quality health care services.

Result 2.1

Increased knowledge on the feasibility of adapting the PROSALUD franchising model in Zambia.

Activities:

PHR will conduct an independent assessment of the feasibility of starting a network of private providers, based on the PROSALUD/Bolivia franchising model, by reviewing and commenting on the feasibility study report prepared by PSI for ODA. As a result of this assessment, PHR will likely recommend that additional data from Zambia be collected, so that the PROSALUD model can be appropriately adapted to the local context. PHR can assist in collecting these data and in designing the program based on the data. Technical staff and consultants familiar with PROSALUD as well as those with knowledge of the Zambian and Southern Africa health context will contribute to this report.

Performance Indicators:

2.1.1 PHR reports on feasibility assessment and if appropriate, program design. The initial assessment of the PSI report will be completed by mid-January 1997.

Result 2.2

Increased collaboration between the public and private sectors in the delivery of health services and increased provision by the private sector of public health services (e.g., primary health care, preventive care).

Activities:

PHR will plan further activities in this area with the MOH and the EU once the EU assessment of the potential for increased public-private collaboration has been completed. PHR will follow up with the MOH to obtain the results of this assessment. It will then be necessary for the MOH and USAID to jointly determine the role of USAID in this area, and to discuss possible activities that PHR can carry out that complement any follow-up activities planned by the EU. Possible activities can include providing assistance to a private sector task force or other coordinating body established for this activity to gather additional information that may be deemed

necessary to further plan policies and activities, and developing policy options and an implementation plan for increased public-private partnership.

Performance Indicators:

To be determined.

In addition to these activities, the analysis of the Living Conditions Monitoring Survey will provide a wealth of information on household health expenditures for and utilization of a variety of private sector providers, which can be used by policy-makers in designing and implementing strategies to increase public-private sector partnerships for the delivery of health care services.

A summary of the proposed activities, performance indicators, and target completion dates for each objective and result is found in *Table 2*. *Table 3* shows a time line of proposed activities.

Table 3: Proposed Schedule for PHR Activities in Zambia

	<i>FY97</i>											<i>FY98</i>			
<i>Activity</i>	<i>Nov 96</i>	<i>Dec</i>	<i>Jan 97</i>	<i>Feb</i>	<i>Mar</i>	<i>Apr</i>	<i>May</i>	<i>June</i>	<i>July</i>	<i>Aug</i>	<i>Sept</i>	<i>Qu 1 (Oct-Dec 97)</i>	<i>Qu 2 (Jan-Mar 98)</i>	<i>Qu 3 (Apr-June)</i>	<i>Qu 4 (July-Sept)</i>
Objective I: Health Care Financing															
1.1 Assistance in Design and Implementation of District-Level Pre-Payment Schemes:															
Agreement made between PHR, MOH and University of Zambia for this activity.			x												
Initial visit to selected urban districts to start data gathering				xx											
Data collection and analysis of district-level records, key informant interviews, etc.				x--	---	-----	-----	-----							
Conduct community-based surveys at selected districts and analyze results						-----	-----	-----	-----	-----					
Interim report of results of analysis								x							
Finalize reports on results.										-----	-----x				
District-level workshops to present findings.											xx				
Refinement of indicators and data collection/analysis methodologies											-----	-----x			

	FY97											FY98			
Activity	Nov 96	Dec	Jan 97	Feb	Mar	Apr	May	June	July	Aug	Sept	Qu 1 (Oct-Dec 97)	Qu 2 (Jan-Mar 98)	Qu 3 (Apr-June)	Qu 4 (July-Sept)
Selection of 2 rural districts to monitor cost-sharing activities.												xx			
Data gathering and analysis in rural districts.												-----	-----	-----	
Development of reports.														-----	
Workshops to report results in rural districts.														x	
1.2 Collaboration on Design and Implementation of PSMAS															
Development of strategies for PSMAS design and implementation (joint trip with WHO).				---	-----	-----	--->								
Provide follow-up assistance with design and implementation, as requested. (Timing to be determined.)															
1.3 Analysis of Living Conditions Monitoring Survey and Dissemination of Results															
Data analysis with University of Zambia and CSO.						---	---								
Present analysis plans and/or preliminary results at SIDA conference and other appropriate fora.						---	-----	-----	-----	-----	-----				

6.0 Evaluation Plan

PHR's performance will be measured against the objectives, performance indicators, and target dates set out in this CAP and shown in *Table 2*. PHR management will internally review the progress of its Zambia activities every six months. PHR will also review the progress of our activities with MOH officials and USAID representatives when PHR staff are in country. Recommendations on changes in the performance indicators or timing resulting from these reviews will be made in collaboration with MOH officials, USAID, and PHR management.

