Promoting health equity in Zimbabwe

A report of the in the discussion on the Zimbabwe equity analysis and the Zimbabwe launch of the Regional analysis of equity in health in east and southern Africa

Training and Research Support centre (TARSC)
with Regional Network for Equity in Health in East and Southern Africa (EQUINET)
and Community Working Group on Health (CWGH)

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1. Background

The Regional Network for Equity in Health in east and southern Africa (EQUINET) is a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health. EQUINET is a consortium network, bringing together academic, government, non state research centres, civil society and parliament institutions from east and southern Africa (see http://www.equinetafrica.org/steering.php) on the basis of common values and a shared programme of work, in co-operation / interaction with regional policy institutions.

To systematise and consolidate its diverse body of work, the EQUINET steering committee produced in 2007 an important consolidation of its work across the network - the book "Reclaiming the Resources for Health" (EQUINET SC 2007). The book drew on about 600 published documents, case studies, policy positions and databases to map and outline the major dimensions of and trends in documented inequality in health and health care in the region to identify the policy and economic context for these trends, and the elements of a health equity oriented responses to these trends.

Giving policy profile to health equity demands the monitoring and measurement of progress on key dimensions of health equity and of action on it. To this end an equity watch is being implemented at district, country and regional level in the ESA region. Implementing an equity watch responds to key dimensions of policy declarations and commitments made at Africa and regional level and builds evidence and capacities to engage on the implementation of those commitments. EQUINET has selected parameters for their availability in existing data sources, because they relate to global, continental and regional commitments, to national policies and processes and to community level perspective and experience. They monitor *key processes, investments and policy decisions* that contribute to health equity outcomes.

Markers of progress in advancing equity in health

1. 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;
2. Achieving UN goals of universal access to PMTCT, condoms and ART by 2010;
3. Eliminating income and urban/ rural differentials in access to immunisation, attendance by a skilled person at birth and access to ANC *within* ESA countries;
4. Eliminating income and urban/ rural differentials in maternal mortality, child mortality, and under 5 year stunting *within* ESA countries;
5. Eliminating differentials in maternal mortality, child mortality, and under 5 year nutrition (weight for age) *between* countries in the region; and
6. Achieving the MDG goal of reducing by half the number of people living on $1 per day by 2015

Markers of progress in household access to the national resources for health

7. Achieving universal primary and secondary education in women;
8. Achieving the MDG goal of reducing by half the proportion of people without sustainable access to safe drinking water by 2015
9. Reducing the Gini coefficient in all ESA countries to at least 0.4 (the lowest current in ESA)
10. Increasing the ratio of wages to profits;
11. Abolishing user fees from health systems;
12. Overcoming the barriers that disadvantaged communities identify that they face in accessing and using health and essential services; and
13. Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems;

Markers of progress in resourcing redistributive health systems

14. Achieving the Abuja commitment of 15% government spending on health - excluding external funding;
15. Achieving the WHO target of $60 per capita spending on health systems;
16. Increasing progressive tax funding to health to a significantly larger share than a reducing share of out-of-pocket financing in health;
17. Establishing a plan and strategy for harmonising the various health financing schemes into one framework for universal coverage;
18. Establishing a clear set of comprehensive health care entitlements for the population;
19. Allocating at least 50% of government spending on health to district health systems (including level 1 hospitals) and 25% of government spending on PHC;
20. Implementing a mix of non-financial incentives agreed with health workers organisations, including access to ART; and
21. 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.

Markers of progress towards a more just return for ESA countries from the global economy

22. Debt cancellation;
23. Allocating at least 10% of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers;
24. No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws;
25. Inclusion of health officials in trade negotiations and explicit inclusion of clauses and measures for protection of health in all relevant trade agreements; and
26. Establishing bilateral and multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration from ESA.

