2014 EQUITY WATCH

Assessing Progress towards Equity in Health

Zimbabwe

Training and Research Support Centre

Ministry of Health and Child Care

in the Regional Network for Equity in Health in East and Southern Africa (EQUINET)

Map of Zimbabwe showing provinces

Source: Zimstat, UNICEF 2009

Produced by Training and Research Support Centre and Ministry of Health and Child Care, Zimbabwe, in the Regional Network for Equity in Health in East and Southern Africa (EQUINET).

Authors: Rene Loewenson, Marie Masotya TARSC
Gibson Mhlanga, Portia Manangazira MoHCC

With gratitude for peer review by Dr D Dhlakama and Dr L Mbengeranwa, Zimbabwe

Cover photo: © F Machingura 2011, Zimbabwe.
Photos on inside pages under creative commons license or used with permission and credited to photographers as shown.
Editorial and layout work by TARSC and Blue Apple Projects.
Funding support from Liverpool School of Tropical Medicine in the Rebuild project is gratefully acknowledged

Training and Research Support Centre (www.tarsc.org) and EQUINET
Box CY2720, Causeway, Harare, Zimbabwe
admin@equinetafrica.org; www.equinetafrica.org;

Ministry of Health and Child Care
P O Box CY1122. Causeway, Harare, Zimbabwe
www.mohcc.gov.zw

Cite as: Training and Research Support Centre and Ministry of Health and Child Care, Zimbabwe (2014) Zimbabwe Equity Watch 2014, TARSC, MoHCC, EQUINET Harare

ISBN : 978-0-7974-6288-5

Foreword

The Zimbabwe National Health Strategy (2009-2015) raised universality, equity and quality as central principles. Whilst the Zimbabwe Constitution for the first time guarantees the right to health care, the government of Zimbabwe has had a consistent commitment to health equity since 1980.

An Equity Watch is a country report that monitors progress in health equity, more specifically, the health system's progress and responsiveness in promoting and achieving equity in health and healthcare. The Equity Watch framework was developed by EQUINET and implements a resolution of the East, Central and Southern African Health Community to monitor progress in health equity. It assesses progress against commitments and goals in four major areas, namely: equity in health, household access to the resources for health, equitable health systems and global justice.

It is with pleasure that the Ministry of Health and Child Care presents the third *Equity Watch* report for Zimbabwe. This report updates the 2008 and 2011 Zimbabwe *Equity Watch*. We are happy that we are now able to release this third report to track the changes between 2011 and 2014.

Prior *Equity Watch* reports highlighted the need for investments in primary health care. This was meant to revitalise the health system closer to communities, to close gaps in access to services, to engage all sectors to address the causes of ill health, and to strengthen domestic health financing and co-ordination of all actors for universal health coverage. It is positive, therefore, that this 2014 *Equity Watch* indicates progress by Zimbabwe on many fronts including the inclusion of the right to health care and to health determinants in the 20'13 Constitution; in the fall in overall inequality and closing of gaps in wealth between rural and urban areas; in sustained high primary enrolment and gender parity in education; (in line with Millennium Development Goal (MDG) targets); in widening access to land; overall improvements in child survival and nutrition, HIV prevalence, immunisation coverage, maternal health, HIV, sexual and reproductive health service coverage; with a fall in inequalities for services such as immunisation and antenatal care that are closer to reaching universal levels. The improvements in health services came from our investments over the years in such areas as , education, health infrastructure and in human resources for health. It has also come from our efforts to improve medicines availability as well as personnel retention at primary care and district level, supported by various innovative financing mechanisms such as the Health Transition Fund, performance based financing among others.

However we know that there are still many challenges to address unfair disparities in health and access to care. Our infant and child mortality rates are far from MDG targets, especially for poorer households. There are also still wide gaps between current levels of child malnutrition and maternal mortality in relation to our MDG targets. There are persistent disparities by wealth and mother's education in the uptake of many services; and chronic conditions present a rising challenge. Our level of domestic health financing from government has fallen below the Abuja commitment and below the percapita levels recommended by WHO and is inadequate to finance the attainment of our health related MDG targets, as well as being below the level needed to finance the essential health benefit which has been identified by Ministry of Health and Child Care. The resource limitations have also limited our ability to reach and widen coverage for underserved groups or to provide new services or act early to prevent and manage chronic conditions.

As many of the determinants of improved health equity lie outside the health sector, this report raises areas where we seek to advance 'health in all policies', to address 'the causes of the causes' or underlying determinants of poor health outcomes, such as improving gender equity in employment and income security, controlling the marketing of unhealthy products, encouraging nutritious weaning foods, rehabilitation of public urban water supplies and promotion of the one household one toilet campaign in all areas. We hope this report will inform and stimulate discussion across a range of sectors, including with development partners, civil society and the legislature on the specific measures we can each take to implement our stated policy commitment to improve equity in health.

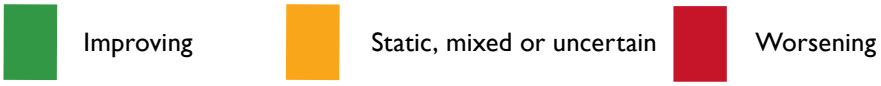
Dr P.D. Parirenyatwa
Minister of Health and Child Care
Zimbabwe
April 2015

About the Equity Watch

An Equity Watch gathers, organises, analyses and reports evidence on the progress being made in advancing equity in health. Equity Watch work is being implemented in countries in East and Southern Africa in line with national and regional policy commitments. In February 2010 the Regional Health Ministers Conference of the East, Central and Southern African Health Community (ECSA¬HC) resolved that countries "Report on evidence on health equity and progress in addressing inequalities in health".

Using available secondary data, the Equity Watch is implemented by country personnel with support and input from EQUINET. It aims to assess the status and trends in a range of priority areas of health equity and to check progress on measures that promote health equity against commitments and goals.

Equity Watch reports were produced in Zimbabwe in 2008 and 2011, using a framework developed by EQUINET in cooperation with the ECSA–HC and in consultation with WHO and UNICEF. This 2014 Zimbabwe Equity Watch updates the evidence using in the same framework, and including areas identified by stakeholders in Zimbabwe as important for achieving equity in Universal Health Coverage (UHC). The report introduces the context and provides evidence on selected parameters of: equity in health, household access to the resources for health, equitable health systems and global justice. It shows past levels (1980–2008), current levels (most current data publicly available for the past 5 years, 2009-2014) and comments on the level of progress made towards health equity. It provides a coloured bar indicating what the situation is, and whether broadly:



It uses mixed yellow-green and yellow-red colours where the findings are mixed, but with overall signs of progress or decline respectively.

