

# **EQUITY WATCH: Assessing progress towards equity in health in Zimbabwe**

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## Executive summary

Economic inequality in Zimbabwe is high. The poorest tenth of people shared less than 2% of national income in the last decade, while the richest tenth shared nearly half the national income. If Zimbabwe is to improve human development and meet commitments in the Millennium Development Goals, it needs to address inequality, including in health. This report assesses progress towards doing this, and achieving equity in health in Zimbabwe. It tracks a selection of progress markers relevant to household, national and global level.

Zimbabwe's progress towards addressing equity has been undermined in recent years by AIDS, economic decline, hyperinflation and political discord. The challenges today are immense, particularly in the context of epidemic outbreaks and service declines. However, the potential exists to make progress. The country has had a longstanding policy commitment to health equity, has experienced recent declines in adult HIV prevalence, land redistribution, has a reasonable public infrastructure, an educated population and an experience of successful Primary Health care (PHC) initiatives. These potentials point to a gain that can be made in health and health equity, if reinforced by investments and an improving economic and socio-political context.

Stated policy commitment to health equity needs to be underpinned by constitutional provisions for the right to health and access to health care; and by plans and budgets to operationalise policy commitments over time with clear targets that are monitored and reviewed. There are opportunities for this in the constitutional review being advocated; in making input to the next national health strategy and through the parliamentary processes.

Planning needs to be informed by updated measurement through facility and household surveys, disaggregated by income, area and gender, including an updated poverty assessment. Available evidence suggests a range of gaps to be addressed. Most profound of these are the gap between:

- need and coverage in access to anti-retroviral treatment; to safe water and sanitation; and in food security;
- “free care” policies and the real formal and informal costs for health services that undermine use in poor households;
- need and supply in drugs and skilled staff at the primary care level of the health system;
- commitments and spending by the international community and government in the health budget, with rising demand on households to meet the gap;
- the expectations and real working conditions and incomes of health workers;
- the social capacities for promoting health within communities, and the legal and institutional recognition and support of these capacities.

Many inputs to health, including primary education, now need to be revitalised as a means to building the universal, comprehensive systems that address these gaps. The cost inflation and rising direct charges in the private sector signal that this can, in the long term, only be public sector led. The package of benefits that every person is entitled to should be clarified, and costed. Inclusive negotiations with health workers through the Zimbabwe Health Services Board need to be strengthened and reinforced with sector wide (vs selective) incentives, including career path support and housing. Financing measures that pool risks, like social health insurance, need to be revisited as soon as economic conditions permit. Market incentives and investments are needed to boost local industry production of drug and health inputs, while a close watch is kept on pricing, financing and pharmaceutical practices in the private for profit health sector. To ensure that people with greatest health need benefit from these investments, focus needs to be given to allocating public resources to rebuild the environments and infrastructures for health, particularly functioning water, sanitation and waste disposal systems and local food production schemes; and to districts

with greater health need, by integrating needs in the formula to guide the allocation of health care resources and using equalisation grants to improve capacities to absorb funds; the primary care and district level of the health system, to strengthen drug, staff, transport and outreach resources at this level, with additional measures to support uptake.

Where is the starting point? The turnaround in child immunisation in the past two years signals the gains that can be made when relevant resources are blended with community action. New investments made in incentives and skills for local health workers, in district services and PHC outreach, including for vehicles and fuel, in the water, sanitation and other aspects of the living environments for health and in the recognition, resourcing and capacity support for community and community health worker roles could inject immediate health gain for low income communities. These may act as entry points around which to navigate measures that address the deeper, structural national and global inequalities that challenge health equity in Zimbabwe.

## An explanation of the equity watch

To advance health equity we need to monitor the key dimensions of health equity and progress in our actions on it. EQUINET is implementing an “equity watch” at both country and regional level to strengthen strategic review, dialogue and networking on equity in health. The equity watch assesses the current status and trends on a range of priority areas of health equity, as identified in the regional equity analysis of health equity in east and southern Africa (ESA) implemented by EQUINET in 2007 (EQUINET SC 2007). The country “equity watch” is not an academic analysis of all dimensions of health equity. Rather it tracks these priority health equity indicators and the progress on measures that promote key dimensions of health equity, particularly within health systems, on

- ◆ Equity in health
- ◆ Household access to the resources for health
- ◆ Redistributive health systems, and
- ◆ A more just return from the global economy.

It monitors progress against commitments and goals, to identify areas for deeper analytic research and for advocacy, to critique and offer positive alternatives to negative influences and initiatives harmful of equity, and to exchange information on promising practice.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. Equity motivated interventions seek to allocate resources preferentially to those with the worst health status. This means understanding and influencing the redistribution of social and economic resources for equity oriented interventions, and understanding and informing the power and ability people (and social groups) have to make choices over health inputs and to use these choices towards health.

EQUINET steering committee. 1998.

Following the introduction, the indicators are shown within four major areas, and with columns of past levels (1980-2006), current levels (most current data publicly available), a comment on the level of progress towards health equity and a bar that shows a colour to indicate whether the indicator is

Improving		Static, mixed or uncertain		Worsening	
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The relationship to the average in ESA is also shown in this bar (+ =above regional average; - = below regional average) (EQUINET SC 2007). The presentation aims to provide an accessible overview of trends on the progress markers in the equity watch.

# Introduction

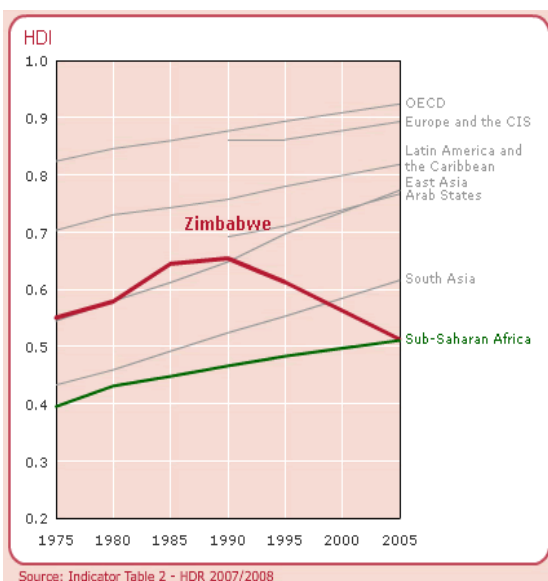


Zimbabwe's progress towards equity in health has been negatively affected in the past decade by HIV and AIDS, economic decline and hyperinflation, and by political discord. AIDS related mortality had a sharp and significant negative impact on health for all groups, leaving Zimbabwe with one of the lowest life expectancies in the world, with only 43.7% likely to live beyond the age of 40 (UNDP 2008). Recent declines in adult HIV prevalence from 25.7% in 2002 to 15.6% in 2007, however, pose new opportunities for health improvements in all social groups (UNICEF 2007). Land redistribution potentially provides low income rural households new opportunities for improving incomes for health, if backed by investments in living environments and access to

production resources. Tapping these opportunities faces a range of challenges, including: A 35% decline in the GDP between 1999 and 2007 (World Bank 2007); an official year-on-year inflation rate in January 2008 of 100 580%, the highest in the world (CSO in Chikwanda 2008); significant declines in tobacco, cotton, maize and winter wheat production post 2000 (FAO 2008); fertilizer and fuel shortages; and shortfalls in a range of basic needs, including food; an orphan population of nearly one million (MoHCW 2008) largely dependent on fostering from poor households; declining real levels of public spending on health and social welfare; rising costs and declining availability of production inputs; a health sector facing high out-migration of skilled and experienced health workers (GoZ 2004); political violence, homelessness and displacement disrupting households, increasing vulnerability and undermining social cohesion (ZADHR 2008; UN OCHA 2008). These challenges set a testing context for addressing the different dimensions of inequality in health that are explored in this analysis.

We assess progress towards achieving equity in health in Zimbabwe, using the EQUINET definition of equity (see box above). Available indicators and peer review from key stakeholders is used to explore progress in how far:

- poor people have been able to claim a fairer share of national resources for their health;
- Zimbabwe has obtained a more just return from the global economy to increase the resources for health; and
- a larger share of global and national resources has been invested in redistributive health systems to overcome the impoverishing effects of ill health.



Zimbabwe ranks 151 of 177 countries in the 2007/8 Human Development Index. After its Human Development Index (HDI) peaked in 1975-1990 at .654, it fell to .513 in 2007/08, its lowest mark in 25 years. The Gender Development Index in 2007 of .505 is lower than the HDI, although higher than other countries in east and southern Africa. Zimbabwe's Human Poverty Index in 2004 was 40.3, putting the country at 91 out of 108 countries (UNDP 2008). Economic inequality is high with the poorest 10% of people sharing only 1.8% of the national income in 1999-2005, while the richest 10% shared 40.3% of the income. The ratio of richest 10% to poorest 10% in the period was 22. (UNDP 2008). The data indicates that inequality remains a determining feature of socio-economic wellbeing and addressing equity central to reducing poverty and achieving targets for the Millennium Development Goals.

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<b>Advancing equity in health</b>			
<p>Formal recognition and social expression of equity and universal rights to health and health care, included, with specific provisions for vulnerable groups, in the constitution and national law</p>	<p>Various constitutional processes and amendments post 1990 have not addressed the right to health or health care, which is not explicitly provided for in the Zimbabwe constitution.</p> <p>There is no single overall National health Act. The Public Health Act (1924) is the major enabling law, and has had numerous amendments. The Medical Services Act (1998) and regulations were introduced to regulate health service standards particularly of private sector services and voluntary medical aid societies.</p> <p>1980 "Planning for equity in Health" made equity a central policy principle. It organised health systems around Primary Health Care (PHC), provided for measures to strengthen access and availability of public services and personnel, and to redistribute resources to district services and between underserved areas. Access in disadvantaged groups was also promoted by health promotion, deployment of Village Health Workers and 'free' services for those earning below Z\$150 (US\$220) (MoHCW 1999) While subsequent health plans and strategies gave more emphasis to quality and efficiency, equity has remained a core policy principle.</p> <p>National Policy promoting gender equity has led to review of laws such as the Equal Pay Regulations, Sexual Discrimination Removal Act, Administration of the Deceased Estates Act and Sexual Offences Act.</p>	<p>The Constitution provides for protection of the right to life, but does not specifically provide for the right to health or health care. The Zimbabwe "National Health Strategy 1999-2007" advocates for the provision of health rights in the Constitution.</p> <p>Zimbabwe is a signatory to the major African and UN declarations, including the ICESCR (Art 12 on the right to health) the African Charter on Human and People's Rights (1990) and the CEDAW<sup>1</sup> The development of a patient's Charter in 1996 provides information on rights and responsibilities of patients and health providers but is not actively used.</p> <p>Zimbabwe "National Health Strategy 1999-2007" makes quality and equity central principles of health policy (MoHCW 1999). The policy underpinned health sector reforms that opened up for greater private sector participation, but also aims to ensure core health services for all Zimbabweans; to promote equity through services based on health needs, to redirect resources to prevention and PHC, to empower local health service managers and communities, to establish national social health insurance, and to improve the resource allocation formula.</p> <p>The MoHCW is currently drafting a new National Health Strategy 2008-2012 and has circulated a Working Consultative Document: 'Developing a National Health Strategy 2008-2012'.</p>	<p>Zimbabwe has had a consistent policy commitment to equity in health since 1980.</p> <p>The commitment has not yet been adequately translated into constitutional provisions. This calls for advocacy to include rights to health and health care in the constitution (with obligations for reasonable measures within available resources to realize these rights) and for updating of public health law.</p> <p>An incremental plan is needed to operationalise longstanding policy commitments to equity (prevention, PHC, equitable resource allocation, social health insurance, local empowerment) through specific targets and time frames that can be monitored; that are not overshadowed by disease specific targets; and so that the impact of health sector reforms on equity commitments can be assessed.</p> <p>The drafting of a new strategy presents an opportunity for awareness and engagement on these issues.</p>