7.0 Management Plan

Oversight for PHR activities will be provided by the MOH Chief Health Planner and other staff of the MOH and Health Reform Implementation Team that he may appoint; the USAID/Zambia Technical Advisor for AIDS and Child Survival; and the management team of PHR. This management team consists of the following staff members:

- ▲ The PHR Technical Director (Dr. Charlotte Leighton), who will provide guidance for the planning and implementation of all technical activities and will review all technical reports and other products;
- ▲ A PHR Technical Officer who will provide technical input on a regular basis in the planning, implementation, and monitoring of activities;
- ▲ An Operations Officer who will be responsible for the day-to-day managing from the U.S. of activities, including identifying and fielding appropriate staff and consultants for field visits; liaising with USAID/Zambia, USAID/Washington, and BASICS; ensuring that all reports and other products are submitted on time; and providing overall managerial and administrative support for field activities.
- ▲ Other specialized technical staff and consultants and operations staff, as appropriate, as well as support staff.

8.0 Budget and Estimated Level of Effort

Table 4 shows the estimated costs and level of effort (for both PHR and local costs to be covered by BASICS) for proposed PHR activities for fiscal year 1997 (October 1996 to September 1997) as well as for FY 1998. These LOE and budget estimates include home-based direct support, as well as work performed in the field. PHR has been allocated \$200,000 of 1996 field support funds, which will be used for the proposed FY 97 (Year 1) activities. PHR's best budget estimate for its proposed Year 1 activities comes to around \$365,000. If additional (FY 1997) funds are not available during this period, PHR will push back certain activities or trips into Year 2.

Since many of the FY 98 (Year 2) activities are yet to be defined, especially PHR's work in the development of public-private partnerships, the Year 2 budget represents our best estimate at the current time. To be responsive to USAID/Zambia's interest in focusing on the development of public-private partnerships, we have programmed a substantial portion of the total Year 2 budget for that activity. Specific activities in this area will be defined at a later date, once the MOH has further developed its plans and has discussed with USAID its role in this area.

Table 4: Level of Effort and Budget for Proposed PHR Activities for FY 1997 & 1998

	FY 1997				FY 1998			
Activity	In-Country Level of Effort (PHR)	Local Level of Effort*	Personnel	Estimated Cost **	In-Country Level of Effort (PHR)	Local Level of Effort*	Personnel	Estimated Cost **
1. Health Care Financing Activities:								
1.1 District-Level Pre-Payment Schemes	2 3-week trips	3 person-months in each of the 2 districts for University staff + 3 students in each district for 1.5 months (total of 15 person-months)	Health Planner/Financing Specialist	\$ 86,500	3 3-week trips	10 person-months	Health Planner/Financing Specialist	\$135,800
1.2 PSMAS design and implementation	1 2-week trip & 1 3-week trip	--	Insurance Specialist	\$ 77,000	1 3-week trip 2 2-week trips		Insurance Specialist Health Financing Specialist	\$108,000
1.3 Living Conditions Monitoring Survey Data Analysis and Dissemination of results	1 3-week trip	2 person-months of University staff	Health Economist	\$ 25,400				
2. Public-Private Partnerships:								
2.1 Franchising Feasibility Assessment and Follow-Up	3 3-week trips	--	Health Economist and Health Financing Specialist	\$ 107,700	4 3-week trips***	6 person-months***	Health Planner Health Economist	\$180,500
2.2 Development of Strategies for Increased Public-Private Partnerships	1 2-week trip	--	Health Planner	\$ 35,100				
3. Visits for Planning and TA in Policy	4 person-weeks (2 people for 2 weeks)	--	Health Economist Public Health Specialist	\$ 35,000	1 10-day trip		Senior Health Economist	\$ 31,000
TOTALS	29 person-weeks (7.25 person-months)	17 person-months		\$366,700	29.5 person-weeks (around 7 person-months)	16 person-months		\$455,300

* Costs for local staff will be covered by the BASICS Project.