We explore the distribution of health, ill health and particular determinants, including those relating to employment, income, housing, water and sanitation, nutrition and food security, and those within the health system. The Equity Watch examines the fairness of resource generation and allocation, and the benefits derived from consuming the resources for health. The 2014 Equity Watch includes available evidence on the private for profit sector in health. We also explore the governance of the health system, given that the distribution and exercise of power affects how resources are distributed and strategies designed and applied towards ensuring access to the resources for health. This 2014 Equity Watch shows the progress made in achieving equity in the health Millennium Development Goals and in achieving goals of equity in a universal health system.

Contents

Key messages

This report continues the work done in the 2008 and 2011 Zimbabwe Equity Watch reports to review progress in delivering on policy commitments to promote health equity.

Progress has been made in improving equity in a number of areas, in:

- The inclusion of the right to health care and to health determinants in the 2013 Constitution.
- A fall in overall inequality and closing of gaps in wealth *between* rural and urban areas.
- High primary enrolment and gender parity in education, in line with Millennium Development Goal (MDG) targets, and
- Widening access to land and food availability.

There have been overall improvements in child survival and nutrition, more recently in maternal mortality; a significant reduction in HIV prevalence, and improved immunisation coverage, maternal health, HIV and sexual and reproductive health (SRH) service coverage, with a fall in inequalities for services such as immunisation and antenatal care (ANC) that are closer to reaching universal levels.

However the levels of under five and infant mortality rates are far from MDG targets, especially for poorer households and after infancy. There are still wide gaps between current levels of child malnutrition and maternal mortality compared to MDG targets. There are persistent disparities by wealth and mothers education in the uptake of SRH and HIV prevention and treatment services; and chronic conditions (NCDs), present a rising and still relatively unmanaged health challenge.

Inequalities in health arise largely due to social inequalities in the factors that affect health. There are widening inequalities in wealth *within* urban and rural areas, with increased urban poverty, and with a more recent growth in rural wealth without a decline in rural poverty. There is persistent gender inequality. Social inequality reflects insecurity of incomes, food poverty in urban areas and gender and wealth inequalities in rural agriculture, contributed to by increased reliance on commercial food markets and rising food prices. Cost barriers to enrolment exist in entry to education, in early childhood development (ECD), and in completing secondary schooling, both of which have implications for improved health. Shortfalls in the provision of *functional* improved water and sanitation are associated with outbreaks and high prevalence of preventable disease.

Within health services, improvements in coverage and equity have been contributed to by:

- The presence of a literate population, an active health civil society and revival of the village health worker programme to support health promotion and service uptake.
- Significant improvements in medicine availability at primary care and district level, and in the training and retention of nurses, doctors and pharmacy personnel in public services.
- Support for HIV and AIDS and for malaria and TB control services, including through an earmarked tax (the AIDS Levy).
- Removal or reduction of fees in public and not for profit services for pregnant women and children, with evidence of a reduction in cost burdens to households.
- Information and service investments implemented in the results based financing programme contributing to capacities for improved use of funds.
- Pooling of external funding in the Health Transition Fund with spending aligned to national goals.
- Updating and costing the health care entitlements at primary care and district level, and
- International partnerships and negotiations to support health services.

There are challenges to sustain these gains and to address disparities in health and access to care. Most importantly, domestic health financing has fallen below the Abuja commitment and below per capita levels set in WHO guidance. Domestic health financing is inadequate to meet the core package of services for the health MDGs and below the level needed for the essential health benefit identified by Ministry of Health and Child Care. This has made the country highly dependent on external funding for key areas of health delivery, particularly for essential medicines and supplies, and for health worker retention incentives for the primary health care and district health services that are critical for the low income majority. Inadequate financing has been associated with low levels of investment in, and inadequacy of, personnel for preventive services, including to prevent the escalation of future costs of NCDs, by acting early to prevent them.

The evidence points to other challenges: In the public sector there are gaps in deployment of personnel to districts with higher levels of poverty; in supplies for chronic conditions and in emergency supplies, transport and services. There is weak monitoring and social accountability, and weak regulation of cost escalation, inefficiencies, segmentation and barriers to financial protection in the private health sector.

Closing gaps in coverage and outcomes calls for strengthened investment in PHC, including to:

- Strengthen nutrition interventions, supporting community health workers to encourage exclusive breastfeeding, nutritious weaning foods and uptake of growth monitoring to identify and link children in vulnerable urban and rural situations with health and other support.
- Sustain the availability of medicines and personnel in primary care services.
- Intervene from adolescence onwards in improving continuity in access to SRH and maternal health services, encouraging earlier more frequent uptake of antenatal care on the one hand, and improved referral for complications in rural areas and lower income households on the other.
- Formalise Health Centre Committee (HCC) roles at system level, widen health literacy, support VHWs and strengthen public involvement and accountability measures in the private health sector.
- Improve tools for harmonised budgeting, planning, reporting and purchasing arrangements across the various public and external funds.

Universal systems are built over years, organised around a shared vision of a national unified health system and with deepening social and state awareness, advocacy and capacities to progressively implement Constitutional rights and pro-equity health policies that are relevant for the next decade. The evidence indicates that mobilising new domestic resources will be a key and critical task, for health promotion, detection and management of NCDs, to ensure supplies and personnel at primary care and district services, and to support outreach for continuity of care, including through schools, communities and workplaces.

Sustaining and widening efforts to achieve universal coverage of key services based on delivery of universal entitlements will need to be funded through mandatory pre-payment financing, such as by taking forward the policy proposals in Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) to improve progressive tax funding, including from earmarking VAT and excise taxes, with measures to ensure equity, efficiency, transparency and accountability in their management. Needs based resource allocation would need to apply to new resources, so that no district receives reduced funds. Measures need to be applied to strengthen monitoring of service gaps and to build capacities to absorb and use funds effectively. A dialogue with the private health sector to co-ordinate a partnership aligned with national goals will need to be based on better information and public domain reporting, including on costs and performance.

As many of the determinants of improved health equity lie outside the health sector, improving health equity also depends on intersectoral processes that advance 'health in all policies', to address 'the causes of the causes' or underlying determinants of poor health outcomes, including:

- Identifying specific measures and targets for improving employment and income security, for supporting food production and markets and for addressing gender equality in access to land, credit and inputs for food production and for encouraging nutritious weaning foods;
- Exploring options for ensuring ECD enrolment in low income households;
- Improving quality of, enrolment in and completion of secondary school and supporting costs for the poorest children.
- Investing in rehabilitation of public urban water supplies and active promotion of improved sanitation with a one household one toilet campaign in all areas.
- Identifying risks and implementing measures to raise social awareness and reduce exposure to risk factors causing chronic diseases, through environmental measures, road traffic systems and regulation of marketing of unhealthy food, tobacco and alcohol, and
- Pooled medicine procurement and tariff measures aligned to policy support for local medicine production, including reduced import costs of inputs for local pharmaceutical production.