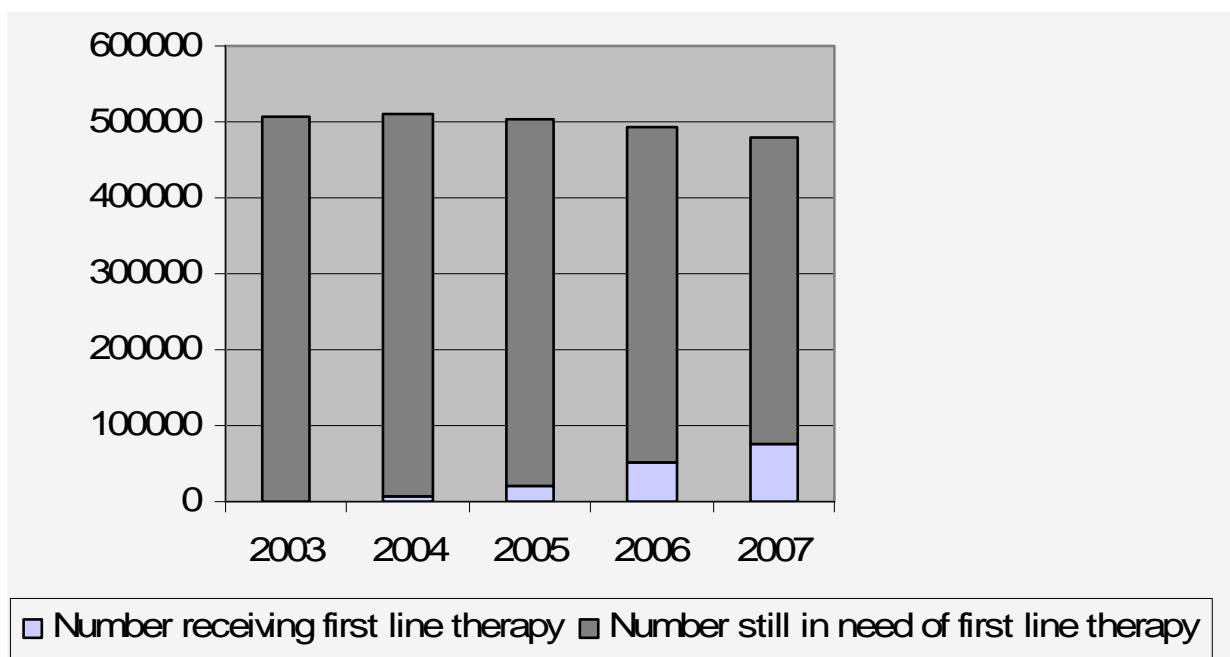
<sup>1</sup> ICESCR = International Convention on Economic, Social and Cultural rights; CEDAW = Convention for the Elimination of all forms of Discrimination Against Women



PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Achieving UN goals of universal access to PMTCT, condoms and ART by 2010</p>	<p>In 2002, government declared AIDS a national emergency. The AIDS levy and National AIDS Trust Fund were established in 1999 as a unique tax based contribution to public spending on AIDS, although implying additional individual tax burdens.</p> <p>Condom consumption in 2005 was estimated at 80mn, about 50% of target levels.</p> <p>VCT uptake expanded 2003-2005, with mobile outreach to hard-to-reach populations.</p> <p>The percent of those in need of treatment receiving ARVs was 1.5% in 2004 (MoHCW 2007), rising to 7% by end 2005 (NAC et al 2006)</p> <p>A national PMTCT programme was set up in 2002 with a target to reach at least 80% of pregnant women and improve child survival in HIV infected/affected children by at least 50% (MoHCW 2006b). In 2005, 80% of new ANC bookings were counselled, 67% of those counselled were tested, 20% of those tested were HIV+ve and 54% of positive mothers received nevirapine and 51% of HIV exposed babies received nevirapine (MoHCW 2006b).</p>	<p>Adult HIV prevalence fell from 25% in 2003 to 20% in 2005, in part due to changing sexual behaviour in young people. Estimates set adult HIV prevalence at 15.6% in 2007 (MoHCW 2008).</p> <p>Young people, sex workers, prisoners, married women, men who have sex with men, sexually abused people and orphans are highly susceptible (NAC et al 2006), Risk is increased by poverty, gender inequality, mobility and spousal separation. Food insecurity increases vulnerability.</p> <p>A national HIV AIDS Strategic Plan is set for 2006-2010 with strategic plans, targets and guidelines in key areas of prevention, treatment and care.</p> <p>There are significant resource constraints in implementing this plan, despite innovative domestic financing through the AIDS Levy and given extremely low levels of external funding (see discussion in a later section on health financing).</p> <p>A target is set of 85% of the population knowing their HIV status by 2010. VCT access is estimated at 15-16% of adults (NAC et al 2006; MoHCW 2007). In 2006, statistics improved: 92% of pregnant women were pre-test counselled for HIV, 72% of women counselled were tested, of these 18% were HIV+ve: 60% of these mothers were treated with nevirapine while 60% of exposed children were treated (MoHCW 2006). Zimbabwe follows the WHO recommended guidelines for PMTCT.</p> <p>In 2007 measures were taken to roll out Provider Initiated Testing and Counseling (PITC) to all patients visiting health institutions (MoHCW 2007)</p>	<p>Zimbabwe has amongst the highest HIV seroprevalence in the region but levels have fallen post 2002. There are still groups with higher risk, and the half a million people needing treatment is likely to increase.</p> <p>The policies, institutions and programmes are in place to respond to these prevention, treatment and care needs. The gap lies in resourcing the level of scale up needed and investing in effective additional measures to promote uptake in vulnerable or marginalised groups. For example while access to paediatric drugs for treating children has improved, both supply issues and cost and specific access barriers in this group need to be identified and addressed to improve currently low coverage rates.</p> <p>Innovative measures such as the AIDS Levy fund provide potential sources of progressive national funding for AIDS, particularly if formal employment levels improve and if equitably allocated to reach to households in need. Integrating equity into the allocation of AIDS resources is still to be done.</p>

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
		<p>Sixteen percent of those in need of treatment received first line ARVs in 2007, with an estimated 394 000 people in need untreated (MoHCW 2008b). Based on estimates of people living with HIV, levels of treatment need will continue to rise. Nine percent of children in need received ART in 2006 (MoHCW 2008).</p> <p>Drug shortages and stockouts, shortages of HIV test kits, staff attrition and low male participation are reported to threaten programmes, including for meningitis and TB, and patients cannot afford drug prices in private pharmacies (MoHCW 2007)</p> <p>The majority of workers are not aware of their legal rights on HIV (SI 202 1998). 6000 people in the private sector were on ART in 2005 against a target of 30 000 by 2010 (NAC et al 2006; GoZ et al 2007).</p>	<p>The barriers to treatment and to PMTCT identified are likely to particularly affect rural, low income populations for whom service access is weaker and cost barriers higher. This calls for specific measures to enhance and monitor uptake in these groups.</p>

Figure: Access to ART 2003-2007

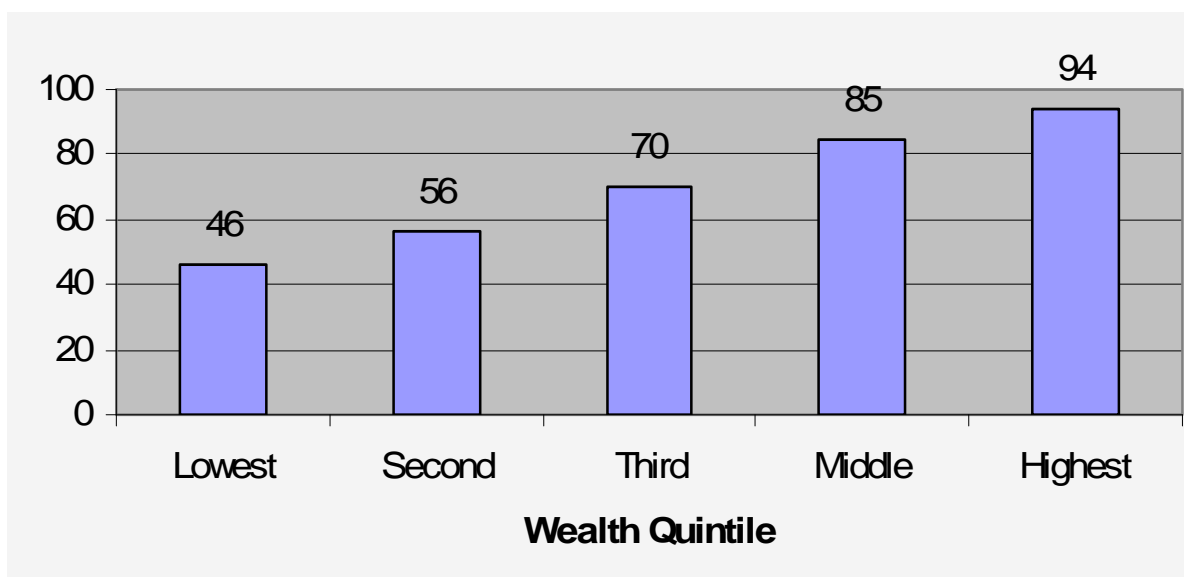


Source: MoHCW 2008



PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
Eliminating income and urban/ rural differentials in access to immunisation, access to ANC and attendance by a skilled person at birth	<p>In 1994, 80% of infants 12-23 mths received all basic vaccinations. Differentials in immunisation rates were: Rural: urban 78% : 84% Mothers educated: not 87%:72% (CSO, Macro Int 1995)</p> <p>In 1999, vaccination coverage in this age group declined to 75% with rural: urban rates at 72%: 81%. (CSO, Macro Int 2000). While some groups such as the apostolic sect raise religious barriers to immunisation uptake, the decline has mainly been due to factors relating to outreach and access to services.</p> <p>While ANC visits increased by 64% between 1990 and 1999, ANC bookings and numbers of women delivering at health facilities decreased by 30-50% in 2005 attributed to shrinking disposable incomes and increases in service fees (MoHCW 2006, 2007).</p>	<p>Infants 12-23 months immunized fell further to 53% by 2005/6, with rural: urban differentials of 50%:58% and lowest: highest income quintile of 43%:64%. (CSO, Macro Int 2007)</p> <p>Child Health Day campaigns from mid-2005 reach 2 million children biannually though a one-week national vaccination outreach. These have had marked impact: Overall immunization coverage has increased to over 80% in 2007. (Singizi 2007; see case study)</p> <p>In 2005/6, 94% of women who had a live birth in the preceding five years made at least one ANC visit. (CSO; Macro Int 2007) Attendance by a skilled person at birth fell to 69% in 2005/6, with significant differentials in rates: Rural: urban 58%:94% Lowest to highest income quintile 46%:95% (CSO; Macro Int 2007).</p> <p>Village Health Workers play an important role in improving uptake of health services but are poorly resourced (GoZ UNICEF 2007).</p>	<p>From one of the highest performances in immunization in the ESA region, by 2005 Zimbabwe's immunization rates fell to amongst the lowest, with rising rich –poor ratios and rural: urban differences to overtake those in some of the neighbouring countries. Thereafter a concerted campaign to immunize children restored coverage to above 80%by 2007.</p> <p>This indicates the potential for reversing declines if resources are organised and directed to PHC, including for fuel, vehicles, supplies and personnel in services and in the community to support outreach, such as VHWs and those in civil society.</p>