EQUINET SC 2007

The production of an "equity watch" at regional and country levels provides evidence to

- track and engage on priority health equity indicators to make visible key dimensions of equity in health and progress on measures that promote *equity,* particularly within health systems.
- monitor progress against commitments and goals,
- identify areas for research, advocacy
- critique and offer positive alternatives to negative influences and initiatives harmful of equity, and
- exchange information on promising practice.

2. The context: the CWGH National Conference and tenth anniversary event

The Zimbabwe Equity Watch is separately reported (Loewenson, Masotya 2008). It presents evidence from public documents from Ministry of Health, Zimbabwe Health Services Board, other health providers, Parliament of Zimbabwe, researchers, civil society, and international organizations on health in Zimbabwe and was peer reviewed by state, parliament and civil society colleagues.

It was prepared in the context of a rapidly changing (and deteriorating) environment: declining economic output, including of household food production; hyper-inflation; fertilizer, food, fuel and safe water shortages; an orphan population of nearly one million; a health sector facing high out-migration of skilled and experienced health workers and vulnerability from homelessness and

displacement. These challenges set a testing context for discussions of health equity, but also make such discussions even more critical, so that those with greatest health needs are given greatest visibility. At the same time the meeting was held during the tenth anniversary of the Community Working Group on Health, with members of community, civil society and health institutions at community levels of the system from 25 districts and from national level, together with health worker and provider organisations, signalling the social capacities that continue to exist for advancing equity, if supported.

CWGH members in discussions at the meeting Source TARSC

Community Working Group on Health (CWGH) is a network of membership based civil society organisations focusing on advocacy, action and networking around health issues in Zimbabwe and will be the lead institution for this programme. The CWGH comprises about 35 national and local civil society membership based organisations representing peasants, workers, informal sector, youths, students, women, churches, disabled, residents and other health linked membership based groups who aim to promote public and civil society participation in health. The CWGH is also a member of the EQUINET steering committee.

The CWGH 15th national conference gathered district health personnel, health literacy facilitators, national member organisations and partner organizations in the health sector. This provided an opportunity for discussion of evidence in the draft Zimbabwe equity watch from the perspective of people from community and primary health care levels of the health system. At the same time the evidence in the Zimbabwe equity analysis provided input to civil society plans within the CWGH and to the resolutions from the CWGH meeting.

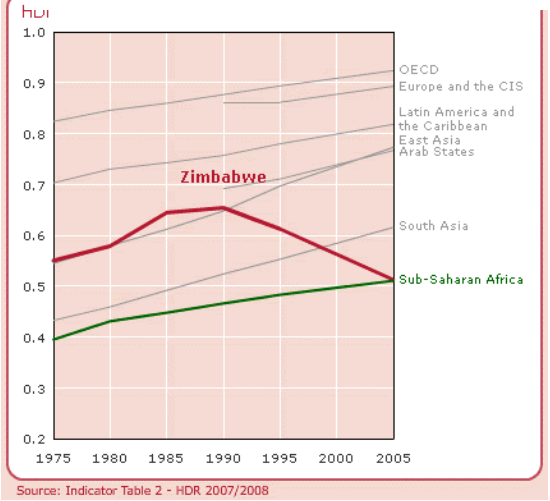
The discussion on the Zimbabwe equity analysis was a build up to the launch of the book **"Reclaiming resources for health":** a regional analysis for equity in Health in East and Southern Africa on the evening of 23rd October 2008 at the CWGH tenth anniversary celebrations. The Community Working Group on Health was formed in 1998 and the tenth anniversary event was hosted by CWGH, with support from TARSC in co-operation with EQUINET. The event was attended by more than hundred people from Parliament (MPs), Ministry of Health, Ministry of education, academics, representatives from the Health Service Board, private sector, civil society, health worker unions, labour movement, and delegates from the region (Uganda. Malawi, South Africa). At the same event the Global Health Watch 2, an alternative World Health report from the People's Health Movement was also launched. The CWGH national meeting and anniversary event is separately reported by CWGH.