Introduction

EQUITY WATCH

Zimbabwe has various assets for health and human development, including a highly literate population and significant natural, mineral and agricultural resources. It is believed to hold 25% of the world's reserves of opencast extractable diamonds with significant potential contribution to the country's economy (Jamasmie 2014). The country benefited from a fall in adult HIV prevalence after 2002, and a low average population growth rate of 1.1% since 2002 (ZIMSTAT 2013; ZIMSTAT and ICF International 2012). The urban: rural ratio has remained relatively stable between 2002 and 2012 with one-third of the population residing in urban areas, contrary to trends of rising urbanisation in many other countries (ZIMSTAT 2013).

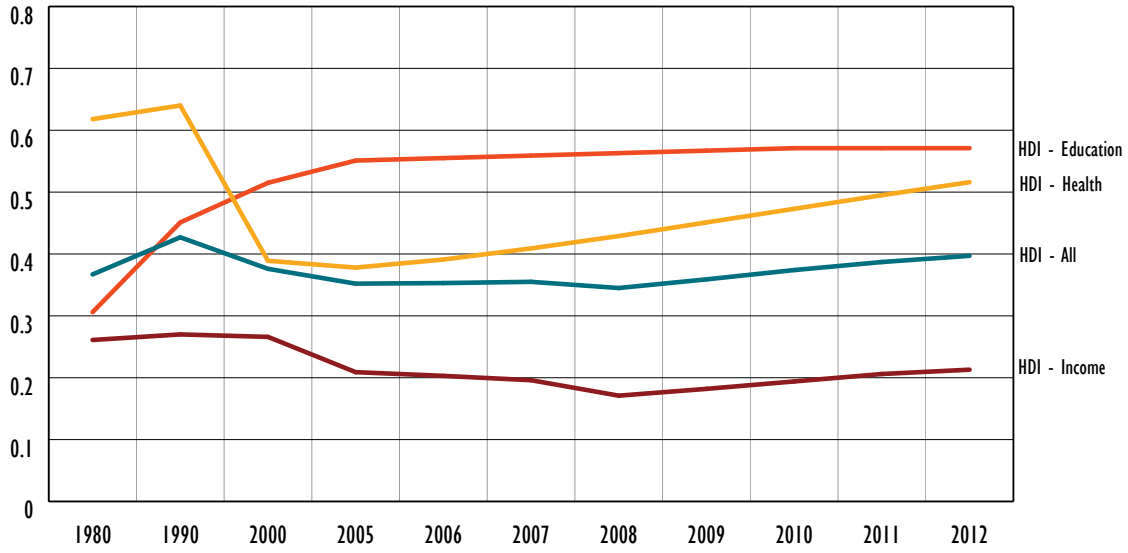
There have been many challenges in the past decade. These include a falling Gross Domestic Product (GDP), hyperinflation, rising debt and falling exports between 1999 and 2008 (ZIMSTAT UNICEF 2009; IMF 2014). Land reform post 2000 led to the transfer of around 8 million hectares of land across 4 500 farms to over 160,000 households, thus raising opportunities for more equitable economic benefit from land and challenges to support production in newly settled farms (Scoones et al. 2010). After high levels of political contestation, a 2009 'inclusive government' was set up under a Global Political Agreement. The adoption of a multicurrency regime was followed by a period of economic recovery, with a real annual GDP growth of 4.4% in 2012, improved manufacturing sector output, a rising supply of goods and services and a contraction in the debt to export ratio (ZEPARU et al. 2013; IMF 2014). The national average household income in April 2013 of US$95 was 12% higher than the same period in 2012 (ZIMVAC 2013). In March 2013 the country adopted a new constitution that included the rights to health care and health determinants, discussed later.

Elections in July 2013 resulted in a ZANU-PF led government, and the launch in October 2013 of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset). ZimAsset set short term interventions to December 2015 and longer term measures to December 2018 within clusters of food security and nutrition; social services and poverty eradication; infrastructure and utilities and value addition and beneficiation (GoZ 2013). At the same time economic improvements have slowed down, with GDP growth estimated at 2.9% in 2013, 3.1% in 2014 and 1% growth forecast in 2015, lower than African averages (ZEPARU et al. 2013, GoZ 2014b, World Bank 2014b). The revenue collection from key economic activities has been lower than expected, with mining company dividends dropping from US$174 million in 2010 to US$ 45 million in 2012 and zero in 2013 (Sibanda and Makore 2013). The Zimbabwe Revenue Authority (ZIMRA) reported a revenue much lower than expected from diamond production (Mzumara 2014).

Zimbabwe's Human Development Index (HDI) fell between 1990 and 2008, at a time when the Sub-Saharan African HDI rose (UNDP 2011). It rose after 2009 to 1980 levels and to 0.492 in 2013 (UNDP 2014). The trends reflect the fall in life expectancy in the 1990s due to AIDS, improving after 2005; rising education completion to 2005, plateauing thereafter and falling incomes to 2008, with a small rise thereafter. The aggregate HDI masks inequality in the distribution of human development across the population. The inequality adjusted HDI for Zimbabwe at 0.358 is 27% lower than the overall HDI, due to inequality in the indices that make up the HDI. While this 27% downward adjustment for inequality is lower than the sub-Saharan average of 35%, it does point to the extent to which inequality affects human development in Zimbabwe.

This report explores this further, in terms of the distribution of health, of both challenges and benefit in key determinants of health, and in access to health care services.

Figure 1 Human Development indicator trends, 1980-2012 Zimbabwe



Source: Authors from data in UNDP (2014)

© F Machingura, Zimbabwe

EQUITY WATCH

© UNICEF Zimbabwe

Household access to the national resources for health

The unequal distribution of diseases and survival in Zimbabwe's population can, in most cases, be explained by the extent to which people, households and social groups are accessing the resources to be healthy. These include resources such as food, water, sanitation, shelter, decent work and incomes. Education has been called a social vaccine. In 2011 and 2014, intersectoral meetings pointed to these social determinants, giving immediate priority to access to water and sanitation and to regulation of goods and services that may be harmful to health such as tobacco, alcohol and unhealthy foods (MoHCW and WHO 2011, MoHCC and WHO 2014). For the health services and for households, it does not make sense to treat people for preventable diseases and send them back to the conditions that made them ill. This section explores what progress there has been towards ensuring that households access these key resources for health.