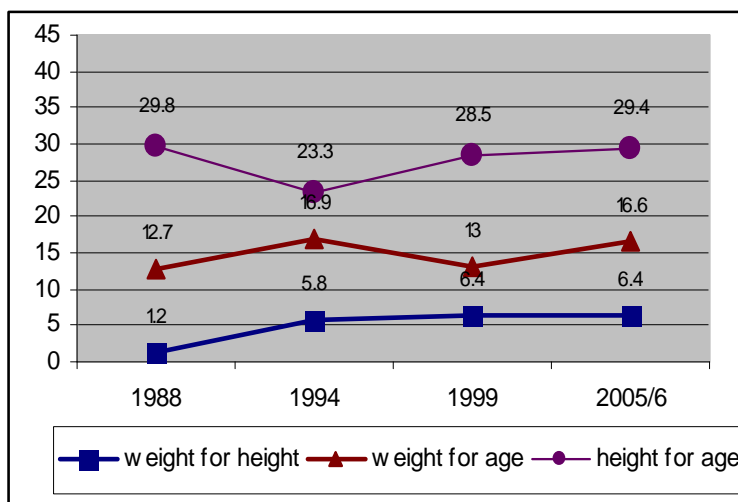
Figure: Percent deliveries in health facility by wealth quintile 2005/6



Source: CSO Macro Int (2007)

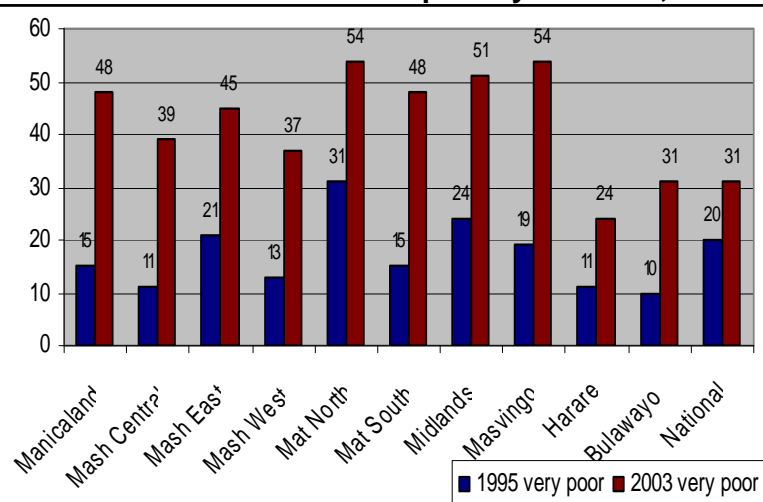
PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Eliminating income and urban/ rural differentials in maternal mortality (MMR), under 5 year mortality (CMR), and under 5 year stunting</p>	<p>MMR doubled from 283/100 000 in 1994 to 578/100 000 in 1999 (CSO; Macro Int 2000). Rural: urban or wealth quintile differentials in MMR are not available, nor in coverage or uptake of sexual and reproductive health (SRH) services. Limits in availability of skilled birth attendants at first referral level, in access to health facilities and transport, together with unwanted teenage pregnancies and abortion complications are reported to underlie a significant share of maternal mortality. Social attitudes that condone violence against women and inadequate services to address gender violence undermine SRH (Parl of Zimbabwe 2008).</p> <p>The CMR in 1999 was 102/1000. Rural rates were 1.6 times urban rates (CSO; Macro Int 2000).</p> <p>Child undernutrition (&lt;5 years; weight for age) was 13% in 1999. Child stunting increased from 21% in 1994 to 27% in 1999 (CSO; Macro Int 2000).</p>	<p>By 2005/06 the MMR had remained relatively stable at 555 per 100,000 (CSO; Macro Int 2007). Improving coverage of adolescent SRH services, post abortion care and skilled birth attendants at primary care level and ensuring security of generic reproductive health commodities are identified priorities. The Domestic Violence Act Ch14 (2006) is a step towards challenging gender violence. Government aims to reduce MMR to 70 / 100,000 by 2015 (MoHCW 2008b)</p> <p>CMR fell to 82/1000 in 2005/6 with rural rates falling to 1.1 times urban rates. Lowest to highest income quintiles were 72: 57 / 1000 (CSO; Macro Int 2007).</p> <p>Child (&lt;5 year) undernutrition increased to 17% in 2005/6, with urban:rural differentials of 11%: 18% and lowest: highest income quintile differentials of 21%:9%. Child stunting in children (&lt;5 years) increased to 29%, with rural:urban differentials of 31%: 24% and lowest: highest wealth quintile differentials of 34%:23% (CSO; Macro Int 2007).</p> <p>Poverty and national food insecurity have affected nutrition. Severe declines in child nutrition have to some extent been buffered by child supplementary feeding (CSFP). Challenges in still low rates of exclusive breastfeeding in the first 6 mths (GoZ UNICEF 2007).</p>	<p>Zimbabwe has a relatively high level of maternal mortality for its income level, with poorer performance than 9 of 6 ESA countries. It would be important to collect disaggregated information on geographical and socio-economic differentials in MMR to identify those with highest risk. Programme targeting and general improvements in access to SRH services underway can then be complemented by more focused measures to address supply and uptake barriers to use of services in highest risk groups.</p> <p>Rates and differentials in CMR are not amongst the highest in the region, and improvements were reported to 2006 in levels and in closing area and income differentials.</p> <p>More recent trends may affect this, including widening food insecurity, chronic in poor households. Under-nutrition and stunting rates are relatively high for the national income level, with some mitigation from relief and supplementary feeding programmes.</p>

### Child and maternal nutrition 1998-2006



Source: CSO Macro Int (2007)

### %Households below the food poverty line 1995, 2003



Source: GoZ UNICEF (2007)

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
Achieving the MDG goal of reducing by half the number of people living on \$1 per day by 2015	<p>Poverty increased between 1995 and 2003. The percentage of population below the Food Poverty Line (FPL) rose from 29% in 1995 to 58% in 2003; and below the Total Consumption Poverty Line (TCPL) increased from 55% to 72% (MoPSLSW 2006, GoZ, UNICEF 2007).</p> <p>The increase in the TCPL between 1995 and 2003 was 21% higher in urban than in rural households although rural households are still poorer than urban. Female-headed-households are poorer by 8% points than male-headed-households (MPSLSW 2006).</p>	<p>Between 1990-2005, 56% of people lived below \$1 US a day and 83% earned below US\$2 a day (UNDP 2008). Poverty tripled between 1995 and 2003 in some provinces (GoZ UNICEF2007).</p> <p>Poverty levels have not been measured post 2005. Zimbabwe is experiencing significant economic problems: the economy has shrunk cumulatively 40% since 1999, hyperinflation has eroded purchasing power, declining investment and aid and periodic drought are reported to have deepened poverty. Remittances from family members outside the country have become an important source of household income (Bracking and Sachikonye 2006).</p>	<p>Zimbabwe's share of people in poverty was higher than that of 8 other countries in the region in 2003, and there is evidence that poverty has increased post 1995.</p> <p>Given the significant changes post 2003, it would be important to carry out a new poverty survey disaggregated by area, income group and by other social factors to identify groups now most at risk. This is particularly important as the informal nature of many cash transfers and the decline of formal employment and markets has made it difficult to make inferences from formal data sources. This is essential data for planning of resource allocation and service outreach given the key role of public sector health services in mitigating poverty.</p>

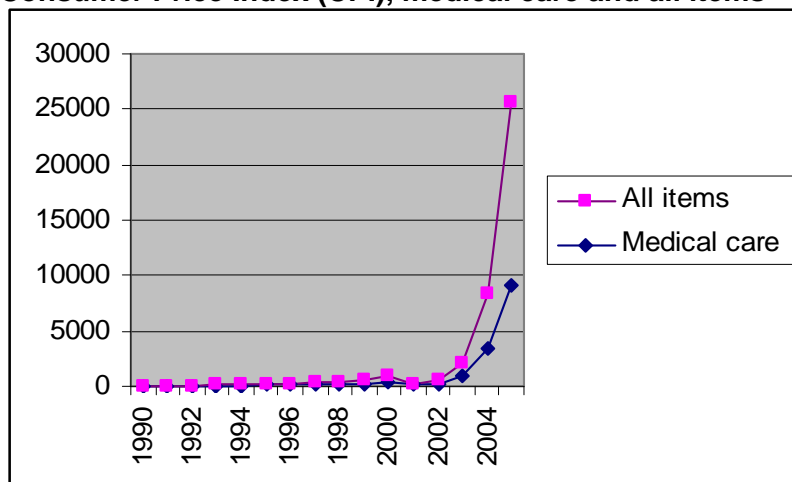
PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<b>Household access to the national resources for health</b>			
<p>Achieving universal primary and secondary education in women</p>	<p>The primary completion rate fell from 73% in 2000 to 68% in 2004 while the secondary completion rate fell from 78% to 73% in the same period. The gender ratio (girls:boys) in primary education increased from 97:100 in 2000 to 98:100 in 2004 and in secondary education from 88:100 in 2000 to 91:100 in 2004 (GoZ UNICEF 2007). Some districts have significantly wider female to male gender gaps (eg Umguza, Bubi, Bullilima and Mangwe).</p> <p>Dropout from primary school in 2003 was slightly higher in males (51:49%), while dropout of secondary school was higher in females (53% females: 47% males). Financial constraints accounted for 20% of non-enrollment in primary school and 70% of non-enrollment in secondary school in 2003. Girl children leave school to care for sick parents or other young children (MPSLSW 2006).</p> <p>Adult literacy for men and women in 2003 was 89% (MPSLSW 2006).</p>	<p>Updated information on enrolment and completion rates is not available.</p> <p>Education is the biggest beneficiary of the national budget, mainly for salaries. Households pay 85% of the cost of primary education and 80% of the cost of secondary education, so cost is a barrier for poor households. The Government BEAM programme has increased in nominal terms from Z\$300 000 in 2001 to Z\$190 billion in 2005 for nearly a million children. It does not, however, meet the level of demand (GoZ UNICEF 2007). The National Girls' Education Strategic Plan launched in 2006 mobilizes resources to keep girls, orphans and vulnerable children in school in spite of economic hardship, with over US\$2 million spent on girls' education in one year: <i>"Educating girls yields a higher rate of return than almost any other investment available in the developing world"</i> (UNICEF 2006).</p> <p>Despite salaries being the major budget line, real wages for teachers have fallen, conditions are poor and teachers have experienced political violence, leading to de-motivation or absence from work (MPSLSW 2006, Dugger 2008).</p>	<p>The 2003 PASS records Zimbabwe's net enrollment ratio (NER) as one of highest among developing countries. This with a positive gain in gender ratios are a positive contribution to health equity.</p> <p>There are however challenges: the shortfall in public sector resources, with constraints on teacher wages, service quality and household support. The cost burden on households has increased, with increased stress for the lowest income households. Marginal groups, such as orphans, who do not access safety nets are particularly disadvantaged. The present BEAM safety net is inadequate and stronger state support is needed for affordable education and include disadvantaged children.</p>