3. The Zimbabwe Equity Analysis: priorities for improving health

"Human development in Zimbabwe has been affected by AIDS, economic decline and conflict, but are all equally affected? Inequality means that the benefits of growth do not necessarily reach poor people. What more does it mean in conditions of decline? Rene Loewenson

Dr Rene Loewenson presented evidence drawn from the Zimbabwe Equity analysis drawing discussion on the evidence in the session. The Human Development Indicator (an index of GDP per capita, life expectancy, literacy, and educational attainment), showed a sharp decline from 1990, associated with AIDS and with economic and social trends. These aggregate figures tell only part of the story- Zimbabwe has high levels of inequality that undermine efforts at poverty reduction. For many countries in the region, current economic growth rates will not reduce poverty to levels that meet the Millennium Development Goals unless inequality is also reduced. The health sector plays an important role in this, especially when oriented to equity. She asked delegates what they understood by "equity". Some felt it was about those with more needs getting more resources, others that it was about fairness. One delegate commented that fairness was relative, "If I am rich I would think it was fair that I got more resources, or unfair that my taxes were spent on others!" Equity is this not only about the allocation of needs to resources, but includes an element of social norms, or what inequalities society feel are unfair, or allocations of resources that society demand as just.

Human development Index Zimbabwe



Zimbabwe has policy commitments to addressing inequalities in health. Policies in Zimbabwe provide that

- Everyone should have the opportunity for health and access to health care
- Prevention of ill health and PHC are priorities
- Health services and resources should respond to need
- Local managers and communities should be empowered in health systems

But she asked, how well are we implementing the policies? There was debate amongst delegates on this. While in theory everyone should access health care, some services are poorly resourced and people can't afford high cost private care. The evidence from the analysis presented showed that while geographical differences in some aspects of health and access to health care between urban and rural areas have been closing over time, differences are persisting across income groups.

In the discussion delegates noted that the lack of adequate resources such as staffing limit the ability to deliver new services like Anteretroviral treatment. This confirms the picture obtained in the equity analysis, where the physical infrastructure is generally well developed, but barriers in staffing, supplies, in costs of transport, and other community barriers need to be addressed for people to access services. Official figures, such as those recording that 98% of urban households access safe

water, reflect infrastructure but not the functioning of water supply systems, where people go for long periods without water in some urban areas.

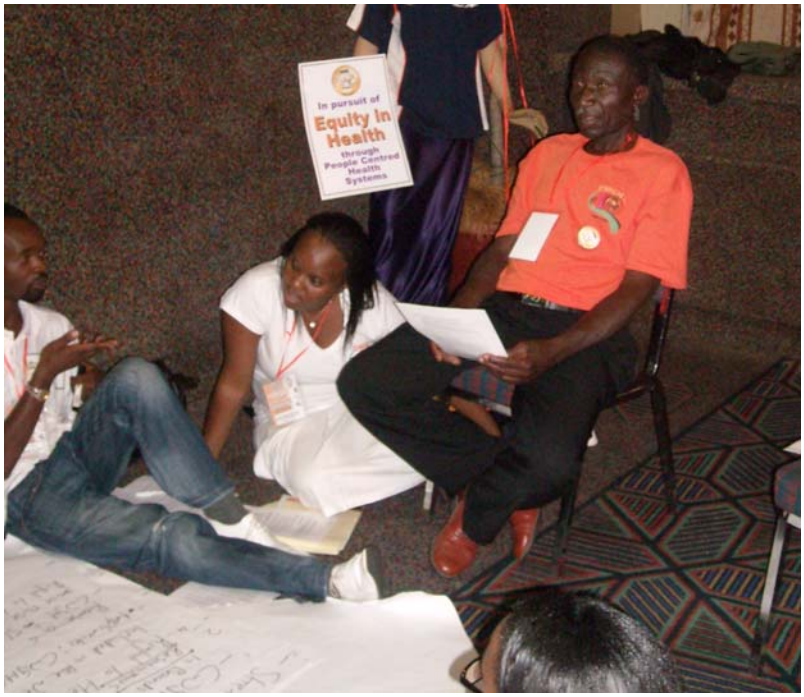
Delegates felt that this was worse for poor urban and rural people. Poor people spend more of their income on health care and face a chain of disadvantage in accessing health care, from within the community to accessing and using services. This further fuels poverty.