Achieving the Millennium Development Goal of reducing by half the number of people in poverty

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
% population living on less than US$1 a day (PPP)	56.0	1990-2008	n.a	
% population living under the food poverty line	29 58	1995 2003	32.7	2011/12
% population living under the total consumption poverty line (TCPL)	55 72	1995 2003	76.7	2011/12
Rural: urban ratio for share below the TCPL	1:1.16	2003	1:0.77	2011/12
Multidimensional poverty index	25.0 18.0	2000-2008 2006	17.2	2011/2
Human Poverty Index	40.3	2005	39.0	2009
Wealth quintiles Rural % in lowest quintile	29.3 29.1	2005 2009	28.8	2011/12
% in highest quintile	1.2 1.4	2005 2009	5.1	2011/12
Urban % in lowest quintile	0.0 0.5	2005 2009	0.0	2011/12
% in highest quintile	60.5 59.9	2005 2009	53.9	2011/12

Source: CSO Macro Int 2007; MoPSLSW 2006; GoZ UNICEF 2007, 2010; UNDP 2008, 2011; ZIMSTAT and ICF International 2012, ZIMSTAT 2013; GoZ and UNDP 2012; OPHI 2013
PPP=purchasing power parity; The total consumption poverty line is the minimum expenditure needed to buy a basic basket of items for subsistence. Food poverty is the income required to sustain a basket of essential foods to meet the minimum recommended family caloric intake.

Past levels: 1980-2008

- Poverty increased between 1995 and 2003, both in terms of the food poverty line (FPL) and the total consumption poverty line (TCPL) (see summary table). Total consumption poverty was higher in urban than in rural households and in female than male-headed households (MPSLSW 2006). State forms of public assistance to deal with vulnerability all suffered limited funding, declining coverage and poor targeting of beneficiaries in the early 2000s (UNDP Zimbabwe 2008). Many households relied on remittances from family members outside the country or in formal employment to support food, school fee and health care costs in 2000-2008 (UNDP Zimbabwe 2008).

Current level: 2009-2014

- The summary table indicates that the share of people below food poverty line (FPL) fell between 2003 and 2011/2, while the share of people under the total consumption poverty line (TCPL) rose. The Multidimensional poverty index fell marginally from 2006 to 2011. The 2011/2012 Poverty Assessment provides the most recent household survey on poverty (ZIMSTAT 2013b). It found that while the share of rural people in the poorest quintile (fifth of the population) was constant 2009-2011, the share in the wealthiest quintile, with wealth based on their assets, grew by 4%, possibly as a result of new ownership from the land reform programme. While there were more wealthy people in rural areas, this was without a significant change to existing poor people. While no urban households were in the poorest quintile, the urban share in the wealthiest quintile fell by 6 percent points. The evidence suggests a shift in the relative distribution of household wealth from urban to rural areas. Total consumption poverty is also higher in urban areas, where dependency on commercial markets is higher, including for food (See *Table 1*) (ZIMSTAT 2013b). The data confirms concerns raised in the 2011 Equity Watch about rising urban poverty. It adds a new dimension of rising rural wealth and rural inequality.
- The distribution of poverty by province is shown in *Table 1*. The 2011/2 poverty assessment found that 77% of employed people earn less than $351 monthly, with earnings in men higher than in women (ZIMSTAT 2013b). According to community monitoring reports, the share of employment in the informal sector has grown since 2008, with a larger share of female headed households dependent on employment with insecure incomes, such as vending and trading (CMP 2012).

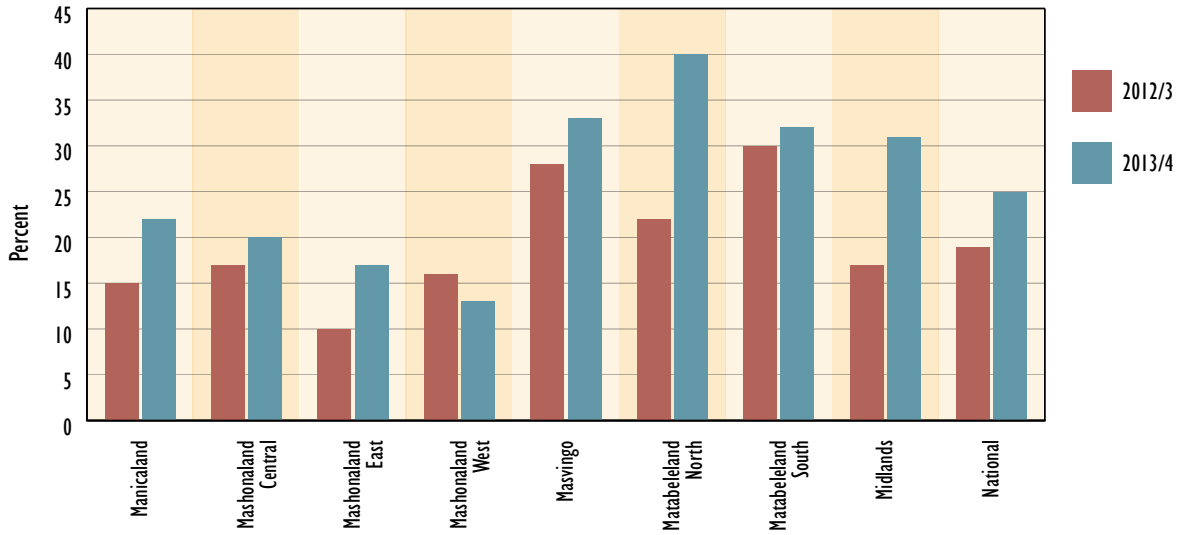
Table 1: Share of people living under the food poverty line by province, 2011/2

Province	Food poverty by residence			Total consumption poverty line		
	Urban	Rural	Total	Urban	Rural	Total
Manicaland	31.2	31.6	31.4	81.3	62.2	71.7
Mashonaland Central	32.0	31.5	31.8	83.3	62.0	72.7
Mashonaland East	31.9	31.8	31.9	83.2	62.6	72.9
Mashonaland West	32.2	33.9	33.0	83.9	66.7	75.3
Matabeleland North	35.5	36.6	36.1	92.6	72.0	82.3
Matabeleland South	35.6	35.9	35.7	92.6	70.5	80.6
Midlands	31.9	32.9	32.0	83.0	63.3	73.2
Masvingo	32.1	32.0	32.0	83.6	62.9	73.2
Bulawayo	32.0	-	32.0	83.3	-	83.3
Harare	31.5	-	31.5	82.0	-	82.0
National	32.6	33.2	32.7	84.9	65.3	76.7

Source: ZIMSTAT, 2013b

- Food poverty was highest in the two Matabeleland provinces, where food cultivation is lower, although not by a significant amount. The 2013 Zimbabwe Vulnerability Assessment (ZIMVAC) found that food insecurity increased in all provinces in 2013/4 except for Mashonaland West (*Figure 2*), projecting that 89% of households would not be able to meet food needs from their own production in 2013/4 (ZIMVAC 2013). Food poverty is not related to a province's potential for food production, possibly as provinces with better farming potential are growing more non-food crops. Small farmers are reportedly moving into cash crops such as tobacco, reducing production of maize (WFP and Vam 2014).