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Achieving the MDG goal of reducing by half the proportion of people without sustainable access to safe drinking water by 2015</p>	<p>Access to clean water and sanitation did not increase between 1990 and 2000. In the 1999 Labour Force Survey (LFS), 75% rural households and 99% urban households accessed safe drinking water. By 2004 this remained constant in urban areas, but had fallen to 66% in rural households (CSO 2006).</p> <p>While only 1% of urban households in the period did not access sanitation, 55% of rural households did not have safe toilets.</p> <p>While access in urban areas is high, overcrowding of services and interruption of supplies has been a problem in urban areas.</p> <p>As an indicator of environmental risk, diarrhoea rates increased from 32 /1000 people in 2004 to 47/1000 in 2005, with highest increases in Mashonaland West, Midlands, Harare and Chitungwiza (MoHCW et al 2004, 2005b)</p>	<p>In 2006, rural: urban access to clean water was 72%:98%, and rural: urban access to sanitation was 37%: 63%. (WHO 2008). This indicates that access had fallen further in both urban and rural areas. Daily urban supply has been reported by authorities to be about 30% of demand, with shortages of chemicals a limiting factor (ZINWA 2008).</p> <p>Government, parliament and civil society reports point to a worse situation, however, with a range of urban problems, including: ageing and unrepaired sewer systems in urban areas, waste put in sewers due to poor waste collection services, illegal waste dumps, overflowing septic tanks and frequent water and power cuts. While high density areas are particularly affected, these problems have spilled into all areas with long term interruption in supplies in some (USAID 2008; CWGH 2008; CHRA 2007; Parl of Zimbabwe 2008b).</p> <p>Increasing costs of water and basic hygiene items, such as soap, have also reduced consumption in poor households. There have been increased reports of epidemic outbreaks of water related diseases, including in urban areas (MoHCW et al 2006), and since August 2008 a cholera epidemic has expanded to significant levels. Poor households are least able to meet the ill health costs of these environmental diseases. One resident of a high density area (Highfield, Harare) relates the story of her 5-year-old daughter's death due to fever and diarrhea: <i>"I took her back to the clinic three times," she said, "but every time they said that she would get better soon if I give her food and lots of water - that it was just the fever and there was nothing they could do because they had no drugs. I thought about taking her to the Harare central hospital, but it costs so much money and people said things are no better there. I just hoped."</i> (McGreal 2008)</p>	<p>While rates of safe water and sanitation coverage are on paper higher in Zimbabwe than many other countries in the ESA region, in practice there has been a fall in the functioning of services.</p> <p>Closing rural – urban differentials in access to safe water and sanitation is a priority to meet MDG targets.</p> <p>The situation on the ground indicates that while infrastructures are present, they are old, poorly functioning and poor availability of safe water leads to sourcing of water from less protected, informal sources. Cost may become a limiting factor for poor households as/ when availability improves. Tariff structures need to protect access to safe water in the poorest urban households. ZINWA currently provides 20 cubic litres at lowest rate but this rate may be too high for some households. Residents and parliament call for safe water to be given higher priority (not included in load shedding, prioritized for chemical procurement); prioritized for infrastructure investment and that communication between residents and authorities be improved. In rural areas, further disaggregation of data by area is needed to inform the allocation of funds to expand infrastructure.</p>

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PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in ESA)	<p>In 1995-96 the Gini coefficient was 0.59 (MPSLSW 2006).</p> <p>By 2003, UNDP report the Gini coefficient to have fallen marginally to 0.57 (UNDP 2005). Government data report that by 2003, the coefficient had increased marginally to 0.61. Medium poverty provinces saw a reduction in inequality, particularly Mashonaland Central and Mashonaland East for unclear reasons (MPSLSW 2006)</p>	<p>By 2005, UNDP report that the Gini coefficient fell to 0.50. (UNDP 2008)</p> <p>The poorest 10% of people in 1999-2005 had 2% of national income. The richest 10% shared 40% of national income, 22 times the wealth of the poorest 10%.</p>	<p>While the Gini co-efficient has fallen since 2003, it remains one of the highest in the region. Extremely high levels of inequality in wealth call for significant investment in redistributive systems.</p>
Increasing the ratio of wages to profits	<p>Public data on this indicator could not be found. Growth in formal employment has been relatively low, with a growth in employment of 1.8% in 1980-1990, declining slightly to 1.6% in 1990-1994 (Chitiga 2004). Growth in formal employment was evident in the public sector in the early 1980s. In the 1990's, the structural adjustment reforms were associated with a planned reduction in public sector employment and a fall in real wages.</p>	<p>Public data on this indicator could not be found.</p> <p>Falling real wages in the public sector have been a push factor for out-migration and industrial action, and efforts to provide incentives have not matched the pull of competitive wages in other countries (HSB 2007). Because there has been a substantial shift towards earnings and profits within informal markets and through remittances it is difficult to track real changes in this indicator through formal data sets.</p>	<p>Assessing overall and disaggregated levels and trends in this indicator calls for household and company survey data not yet available.</p> <p>The shift towards informal markets and earnings has implications for the design and implementation of health financing and social protection schemes.</p>

**Consumer Price Index (CPI), medical care and all items**



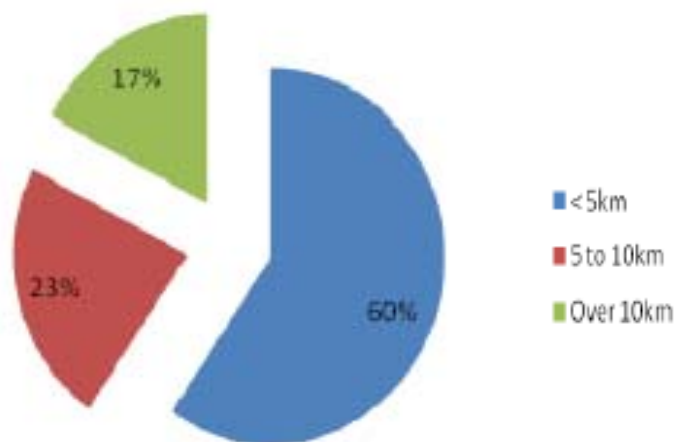
Source: CSO 2008



PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Abolishing user fees from health systems</p>	<p>In 1980 a policy of free health care for those on low incomes (&lt;Z\$150; US\$220) was introduced, and user fees were reduced as a financing source.</p> <p>The policy position on user fees has been that those who can afford to pay for services should do so. The implementation of the principle has been mixed. Managing exemption from fees has been difficult and costly, with some consequent injustices in who is exempted. In 1990, more emphasis was placed on the fee collection, although, after evidence of high dropout from services, user fees in rural primary care services were suspended in 1995. The Medical Service Act (1998) gave the Minister the authority to fix fee/ no fee levels at government and state-aided hospitals. The National Health Strategy for Zimbabwe 1997-2007 cited free treatment for the majority as a goal, but also stated that the policy of free health “creates a disincentive for people to join medical insurance schemes.” While consultation is free at rural health clinics, this is reported to have been variably implemented, with different fee levels charged for drugs and consultations by the same types of facilities in different provinces (Euro Health Group 2005).</p> <p>Poor people have thus faced a variety of de facto cost barriers: the falling real value of the threshold for free care; transport costs; private purchases of medicines due to drug stockouts; and poorly functioning exemption schemes (MoHCW 1999).</p> <p>At the same time higher income people obtained a number of tax funded public subsidies, including: tax relief for medical insurance subscriptions and free services due to difficulties with determining earnings and a ‘treat first, pay later’ practice.</p>	<p>The policy of free public sector care at rural clinics is still in force. Pregnant mothers, children under 5 and adults over 65 are also fee exempt up to district level.</p> <p>In 2008, the Access to Health Services Study found that 59% of respondents were charged for health care services, especially in urban, large scale farm and mine areas. Of these 36% reported inability to pay. The study recommends removing user fees, especially at rural health centres and clinics, because they are barriers to access and do little in terms of income generation due to the hyperinflationary environment. This view was also held by the majority of the survey respondents and by the parliamentary committee on health (Makuto, James 2007; Parliament of Zimbabwe 2007).</p> <p>The greatest inflation has been in the private for profit sector, although the medical CPI has been lower than the all items CPI (See figure on page above). Cost increases in the private sector are likely to have been a push factor in the urban shift from private to public services noted from surveys.</p> <p>Private sector fee increases require Ministerial approval. In March 2006, government invoked this authority to impose a short-lived freeze on fees in the private sector, but the hyperinflationary environment limits the effectiveness of this policy.</p>	<p>There has been some shift in the region towards abolition of user fees, with evidence that this is more successful when accompanied by increased investment in primary and district level services. Zimbabwe has both geographical and income level fee exemption policies, but application has been mixed, with informal charges and consequent cost barriers for poor households.</p> <p>There would be equity gains from blanket abolition of user fees at primary care and district level services, including in urban areas, with targeted investment in supply side issues and community awareness, to prevent informal charges; and increased funding to services in the lowest income areas and in community outreach to promote uptake in the lowest income groups.</p> <p>While MoHCW has a policy of free care at clinic level this has not been applied uniformly by local government and mission clinics. This needs follow up with relevant ministries and increased funding, including grant funding, to replace fee income.</p>