** Does not include costs of local personnel.

*** The Year 2 activities for public-private partnership development can include both franchising and other activities.

Annex 1 Summary of Committed/Anticipated Donor Support

Summary of committed/anticipated donor support 1994 - 1998

Donor Agency	Activity/Programme	Amount**	Duration
1. ODA	<ol style="list-style-type: none"> 1. Human Resource 2. Kitwe/Ndola Hospital Management Board 3. UNZA School of Medicine-performance related rewards 4. Population/Fan-Lily Health 5. Lusaka Urban Primary Health Care support 6. AIDS 	19 Million British Pound (US\$22.5 million)	4 years (1994 - 1998)
2. SIDA	<ol style="list-style-type: none"> 1. Health Planning and Management 2. Sexual and Reproductive Health 3. AIDS 4. External Procurement including Essential Drugs 	170 Million SEK (US \$21.25 million)	4 years (1994 - 1998)
3. DANIDA	<ol style="list-style-type: none"> 1. Planning and Management 2. District Provincial Capacity Building 3. Management Information System 4. Quality Assurance 	175 Million Danish Krona (US\$25 million)	4 years (1995-1999)
4. Netherlands	<ol style="list-style-type: none"> 1. Essential Drugs 2. PHC Western Province 3. PHC Northern Province 4. Technical Assistance (Dutch Doctors supplementation scheme) 5. TB drugs 	US\$ 8 Million (annually)	4 years (1994 - 1998)
5. USAID	<ol style="list-style-type: none"> 1. Population and Family Planning 2. AIDS 3. Child Survival 	39 Million US Dollars 20 Million US Dollars	4 years (1994 - 1998) 7 years
6. EC	<ol style="list-style-type: none"> 1. Blood Transfusion Services 2. Rehabilitation 3. Management Support/Training 4. Water & Sanitation 5. Laboratory Support 	9.982 Mil ECU (US \$11.98 million)	4 years (1995 - 1999)
7. WHO	<ol style="list-style-type: none"> 1. Human Resource Development 2. Health Systems Research 3. Primary Health Care 4. Malaria 5. UCI/EPI 6. CCD 7. Vaccines/Emergency drugs 	1 Million US Dollars annually	5 years (1995 - 1999)
8. UNFPA	<ol style="list-style-type: none"> 1. Population/Family Health Trust/AIDS 	US \$7 million	3 years (1994-1996)
9. UNICEF	<ol style="list-style-type: none"> 1. Maternal Health 2. Universal Child Immunization (UCI) 3. Control of Diarrhoeal Diseases (CDD) 4. Nutrition 5. District PHC Strengthening 6. Institutional Strengthening 7. HIV/AIDS 	US \$ 10 million	3 Years (1994 - 1996)
10. International Development Association (IDA) of the World Bank (Credit 40 years grace period, 0.75 interest rate)	<ol style="list-style-type: none"> 1. Policy development/Operations research 2. Investment Programme (Infrastructure, rehabilitation, drugs, equipment) 3. Recurrent Budget 4. Monitoring and evaluation 	US \$56 Million	1995 - 1998

Annex 2 Description of the Living Conditions Monitoring Survey 1 (1996)

Description of the Living Conditions Monitoring Survey 1 (1996)

Organization : Central Statistical Office
 Type: National Multipurpose Household Survey
 Sample size: 12,000 households

Sample expected characteristics

App. number of ind.:	80,000 individuals	total	
	41,200 "	urban	
	38,800 "	rural	
	19,700 "	Copperbelt	
	14,000 "	Lusaka	
App. number of sick.:	16,000 individuals	total	(Assumption: 20% sick)
	8,200 "	urban	
	7,800 "	rural	
	3,900 "	Copperbelt	
	2,800 "	Lusaka	
App. number of sick.:	8,000 individuals	total	(Assumption: 50% sick visited a HP)
who visited a			
health provider			
	4,100 "	urban	
	3,900 "	rural	
	1,950 "	Copperbelt	
	1,400 "	Lusaka	