Figure 2: Household food insecurity – percent households food insecure by province 2012 and 2014



Source: ZIMVAC 2013

© UNICEF Zimbabwe

Progress

The MDG target of halving the proportion of people whose income is less than the TCPL has not yet been achieved. Increased rural wealth without a reduction in the share of the poorest households coming from rural areas is associated with rising inequality within rural areas. Poverty and insecurity of incomes have also grown in urban areas. Socio-economic inequalities between urban and rural areas have been a key focus for health and social policy post independence. The evidence suggests that inequality *within* both urban and rural areas is becoming more significant, calling for measures that reach disadvantaged groups within both urban and rural areas. Food poverty has become more strongly influenced by availability and prices of food in commercial markets, including in rural areas.

Reducing the Gini coefficient to at least 0.4

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
Gini coefficient	0.59	1995/6	0.39	2010/11
	0.57-0.61	2003		
	0.50	2005		
	0.51	2007		
Highest : lowest province	Na		7.4:1(i)	2010/11
Urban: Rural	Na		1: 4.4	2010/11
Wealth quintiles				
Rural % in lowest quintile	29.3	2005	28.8	2011/12
	29.1	2009		
% in highest quintile	1.2	2005	5.1	2011/12
	1.4	2009		
Urban % in lowest quintile	0	2005	0.0	2011/12
	0.5	2009		
% in highest quintile	60.5	2005	53.9	2011/12
	59.9	2009		

Source: MPSLSW 2006; UNDP 2005; 2008; CSO Macro Int 2007; GoZ UNICEF 2009; ZIMSTAT and ICF International 2012, ZIMSTAT 2013b. na= not available The closer to zero the gini coefficient value is, the greater the equality in income distribution. (i) (Matabeleland North: Bulawayo)

Past levels: 1980-2008

- The Gini co-efficient remained relatively stable between 1995 and 2003 but fell in 2005-2007 (see summary table). Provinces with medium levels of poverty saw a reduction in inequality, particularly in Mashonaland Central and Mashonaland East, for unclear reasons (MPSLSW 2006). In 1999-2005 the richest 10 per cent of households had 22 times the wealth of the poorest 10 per cent (UNDP 2008). Inequality *within* rural and urban areas contributed more to inequality in 1995/1996 and was more than twice the contribution of inequality between urban and rural areas (World Bank 2011).

Current level: 2009-2014

- The evidence in the summary table suggests that inequality fell in Zimbabwe between 2007 and 2011, although with sevenfold differences between provinces and fourfold higher rural inequality as urban. As noted earlier, rural inequality appears to have grown from a rise in rural wealth (measured in terms of household assets) without a similar fall in rural poverty. Matabeleland North had the highest level of inequality, with a gini coefficient of 0.59 (ZIMSTAT and ICF International 2012). Gender inequality is also noted to have persisted, with role stereotypes and a gender division of labour. There is a continuing perception that women's role in the family overrides all their other socio-economic roles (Chabaya et al. 2009). A 2013 government report on gender stated that "women continue to be under-represented in all areas of decision making … and face significant barriers to their full and equal participation in the structures and institutions which govern their lives." (GoZ 2013d: 42). Civil society confirmed this, noting that while the 2013 Constitution outlaws gender discrimination, the ZimAsset does not adequately operationalise gender equality in the economy (NGO Human rights Forum 2014).

Progress

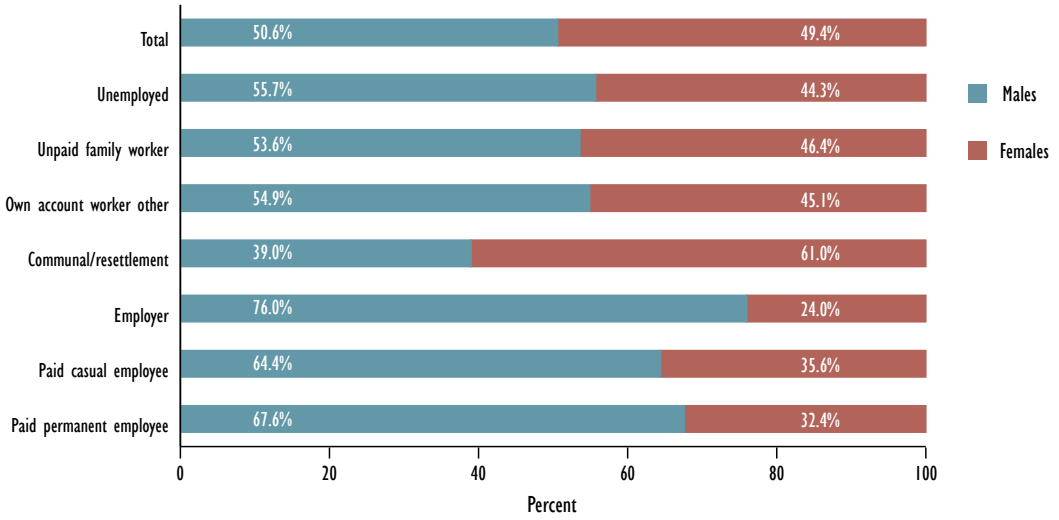
The Gini co-efficient has fallen steadily since 2003, suggesting a fall in overall inequality to levels more comparable with other countries in the region. There is some evidence of falling urban: rural inequality, and also of a rise in within-area inequality in rural areas. One factor driving inequality *within* areas appears to be persistent gender inequality. This suggests that reducing inequalities within urban and rural areas calls for more explicit attention needs to be given to overcoming gender inequalities in the economy.

Increasing ratio of wages to Gross Domestic Product

Past level: 1980- 2008

- Growth in formal employment has been at low levels of less than 2% since 1980-1990. Real wages and the share of wages and salaries in the GDP fell from 1995 to 2003, while the share of profits increased (Chitiga 2004). The increased profit share was not associated with increased job creation and may have contributed to widening inequality. The share of the adult population employed fell from 70 percent in 1991 to 65 percent in 2008 (UNDP 2010). In 2000-2008, women made up only 38 percent of total employment and 62 percent were in 'vulnerable employment' (UNDP 2010).