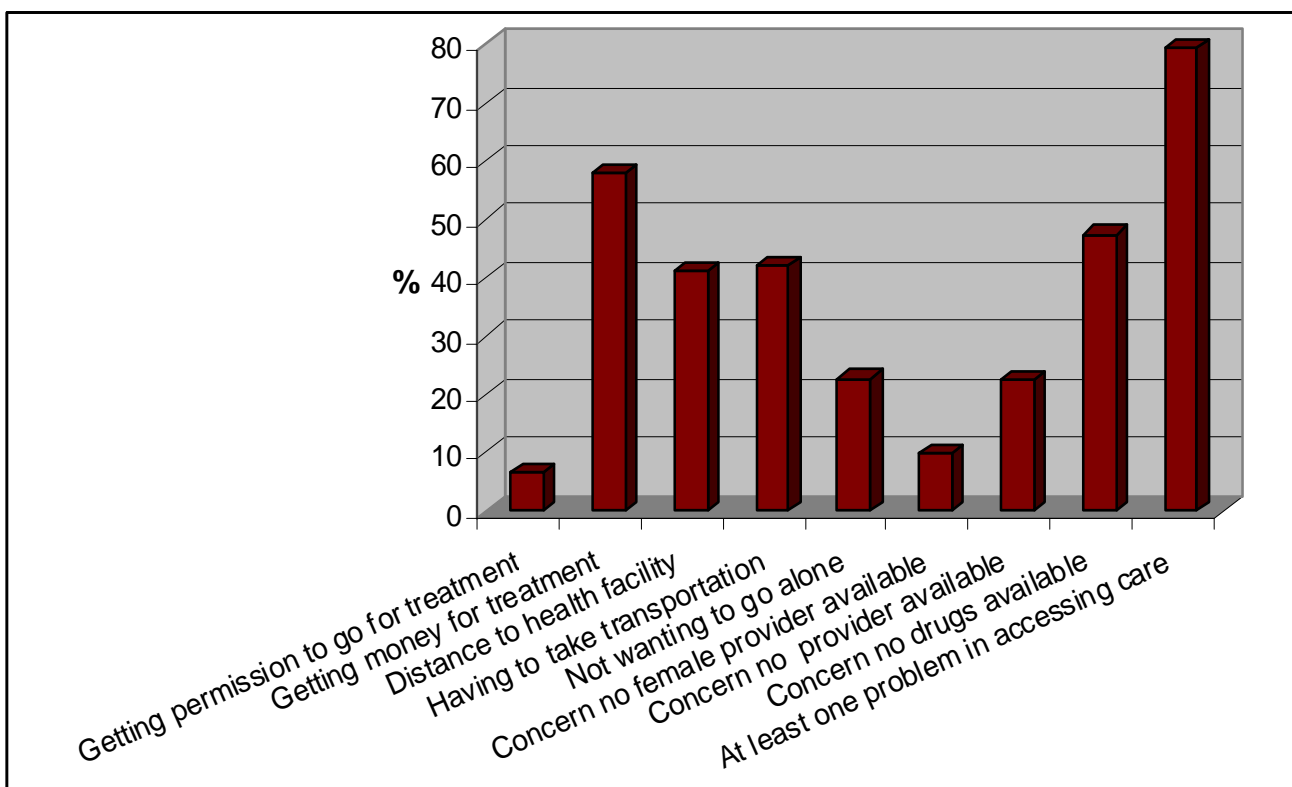
PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Overcoming the barriers that disadvantaged communities identify that they face in accessing and using health and essential services</p>	<p>The National Health Strategy 1997-2007 aims to ensure that households are no more than 8-10km from a health centre. In 2003 25% of households were &gt;10km from a facility, higher in the poorest households (30%) (MPSLSW 2006)</p> <p>Labour Force Surveys show an increase 1994-2004 in those ill in the past month visiting a facility (62% to 71%), with both urban and rural areas showing increasing use of public health facilities. Use of private sector facilities was significantly higher in urban than rural areas in 1994 (25%;3%) and 1999 (18%;3%) in 2004 but had fallen significantly by 2004 (8%;5%). For those not visiting services after illness in 2004, cost was cited as a barrier in 23% (CSO 2006)</p> <p>While poverty was cited as a general barrier to access, orphans and other vulnerable children were identified in 2004 as facing cost and social barriers in accessing health services (UNICEF 2005). By 2005/6, 24% of children were orphans (GoZ, UNICEF2007).</p>	<p>The share of households &gt;10km from a facility had fallen to 17% by 2007, although 40% were &gt;5km from a health facility (See Figure overleaf).</p> <p>Policy documents set goals of universal access to health care. A number of factors contribute to inequality in access: The shortage of drugs, ambulances, water, electricity and sanitation services at health institutions and a long and costly referral process present barriers to health service uptake in poor households. Patients prefer receiving care at facilities closer to home but these constraints mean they are referred to or use more distant referral facilities (Makuto, James 2007). This undermines PHC and raises significant costs on households for transport, drugs and charges.</p> <p>Women face a number of barriers: money for treatment; availability of drugs and transport and distance to facility. Financial barriers were cited by 75% of women in the lowest income quintile compared to 35% in the highest income quintile (CSO; Macro Int 2007; See Figure overleaf).</p> <p>Recent reported efforts to improve access to services include: conversion of farm houses into rural health centres; immunisation outreach (see Case study), introduction of incentives for staff working in districts and institutionalisation of traditional medicine. Civil society activities have promoted health service uptake in vulnerable communities.</p>	<p>Zimbabwe has a reasonable level of infrastructure to support universal access, particularly if shortfalls in public services in large scale farm areas are addressed, such as through the measures underway to establish clinics in large scale farm areas.</p> <p>The identified barriers to access in poor households imply a need to ensure that services in the lowest income areas are adequately resourced so that people are not forced to leave services close to them, or spend significant amounts on costs of transport, drugs and fee charges for higher level services.</p> <p>Further households and individuals facing cost and social barriers need to receive additional inputs to support uptake and coverage, including through co-operation with civil society organisations. The shift to public sector use is an opportunity to revive the role of the public sector in health, important for equity, if supported by adequate investment.</p> <p>Disaggregated monitoring and reporting of service coverage and monitoring is essential to plan equitable deployment of resources.</p>

**Percent households at varying distances from health facilities 2007**



Source: Makuto, James (2007).

**Percent women citing problems in accessing health care**

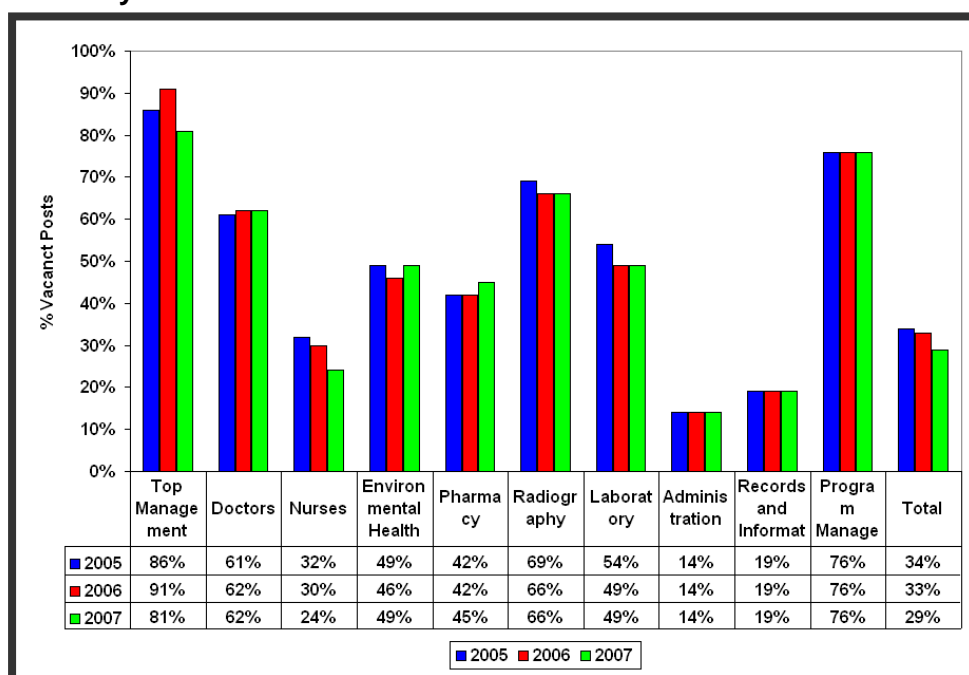


Source: CSO, Macro Int (2007)

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems</p>	<p>Adequacy and distribution of health workers has been a persistent issue. In 1980, a range of measures were applied to produce, deploy and redistribute health workers, including training of new para-professional cadres.</p> <p>In the 1990s adequacy and internal migration were the main constraints: The density of doctors was 0.15/1000 and of nurses 1.18. In 1992 46% of registered doctors practiced in the public sector, the majority of these (64%) at central hospitals with only 21% at district level. Almost all private sector doctors worked in urban areas. For nurses the respective figures were 45% at central level and 33% at district. (MoHCW 1999; Normand et al 2006).</p> <p>In the 2000s, there was a marked shift towards external migration of health workers. Staff vacancies rose sharply between 2001 and 2003 from 40% to 80% for pharmacists; 10% to 60% for doctors and 10% to 20% for nurses (UNICEF 2007b). In 2000, 20% of health professionals migrated annually out of Zimbabwe. By 2004, 68% of health workers surveyed indicated intentions to migrate (Chikanda 2005).</p> <p>Push factors were poor pay; low savings; poor living conditions; under-resourced health services; job stress and lack of confidence in their future (Awases <i>et al</i> 2004).</p> <p>By 2004, the density of doctors remained at 0.16 / 1000 but that of nurses fell to 0.72 (WHO 2007).</p> <p>MoHCW implemented an essential drug programme in 1980 and significantly</p>	<p>Policy targets are for 80% coverage of essential medical personnel and for vacancy rates to be reduced to 10% (HSB 2007). In December 2007, vacancy rates rose to 62% of posts for doctors, 24% for nurses posts and 45% for pharmacists, with 61% of total health worker posts filled (MoHCW 2008b). These figures are higher than December 2006 levels.</p> <p>External migration is high, and deployment to rural, peripheral areas continues to be a problem, although there is some report of improved deployment of doctors to rural services in 2008.</p> <p>Push factors are financial (pay, cost of living) and welfare (lack of accommodation, inadequate supervision) (HSB 2007; MoHCW 2008b). Many facilities have less qualified staff standing in for more highly skilled counterparts, e.g. Primary Care Nurses in place of State Registered Nurses (Makuto, James 2007). See figure overleaf</p> <p>Incentives have been used to address internal distribution: bonding agreements in district hospitals are for one year vs two years in central hospitals; the Primary Care Nursing Programme and scaling up of nursing training has helped to limit vacancy levels of trained nurses at rural facilities (HSB 2006). Recent training of primary care nurses in midwifery also improves assisted facilitated deliveries.</p> <p>In 2005 drug availability had fallen to 41%, with vital drugs dropping to 63% and essential drugs to 21% (GoZ UNICEF 2007). (See Table overleaf) Drug availability at central, district and clinic levels in 2006 was reported to remain constant, with lower availability at rural health centres (MoHCW et al 2006b).</p> <p>Drug availability is limited by lack of foreign currency, with limited or no buffer stocks of many drugs. A 2004 consumer survey reported access to be limited by overall availability</p>	<p>Zimbabwe had lower densities of nurses than nine of 16 ESA countries in 2004, and of doctors than seven. The position has worsened since then, and external migration (vs internal migration) has become a more dominant problem. Measures have been put in place to improve the communications and incentives in the sector, but factors beyond the health sector drive migration and limit the impact of incentives applied. There has been some recent report of improved deployment of doctors to rural facilities.</p> <p>Failing availability (drug and staff) mask to some extent the role of cost escalation as a barrier to access, but the observation that private sector drug prices in Zimbabwe are higher than other countries in the region is worrying and recent provisions allowing pharmacies to charge for medicines in foreign currency may further escalate prices unless closely monitored.</p> <p>This calls for monitoring both by public authorities and communities to markups and pricing of key health service inputs, including drugs, to prevent unfair mark-ups due to scarcities; and pressure to improve adequacy of supplies in the public sector.</p>

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
	<p>improved drug management, monitoring and evaluation. Prescription of generic drugs was adopted in the public sector (MoHCW 1999). Drug availability was reasonable, but did not fully match demand, with 72% availability of vital drugs and 56% availability of essential drugs (GoZ UNICEF 2007). The Shortfalls were more pronounced at the primary care level services most used by poorest communities.</p> <p>In 2004, drug availability fell from 82% at central hospitals to 80% at district hospitals and 60% at rural health centres (MoHCW et al 2004).</p>	<p>(89%), followed by cost (7%). Scarcity may be driving cost increases in the private sector, with drug prices in Zimbabwe higher than in neighbouring countries (Euro Health Group 2005). Rural communities report greater difficulty with affording the additional charges to pay for drugs than urban communities (Makuto, James 2007).</p> <p>Limited drug availability in public sector primary care institutions and high private sector prices present a higher cost burden for lowest income, peripheral communities, who also have highest health needs, but are an issue across a wide range of communities. <i>“Zimbabweans have been pelted left, right and center by shortages of drugs, inaccessible hospitals especially in remote areas and by a general increase in medical care expenses.”</i> (ZCTU 2007).</p>	<p>The fall off in drug availability from secondary to primary care level undermines equity, pointing to the need to address the determinants of this falloff.</p> <p>The existence of an industry for local production of key pharmaceuticals represents a strategic asset, reported to be able to satisfy an estimated 30% of essential drug needs. Investments (foreign currency and raw materials) are needed to tap this on the basis of predictable demand through public sector procurement.</p>

