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Zambia Community Health Waiver Scheme: Final Evaluation

February 2006

Prepared by:

Kafue District CHEWS Team

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February 2006

Recommended Citation

Kafue District CHEWS Team. February 2006. *Zambia Community Health Waiver Scheme: Final Evaluation*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

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Contract/Project No.: HRN-C-00-00-00019-00

Submitted to: USAID/Lusaka

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Abstract

This report is an evaluation of the Community Health Welfare Scheme (CHEWS) pilot implemented in Kafue, Zambia, from 2002 to 2004. The goal of CHEWS is to increase health care services utilization by the most vulnerable populations through the provision of a user fee voucher. The identification of beneficiaries and allocation of vouchers is done by a community-based institution (the community welfare assistance committees, CWAC) using a criteria matrix for identification. This evaluation report is based on a household survey of CHEWS and non-CHEWS households, and focus group discussions of health providers and CWACS members. The results show that there were no differences in health seeking behavior and in health status in CHEWS and non-CHEWS households, leading to the conclusion that the targeting matrix was not used correctly or was too complex to use at all. However, the evaluation did find that there was increased collaboration between the Ministry of Community Development and Ministry of Health and that health center personnel were attending to voucher clients without prejudice. It is posited that the inability or unwillingness to use the targeting criteria is a result of the complexity of the matrix, the difficulty of identifying and selecting the poorest in a generally poor population, and the lack of resources for support/supervision. It is recommended that the matrix and its use be reviewed and field-tested to improve upon it. Finally, an exemption mechanism needs adequate funding to function correctly; it cannot be implemented without appropriate investments.

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Acronyms

ACC	Area Coordinating Committee
ARV	Antiretroviral drug
CBoH	Central Board of Health
CHEWS	Community Health Waiver Scheme
CWAC	Community Welfare Assistance Committee
DDCC	District Development Coordinating Committee
DHMT	District Health Management Team
DHO	District Health Office
DSWO	District Social Welfare Office
DWAC	District Welfare Assistance Committee
HCC	Health Center Committee
HH	Household
HIV/AIDS	Human Immuno Virus/Acquired Immuno Deficiency Syndrome
HSSP	Health Services and Systems Program
IEC	Information, Education and Communication
Km	Kilometer
KTZ	Kafue Textiles
MCDSS	Ministry of Community Development and Social Services
MOH	Ministry of Health
NCZ	Nitrogen Chemicals of Zambia
NHC	Neighborhood Health Committee
PHR_{plus}	Partners for Health Reforms _{plus} Project
PMU	PWAS Management Unit
PWAS	Public Welfare Assistance Scheme
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
ZIHP	Zambia Integrated Health Programme

Acknowledgments

The CHEWS secretariat acknowledges the financial support from the Royal Danish Embassy in Zambia, without which this pilot project would not have been implemented. The pilot required the cooperation of many stakeholders, without whom there would be no story to tell; therefore the CHEWS team would like to thank the following:

The Kafue Social Welfare Office and District Health Management Team are acknowledged for their tireless dedication and commitment throughout the implementation process. The CHEWS secretariat is grateful to the USAID-funded Zambia Integrated Health Programme and the Partners for Health Reform*plus* Project (PHR*plus*) for funding the design and printing of the waivers, producing training materials, funding the training sessions and data entry processes, and carrying out the final evaluation. The Ministry of Community Development and Social Services and Ministry of Health, through the Management Unit of the Public Welfare Assistance Scheme and Central Board of Health respectively, are thanked for their participation and input in the process of implementing the CHEWS pilot.

The CWACs are also owed a great gratitude for rising to the challenge and making the pilot succeed to the extent that it did. The community and indeed the respondents are appreciated for their cooperation and time sacrificed answering the many questions.

PHR*plus* and the Health Services and Systems Program are acknowledged for the financial and logistics support rendered during the final data collection and report writing phases of this work.

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Executive Summary

In an effort to improve the quality of care delivered by the Zambian public health care system, cost sharing was introduced to encourage participation of the general population in the delivery of health care services. Under cost sharing, patients participate in the planning and management of health care delivery – and in the financing of care by paying a user fee when they seek health services. This financing strategy resulted in the vulnerable in society failing to access health care, because they were unable to pay the new fees.

Growing concern about this problem led to development of a mechanism intended to mitigate the impact of user fees on the vulnerable. A social security scheme for health was developed and named the Community Health Waiver Scheme (CHEWS). In 2002-04, CHEWS was piloted in the Kafue district to see to what extent the vulnerable individuals and households could be assisted in accessing health care in public health centers.

The CHEWS built on the Public Welfare Assistance Scheme (PWAS) and used the matrix designed under PWAS. Community welfare assistance committees (CWACs) used this matrix to select individuals and households that qualify for a voucher to use as non-cash payment at health centers. This evaluation was conducted at the end of the pilot to determine the extent to which vulnerable individuals and households took advantage of the scheme to access public health care. The evaluation survey also reviewed knowledge of CHEWS/PWAS and factors associated with utilization of health care.

The evaluation indicated that:

- ▲ There is no difference in the health seeking behavior of CHEWS households and non-CHEWS households.
- ▲ CWACs appear to have distributed vouchers to households that are not any more vulnerable than those that did not get vouchers, giving the impression that CWACs' decisions may have been based more on familiarity than on the objectivity and rationale that the matrix was to have imposed.
- ▲ Health center staff were noted to have been motivated and were increasingly willing to attend to voucher patients following realization that the consumed services would be paid for, albeit at a later date, by the district social welfare office (DSWO).
- ▲ There has been enhanced cooperation among the various stakeholders, particularly between the sister departments of the DSWO and district health management team (DHMT).
- ▲ There has been improved and strong collaboration between the Zambia Integrated Health Programme/Health Services and Systems Program and DSWO and DHMTs.
- ▲ The pilot provided capacity-building opportunities for district supervisory staff, facility staff, and the CWACs.

- ▲ The pilot created a reimbursement mechanism between the DSWO and DHMT.

In that the major challenge of the CHEWS pilot project was to identify the most vulnerable and allocate vouchers to their households, evaluation findings lead one to conclude that the CWACs had difficulties in using the eligibility criteria matrix correctly (meeting all the required qualifiers). This has implications for continued use of the matrix – was it too complicated or stringent, were the CWACs unwilling to use it? Another finding is that, as has been demonstrated in other studies, user fees are but one barrier to access to health care for the most vulnerable.

Among the recommendations made was that the eligibility matrix should be modified and stricter adherence to qualifiers enforced in order for the most vulnerable to be targeted for vouchers. However, this calls for more resources for the PWAS to train, supervise, and support the CWACs. In addition, a different design and additional field-testing for the qualifier/matrix could be considered.

In short, the CHEWS evaluation demonstrates that the identification of the most vulnerable remains a challenge in resource-poor setting with a largely poor population. It also points out that such a program cannot succeed without adequate resources for implementation. A waiver program should have as much resources as any other public health program.

The CHEWS evaluation results could contribute to policy making relating to equity of access issues, strengthen the national exemption policy, assist in clarifying procedures for providing the vulnerable access to health care, and enhance possible expansion of the waiver scheme to the rest of the country.

1. Introduction

Zambia's Community Health Waiver Scheme (CHEWS) was designed with the goal of enhancing access to health care for the vulnerable in society by mitigating the negative effects of the cost-sharing policy in the health sector. CHEWS was made an integral part of the policy aimed at improving health care delivery through community participation, a level as close to the family as possible.