Figure 3: Distribution of economically active persons aged 15 years+ by sex, 2011/12



Source: ZIMSTAT, 2013c

Current level: 2009-2014

- The 2011/12 income and employment household survey reported that 8 percent of economically active persons were unemployed, 14 times higher in urban than rural areas, and 52 percent own account workers, largely communal and resettlement area farmers. *Figure 3* highlights the gender inequalities, with 46 percent of those identified as economically inactive being 'housemakers' or unpaid domestic labour, and women more commonly working as farmers, and men as formal sector workers (ZIMSTAT 2013c).
- The increasing level of earnings coming from informal activities makes it difficult to track income trends from formal data. In 2011, 94% of paid employees were reported to receive an income below the total consumption poverty line (TCPL) (GoZ and UNDP 2012). There are wide disparities in earnings. In 2011, a Paterson job evaluation found top executives in Zimbabwe to be earning an annual median total package 100 times higher than that of lowest grade workers, compared to a ratio of 21;1 in Botswana (Chulu 2011). This is a matter that the Zimbabwe Congress of Trade Unions has protested. A reported monthly salary in 2014 of US$535 000 in one of the leading medical aid society executives triggered announcement by government of a $6000 monthly cap on chief executive salaries for any state, parastatal or local authority. This is still 17 times higher than the $350 or less earned by 77 percent of employed people (ZIMSTAT 2013c). It has not been fully implemented for legal reasons.

Progress

Data on the share of wages to GDP was not publicly available to interpret trends across the period. However the evidence on falling real wages, job insecurity and high income inequalities indicate that employment is not performing well as a vehicle for access to national income and resources, limiting possibilities of contributory social protection schemes, discussed later. Efforts have been made to control inequalities in earnings by reducing executive pay in the formal public sector, but the high level of informal earnings and lack of evidence on earnings relative to profits make it difficult to assess progress in this indicator.

Achieving and closing gender differentials in attainment of universal primary and secondary education

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
% net enrolment in primary school of primary school age children	65.2 89.9 91.4	1999 2001-8 2005/6	91.0 87.0 93.7	2009 2010/11 2014
• Urban: Rural ratio • Male: Female ratio	0.96 1.02 1.00	1999 2004 2005/6	0.98 1.02	2009 2010/11
% net enrolment in secondary school of secondary school age children	76.6 38.0 44.5	1999 2001-8 2005/6	45.1 47.8 57.5	2009 2010/11 2014
Male: Female ratio, number:1	1.11 1.10 0.98	1999 2004 2005/6	1.01 0.99 0.99	2009 2010/11 2014
Primary school completion rates % (overall) (i)	73 68	2000 2004	82.4 87.7	2009 2013
Secondary school completion rates % (overall)	78 73	2000 2004		
Primary school drop out rates Male: Female ratio Secondary school drop out rates Male: Female ratio	1.04 0.89	2003 2003		
% adult literacy (overall) Males +15 years Females +15 years	89.0 91.4 94.4 88.8	2003 2008 2008 2008	87.3 98.0 94.4 88.7	2009 2010/11 2010/11 2010/11
Rural: urban ratio			0.91:1	2010/11

Source: CSO and Macro Int 1999; GoZ UNICEF 2007; MPSLSW 2006, UNESCO 2009, UNDP 2010, ZIMSTAT UNICEF 2009; ZIMSTAT and ICF Intl 2012; GoZ and UNDP 2012; UNICEF, 2013; ZIMSTAT 2014
(i) primary is lower than secondary as intakes are higher

Past level: 1980-2008

- As shown in the summary table, adult literacy rates in Zimbabwe have been consistently high at about nine in ten adults, with high gender parity. There was no available evidence on early child development and care (ECD) enrolment in the period, but Zimbabwe has since 2004 had a national policy on ECD that requires primary schools to offer a minimum of two ECD classes for 3 to 5 year olds, noting that late entry into ECD is associated with increased risk of dropout from school. The salaries of temporary ECD teachers are paid by parents, imposing financial barriers to child enrolment in poor households (GoZ and UN 2012). In 2004 the MoESC set a policy to expand the number of primary schools offering ECD (Munjanganja and Machawira 2014). Education has been the biggest beneficiary of the national budget, most of this going to teacher salaries. Primary and secondary school completion rates rose from 1990 to 2005 and gender equity improved. Falling real wages, poor conditions and political violence in the 2000s was associated with teachers leaving their jobs and shortfalls in teacher numbers (MPSLSW 2006; UNICEF

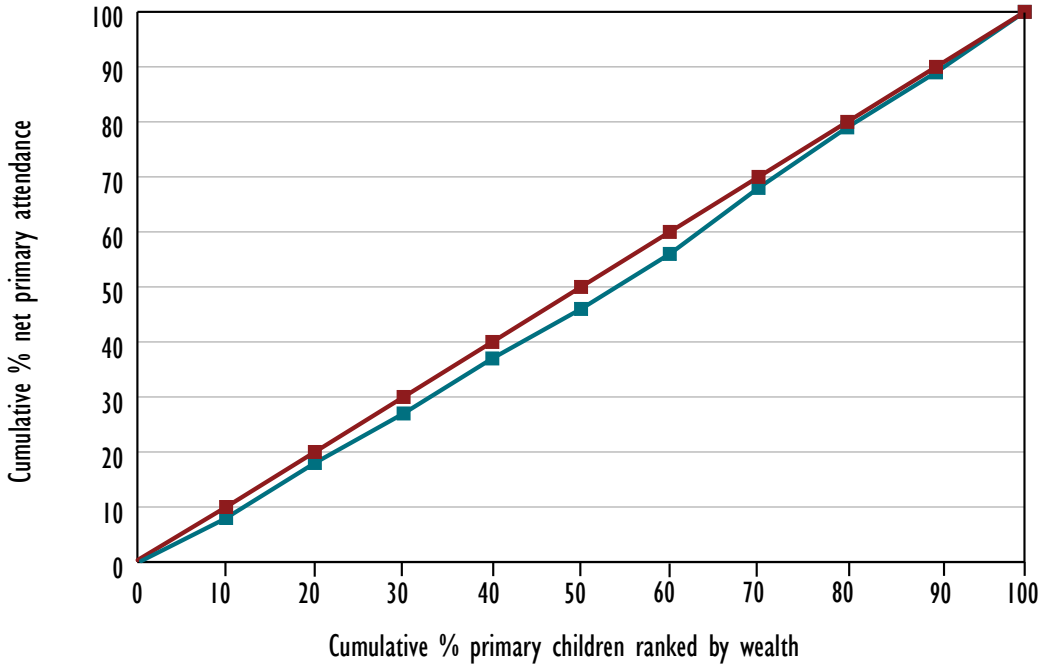
2012). Less than half of children transited from primary to secondary school in the period, even less in girls. Dropout was reported to be due to financial constraints and girl children playing caring and domestic roles (MPSLSW 2006). Responding to this, a National Girls' Education Strategic Plan launched in 2006 mobilised resources to keep girls, orphans and vulnerable children in school (UNICEF, 2006) and a Government Basic Education Assistance Module (BEAM) supported payment of school fees for nearly a million children by 2005 (GoZ/UNICEF 2007).