#### Vacancy rates for health workers 2005-2007.



Source: MoHCW 2008

#### Drug availability at NatPharm 2004, 2005 (GoZ UNICEF2007)

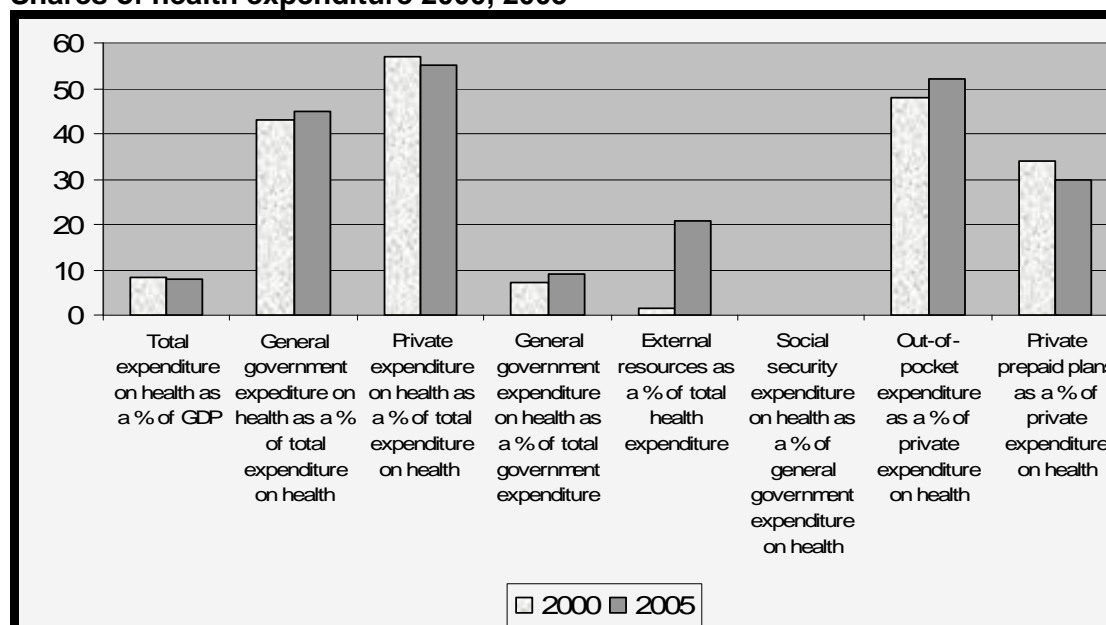
	% total in 2004	% total in 2005
All drugs	65	41
Vital drugs	73	63
Essential drugs	56	21

Source: GoZ UNICEF (2007)



PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<b>Resourcing redistributive health systems</b>			
Achieving the Abuja commitment of 15% government spending on health - excluding external funding	Government expenditure on health was at its peak of 17% in 1997, falling to 7.4% in 2000 and rising to 9.2% in 2003. (Govender et al 2008). Expenditure on health peaked in 1998 at 10.8% GDP. It fell thereafter to 6.5% - 8.1% GDP in 2005 (WHO 2008c).	The revised budget estimates for 2007 put health spending at 8.7% of the total budget. (MoFin 2008)  Budget Estimates for 2008 allocated 12.2% of the annual government budget to health. Actual expenditure will need to be assessed given the practice of supplementary budgets and direct disbursements from the central bank (Shamu and Loewenson 2006).  While the share of spending has increased, the real value of this spending has fallen due to high inflation and the overall levels of public spending are low relative to need.	Zimbabwe has not met the Abuja commitment, although there have been some efforts to reverse significant declines in the health share of the budget.  An additional per capita spending of US\$30 was needed in 2003 to meet the Abuja commitment. Given the extent to which the lowest income communities with greatest health need are reliant of public sector services, increased funding should largely be spent within the public health sector.
Achieving the WHO target of \$60 per capita spending on health systems in the public sector	Total per capita health expenditure (average US dollar) fell from \$48 in 2000 to \$21 in 2005. Per capita government expenditure on health was about half of this, falling from \$21 in 2000 to \$9 in 2005 (WHO 2008).	Per capita expenditure on health fell marginally further to US\$19 in 2006 (WHO 2008c). Figures for 2007 are not available.	Per capita spending on health is relatively high, but a large and increasing share of this is in the private sector. With high poverty levels and wide use of public services by poor households this trend has negative impact on equity.

**Shares of health expenditure 2000, 2005**



Source: WHO (2008)



PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
Increasing progressive tax funding to health to a significantly larger share than a reducing share of out-of-pocket financing in health	<p>In 1994 public expenditure was 51% total health expenditure, and private expenditure 49% of total spending (Normand et al 2006).</p> <p>By 2000 these shares had reversed, with public expenditure 42% total health expenditure, and private expenditure 58% of total spending. The out of pocket share (ie on user charges, direct purchases) was at 48% and external funding at 1.6% (WHO 2008; Shamu and Loewenson 2006).</p> <p>The AIDS Levy added a new source of tax revenue in 2001, with increased revenue in real terms from \$59mn in 2001 to \$75mn in 2005 (GoZ, UNICEF 2007).</p> <p>This does not meet the gap left by relatively low levels of international funding post 2000. Although this share rose to 14% by 2003, it still remained relatively low. Average annual donor-spending-per-HIV-infected-person in Zimbabwe is US\$4, compared to US\$74 in Southern Africa. (see below; GoZ, UNICEF 2007).</p>	<p>By 2005, public expenditure was marginally higher at 45% total health expenditure, and private expenditure 55% of total spending.</p> <p>Although the share of external funding has risen (21%), so too had the share of out of pocket spending 52% (WHO 2008a) Later data is not publicly available.</p> <p>General tax revenue funds budget allocations, generated from tax on income and profits (50%), VAT (32%), custom duties (12%), excise duties (3%) and other taxes (2%). Income tax is progressively structured and low-income groups are exempted from paying tax. There is an element of pooling via the AIDS Levy – a levy on income tax (McIntyre et al 2008). Individual taxes have fallen, as have customs duties, while VAT and company tax shares have risen.</p> <p>Social health insurance is a policy goal that could reduce the rising rate of out of pocket spending, but is as yet unimplemented. Voluntary insurance covers mainly higher income groups, and the majority of women (91%) do not have health insurance (CSO; Macro Int 2007). Upfront cash charges and high inflation rates undermine the value of medical aid reimbursements.</p> <p>Other tax revenue proposals for health have been raised, such as that by the Parliamentary Portfolio Committee on health in 2007 to introduce a “sin tax” on luxury items that negatively affect health such as liquor or tobacco. They have however not been implemented.</p>	<p>High shares of out of pocket spending are associated with inequity in health financing, and pose fee barriers that together with informal charges undermine the redistributive nature of health systems. Zimbabwe’s shares are relatively high in the region.</p> <p>This points to the need to strengthen conditions for improving progressive tax financing to improve services, reducing reliance on less progressive taxes like VAT. This calls for improved economic conditions.</p> <p>It would also be important thereafter to revive the social health insurance debate as soon as the economic environment permits.</p> <p>The diminished pool of voluntary insurance and private sector use provides a limited opportunity for this (and it is possible that the private sector will expand rapidly under improved economic circumstances).</p> <p>There is a need for annual review of and report on the relative shares of different funding sources to underpin strategic public health leadership in and social support for fair financing.</p>

#### Out of pocket payments as a percentage of total health care funding, 2004

Country	Out of pocket funding as a percent of health care funding
Malawi	8.9
Namibia	5.6
South Africa	10.3
Tanzania	46.9
Uganda	34.5
Zambia	32.3
Zimbabwe	26.2

Source: WHO, 2007 in Govender et al 2008.

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Establishing a plan and strategy for harmonising the various health financing schemes into one framework for universal coverage</p>	<p>Planning for Equity in Health (1980) sought to provide universal health coverage and strengthen the public sector to harmonise different providers within one policy framework aimed at redistributing health resources towards health needs. Not-for-profit mission services were for example co-ordinated with government services through public grants.</p> <p>In the 1990s, falling public sector revenues limited the leverage of the state to achieve this. Health strategy in the 1990s gave greater emphasis to partnership between public and private sectors to widen the base for health care provision and financing (MoHCW 1999).</p> <p>A 1991 study commissioned by government concluded that a case existed for establishment of a National Health Insurance Scheme (NHIS). The 1997-2007 National Health Strategy confirmed the policy intention to introduce National Social Health Insurance as a means of complementing tax revenue to cover all citizens with basic health services and to improve equity in financing and provision of care (MoHCW 1999).</p>	<p>While public and not for profit mission services continue to co-ordinate provision, the financing of health services remains largely segmented between different providers with private funding shares higher than public and limited cross subsidies across funding pools. In 2007 government announced modalities for the proposed NHIS including a minimum benefits package defined by Ministry of Health financed from a 5% levy on gross formal sector salaries and administered by the National Social Security Authority (NSSA). Members were encouraged to supplement their benefits through private medical aid societies, while unemployed and informal sector earners would be funded through the public sector from tax revenue.</p> <p>The scheme was reviewed through public and parliamentary consultation. Concerns were raised over the adequacy and transparency of the management of funds, the scope of the benefits package (which excluded ART), the tax burden on formal employees in an unfavourable economic climate and the adequacy of measures to promote service quality for poor households (Parliamentary committee on Health 2007b).</p> <p>The introduction of the scheme was postponed although relevant regulations have been drafted.</p>	<p>While there is a stated policy intention to provide universal health coverage through a harmonized health system, the financing of health services remains largely segmented between different providers with limited cross subsidies across funding pools. Potentials for strengthening the harmonized framework for health financing exist in the formal agreements between the public and large not-for-profit mission sector and the dialogue on social health insurance. While cost barriers have reduced use of private services, this may rapidly change and the demands for cross subsidy of low income groups made on private voluntary insurers are modest.</p> <p>There is scope for a more active review of the policy and financing measures needed to strengthen the framework for universal coverage.</p>

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Establishing a clear set of comprehensive health care entitlements for the population</p>	<p>The 1997-2007 National Health Strategy 1997-2007 states a policy intention to set health care entitlements: <i>“To underpin future financing strategies the country will need to guarantee its citizens access to a strategic package of Core Health Services”</i> (MoHCW 1999) There is no public document in the period that elaborates what these entitlements are.</p>	<p>While the NHIS made provision for a limited benefits package, no clear set of comprehensive health care entitlements has as yet been published or operationalised. MoHCW has conducted studies to identify and cost core health services at the various levels of care to assess the viability of financially guaranteeing these services (MoHCW 2008b).</p> <p>Core health services are currently identified as those interventions for conditions treatable at the primary care level; environmental health and disease control measures; TB treatment and follow-up; ANC and uncomplicated deliveries; and health education within communities. (Chihanga 2008).</p>	<p>There is a need for technical and policy dialogue (including with parliament and civil society to establish, cost and raise awareness on a clear set of comprehensive health care entitlements for the population at the various levels of the health services.</p> <p style="text-align: right;">-</p>
<p>Allocating at least 50% of government spending on health to district health systems (including level 1 hospitals) and 25% of government spending on PHC</p>	<p>The weakness of resource allocation on historical or demand basis and by province and institution was recognized in policy from the 1980s on. Reallocation of resources from central to district level and towards higher need rural services was implemented in the early 1980s. There was some shift in shares back to central level facilities in the later part of the decade (Loewenson and Chisvo 1994).</p> <p>Policy intentions were stated in the 1990s to allocate resources on the basis of health need and for district allocations to be weighted by total district workload and split between the district hospital and peripheral facilities (MoHCW 1999). No specific cost centre was set up for health centre level, which was covered under the district vote. This made it difficult to monitor trends in expenditures at that level.</p> <p>Review of data in 1994</p>	<p>Initiatives were taken in 2000-2001 to introduce needs based indicators into the resource allocation formula. However with significant levels of real underfunding, demand and historical allocations reverted to being the primary mode of allocation.</p> <p>Currently, resource allocation is based on ‘budget bids’ submitted by Medical Superintendents of central hospitals and Provincial Medical Directorates in dialogue with facilities in their province to MoHCW headquarters for final consolidation and submission to Treasury. Budget allocations are not broken down by primary, district and provincial levels making it difficult monitor spending by different levels, although the 2005/06 District Health Survey notes the inadequacy of budget allocations to districts (MoHCW 2008b)</p> <p>Health Centres are still not cost centres with no accessible disaggregated data for monitoring spending to or at this level (Euro Health Group 2005).</p> <p>The AIDS Levy Fund is allocated on the basis of equal shares to all</p>	<p>Positive trends exist in the improvement in district shares of the AIDS Levy Fund, the establishment of the Equalization fund, and the work done in the past on the resource allocation formula and the Health Services Fund.</p> <p>However improved allocation to district and primary care levels is weakened by the primary care level not being a cost centre and shortfalls in staffing limit capacity to demand and use resources at lower levels, particularly given the use of demand based allocation. The negative impact is signaled by indicators such as the reduced availability of vital and essential drugs at lower level services. Budget and costing modules and capacities are needed for primary care level.</p> <p style="text-align: right;">-</p>