Dealing with this means that health systems have to make deliberate efforts to distribute resources to where need is greater. She asked how far people felt that this was taking place. Delegates felt that this had happened in the public sector but not in the private for profit services. However in the public sector there is still some mismatch between health needs and resources. For example the clinics closest to poor communities for care have low and falling levels of drug availability. There was a long discussion on why clinics are under-resourced. For example the evidence in the analysis shows a big fall off in essential drug availability from district hospital to clinic level, although they are in the same area. It was raised for example that clinics lack the staff to manage resources and so don't effectively demand these resources. This sets up a vicious cycle, where poorly resourced communities and services are less able to demand and absorb resources.

Dr Loewenson asked how the cycle can be broken?

A number of areas were raised in the plenary and group discussions around the watch.

One issue was for the right to health to be included in the constitution. The delegate from South Africa warned that this was not enough, as wealthier people may claim and use this right more than poor, and it can lead to costly legal battles. Delegates felt that it was essential however that the right to health be included as a 'bottom line' and that it be claimed through social action. The right to health was not understood to simply mean the right to health care, but also the right to determinants of health like safe water.



Discussion of options for strengthening equity Source TARSC

"The Right to heath must be included in the National Constitution" "CWGH should embark on a massive campaign on the right to health"

CWGH delegates

It was also noted in the discussion that beyond this the Ministry of Health must fulfill its mandate by abiding by all its policies and declarations on health and that communities also needed to advocate for and monitor the implementation of health policies.

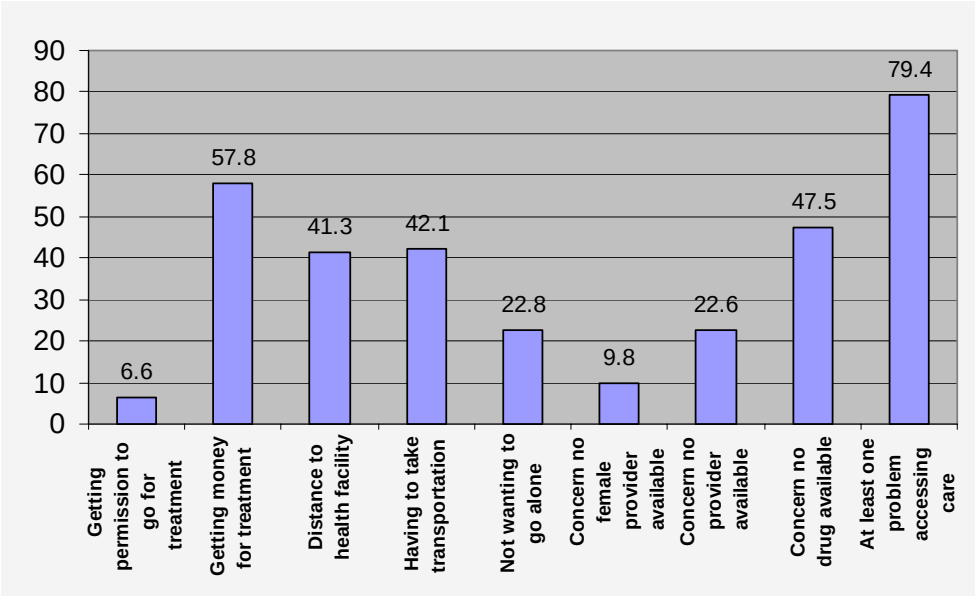
The Zimbabwe equity analysis proposes that inequalities in health need to be tackled first in the environments that make people ill. In Zimbabwe the priorities from the evidence are for

- Investments to improve household food security
- Rehabilitation of services to ensure affordable water, sanitation and waste disposal
- Improvements in the quality of education
- Incentives to stimulate the local production of health inputs like nutritious food, soap, essential medicines

Of these water was seen by delegates as a priority, not only in terms of availability, but also in terms of affordability. It was felt that public funds should be used to subsidise water tariffs for households to ensure access.