CHEWS builds on two programs: cost sharing, developed by the Ministry of Health (MOH)/Central Board of Health (CBOH); and the Public Welfare Assistance Scheme (PWAS), developed by the Ministry of Community Development and Social Services (MCDSS). At the heart of CHEWS are two instruments: the eligibility matrix and the voucher. The matrix is used to identify vulnerable households; vouchers then are distributed to the vulnerable so that they can access care.

The identification of eligible households in a community is done by community welfare assistance committees (CWACs); as the name implies, these are community-based organizations. Using the matrix developed by the PWAS (please see Annex A), the CWACs identify the eligible individuals (which qualifies their households). In Kafue, members of the CWACs and the Health Center Committee (HCC) are the same; this was one of the reasons for choosing Kafue for the pilot scheme. (Neighborhood health committees [NHCs], community-based organizations that are part of the MOH system, could be just as effective in conducting the identification and distribution of the vouchers.) Health centers collect vouchers when their bearers use care, record the numbers of the vouchers, and forward the used vouchers to the District Health Office (DHO). The DHO then redeems the vouchers for cash at the Department of Social Welfare.

The goal of this process was to expand individuals' access to health care while not depriving the health system of revenue from non-payment of user fees.

The evaluation of the pilot was undertaken primarily to assess the extent to which the waiver scheme improved access to health care among the vulnerable groups and, secondarily, the extent to which the system and organizations developed during the pilot.

The following sections of this report present a background of the district, PWAS and cost sharing, and CHEWS; evaluation methodology and methods of analysis; and findings and recommendations.

2. Background

2.1 District Profile

Kafue district is situated in Lusaka Province, 45km south of the capital city of Lusaka. Its 23,250 square kilometers represent 3 percent of the country's surface area. It shares borders with Mumbwa district to the northwest, and Chongwe district to the northeast. On the southwest, Kafue borders Mazabuka district, with the Kafue River as the natural boundary between the two districts. (See district map at the end of the chapter.)

The district is largely mountainous; the Kafue River empties into the Zambezi River at Chiawa. In the rainy season (December to March), many seasonal streams prevent physical accessibility to some rural health centers.

Two main roads serve the district. The Great North road traverses the district; Mumbwa road runs along the western periphery of the district. Improved dirt roads serve the rest of the district. Some of these become impassable during rainy season.

The diseases commonly affecting Kafue are malaria, pneumonia, and diarrhoeal diseases. The district is serviced by 14 health centers. Table 1 shows the distances to health centers from the District Health Office.

Table 1: Distance from DHO to health centers

Health center	Distance (Km)	Health center	Distance (Km)
Chanyanya	26	Kafue Mission	10
Chiawa	140	Kambale	105
Chikupi	16	Kazimva	65
Chilanga	30	Mt Makulu	35
Chipapa	25	Mwembeshi	92
Chisankane	56	Nangongwe	7
Estate	1	Railway	6

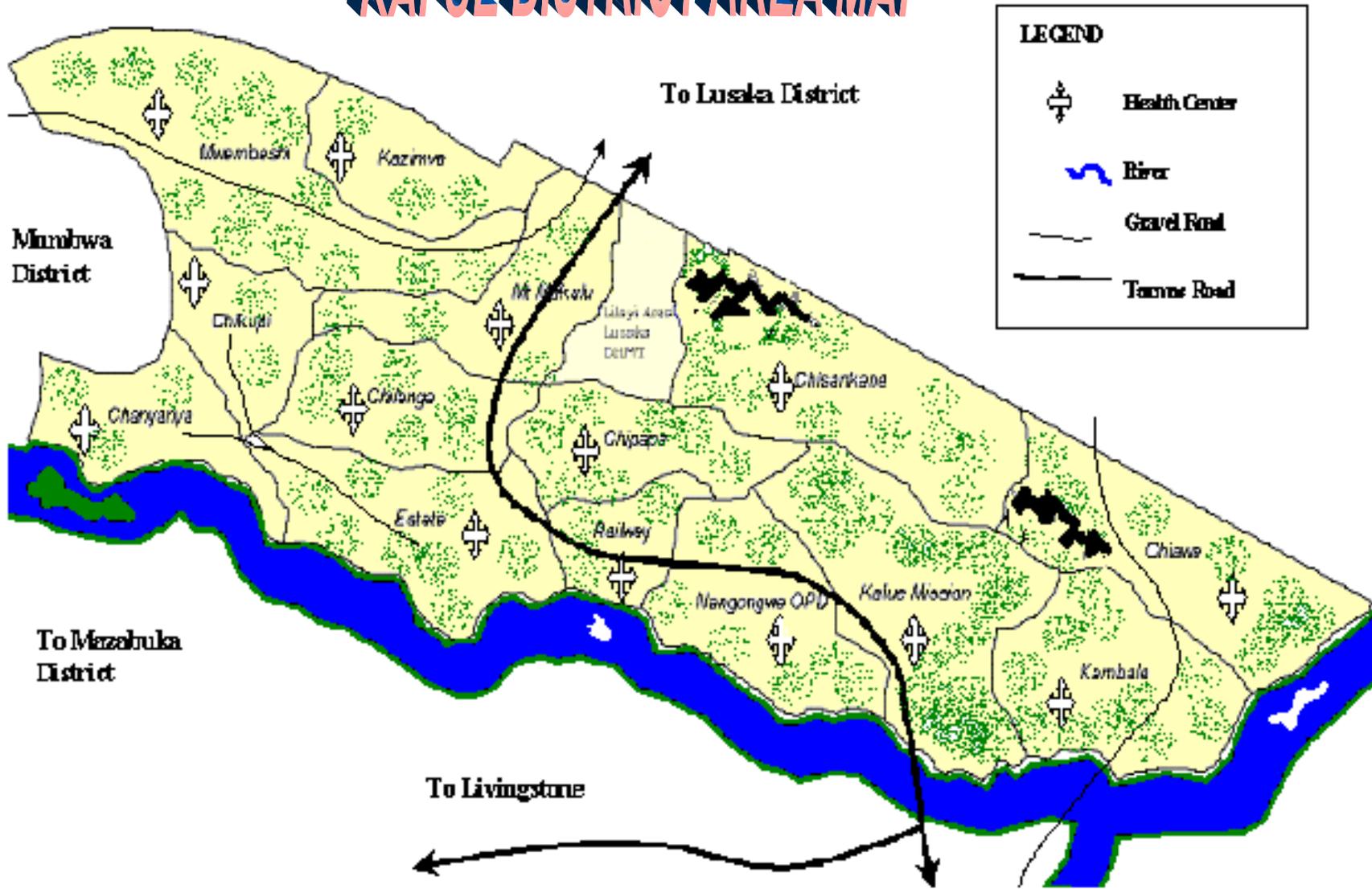
Kafue district has a fast-growing population. Currently the population is 249,919, 51 percent of which live in rural areas with little access to the formal economy other than peasant farming, although there are commercial farms in the Zambezi river valley. In areas around Mwembeshi and Chiawa, most people are laborers at commercial farms; others are engaged in subsistence farming.

Development in Kafue is mainly industrial. Kafue proper (Kafue Town & Estate) was built on the economic strength of Nitrogen Chemicals of Zambia (NCZ) and Kafue Textiles of Zambia (KTZ) since 1998. Presently NCZ does not operate at full capacity and employees sometimes go for months

without salaries. KTZ closed in 2003 and in May 2005 reopened as African Textiles; however, production has not started.