Household Characteristics

Household monthly expenditures
 Household Size
 Household Amenities and housing conditions
 Household Access to Health facilities (other facilities)
 Household Assets

Household Medical Expenses (last month)

Medicines
 Fees for Doctor/Health Assistance/Midwife/Nurse
 Fees to Traditional Healer
 Payment to Hospital/Health Center

PREPAYMENT SCHEME

Household Other Expenses
 Characteristics of head of household

Individual Health Seeking Behavior

All Individuals

Illness during the last 2 weeks
Symptoms in last two weeks (27 symptoms precoded)
Self-medication
 Amount spent on self-medication
Care to health care provider
Type of health provider
 Gov Hospital
 Gov Clinic
 Missions Inst.
 Industrial/Company Health Institution
 Private Institution
 Traditional Institution
 Medical Personnel
 Health Institution outside Zambia
Medical or Paramedical Personnel visited
Mode of payment
 Prepayment scheme low cost
 Prepayment scheme high cost
 Paid for by employer
 Paid for by other
 Paid for partly and other part paid by employer (or other)
 Paid directly
 Did not pay
Amount of payment for last consultation
 cash
 in kind
Diagnosis of following diseases
 Diabetes (Sugar disease)
 Cancer
 Asthma
 Tuberculosis (TB)
 Bronchitis
 Hypertension
 Leprosy
Do you smoke
Do you drink alcoholic beverages

Children born in the last five years

(May Want to Limit the sample to last 12 or 24 months: sample size large enough)

Place of birth
 Gov Hospital high cost
 Gov Hospital low cost
 Gov Clinic/health center
 Missions hospital.
 Industrial/Company Health Institution
 Private hospital/Clinic
 At home
 Other (Specify)

Assistance during delivery
Breastfeeding practice

**(May Want to Limit the sample to children between the ages of 12 or 23 months:
sample size large enough)**

BCG
DPT 1,2,3
Polio 1, 2, 3
Measles 1
Measles Booster
Use of under 5 clinic
Anthropometric Measure
 Weight
 Height

Types of Private Sector-Related Questions Which Could be Answered by the Survey

Note: All of these questions can be compared for different income groups and by urban/rural residence:

What is the level of utilization of private vs. public providers by the population (and for different types of private providers -- Missions, mines, private for-profit, industrial clinics, etc.)?

How much do people spend for private vs. public providers?

How does the utilization of private vs. public providers differ for selected MCH services and disease categories (including deliveries)? (e.g., for what services do people tend to prefer the private sector, the public sector?)

How much do people spend for selected MCH services in the private vs. the public sector?

Types of HCF Related Questions Which Could be Answered By Survey

Prevalence of Prepayment Scheme Among Households

What is the prevalence of prepayment scheme participation?

What are the socio-economic characteristics of households participating in prepayment schemes?

Who much do households spend per month in prepayment scheme?

What is the incidence of prepayment scheme payments on household monthly expenditures?

What is the ratio of prepayment scheme payments on compressible monthly expenses (tobacco, alcohol beverages)?

This analysis can be stratified between rural vs urban, Copperbelt vs Lusaka vs other areas, etc... ,

Household Monthly Health Expenditures

How much do households spend on health? (Total monthly health expenditures)?

How much do households spend on specific health related goods and services? (Medicines, Fees for Doctor/Health Assistance/Midwife/Nurse, Fees to Traditional Healer, Payment to Hospital/Health Center, Prepayment scheme)

How do these expenses vary between different socio-economic group?

This analysis can be stratified between rural vs urban, Copperbelt vs Lusaka vs other areas, etc... ,

Health Seeking Behavior

Curative Care

How much do the sick spend on self-medication?

What types of providers are used by the sick? How do utilization patterns changes by symptoms, socio-economic characteristics of the sick, of its household (including level of monthly expenditures)?

How do utilization of health services vary with the availability of health facilities?

Does participation of the household in a prepayment scheme affects its health care seeking behavior?

This analysis can be stratified between rural vs urban, Copperbelt vs Lusaka vs other areas, etc... ,

Delivery Care

(same questions for curative care)

Immunization

(same questions for curative care)