Dr Loewenson pointed to evidence from the region showing that primary health care and investments in the primary and district levels of health systems have an important impact on inequalities in health. However she also presented evidence that showed how groups with high health needs, like women, face barriers to accessing services, in part due to factors in the community and in part due to cost and lack of resources in the services. (See Figure below)

Percent of women citing problems in accessing health care, Demographic and health survey 2005/6



Source: CSO, Macro Int 2007

Delegates agreed with the need to invest in these services close to communities and in PHC, and in discussion raised a number of ways this should be strengthened, such as through incentives to attract and retain staff, for joint action by government and communities to motivate and retain health workers and for action by

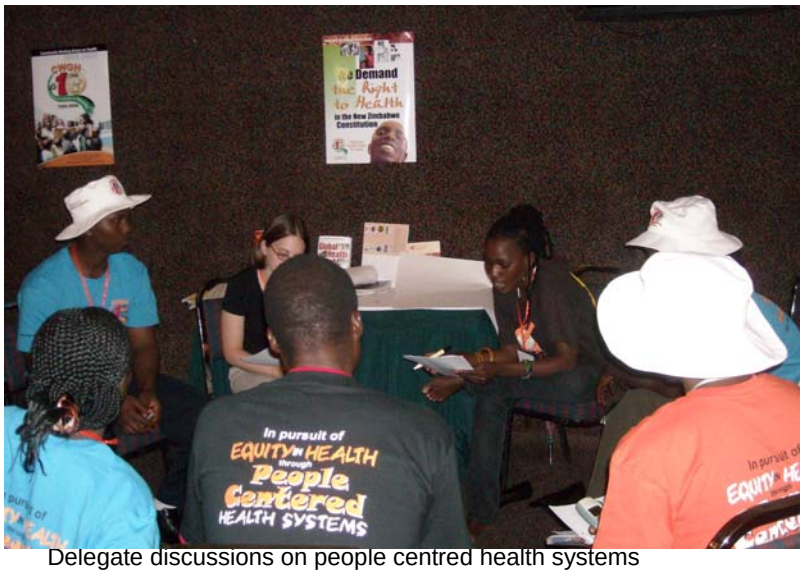
communities to make sure that resources that reach districts do get to the clinic levels. At the same time the equity analysis shows that while health has been getting more of the government budget, more needs to be done to allocate a level of public sector resources to health always above the 15% in the Abuja commitment (a commitment made by heads of state in 2001), and to ensure that these resources are allocated to districts on the basis of need and not demand.

"CWGH must sensitize communities on the Abuja Declaration and carry on lobbying the Parliamentary Portfolio Committee on health for increased funding to health in the budget." "CWGH should continue to lobby for the fair allocation of resources at national level and also to tap resources from those who are at the top (who have vast resources) to strengthen the bottom"

Meeting delegates

Dr Loewenson noted that EQUINET has since 1998 recognised that equity in health is not just about addressing differences in health status that are unnecessary, avoidable and unfair, or directing more resources for health to those with greater health need. Equity in health also means having the power to influence decisions over how resources for health are shared and allocated. She presented evidence in the analysis from surveys of high levels of community *activity* in health, but asked how far this translates into high levels of *involvement in decision making.* The equity analysis explores how far social empowerment is built into our health system, such as through primary health care oriented health systems, through recognising mechanisms for community involvement in decision making in law, with resources, capacities and powers to support roles, through resource support to community health workers and through processes that build public accountability of public and private services.