Most of Kafue's population is in medium to poor strata of society, with literacy levels of 40 percent. The low income levels means the district needs to have in place a social safety net to cover the cost of medical services in this era of cost sharing.

KAFUE DISTRICT AREA MAP



2.2 PWAS and Cost Sharing

2.2.1 PWAS

The Public Welfare Assistance Scheme of the Ministry of Community Development and Social Services has existed since 1950. It is administered by the District Welfare Assistance Committee (DWAC), a subcommittee of the District Development Coordinating Committee (DDCC). The District Social Welfare Office (DSWO) is the DWAC secretariat. Districts have many communities; each community has a community welfare assistance committee. Because there are too many communities for the DSWO to work with directly, PWAS groups communities into area co-ordinating committees (ACCs), which represent all CWACs in a given location. The ACC comprises two representatives (chairperson and secretary) from each CWAC.

Over the years, inadequate funding has made PWAS less beneficial to vulnerable communities and individuals. An evaluation of PWAS in 1996 showed that most resources went to the wrong people, and that assistance was limited to those in and around district towns. Redesigned guidelines were approved in 1997 and implementation began in 2000. The new guidelines use a decentralized approach and a community targeting method to identify clients and allocate welfare resources. A qualifying matrix serves to determine an individual's or household's eligibility for assistance by subjecting the potential clients to established criteria. This is intended to improve the accuracy of targeting, and complement and strengthen local resource mobilization.

2.2.2 Cost Sharing

In 1991, Zambia instituted a broad program of public sector reform aimed at improving the delivery of social services to the population. Health reforms were to “provide all Zambians with equity of access to cost effective, quality health care as close to the family as possible.” This included decentralization of the public health system.

In the decentralized public health system, the Ministry of Health/Central Board of Health contracts the provision of health services to hospital and district health boards. Services are provided through hospitals and health centers that work closely with neighborhood health committees, members of which form the Health Center Advisory Committee. NHC members also work closely with community-based agents such as community health workers, malaria agents, family planning agents/community-based distributors, and traditional birth attendants.

Another reform was cost sharing, intended to ensure financial sustainability of the decentralized health system. Cost sharing in the health sector refers to the contributions (user fees) made by the population toward the cost of the Basic Health Care Package of promotive, preventive, and curative services that address the major disease burden in the community. Cost sharing also comprises community participation and ownership in the management, planning, and utilization of health care, so that delivery, accountability, and quality of services are enhanced. Contributions received through cost sharing create a fund, all of which is returned at the community's request, to improve health services.

While cost sharing has the potential to improve community participation and quality of services, there is inevitably a segment of the population for whom paying user fees is not feasible. The percentage of the population that is unable to pay ranges from 6 percent in Katete (1999-2000) to 8

percent in Livingstone (2001), and 11.5 percent in Kitwe (2001). For this reason, Zambia has an extensive cost-sharing exemption policy. As Table 2 shows, this policy is for the most part absolute, i.e., patients who qualify under the exempted criteria are given free health services. The vulnerable are the only group that needs to undergo additional need-based testing to qualify for exemption.

Table 2: Cost-sharing exemption policy

<p>The following medical services are delivered free of charge:</p> <ul style="list-style-type: none"> ▲ Treatment of chronic illnesses such as tuberculosis and HIV/AIDS ▲ Treatment of sexually transmitted infections ▲ Treatment of epidemic diseases such as cholera ▲ Ante-natal, delivery, post-natal care ▲ Family planning ▲ Emergency cases such as accidents 	<p>The following populations are to be treated free of charge:</p> <ul style="list-style-type: none"> ▲ Children under the age of 5 years ▲ People over the age of 65 years ▲ The vulnerable with evidence from the Social Welfare Office or other
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Patient mix surveys conducted in Katete, Livingstone, and Kitwe between 1999 and 2001 showed a range in compliance with the government’s exemption policy; qualifiers such as age (under five and 65 and over) were found to be the most closely followed. Vulnerability exemptions are least adhered to. The CHEWS pilot was initiated to address this issue.

2.3 CHEWS

CHEWS was a two-year pilot project launched in Kafue district in 2002 to assist in implementation of the government cost-sharing and exemption policy while protecting access to health care by vulnerable individuals or households. The pilot was the first step in examining the modalities, constraints, and opportunities in implementing a waiver scheme.

2.3.1 CHEWS Partnerships

The CHEWS pilot project was a collaborative effort between the MoH through the Kafue District Health Board, the MCDSS through PMU and the Kafue District Social Welfare Department, the Royal Danish Embassy to Zambia, Zambia Integrated Health Programme, the Health Services and Systems Programme, and Partners for Health Reform*plus*, a USAID-funded global health systems reform project. Other partners included the community through the NHCs/CWACs. The CHEWS team, with representation from all involved organizations is the management body for the pilot project.

2.3.2 The Eligibility Matrix

As noted above, the cost-sharing policy had no clear indicators or criteria to identify vulnerable patients, i.e., those who were unable to pay user fees. This meant that health care staff made subjective decisions about who should be exempted from fees. As a result, undeserving individuals received exemptions, and access for the truly vulnerable was inconsistency and unpredictable.

In response, PWAS developed a matrix of criteria that health staff could systematically apply to identify the vulnerable. Kafue district adopted the matrix in order to implement the CHEWS pilot.

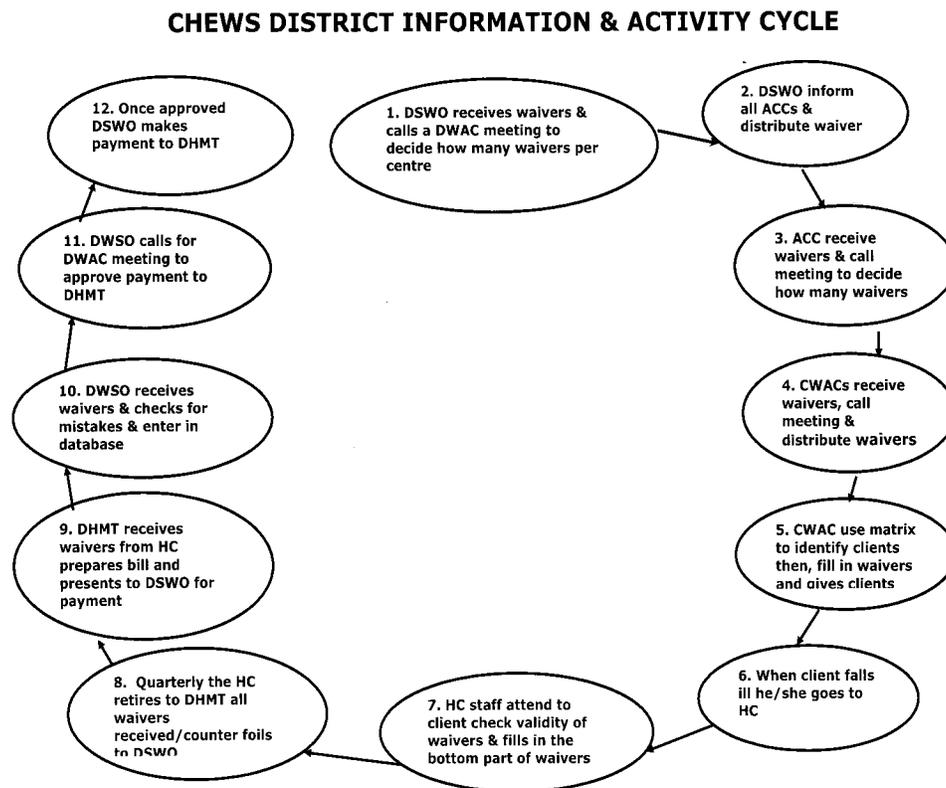
The matrix has three categories of qualifiers: social, economic, and other. (See Annex A for the matrix.) The minimum for an individual or household to qualify for a waiver was to meet one social and two economic qualifiers. The category of “other” was used to gauge the level of vulnerability. The more ticks one has, the more vulnerable. The final decision to award a voucher depended on the number of ticks on the matrix form. The voucher is in form of a coupon (see Annex B) that qualifying individuals or households present at the health center to receive health services without cash payment.