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
	<p>shows that central hospitals received 34% of total funds, while district hospitals and clinics received 30% and 11% was allocated to prevention (Normand et al 2006) (See Table below)</p> <p>In 1997, the Ministry of Finance authorized fee retention at health facilities for local use. However, user fees accounted for minimal share of revenue (Makuto, James 2007).</p> <p>The Health Services Fund set up in 1996 provided resources for district and community level activities in health, drawing resources from retained fees and external funders. A share (40%) was earmarked for community and disease control activities, although expenditures did not rigorously follow these guidelines.</p>	<p>districts. Funds allocated from the AIDS Levy Fund to Provincial and District AIDS Action Committees increased from 46% in 2002 to 75% in 2005 (GoZ UNICEF 2007). There still remain constraints in capacity to absorb and uptake at district levels (Mpofu et al 2008).</p> <p>While donor contributions to the Health Service Fund have diminished, the Ministry of Finance continues to make allocations in the form of an "equalisation grant" for districts with low income generation. However, hyperinflation has rendered the fund insignificant. (MoHCW 2008b)</p> <p>In the absence of specific allocation targets there has also been a tendency for shares allocated to prevention to fall, with resources to medical care services increasing. Even though some medical services also have prevention functions, this signals reduction in resources for population health activities at primary care / community level (See Table below).</p>	<p>An incremental plan to allocate resources on the basis of needs would strengthen equity, particularly if aligned to other funding pools (the health basket fund; AIDS Levy Fund etc) and coupled with investments in the monitoring, staffing and capacity support needed to absorb funds. A needs based resource allocation formula could also be developed for the AIDS Levy Fund.</p> <p>Equity goals should be raised with civil society and parliament, who have a role in monitoring equity in the allocation of resources to districts and PHC levels.</p>

#### Public spending by level of care 1994/ 5

Level of care	Approximate share 1994/5 (%)
Parirenyatwa hospitals	9.4
Central hospitals	24.2
Provincial hospitals	11.2
District/ General hospitals	20.0
Rural hospitals and clinics	9.5
Councils and voluntary organisations	7.2
Preventive services	11.2
Other	7.3
Total	100.0

Source: Normand et al (2006)

#### Budget allocations by allocation head 2002-2008

Allocation Head	2002	2003	2005	2006	2008
Administration	4.8%	6.7%	6.8%	8.3%	9.09%
Medical Care	78.0%	81.3%	80.5%	81.7%	80.56%
Preventive Services	16.0%	10.9%	11.3%	6.7%	9.57%
Research	1.2%	1.1%	1.4%	3.3%	0.78%

Source; Ministry of Finance 2002-2008

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Implementing a mix of non-financial incentives agreed with health workers organisations, including access to ART</p>	<p>In the 1980s investments were made to train, deploy and reorient health workers around health policy priorities. The 1997-2007 National Health Strategy noted that the non-monetary rewards that contributed to high staff morale in early periods of post-independence such as housing, transportation, education and recreational activities had declined in the 1990s, along with the purchasing power of staff salaries. This undermined efforts to retain personnel in peripheral services. In the late 1990s and early 2000s a series of industrial actions signalled rising discontent over pay and conditions of service in the public sector.</p> <p>A Health Services Board was established in 2005 (Health Services Act No. 28/2004) to address this situation, including the brain drain, discussed earlier (HSB 2005)</p> <p>A range of measures were introduced post 2005: a Public Service Skills Retention Fund, a scheme for training Primary Care Nurses, bonding after basic training for nurses; provision of ART prophylaxis after occupational exposure and access to ART treatment (MoHCW 2007a).</p> <p>Salaries and conditions are negotiated in a bipartite negotiating panel consisting of six employer and six employee representatives, chaired by an independent expert in labour matters (HSB 2006). While this formalised labour relations in the sector, it did not cover all health workers. For example junior doctors were not included in 2006, and neither were clinical staff in training institutions.</p>	<p>The public sector offers as incentives salary reviews, call allowance, dual practice, part-time work in non-health sector, assistance with school fees and housing allowance. Other retention measures include measures to improve opportunities for housing, bonding, training opportunities, housing and work environment improvements (EQUINET SC 2007). While significant effort has been made to improve incentives, they have been eroded by inflation and wider insecurity, while variable application of allowances and current bonding arrangements are reported to be a source of frustration (Chimbari et al 2008).</p> <p>In 2007, strikes for better wages in the health sector of up to 10 weeks took place in January, February, June, September and December 2007. The Bipartite Negotiating Panel met thirteen times in 2007 to negotiate on salaries and conditions of service. Junior doctors were brought into this framework in 2007 (HSB 2007). The HSB is constrained by not having the authority or funds to implement many of its recommendations (HSB 2007), while its role and work is poorly understood by the public and even by some health workers (CWGH 2008; Chimbari et al 2008).</p>	<p>While the health care worker situation is poor (see earlier), a range of steps have been taken to better manage and respond to issues, institutionally through the Health Services Board and more inclusive negotiating mechanisms and through the incentives offered.</p> <p>Blocks to the effectiveness of the ZHSB still need to be addressed, including resources and authority.</p> <p>Non-financial incentives that are less directly eroded by inflation could be given greater attention, including in partnership with non government organisations and communities. This includes support for career paths and increased opportunities for housing. With external migration across all categories of staff sector wide retention incentives and strategies are needed, including for those in training institutions (see later discussion on negotiations with external partners).</p>

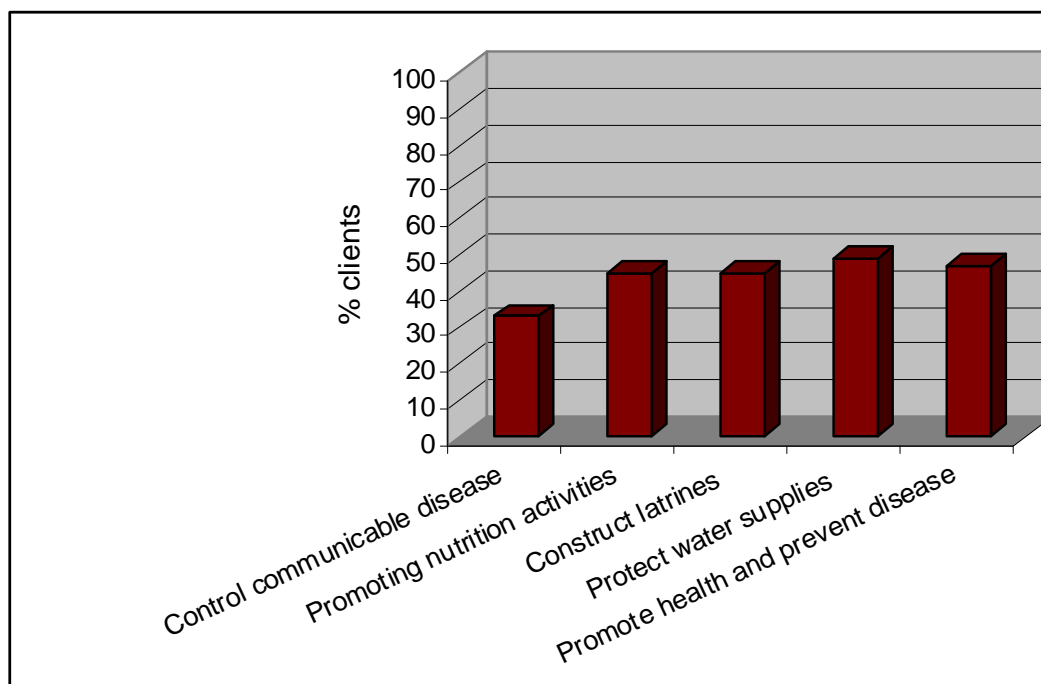


PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Formally recognising in law and earmarking budgets for training, communication and functions of mechanisms for direct public participation in all levels of the health system</p>	<p>Participation of communities has been a central element of health policy since 1980. Participation was organised through village and ward health teams, supported by community health workers and with social mobilisation around a range of PHC oriented services.</p> <p>In the 1990s these mechanisms became less active, as PHC services also declined. Evidence suggests strong mutual links between mechanisms for participation and the strength of PHC services (Loewenson et al 2004). Community health workers such as Village Health Workers, Community based distributors played an important role in this link.</p> <p>The National Health Strategy 1997-2007 sought to strengthen participation to improve efficiency and accountability of resource use in the health sector through self-managing entities. The Health Services Act (24/2004) established hospital management boards. While operations were decentralised, financial authority remained at ministry headquarters.</p> <p><i>“Decentralisation of health services, as other programmes, has remained largely a matter of intention within a centralised management system”</i> (MoHCW 1999).</p> <p>Within communities the growth in civil society brought new forms of community involvement in health, including demand for involvement in policy decisions. For example, the Community Working Group on Health (CWGH), formed in 1998, involves 35 membership based organisations that support participation in the health sector. Civil society</p>	<p>Community participation in different health activities was found in half or fewer communities in a 2007 survey (Makuto and James 2007, See Figure overleaf).</p> <p>Village Development Committees (VIDCOs) and Ward Development Committees (WADCO) in many districts are reported to not meet regularly or to have been disbanded. Although Health Centre Committees do meet at district and health centre level they do not always have skills or resources for their roles (MoHCW 2008b).</p> <p>The VHW programme which declined in the 1990s was reintroduced in 2001 and a 2008 priority of the MoHCW was to increase the coverage of VHWs by 10%, due to their role in driving <i>“one of the most important preventive measures, health education that is directly related to increasing health literacy”</i> (MoHCW 2008b). 14% of the 2008 preventive services budget was allocated to the VHW programme (GoZ UNICEF 2007).</p> <p><i>“The major outcry from communities and health workers is for policy making and the mechanisms for its implementation to be accountable to them. This demand goes beyond the usual perception of community participation as a simple act of assembling stakeholders in a workshop in order to gather their views. Building participation in the development of health services, is, by its very nature, a social and political process, which will ultimately demands the achievement of visible results.”</i> (MoHCW 2008b:120).</p> <p>The involvement of communities in decision making is still to be achieved, given that</p>	<p>The range of positive features provides a good basis for strengthening this vital contributor to equity, ie the level of adult literacy, active civil society and parliament, legal and institutional provisions for joint planning, revival of VHWs and policy recognition of the role of participation in health:</p> <p><i>“Policy accountability, at the national level, most likely depends on the extent to which structures such as the Public Health Advisory Board, the Health Services Board and the Parliamentary Portfolio Committee on Health, are able to facilitate wider public participation and consultation”.</i> (MoHCW 2008b:120).</p> <p>Consolidating this calls for greater recognition of, and investment in the capacities, mechanisms and processes for community and public participation.</p> <p>This includes adequately supporting cadres such as village health workers, farm health workers; community based distributors; chloroquin holders; traditional health personnel and school health personnel.</p> <p>The involvement of communities would also be strengthened by investing in mechanisms such as Health Centre Committees,</p>



PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
	<p>organisations have supported outreach to vulnerable groups and helped to re-establish, support and capacitate mechanisms for joint participation in planning and communication in health. The Public Health Advisory Board and a range of committees and boards at different levels of services provide mechanisms for public input to health issues, although often with limited participation of the most vulnerable groups and often on an advisory basis rather than in co-decision making.</p> <p>There has also been an increase in parliamentary involvement in health. Reforms in 1999 led to the establishment of Portfolio Committees, including the committee on Health and Child Welfare which has held public hearings, engaged stakeholders and provided forums for community input to budgets and laws.</p>	<p>there is still no comprehensive legal framework for involvement of communities in decision making on design and management of health programmes and services.</p> <p>Health has continued to receive support from both the parliamentarians and its portfolio committees. One signal is in its positioning as one of the top five ministries in allocation of Government funding. (MoHCW 2008b). The Parliament Portfolio Committee on Health and Child Welfare has held a number of public consultations with stakeholders, including on the proposed National Health Insurance Scheme.</p>	<p>underpinning their functioning with laws and earmarked resources to support increased capacities and powers for local decision making.</p>

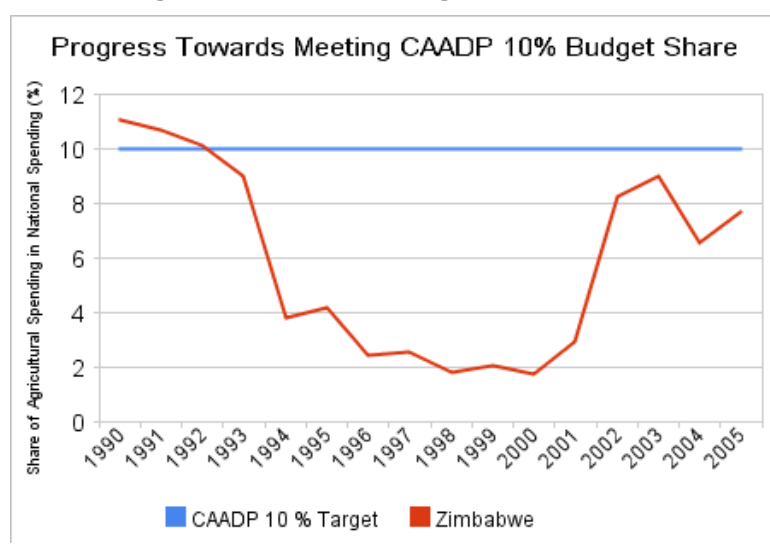
### Reported level of community activities 2007



Source: Makuto, James (2007)

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS	
<b>A more just return for countries from the global economy</b>				
Debt cancellation negotiated	<p>Total external debt in 1998 was 78% of GDP. By 2000 this had fallen to 68% GDP, with about a quarter of the revenue from the export of goods and services used to service debt (IMF 2001).</p> <p>Zimbabwe was not a part of the 14 African nations that received debt cancellation in 2005, nor was listed among countries eligible for debt relief in the near future.</p>	<p>By 2006, Zimbabwe's external debt had risen to 72% GDP, with 94% of this owed to multilateral and bilateral creditors (SADC Bankers 2007). Public debt was 128% of GDP in 2007 (SADC 2008).</p> <p>The economic incentives provided to stimulate domestic manufacturing, particularly for key products like pharmaceuticals and health supplies, will be as important as measures to address aggregate debt.</p>	<p>Zimbabwe has not negotiated debt cancellation and despite high poverty levels would not be eligible for debt relief under the HIPC scheme due to its classification as middle income.</p>	-
Allocating at least 10% of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers	<p>Agriculture was allocated 11% of the national budget in 1990 (AU, NEPAD 2007). It fell thereafter to low levels up to 2000.</p> <p>The land reform programme in 2000 onwards had stated policy aims of redistributing large scale land to smallholder farmers. Data on the number of small holder beneficiaries by gender is not publicly available. Government spending on agriculture is not disaggregated by producer level and there is no gender analysis of agricultural spending.</p>	<p>There was a sharp increase in agriculture as a share of the budget in 2001. In 2007, the share allocated to agriculture fell to 8% of the budget (AU, NEPAD 2007). The real value of this allocation is eroded by hyper-inflation.</p>	<p>While the allocations to agriculture dipped significantly in the 1990s, the levels recovered in the 2000's, with current shares higher than the AU average of 6.6%. Only one country in the ESA region, Malawi, allocated more than 10% in 2005 (AU, NEPAD 2007). The distribution of this budget and the extent to which it reaches poor households and particularly women farmers would need to be further assessed.</p>	+

**Share of agriculture in the budget 1990-2005**



Source : AU NEPAD (2007)

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws</p>	<p>Zimbabwe has made no commitment to GATS and has ensured that its laws include all TRIPS flexibilities. The country applies an essential drugs list and promotes generic prescribing across public and private sectors.</p> <p>In 2002, the Minister of Justice, Legal and Parliamentary Affairs issued a "Declaration of Period of Emergency (HIV/AIDS)" for six months to allow the government or any person authorized by the Minister to manufacture patented medicines or import generic ones to treat people with HIV and AIDS. This was extended to December 2008 through Statutory Instrument 32 in 2003. In 2003 Varichem Pharmaceuticals (Pvt) Ltd was granted authority to produce HIV related drugs and supply 75% of its product to public health institutions at fixed prices. By October 2003, it had marketed seven generic ARV medicines (Khor 2007)</p>	<p>Zimbabwe has made no commitment to GATS and has ensured that its laws include all TRIPS flexibilities.</p> <p>The commercialisation of public services and growth of the private for profit sector makes Zimbabwe open to liberalization of its health service sector. A limiting factor is the poor purchasing power of consumers due to the current economic environment, and the falling consumption of private for profit services (referred to earlier).</p> <p>The Zimbabwe National HIV and AIDS Strategic Plan 2006-2010 acknowledges the need for affordable AIDS treatment and raises attention to review of trade barriers and tariffs and the further strengthening of local production of pharmaceuticals with the aim of "facilitating local companies to pre-qualify according to WHO and other standards" (MoHCW et al 2006)</p>	<p>Zimbabwe has preserved its flexibilities in relation to WTO agreements. However relatively wide commercialization of services through medical aid purchases of providers, pharmaceutical companies make it vulnerable to wider liberalization.</p> <p style="text-align: right;"><b>+</b></p>
<p>Inclusion of health officials in trade negotiations and explicit inclusion of clauses and measures for protection of health in all relevant trade agreements</p>	<p>Civil society has campaigned in the past decade for greater recognition of health in trade and investment policies. <i>"We also need to take wider civic action to ensure that public health is given priority over trade, and that people's welfare is not damaged by the rush for profits"</i>. (CWGH 2004p3)</p>	<p>Health sector officials are not directly involved in trade negotiations, which are led by the trade ministry. Health officials are, at most, consulted by the Ministry of Industry and Trade.</p> <p>Trade negotiations have increasing impact on health: For example a proposed Economic Partnership Agreement (EPA) with the EU is being finalized by the end of 2008 including negotiations on services.</p> <p>While the parliamentary committee on health and civil society have raised trade and health issues, this area is still relatively poorly defined in health advocacy (Mabika 2008).</p>	<p>There is scope for greater audit and protection of health in trade agreements. The public health obligations and roles within trade measures are not well defined in public health law. This is not only the case for Zimbabwe, but across the region as a whole.</p>

PROGRESS MARKER	PAST LEVELS (1980-2006)	CURRENT LEVEL (most recent data)	PROGRESS
<p>Bilateral /multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration</p>	<p>Zimbabwe is signatory to the 2003 Commonwealth code of practice on the international recruitment of health workers, and to agreements with South Africa preventing recruitment of health personnel and blocking applications for permanent residence after completion of training in South Africa. Zimbabwe has been part of the African Ministers caucus motivating the discussion of health worker migration at the World Health Assembly.</p>	<p>While agreements in the late 1990s focused on 'ethical recruitment' practices, in the 2000s attention has been given to more direct forms of funding of health workers.</p> <p>UNICEF and WHO provide foreign currency contributions to retention incentives for government personnel, and the Global Fund for AIDS, TB and Malaria provides top-up incentives in 26 districts for district medical officers, district laboratory scientists and pharmacist/ pharmacist technicians. UNFPA and the EU also provide support for salaries or top up incentives for selected provincial and district personnel. (Midzi 2008).</p> <p>A number of bilateral agreements for funding health worker training are in place, including: WHO, IAEA and EU scholarships (MoHCW 2008b).</p>	<p>Zimbabwe has been actively involved in the policy dialogue on health worker migration. The negotiation of agreements around retention incentives could be widened to address other dimensions of the incentive regime developed by the Health Services Board. A proposal to pool resources by external partners to provide equitable top ups to all key staff in the sector in 2009 would avoid internal tensions caused by selective incentives to particular categories of personnel.</p>

## From decline to progress in two years: Immunising children in the Child Health Days

After significant achievements in immunisation coverage in the 1980's, Zimbabwe experienced equally significant declines in rates of child immunisation in the 1990's. Realising the need for further community mobilization to increase child immunization, the Ministry of Health and Child Welfare, in partnership with UNICEF, Helen Keller International and WHO, initiated Child Health Days in June 2005. These week-long campaigns deliver polio vaccines, vitamin A supplementation and basic immunisations to approximately two million children across the country bi-annually, in June and November.

Hundreds of health workers and volunteers have been trained to conduct community outreach education on immunisations which protect against tuberculosis, measles, diphtheria, tetanus, whooping cough, hepatitis B and polio. Village health workers and community mobilisers move throughout schools, township centres and churches ensuring that communities are aware and supportive of the campaign so that *"no child falls within the crack"* and *"all parents know why and where to take their children to be immunised,"* says Dr. Colleta Kibassa, UNICEF Zimbabwe.

Mobilisers like Hedwig Makumbe work to get the message to even the most remote areas: *"Often I have to travel for 10 to 15 kilometres in a day conducting door-to-door mobilization. Sometimes I am lucky with the help of the traditional leadership and I meet the people at central points."*

According to UNICEF spokesperson, James Elder, *"Child Health Days are a critical boost to health services that are under great stress. They have dramatically increased coverage of immunisation for Zimbabwe's children."* The initiative has played a role in increasing immunisation in children under five to over 80% after the figure had plummeted to below 60% in 2001. Vitamin A supplementation has increased from less than 10% in 2005 to over 80% in 2007. The country has also seen an 84% drop in suspected measles cases since 2004.

While this case study blends top down planning with bottom up support, it does demonstrate that even in contexts of economic and social difficulty, social organisation and action combined with resources directed to primary health care level can make a difference in vital areas of community and child health at a universal level and including low income households.

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**Equity in health** implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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