**Monitoring and Evaluating Progress towards Universal Health Coverage in Zambia**

by

Benjamin Nganda, Buleti Nsemukila, Shebo Nalishebo, Hussen Chanda, Laurent Musango, and Solomon Kagulura.

Monitoring progress towards universal health coverage (UHC) – ensuring that everyone who needs health services is able to get them, without undue financial hardship – is critical to achieving the sustainable development goals (SDG) health outcomes goal and that of ending extreme poverty by 2030. Monitoring UHC in countries serves to ensure that progress towards UHC reflects a country’s unique epidemiological and demographic profile, health system and level of economic development and the population’s demands and expectations. Given the widespread interest in accelerating progress towards UHC in countries, there is value in standardizing measures to that they are also comparable across countries and over time. It was in this context that the World Health Organization (WHO) and the World Bank (WB) partnered in 2014 and proposed a framework aimed to encourage countries to adopt a common approach to monitoring UHC and measuring progress with internationally standardized indicators. The Framework provides indicators and targets for three dimensions relevant for UHC – coverage of essential health services (preventive and treatment), coverage of financial protection (catastrophic health spending and impoverishment due to out of pocket spending), and equity in coverage. The ultimate goal of UHC with respect to service coverage is that everyone can obtain the essential health services they need, that is, 100% coverage. It is practical to set targets based on empirical baseline data and past trends in the whole population and among the poorest, taking into account issues in measuring need and effective coverage. The latter is not easily measurable, making it exceedingly difficult to realize this goal.

The WHO Regional Office for Africa (WHO-AFRO) desiring to build country specific 2015 baselines for monitoring progress towards UHC commissioned a number of country studies to be undertaken using the framework in Botswana, Lesotho, Namibia, Swaziland, Zambia, and Zimbabwe. This paper presents the results of applying the framework for Zambia.

The percentage of the demand for contraception that is satisfied was estimated at 63.8% in 2013/14. Urban women had highest at 73% compared to women in rural areas at 57.3%. Women with more than secondary education had highest at 79.1% while those with no education had lowest at 53.1%. Correspondingly, women in highest wealth quintile had highest level at 78.4% compared to women in the lowest wealth quintile at 49.1%. Women with at least four antenatal visits were estimated at 55.5% in 2013/14 with little difference between urban and rural areas. The proportion of women with at least four antenatal visits declined from 71.6% in 2001/2 to 60.3% in 2007. Measles vaccination in children was estimated at 84.9% in 2013/14 with children in urban areas having highest levels at 89.3% compared to rural areas at 82.8%. Children from mothers with more than secondary education had highest levels of measles vaccinations at 91.5% compared to 75.6% for children from mothers with no education. This was equally true for children from highest wealth quintile at 92.7% compared to those children from lowest wealth quintiles at 80.9%. Measles vaccination remained unchanged being 84.9% in 2001/2, 84.4% in 2007 and 84.9% in 2013/14.

Only63.1% of the population was using an improved drinking water source with highest levels in urban areas at 89.2% compared to rural areas at 46.9%. The population with access to improved sanitation was at 27.3% with urban population access at 39.2% compared to rural areas at 19.7%. The situation improved slightly since 2007 from 23.9% with urban and rural access levels at 43.7% and 12.9%, respectively.

Non-use of tobacco was estimated at 98.4% for women aged 15-49 compared to men of the same age category at 80.7%. While there was little difference in non-use of tobacco for women in urban and rural areas estimated at 98.6% and 98.3%, respectively, non-use of tobacco was highest for urban men at 83.1% compared to their rural counterparts at 78.6%. Moreover, more educated and relatively wealthy women and men were less likely to use tobacco when compared to their counterparts with no education and of lowest wealth status.

For coverage of treatment health services, 64.2% of women were delivered by a skilled provider. This was highest for mothers aged less than 20 at 70.1% compared to older women aged 35-49 at 54%. Women from urban areas were more likely to be delivered by skilled providers at 88.5% compared to women in rural areas at 51.6%. In addition, women with more than secondary education were more likely to be delivered by skilled providers at 95.6% and so were women from highest wealth quintile at 94.3% compared to women with no education and from lowest wealth quintile at 46.2% and 45.2%, respectively. There has been improvement in the proportion of women attended to by skilled birth providers from 43.4% in 2001/2 to 46.5% in 2007 and 64.2% in 2013/14.

In terms of coverage and equity of financial protection, the vast majority of Zambians (97%) did not have any health insurance. For those with health insurance, 2% have employer-based insurance and less than 1% has other types of health insurance. Using the threshold of 40% of non-food household expenditure, 4.8% of Zambians incurred catastrophic spending in 2006 increasing to 8.1% in 2010. In terms of equity, household health expenditures of more than 40% threshold of non-food expenditure stood at 2.8% for rural households compared to 3.2% for their urban counterparts in 2010. On impoverishment indicators using poverty head count, 2.2% of Zambians were impoverished in 2006 as a result of Out-of-Pocket (OOP) health expenditures increasing to 3.7% in 2010. Using the concept of poverty gap to determine households for which OOP spending pushed them below the poverty line, the impoverishment gap for 2006 was 3.8% increasing to 9.2% in 2010. In terms of equity, impoverishment head count for the poor was 0.3% in rural areas and 6.8% for urban areas in 2006 increasing to 1.6% and 7.2% in 2010, respectively. In 2010, the impoverishment head count was highest for female headed households at 4.5% compared to male headed households at 3.4%.

The study concludes that despite the Zambian Government’s efforts to ensure universal health coverage, there still exists inequalities with respect to coverage of essential health services provision that are biased towards the urban areas. Also, the absence of mechanisms to enhance financial protection among service users to increase access to needed services has slowed Zambia’s progress towards UHC. However, the study concludes that Zambia has the necessary infrastructure and systems to monitor and evaluate progress towards UHC. But in order to conform to the proposed WHO/World Bank framework, there is need to harmonise and align these systems to compliment the already existing efforts in health system strengthening.