2.3.3 Implementation

Implementation of the pilot began with sensitization meetings for various stakeholders: DWAC, councillors, DDCC, traditional leaders, ACC/HCC, and the CWACs/NHCs. After sensitization, health center staff and ACCs were trained to implement the project – how to fill in the vouchers, obtain reimbursement, etc.

Figure 1 illustrates the CHEWS district information and activity cycle.

Figure 1: CHEWS activity cycle



The Department of Social Welfare received the vouchers from ZIHP. DWAC held meetings to determine the quantity of vouchers to allocate to each ACC/HCC. The DSWO, as secretariat to DWAC, then delivered vouchers to the ACCs/HCCs. The ACCs/HCCs held additional meetings to determine the number of vouchers to be given to each NHC/CWAC, which in turn gave them to eligible individuals and households. (A replacement voucher could be obtained from the CWACs.) Patients submitted vouchers to the health centers in return for services; the health centers then submitted the vouchers to the DHMT. After verification by the DHMT, the vouchers were submitted to DSWO for redemption and data entry.

After receiving the reimbursement from the DSWO, the DHMT reallocated 90 percent of the funds as part of the general medical fees to health centers according to the number of vouchers submitted. Health centers, together with the community, reallocated this money to other community interventions.

As the CHEWS pilot was implemented, process indicators were monitored. These indicators included the number of vouchers allocated to each CWAC, and the number handed out to individuals or households. After two years of implementation, the CHEWS pilot partners captured and assessed the output of the project on the target population. At the health center, the number of patients using vouchers was monitored for several reasons including the level of utilization of the vouchers as reflected by the number of clients in the register who were unable to pay

It is intended that the lessons from the pilot project will be integrated into the existing government policy, programming, and budgeting related to health care financing for the vulnerable.

3. Methodology of the CHEWS Evaluation

The CHEWS evaluation was conducted to assess the implementation of the pilot project and to measure the pilot's impact on vulnerable groups' access to health care. Results of the evaluation could be used as a basis for improving the process of client identification and improving access to health care for the vulnerable in Zambia.

3.1 Review of Baseline

A household survey was conducted in 2002 to assess the pattern of utilization of services and estimate the number of Kafue residents who were unable to pay for health care. The mix of patients – paying, exempt, and unable to pay patients (de facto vulnerable waivers) – visiting outpatient departments was identified by surveying the outpatient registers of all health centers over a defined period of time. This provided data to estimate the required number of vouchers. The complementary patient mix survey done at health centers indicated that 3 percent of the population was unable to pay.

3.2 Evaluation Components/Design

3.2.1 Household Survey

Sampling Strategy

The household survey sampled CHEWS and non-CHEWS households in Kafue district to examine utilization of health care services. The survey was conducted in the catchment areas of 11 of the 14 health centers in the district, because only those CWACs were able to provide lists of CHEWS household records. The total number of households who benefited from CHEWS in the 11 catchment areas at the time of the survey was 2,497.

The sample size for the household survey was determined using an online sample calculator¹ at a confidence level of 95 percent. From the total number of CHEWS households, 334 households were selected and interviewed. The selected households were proportionally representative of the 11 catchment areas.

The relative distribution was based on the total number of households within the 11 areas sampled (Table 3). The relative distribution of CHEWS households throughout the district was applied to the extent possible when selecting the sample of the 334 CHEWS households for interview. The actual households to be interviewed within each of the areas were then selected by randomly sampling from the available lists of CHEWS households in each area using published tables of random numbers (see Annex D).

¹ <http://www.surveysystem.com/sscalc.htm#cineeded>

Table 3: Distribution of CHEWS households in 11 catchment areas of Kafue district

Health center catchment area	Total number of benefiting households	Relative distribution (% of total)	Number of households in sample
Kafue Estates	298	12	40
Nangongwe	361	14	48
Railway	217	9	31
Kafue Mission	197	8	26
Chanyanya	302	12	40
Mwembeshi	209	8	28
Chipapa	297	12	40
Chiawa	144	6	19
Chikupi	147	6	20
Chisankane	153	6	20
Kambale	172	7	23
Total	2,497	100%	335

N/B: During field visit an extra household for CHEWS was interviewed as well as a control household. This was included in the analysis, bringing the total number of the households interviewed to 670.

In order to select a similar socio-economic control group, enumerators surveyed the third house away from the CHEWS household. However, the control group sampling technique could by chance have selected a household that benefited from CHEWS, leading to a situation where the control group contained a few CHEWS households that were not on the list provided by the DSWO.

Data Collection

Following the selection of a representative sample of the target population, 16 enumerators administered a structured questionnaire to collect household data on socio-economic status. The survey was designed to collect data on the number of individuals and households who would have utilized a voucher in the 12 months preceding the survey.

Data collection was preceded by a three-day orientation of the 16 enumerators to the survey background and the objectives of the CHEWS evaluation. In order to ensure that data collection was consistent and of high quality, significant time was spent on understanding the data collection instrument and the meanings and expected responses to all the questions. After the orientation, a pre-test was conducted over two days followed by one day of questionnaire modification (a few minor alterations were made).

The survey was conducted in the 11 catchment areas over a period of 15 days using the structured questionnaires. Logistical support and mobilization for fieldwork was provided by ZIHP, DHMTs, and the DSWO. CWACs also supported the enumerators by locating respondents.

In order to provide quality assurance of the data collected, a 10-day field supervision was undertaken by the CHEWS team comprising one representative from the DHMT and one from the DSWO led by the field manager. The team identified some errors in some questionnaires of a few enumerators and on-the-spot technical assistance was provided.

At the end of the fieldwork, the field manager rechecked each question on all questionnaires and made corrections where possible. It was noted that the quality of some questionnaires from two enumerators were unsatisfactory as certain information was completely missing. These enumerators were asked to revisit and re-interview the respondents.

Survey Analysis

The data from the household survey were compiled in a Microsoft Access database and analysed using the Statistical Package for Social Scientists (SPSS). Households were divided into CHEWS and control groups based on selection during sampling. Control group households whose household head indicated that the household qualified for a voucher and had used at least one voucher in the preceding 12 months were considered to be CHEWS households.

In settings such as Kafue district (primarily rural with little access to the formal economy), income is often not an ideal measure of economic status and, therefore, an asset index was created for use as a proxy for income.

The following variable definitions were used in the analysis:

CHEWS households denote all households that were identified by the CWACs through the matrix to receive vouchers or households that reported qualifying for and using at least one voucher.