There was active debate on how far this existed in Zimbabwe. The presence of mechanisms and committees at district level was noted. But how capable are these mechanisms? How representative are they? How far have they been affected by the polarised partisan environment?



Delegate discussions on people centred health systems
Source TARSC

The existing structures were acknowledged as important and present but limited in their impact. They were felt to need capacity building, for them to be more effective and proactive in their engagement and to not be used as a platform for party politics. This type of change needed to be organised for at community level.

"Communities must organise their own power to health".

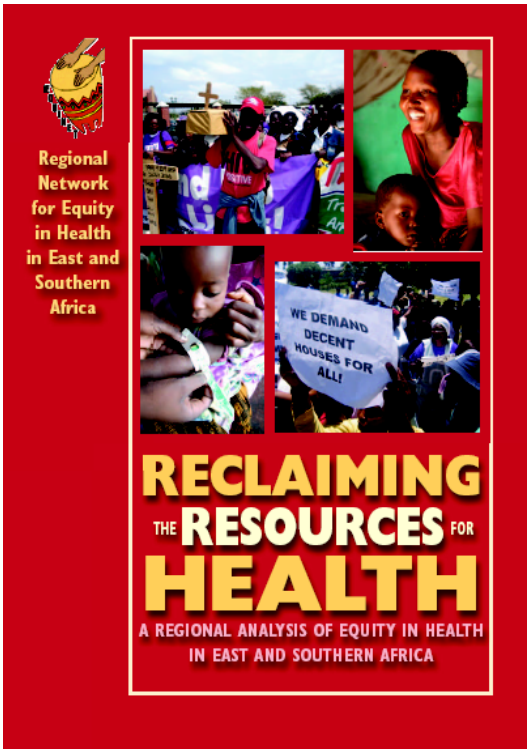
Meeting delegate

In the conclusion Dr Loewenson noted the turnaround in child immunisation made in Zimbabwe in the two years after 2006, signalling 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 environments for health like rehabilitating safe and affordable water supplies, and in the recognition, resourcing and capacity support for community and community health worker roles could inject immediate health gain for low income communities. She suggested that in the current hostile environment, these may be good entry points around which to navigate measures that address the deeper inequalities that challenge health equity in Zimbabwe.

The delegates felt that the equity analysis was an important tool for making equity issues visible and monitoring equity goals. They called for CWGH to be involved in and advocate around an equity watch every year to see what changes are taking place and to lobby for actions that close the gaps in health.

4. Launch of the book- "Reclaiming the Resources for Health" Regional Analysis For Equity In Health In East And Southern Africa.

The EQUINET steering committee was fortunate to join with the Community Working Group on Health (CWGH) and its partners and communities to celebrate ten years of successful collaboration; unique work, positive change and one of the longest and most unique examples of community participation in the region. With CWGH and TARSC both steering committee members, and active leadership in the network of the Zimbabwe Parliament Committee on health and other Zimbabwe based institutions, the CWGH anniversary was an excellent opportunity to launch the EQUINET book in Zimbabwe, while also recognizing the importance of the ten years of CWGH to the wider leadership for health in the region.



The EQUINET book was first launched in the region in Malawi exactly a year ago on October 23rd 2007. Since then launches have been held in other countries and it has been presented at various regional platforms. The three paths in the analysis to reclaiming the resources for health at a means to improve health equity, have been supported in these different forums

- For poor people to claim fairer share of national resources to improve their health
- For a more just return for East and Southern African countries from the global economy to increase the resources for health; and
- For a larger share of global and national resources to be invested in redistributive health systems to overcome the impoverishing effects of health.

As the discussion in the afternoon session on the Zimbabwe equity watch showed, these issues drawn from regional analysis also have relevance in Zimbabwe.