© COSV, 2008

Current level: 2009-2014

- Adult literacy rates remained high to 2010/11, although without further increases and lower rates in rural areas (see summary table). A curriculum for ECD was developed by 2011. By 2012 98% of primary schools offered ECD classes. While it is planned to train 5 000 ECD teachers by 2015, there were only 2400 trained by 2014, with paraprofessionals filling the gap (Munjanganja and Machawira 2014; VVOB 2014). ECD programmes were attended by 22 percent of children aged 36-59 months; and 62 percent of children aged 46-59 months were reported to be developmentally on track in at least three of four domains of literacy-numeracy, physical, social-emotional and learning (ZIMSTAT 2014).
- The 2013 Constitution guarantees the right to education. Primary school enrolment remained high in the period and primary school completion rates improved to 2014 (summary table). There were negligible differences across social groups, high gender parity in primary school and a concentration curve that showed almost no wealth differentials in education (See *Figure 4*). Improving completion rates post 2008 were reported to relate to improvements in the economic situation enabling children to remain in school, backed by a national information campaign to sensitise parents on the need to educate girls (GoZ and UNDP 2012).
- Inequalities are more pronounced at secondary school with secondary school enrolment rising slightly to 48 percent (see summary table). In April 2014, parents were reported to be paying private fees and incentives for public schools, more so in urban than rural areas, with sums paid reported to range from $25 - $250 (CMP 2014). Community sentinel site monitoring reported the share of households having difficulty with meeting these costs rising up to 2011, but falling thereafter, as did the reported level of dropout (CMP 2014). The budget allocation to BEAM fell from $73 million in 2013 to $15 million in 2014. External funders directly supplemented costs for children with $10 million (NGO Human rights Forum 2014). A shortfall in public assistance has had the most impact on vulnerable children and their schools: In the poorest quartile of schools, BEAM funds constitute 25 percent of school income, largely benefitting vulnerable children (Smith et al. 2012). Social inequalities are also affected by the quality of education. The low pass rate for Ordinary Level, at 21 percent in 2013, suggests concern with education quality (NGO Human rights Forum 2014). Community sentinel site monitoring reported that education quality improved in their areas in 2009 to 2012, but report of improvements plateaued thereafter (CMP; 2014 *Table 2*).

Figure 4: Concentration curve, net primary school attendance



Source: authors from Zimstat UNICEF 2009

Table 2: Community monitoring report of changes in quality of schooling, 2009-2014

	No of sites	Percent sites reporting that quality of schooling has		
		Improved	Stayed the same	Got worse
Total April 2014	244	32	65	3
Total March 2013	240	38	53	9
Total March 2012	239	69	20	5
Total March 2011	237	80	14	6
Total March 2010	240	66	26	9
Total March 2009	182	5	60	35

Source: CMP 2014

Progress

Zimbabwe's high net enrolment and gender parity in education, nearing to MDG targets, has contributed to health equity. While parents and government have sustained high enrolment and primary completion throughout the period, there have been challenges in ECD enrolment, in transition to and completion of secondary school and in education quality. Operationalising the constitutional right to education is important to sustain education's contribution to health, including through support of costs for the poorest children and improving teacher pay and conditions.

Achieving the MDG goal of halving the proportion of people with no sustainable access to safe drinking water by 2015

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
% households using improved water source (Overall)	78.2	2005/6	73.0	2009
			78.7	2010/11
			76.1	2014
• rural	75.1	1999		
	66.5	2004	61.0	2009
	67.1	2005/6	68.7	2010/11
• urban	99.0	1999	98.0	2009
	99.0	2004	95.1	2010/11
	99.4	2005/6		
• Urban: rural ratio	1.32	1999	1.61	2009
	1.50	2004	1.38	2010/11
	1.48	2005/6		
% households using improved sanitation (Overall)	40.0	2005/6	60.0	2009
			55.9	2010/11
			35.0	2014
• rural	45.0	1999	43.0	2009
	30.5	2005/6	33.3	2010/11
• urban	99.0	1999	97.0	2009
	58.56	2005/6	95.1	2010/11
• Urban: rural ratio	2.20	1999	2.26	2009
	1.92	2005/6	2.86	2010/11

Source: CSO Macro International, 2000, 2007; CSO 2006, MoHCW 2009; ZIMSTAT and ICF International, 2012, ZIMSTAT 2013b; 2014

Past level: 1980-2008

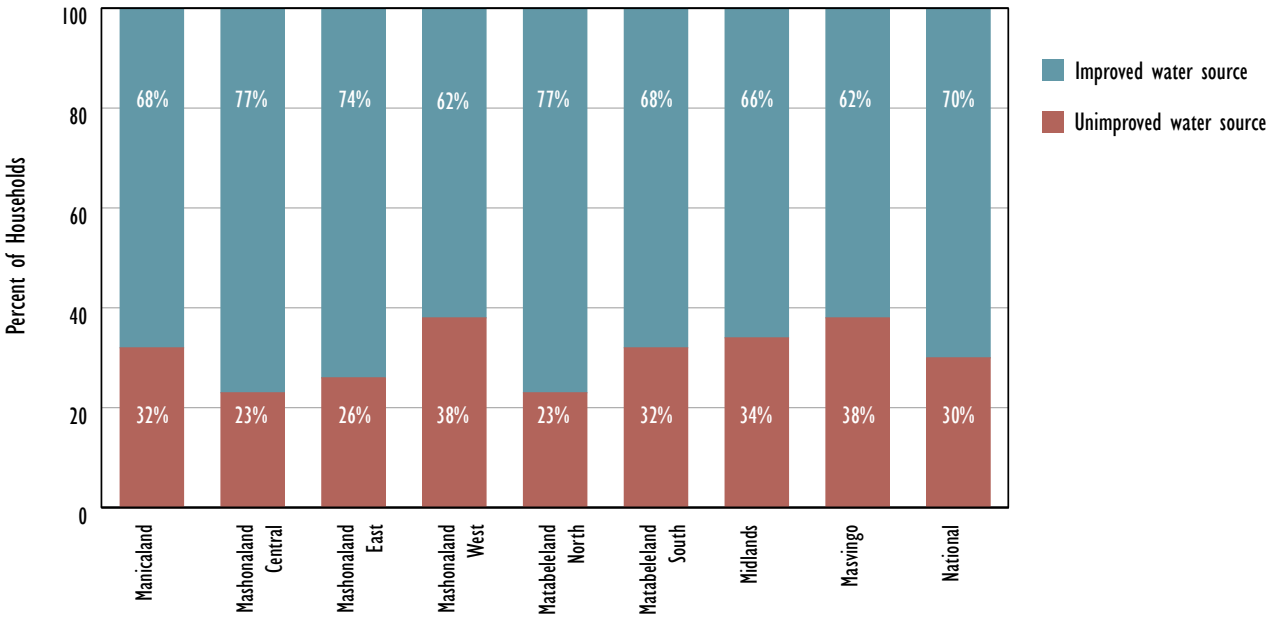
- Access to clean water remained static in urban areas and fell in rural areas between 1999 and 2005/6, with a consistently wide gap between rural and urban areas (see summary table). A far greater share of urban than rural households had access to sanitation, although access to improved sanitation fell in both rural and urban areas between 1999 and 2005/6. Government, parliament and civil society reported a worsening situation in 2008, with aging and unrepaired sewer systems and treatment works; illegal waste dumping and waste put in sewers due to poor waste collection; overflowing septic tanks; frequent water and power cuts and frequent interruptions in supplies (MoHCW 2009; USAID 2008; CHRA 2007; Parliament of Zimbabwe 2008). Diarrhoea rates increased from 32 to 47/1000 between 2004 and 2005 (MoHCW et al. 2004, MoHCW 2005b).