Asset index: The sample was divided into five asset groups, ranging from households with the least number of assets to households with the most number. The asset index was based on:

- ▲ Housing material (walls and roof)
- ▲ Radio ownership
- ▲ Boat ownership
- ▲ Electricity in the house
- ▲ Running water in the house
- ▲ Bicycle ownership, and
- ▲ Livestock ownership.

CHEWS qualifiers: This refers to the categories of economic, social, and other qualifiers outlined in the matrix. The matrix was designed to aid in identifying vulnerable households. A *CHEWS-qualifying household* is one that satisfies at least one of the social and two of the economic qualifiers and any other qualifiers listed in the matrix.

Rural and urban: The survey used the following definitions:

Urban: Presence of the following facilities within a 5 kilometer radius – shops for essential commodities, bank, post office, railway station, filling station, and density population of more than 10 people per Km².

Rural: Absence of the following within a 5 kilometers radius – shops for essential commodities, bank, post office, railway station, filling station, and density population of less than 10 people per Km².

There are some discrepancies in data analyzed. Many of those surveyed who reported a chronic or acute illness did not answer the corresponding questionnaire modules on behavioral response to acute and chronic illness. This was observed with the household heads who were responding on behalf of the chronically or acutely ill. One household in the control group reported not qualifying for a voucher but then reported using a voucher. This household was dropped from the data analysis.

3.2.2 Focus Group Discussions

Qualitative focus group discussions were conducted in order to obtain an insight of the project from the CWACs and the health center staff. Seven of the 14 health centers were visited: Chanyanya, Chipapa, Chisankane, Estates, Kambale, Mwembeshi, and Nangongwe.

3.2.3 CHEWS Monitoring System

A database was developed to monitor utilization under CHEWS. The database tracked client details such as frequency of CHEWS qualifiers, sex, and age among voucher users as well as health center visit details, such as diagnosis and procedures performed. It also tracked CWAC and zonal areas that were contributing to the utilization in specific health centers. The tracking included the total sum of redemption per health center. The database is maintained by the DSWO.²

² 1,800 vouchers were entered into the database at the time of this survey.

4. Findings

4.1 Household Survey

4.1.1 Demographics of the Study Population

Out of the 43.1 percent of male-headed households sampled, 45.4 percent were non-CHEWS and 40.5 percent were CHEWS. There was no significant difference in the household head's sex between CHEWS and non-CHEWS households.

CHEWS-designated households are significantly more likely to have at least one social qualifier than non-CHEWS households. However, there is no significant difference in fulfilling CHEWS qualifiers between CHEWS and non-CHEWS households. Of the 24 households that met the minimum requirements in the CHEWS matrix, only 13 (54 percent) were designated as CHEWS households (Table 4).

Table 4: CHEWS and non-CHEWS households (HHs) by type of CHEWS qualifier³

	Non-CHEWS HHs (382) (%)	CHEWS HHs (291) (%)	Total
At least one social qualifier	162 (42.2%)	245 (84.2%)	407
At least two economic qualifiers	11 (2.9%)	15 (5.2%)	26
At least one other qualifier	90 (23.6%)	129 (44.3%)	219
At least one social and two economic qualifiers*	11 (2.9%)	13 (4.5%)	24

*Satisfies minimum requirements for CHEWS matrix.

The frequency of CHEWS qualifiers among those who used vouchers at the health center shows that 'household does not have enough food' and 'housing is below average standard' are the most common qualifiers by an order of magnitude, followed closely by female-headed households (Table 5).

³ Except where noted, the source for data in all tables in this section is the household survey.

Table 5: Frequency of specific CHEWS qualifiers among CHEWS voucher users

Qualifier	Frequency
Child-headed household	90
Aged-headed household	248
Female-headed household	921
Chronically sick head of household	348
Disabled head of household	100
Applicant is a disaster victim	78
Children do not attend school	208
Household has no productive assets	3
Household does not have enough food	1332
Not stated	29
Applicant is an orphan or vulnerable child	126
Housing is below average standard	1046
Recent death of household head	330

Source: CHEWS voucher database output, DWO

The assets index shows no clear difference between CHEWS and non-CHEWS households. Approximately the same percentage of CHEWS and non-CHEWS households falls into each economic quintile (Table 6).

Table 6: Asset quintiles of CHEWS and non-CHEWS households

Asset index	Households	
	Percent of non-CHEWS HHs in quintile	Percent of CHEWS HHs in quintile
Lowest	22.2%	20.4%
Low	21.5%	25.0%
Middle	15.2%	18.6%
High	20.4%	19.9%
Highest	20.8%	19.1%
Total	100%	100%

There is no apparent difference in the economic quintile of CHEWS households using and not using vouchers in the 12 months preceding the survey (Table 7).

Table 7: Asset quintiles of CHEWS households with at least one member using voucher in previous year

Asset index quintile	Percentage of CHEWS HHs with at least one member using voucher in last year	
	HH not using voucher	HH using voucher
Lowest	20.5	22.9
Low	20.5	20.5
Middle	23.1	21.7
High	23.1	16.9
Highest	12.8	18.1
Total	100	100

More than 60 percent of survey respondents did not reveal the household's monthly income figure to the enumerators. Of those who did respond, 52 percent of CHEWS households were in the lower half compared to 43 percent of non-CHEWS households. Only 16 percent of CHEWS households, compared to 23 percent of non-CHEWS households, were in the highest (Table 8).

Table 8: Monthly income among CHEWS and non-CHEWS households

	Non-CHEWS HH	CHEWS HH
K0-5,000	7.54%	7.8%
K5,100-10,000	15.73%	20.35%
K10,100-20,000	20.91%	25.07%
K20,100-30,000	20.91%	13.27%
K30,100-40,000	12.07%	18.88%
K40,100-50,000	23.28%	15.63%

* At the time of the survey, K4800=US\$1 (http://www.economist.com/markets/currency/md_conv.cfm).

Note: this is a breakdown of households that responded – 60.7% did not respond.

There were no apparent differences in education attainment between CHEWS and non-CHEWS households. Among all households surveyed, 68.9 percent of the population had never gone to school or attended only primary school (Table 9).

Table 9: Educational attainment among household heads of CHEWS and non-CHEWS households

Completed...	Non-CHEWS HH	CHEWS HH	Total
No school	23.2%	22.6%	22.7%
Primary school	41.6%	49.7%	46.2%
Secondary school	29.9%	25.1%	27.2%
More than secondary school	1.4%	1.6%	1.5%
Don't know	4.1%	1.1%	2.4%

More CHEWS household heads report worse health than non-CHEWS household heads (Table 10.).

Table 10: Health status of CHEWS and non-CHEWS household heads

		Non-CHEWS HH (494) (%)	CHEWS HH (494) (%)
What is your perceived health status compared with your peers?	Better	32 (16.5)	35 (11.7)
	Similar	58 (29.9)	90 (30.0)
	Worse	92 (47.4)	164 (54.7)
	Don't know	12 (6.2)	11 (3.7)

Of the 670 households surveyed, 496 (74.0 percent) were located in rural areas, of which 215 were non-CHEWS and 281 were CHEWS households. There is no significant difference in percentage between CHEWS households in rural versus urban areas.

4.1.2 Knowledge and Utilization of Free Public Health Services

Knowledge and utilization of free health services varies between the baseline and final evaluations, as well as between CHEWS and non-CHEWS households.

The heads of CHEWS households are more likely to be aware of free health services than heads of non-CHEWS households, although this is not a statistically significant relationship (Table 11).