"This book has been put together by EQUINET steering committee members from the region based on the experience from the region. The book is communicating that we have a capability and responsibility to produce health in our region. What we need to do is to reclaim our resources for health, for poor people to reclaim national resources, for our countries to reclaim resources that are flowing to global level and for health systems to reclaim resources that they deserve from our economies."

Rene Loewenson, EQUINET

The EQUINET steering committee congratulated the CWGH for ten years of work towards improving health and lives. Copies of the book had been given by CWGH to all its districts, and it was presented to the Ministry of Health with a challenge to support people to reclaim the resources for health.

"On behalf of the Ministry of Health I would want to accept the challenge you have given us. And we will try our best to realise the vision. We can only succeed pushing the agenda of people centred health systems with your support and with your participation and involvement."
Mrs Chasokela MOHCW

Mr Itai Rusike, the CWGH Director noted the demand for urgent action in Zimbabwe's health sector, when cholera had taken more than 20 lives in a short period of time.

"Our health sector has literally collapsed. Zimbabwe has become a cholera country, which is sad. However, this should not deter us but energise us. We have work to do. We have to make as much noise and as much action at community level".

Itai Rusike CWGH

One institution that is able to raise the profile of health issues and actions is parliament:
"We, as members of the parliament of the Republic of Zimbabwe, and as former members of the Health portfolio committee in Parliament congratulate the CWGH on its tenth anniversary! We also extend the same to EQUINET for launching an important resource Reclaiming resource for Health. We are proud to be associated with these partners. We have walked the long road together for a long time. The long journey to address health challenges remains, but we believe our contribution and voice will make a difference. The book is a very precious resource for members of parliament, there is no doubt that this book will be useful in our debates in Parliament. Let's fight together to reclaim our health rights"

Honourable MP Mupukuta

The combined role of critical analysis and community action was recognized by a range of orqanisations, congratulating both CWGH for ten years of sustained community action and EQUINET for its contribution to knowledge and learning.
Mrs Cynthia Chasokela on behalf of Dr Mabhiza, Permanent Secretary for Health highlighted the importance of the work at community level and the appreciation the Ministry has for this, as well as the research and knowledge sharing in EQUINET.

"*It is indeed gratifying to some of us who where there at the beginning ten years ago, to see that ten years later the CWGH is still on its feet and doing well. The CWGH is such an important part of the health care delivery system in Zimbabwe'*

MOHCW-Cynthia Zandile Chasokela

Mr Tikiwa, the National Organising Secretary of the Zimbabwe Nurses association applauded the CWGH for the advocacy work done in the last decade. He described the nightmare that that nurses in Zimbabwe face in a working environment where there is critical shortage of drugs and supplies and a massive brain drain.

"May you continue to advocate for the voiceless. Congratulations to EQUINET for the book. We challenge, the Health services Board, the MOH, Government and communities to play their role now that EQUINET has provided such critical analysis"

Mr Tikiwa, the National Organising Secretary of the Zimbabwe Nurses association

In a situation of recognized difficulty and decline, the issue was raised that affirmative critical analysis and community leadership and action offer a motivating glimpse of the potential for the positive transformation.

"The work that the CWGH has been doing on the ground over the last decade, shows us important ways on how to ensure that people are part and parcel of the processes of governance in this country… The critical content from EQUINET shows not only what is going wrong, but importantly what can be done right and presents clear alternatives for health equity to be achieved."

Mr, McDonald Lewanika- Crisis of Zimbabwe Coalition, Students Solidarity Trust

A more detailed report is being produced by CWGH of its national meeting and ten year event. This summary report of the debate on the Zimbabwe equity analysis presents review from community level on the equity watch that will be integrated into the final version, together with peer review from other stakeholders. With the launch of the EQUINET book the events provide a glimpse of possibilities: of critical debate on problems and on what needs to be prioritized for health; and on the possibility of bringing together diverse constituencies in health around shared goals and how to achieve them. Perhaps the critical feature was the core of energy for this dialogue on health came from people working at community level.
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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 east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

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