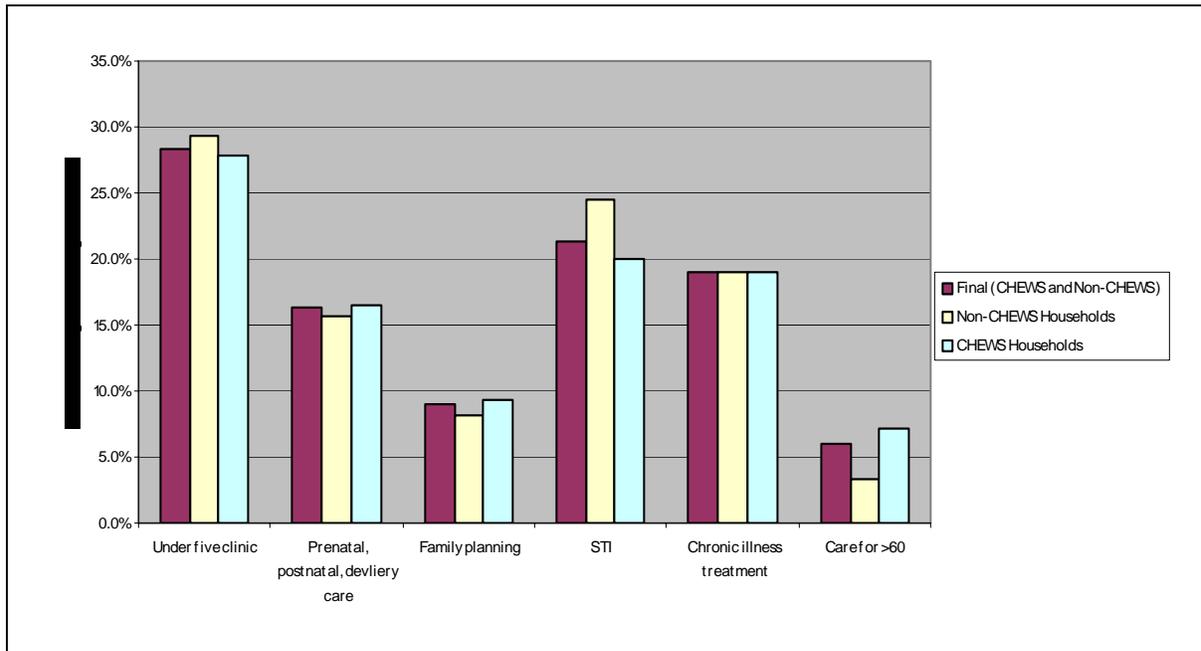
Table 11: Awareness of free health services among CHEWS and non-CHEWS households

		Non-CHEWS	CHEWS
Aware of free services at public health center	No	99	127
	Yes	86	154

P= 0.07 OR = 1.40 (OR=odds ratio)

There has been a substantial increase in awareness of certain services such as the under-five clinic, prenatal care/delivery, treatment for sexually transmitted infection (STI) and chronic illness, except for family planning services (Figure 2).

Figure 2: Knowledge of free health services at final evaluation



Sixty-five percent of households in the final evaluation reported having used at least one free health service (Table 12) compared with only 17.0 percent in the baseline. This indicates that the majority of households are taking advantage of free health services as a result of the NHC/CWACs being oriented on the benefits of the waiver and services requiring exemption and in turn orienting communities.

CHEWS households are significantly more likely than non-CHEWS households to report having used a specific health service. Of the 324 households that reported having used at least one specific free health service (Table 13), three had not reported having used free services (Table 12)

Table 12: Free use of health services by CHEWS and non-CHEWS households

Reported having used services		Non-CHEWS HH	CHEWS HH
	No	71	102
Yes	123	198	

P = 0.35 OR = 1.12

Table 13: Utilization of specific free health services among CHEWS and non-CHEWS households

Reported specific service used		Non-CHEWS HH	CHEWS HH
	No	166	180
Yes	123	201	

P = 0.00 OR = 1.51

4.2 Knowledge and Utilization of CHEWS

There is a significant difference in knowledge of the CHEWS project between CHEWS and non-CHEWS households. CHEWS households are significantly more likely to know and utilize the CHEWS than non-CHEWS households (Table 14).

Table 14: Knowledge and utilization of CHEWS by CHEWS and non-CHEWS households

Knowledge and utilization of CHEWS		Non-CHEWS HH	CHEWS HH
	No	135	55
Yes	56	244	

P = 0.00 OR = 10.69

Of the 299 CHEWS household participating in the CHEWS project, 55 seemed not to be sure of what the waiver scheme was (Table 14). It cannot be ascertained whether these 55 households definitively received a voucher when designated as a CHEWS household. These households do not share characteristics such as a common health zone, health center, or enumerator, so it is unlikely that these data are a product of a specific CWAC or a surveying error.

Just over half of CHEWS households reported having used a voucher at least once in the 12 months preceding the survey (Table 15). Of those households using a voucher at the health center, a large majority only used a voucher only once (Table 16).

Table 15: Percentage of CHEWS households using voucher in past 12 months

	CHEWS HH (%)
Did not use voucher in last 12 mo	48.8
Used voucher in last 12 mo	51.2

Table 16: Frequency of health facility attendance by CHEWS beneficiaries, as reported by the health center

Number of CHEWS beneficiaries	Frequency of attendance
1,424	1
121	2
17	3
6	4
3	5
0	6
0	7
0	8
1	9

Source: CHEWS voucher database output, DWO

Female-headed households are more likely than male-headed ones to have used a voucher for the household head in the last year (Table 17), though not significantly so.

Table 17: Gender of household heads among CHEWS household heads using voucher

Head of household is:	Household head used voucher in last 21 months		
		No	Yes
	Male	130	67
Female	105	79	

P = 0.07 OR = 1.46

Female-headed households are significantly more likely to have used a voucher for a member of their households in the last year than male-headed households (Table 18).

Table 18: Gender of household heads among CHEWS households using voucher

Head of household is:	Household member used voucher in last 12 months		
		No	Yes
	Male	107	90
Female	79	105	

P = 0.03 OR = 1.58

CHEWS households are more likely than non-CHEWS households to use a public health facility when they have an acute illness (Table 19).

Table 19: Public health facility treatment of acute illness among CHEWS and non-CHEWS households

Did you visit a public health facility for treatment of your illness in the past 4 weeks?		Non-CHEWS HH	CHEWS HH
	No	13	20
	Yes	25	52

P = 0.48 OR = 1.35

4.2.1 Major Challenges to the Use of CHEWS

There is no apparent trend in educational attainment between or among CHEWS households that use or do not use vouchers (Table 20).

Table 20: Educational attainment of CHEWS household heads using and not using vouchers

% of household heads completed...	Member of CHEWS HHs not using voucher in last year	Member of CHEWS HH using voucher in last year
No school	22.0%	23.1%
Primary school	48.4%	50.8%
Secondary school	25.3%	25.1%
More than secondary school	3.2%	0.0%
Don't know	1.1%	1.0%

CHEWS households in the rural areas are significantly more likely to use the voucher than CHEWS households in urban areas (Table 21).

Table 21: Voucher usage in rural and urban areas

	CHEWS HH did not use voucher	CHEWS HH used voucher
Rural	142	139
Urban	44	56

P = 0.26 OR = 1.30

CHEWS households located close to a health facility are more likely to use a voucher (Table 22) than those located farther.

Table 22: Proximity to health facility versus voucher utilization

Is there a government facility close (w/in 12 km) to where you live?		CHEWS HH did not use voucher	CHEWS HH used voucher
	No	2	2
Yes	15	32	

P = 0.46 OR = 2.13

4.2.2 Borrowing to Pay for Public Health Services

Non-CHEWS clients are more likely to borrow money to access primary health services than CHEWS households that present the voucher. However, CHEWS households requiring secondary services may have to borrow money to pay for these services because the voucher does not cover these costs (Tables 23-25).

Table 23: Borrowing behaviors for the acutely ill

Did you borrow money to help pay for the total cost of seeking health care?		Non-CHEWS HH	CHEWS HH
	No	39	23
Yes	1	7	

P = 0.01 OR = 11.87

Table 24: Payment for health services for acute illness among CHEWS and non-CHEWS households, part I

Did you pay anything for treatment?		Non-CHEWS HH	CHEWS HH
	No	7	17
Yes	30	19	

P = 0.01 OR = 0.26

Table 25: Payment for health services for acute illness by voucher qualification, part II

Was your last visit to the health facility provided free of charge?		Doesn't qualify in CHEWS matrix	Qualifies in CHEWS matrix
	No	31	1
Yes	38	1*	

P = 0.89 OR = 0.82

*This household was never interviewed by the CWAC and never issued a voucher.

4.3 Focus Group Discussions with Health Center Staff and CWACs

As part of the CHEWS evaluation, seven of 14 ACCs/HCCs were sampled in order to gauge the knowledge of CHEWS, and its implementation and utilization process. (See Annex C for focus group discussion guidelines.) Challenges and recommendations were highlighted. The following sections discuss the views obtained from the focus group discussions.

4.3.1 Knowledge of CHEWS

Of the seven health centers visited, the staff at six knew what the acronym CHEWS stood for (86 percent). In addition, staff at all the health centers showed an understanding of how beneficiaries of CHEWS were identified (100 percent). This level of knowledge can be attributed to the training and sensitization that the health center staff received during pilot project implementation.

Out of the seven ACCs/HCCs visited, five had adequate knowledge on what CHEWS stood for and what its functions were. The other two had problems defining CHEWS and were only able to define it after the questions was rephrased several times. All seven ACCs knew and did not have any problems on how to use and complete the matrix for identification of potential beneficiaries. In addition, all ACCs clearly indicated who the beneficiaries were, e.g., female- and child -headed households.

Therefore, it can be concluded that the matrix simplifies the process of client identification

4.3.2 Utilization

Staff at all seven health centers noted that the vulnerable individuals and households had increased access to health services (100 percent). All the ACCs interviewed indicated that many of the vulnerable were able to receive health care from the health center.

Two health centers pointed out that mortality had decreased as people were being treated in the early stages of the disease (29 percent), though there is a need to do a survey to compare mortality before and after project implementation.

One health center mentioned that they were overwhelmed with the increase in patients (14 percent).

All seven health centers said that they referred patients to the next level that offered secondary support services like x-ray (100 percent), while one stated that they were offering laboratory and dental services (14 percent). For the patients who were unable to pay for the secondary support services, two of the seven health centers (29 percent) stated that they wrote referral letters to the DSWO for assistance.

One of the benefits cited by three health centers (43 percent) was that CHEWS had increased their medical fees revenue.

Two health centers (29 percent) were knowledgeable about how the reimbursement mechanism worked though they received money on an irregular basis. The other five (71 percent) did not know or were not sure of how the mechanism worked and denied having received any money from DHMT. No reason(s) were given by the DHMT.

The different categories of patients, i.e., clients with vouchers, those who would have paid for health services, and those who were unable to pay, were attended to and treated in the same way, with female- and child-headed households benefiting the most.

4.3.3 Support

In addition to the support from the DHMT and DSWO, the vulnerable also received help from the Christian Children's Fund, faith-based organizations, and community-based organizations. The assistance includes the following:

- ▲ Tuberculosis patients are helped with blankets, food, drugs, and high-energy protein supplements (HEPS).
- ▲ Counselling, and patients are referred to health centers to obtain medical care
- ▲ Patients are encouraged to join support clubs and income-generating groups.

4.3.4 Problems with the Implementation of Vouchers

Four of the seven health centers visited stated that people who did not deserve a voucher had actually benefited. Four indicated that there was misuse of waivers by CWAC members.

Five of the seven ACCs visited indicated that most beneficiaries failed to access health care due to the long distance to the health center. Another problem for beneficiaries was meeting costs such as those for laboratory investigations, x-ray examinations, dental services, and travel to facilities. Other reasons were:

- ▲ Negligence by the household head

- ▲ Traditional and religious beliefs
- ▲ Poor and negative staff attitude

It can be deduced that the factors affecting vulnerable individuals and households in the different catchment areas are almost the same.

4.3.5 ACC/HCC Recommendations to Improve CHEWS

Three of the seven health centers sampled stated that there was need to increase staff and establish health posts in distant parts of their catchment areas in order to provide quality and effective health services (43 percent). Increasing the number of outposts would necessitate an increased fuel supply, to enable supervision of outlying posts.

The ACCs/HCCs at three health centers visited indicated that there was need for them to provide secondary support services (e.g., laboratory, dental, x-rays) to lessen the burden of patients covering long distances (43 percent).

ACCs/HCCs at all seven health centers indicated that incentives such as refresher training (with certificate of attendance), allowances, raincoats, bicycles, photos on the identity cards, T-shirts, were essential to motivate the ACCs/HCCs.

As a way of improving communication and appreciation of CHEWS, two health centers suggested that the DHMT should clarify the mechanism of medical fees.

These findings show that there is need to increase the level of staff and community awareness on the various components of CHEWS. In fact, at the time of the focus group discussions, the communities were not yet aware that all government health facilities were to start giving free antiretroviral drugs (ARVs) beginning in August 2005 – they recommended that ARVs should be distributed free and that the waivers should cover support services for ARVs. This would necessitate an increased number of vouchers be allocated to CWACs.

The ACCs/HCCs were of the view that there was need for the CHEWS team to increase the level of supervision and provide feedback.

In conclusion, all ACCs recommended that CHEWS be continued and replicated in other districts, because of the high poverty levels.

4.4 Major Successes and Challenges of the CHEWS Pilot

In a district such as Kafue, the CHEWS pilot provides a means by which vulnerable households can overcome the barriers to access to care that are created by the cash-based user fee system.

The program has scored many successes, which are outlined below. It is clear from the data collected through surveys and focus group discussions that a program such as CHEWS is more likely to be accepted when department heads, and civic and traditional leaders in a district are all involved from the design stage to the implementation of the program.

- ▲ Health center staff were motivated and increasingly willing to attend to voucher patients once they realized that the consumed services would be paid for, albeit at a later date, by the DSWO. Motivating staff is quite an achievement given all the other factors impacting on the delivery of health services in the country.
- ▲ The pilot strengthened the reimbursement mechanism between the DSWO and DHMT with the health center facilitating this process by compiling and forwarding used vouchers for redemption by the DHMT.
- ▲ The mechanism for redeeming the vouchers worked well, particularly because the staff were equally benefiting from the reimbursements, which were being made on a regular basis by the DSWO to the DHMT. It was noted that the regularity of payments was a motivating factor and thus should be made part of the regime for managing a reimbursement mechanism. However, it should be noted that the reimbursement mechanism can only succeed if there is substantial funding. This finding thus has implications for sustainability and roll-out of the scheme to other districts
- ▲ The project provided capacity-building opportunities for district supervisory staff, facility staff, and CWACs. The community-based CWACs were noted to have been effective in identifying and allocating vouchers to the vulnerable, indicating that a redesigned matrix could be an effective tool in the identification process. However, minor problems were noted in that CWACs were reported to have favored the households of acquaintances in a group of vulnerable eligible households.
- ▲ The pilot provided an opportunity for enhancing cooperation among the various stakeholders and particularly between the sister departments: DSWO and DHMT and the community. There has also been improved and strong collaboration with ZIHP/HSSP and DSWO and DHMT.

The major challenges of the CHEWS pilot project centered around identifying and reaching the most vulnerable households in the district, and the lack of resources for the DWO to support the implementation of the pilot (refresher training of CWACS, supervision, sustained, broad information, education and communication [IEC], and sensitization campaign).

4.5 Summary of Evaluation Findings

The final CHEWS evaluation showed that there were no significant demographic differences between CHEWS and non-CHEWS households. There were few significant differences between CHEWS households that used the voucher and those that did not. These findings indicate that the households that were targeted as vulnerable by the CWACs were not, in reality, any more vulnerable than their neighbors or those households that did not receive vouchers. Although there has been an increase in awareness of free public health services, and specific free health services, such as the under-five clinic, have high utilization rates, it is not clear if this is due to CHEWS.

CHEWS households are significantly more likely to be familiar with the CHEWS pilot project than non-CHEWS households; however, only about half of CHEWS households had used a voucher in the year preceding the evaluation, and 55 CHEWS households were not familiar with the scheme. In addition, 19 CHEWS household reported paying for health services at their last facility visit, though this payment is probably (data are not available) for secondary health care services, which are not covered by the scheme.

While the identification of vulnerable households and distribution of vouchers is an important part of making the CHEWS pilot functional, a knowledgeable and informed beneficiary population will increase the beneficiaries' optimal usage of the program, thereby maximizing the effectiveness of a voucher-based intervention. In this manner, beneficiaries also have the opportunity to truly access the benefits they are afforded

5. Conclusion

CHEWS has demonstrated that an identification matrix is difficult to implement in a resource-poor setting. A system for distributing vouchers to identified beneficiaries can be effective when community-based organizations are allowed to play a role and are supported by in their responsibilities. A consistent reimbursement mechanism with regular payment schedules will ensure not only funding for other community health-related activities that directly benefit the community, but will also motivate staff to provide quality health services to those who otherwise would shun the health facilities for fear of being turned away.

5.1 The Way Forward for Health Waivers in Zambia

The CHEWS pilot demonstrated the challenges faced when implementing a waiver scheme. In order for a waiver program such as CHEWS to achieve a high degree of efficacy and effectiveness, sufficient resources and time must be devoted to an IEC program to accompany the targeting and voucher distribution, and funding must be set aside for the continuing support of implementing partners. Other services offered by the DHO and DSWO would also benefit from a strong IEC program.

The CHEWS assessment has been useful in that the results will be used to inform the national-level policy dialogue on possible expansion of the waiver scheme. If the government of Zambia chooses to scale up the CHEWS pilot or implement a similar waiver scheme at the national-level, addressing issues of IEC and support – and funding for these activities – is integral to success.

5.2 Recommendations for CHEWS Modifications

The PWAS targeting strategies used by CHEWS were effective in identifying vulnerable households, but to make CHEWS more effective, the targeting strategy or implementation should be improved and the eligibility criteria should be reviewed. A grading system should be incorporated into the matrix to determine the level of vulnerability of individuals and households.

As user fees are not the only barrier to access for vulnerable populations, the benefit package covered by the voucher could also include support for transport. Having the voucher cover other health costs such as laboratory work and services at the secondary level, with a reference, should be considered.

The successful implementation of an exemption system for the most vulnerable population needs adequate resources to support the system. This includes funding for support and supervision visits, continued training of the CWACs, more funds for IEC and sensitization. An exemption system needs to be funded at the same level as other critical public health interventions.

Annex A: Client Identification Matrix

Annex B: Voucher

Name of beneficiary: _____

Age: _____ Sex: _____

Date Issued: _____

No. 16 & over in household _____

No. under 16 in household _____

Qualifier	Tick All
House Head:	
Aged	
Child	
Disabled	
Sick	
Female	
OVC	
Disaster	
Household	
Individual	

Nº 11951

CWAC:

Client name: _____ Age: _____ M/F: _____ Individual Household

Please enter characteristics of household head / individual issued with this waiver - tick all

ISSUED TO HOUSEHOLD: Describe household head				ISSUED TO INDIVIDUAL		
Aged	Child	Disabled	Chronically Sick	Female	OVC	Disaster victim
Not enough food		Don't go to school		Poor housing	Recent death of household head	

HEALTH CENTRE:

This waiver is payment for one visit to the health centre - only valid for the above named household head & dependents, or individual; only valid if all the information has been filled in.

Please enter information from the OPD Register for this patient, & stamp on reverse:

Patient name: _____ Age: _____ M/F: _____ Zone: _____ Date: _____

Diagnosis: _____

Lab test(s) X-Ray Drugs dispersed Yes No

Referral: _____

Nº 11951

Annex C: Focus Group Discussion Guidelines: Questionnaire for HCCs & CWACs

Questions for the CWACs

1. What does CHEWS stand for?
2. How do you identify the beneficiaries?
3. Who are the beneficiaries of the waivers?
4. What sort of problems have you encountered during the Identification of the beneficiaries?
5. What sort of problems have you encountered in the implementation of the waiver?
6. What sort of benefits do you think the beneficiaries have received through the implementation of the waiver scheme?
7. What are the problems faced by the patients who are made to pay?
8. Do you have any vulnerable people in your area failing to access care and why do they fail to access care?
9. Is there any type of support from the community or Health Center for these people?
10. What is the source of support?
11. How has that helped the vulnerable?
12. In your opinion, do you think this has had any significant impact on access to care?
13. What are the barriers to accessing care for people in your community?
14. What recommendations would you give for improving the implementation of the waiver?
15. Is there anything else you would like to make note of about the waivers?
16. Would you recommend the waiver program to be implemented in other areas?

Questions for the health center staff

17. How can access to care be improved?
18. How do you deal with patients who have waivers but require secondary support services?
19. How do you treat patients who are able to pay user fees, but are unable to pay for the secondary service provision?
20. What benefits have you identified with the waiver scheme?
21. What wrong practices have you identified that may be associated with the waiver scheme?
 - a. Are there wrong people who are benefiting?
 - b. Is there any misuse by CWAC members?
 - c. Is there any abuse by the beneficiaries?
22. What sort of incentives should the health staff be given in order to encourage improved service provision?
23. How has the reimbursement mechanism been working?
24. Does the money from the DHMT reach you on a regular basis?
25. If not, what reasons does the DHMT give for not sending the money?
26. Does this affect you in the way you treat those who are waiver holders?
27. What would you suggest the DHMT do in order to improve your working relationship with clients who have waivers?
28. Are the rightful or deserving patients being reached through the issuance of waivers?
29. Which category of patients do you feel have benefited most from the waivers?
30. Which patients receive consultation from your clinic
 - a. Those who are unable to pay
 - b. Those with a waiver?
 - c. Those with money to pay?

Annex C: Bibliography

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