© UNICEF Zimbabwe

Current level: 2009-2014

- Section 77 of the 2013 Constitution guarantees the right to safe, clean and potable water and sufficient food and for the State to take legislative measure to secure these rights. Between 2008 and 2011/12 the share of households using an improved water source nationally fell, with the urban:rural ratio falling as rural areas improved relative to urban (See summary table). Even where services exist, water supplies from them have been noted to be erratic, especially in urban areas (ZIMSTAT 2013b). Community sentinel site monitoring reported that access to safe water infrastructures within 500 meters improved between 2012 and 2014, albeit with erratic supplies resulting in households having to buy water or to sink wells and drill boreholes, at costs that raise financial barriers to access for some.
- Access to improved sanitation increased in both rural and urban areas between 2005 and 2009 but has since fallen, especially in rural areas. Urban-rural differentials widened with a greater decline in rural areas. Use of improved sources of drinking water and sanitation increased with education of household head and wealth, with 80 percent points difference across social groups in 2009. (ZIMSTAT UNICEF 2009). These wide inequalities were sustained to 2010/11 (Summary table; ZIMSTAT 2013b), together with geographical inequalities, with lowest levels of safe water and sanitation in Matabeleland North (See *Figure 5a and b*).

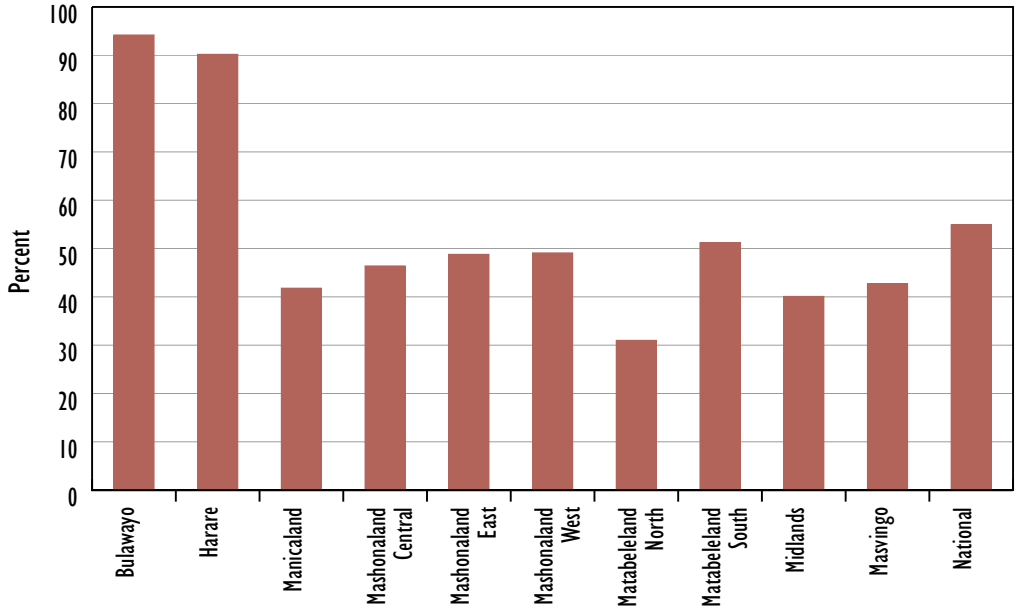
Figure 5a: Provincial distribution of access to improved water 2013/4



Source: ZimVAC 2013

- While Zimbabwe's urban sanitation still outperforms many other countries in the region, there has been a significant decline in the quality of urban and rural sanitation, sewer blockages and dysfunctional wastewater treatment plants (WSP et al. 2011). Water supplies were also intermittent and of poor quality. Harare residents in 2013 reported drinking contaminated water from shallow, unprotected wells and defecating outdoors, violating their right to water and sanitation and raising the risk of disease (HRW 2013).
- A national cholera epidemic covering all ten provinces from August 2008 had by April 2009 led to a reported 4,269 deaths and 97,469 cases (MoHCW 2009). In 2010, 14 out of 62 districts in the country were affected by a further cholera outbreak that started in February, 2010, with 72 percent of cases from rural areas, compared to 53 percent in 2009 (WHO MoHCW 2010). Typhoid and high levels of diarrhoea were reported by government in both 2012 and 2014 (NGO Human rights forum 2014).

Figure 5b: Provincial distribution of access to improved sanitation 2012



Source: Zimstat 2013

© F Machingura, 2011

Progress

A recovery in water and sanitation is critical to prevent cholera, diarrhoeal and other disease outbreaks and their associated human cost, and to address the time and other costs to households, particularly for women and children, to access safe water. In 2011, government published its National Strategy to Accelerate Access to Sanitation and Hygiene 2011- 2015 (GoZ 2011), and ZimAsset proposed substantial investments in water and sanitation infrastructure (GoZ 2013). Addressing the longstanding neglect of improvements in water and sanitation services was estimated in 2011 to require US$3.7 bn (AfDB 2011), with a six-fold increase in capital investment needed to rehabilitate services to meet MDG goals (WSP et al. 2011). While some resources have been raised towards this, the shortfall remains wide and the issue continues to be a critical deficit area affecting health.

Allocating at least 10% of budget resources to agriculture, particularly for smallholder and women producers

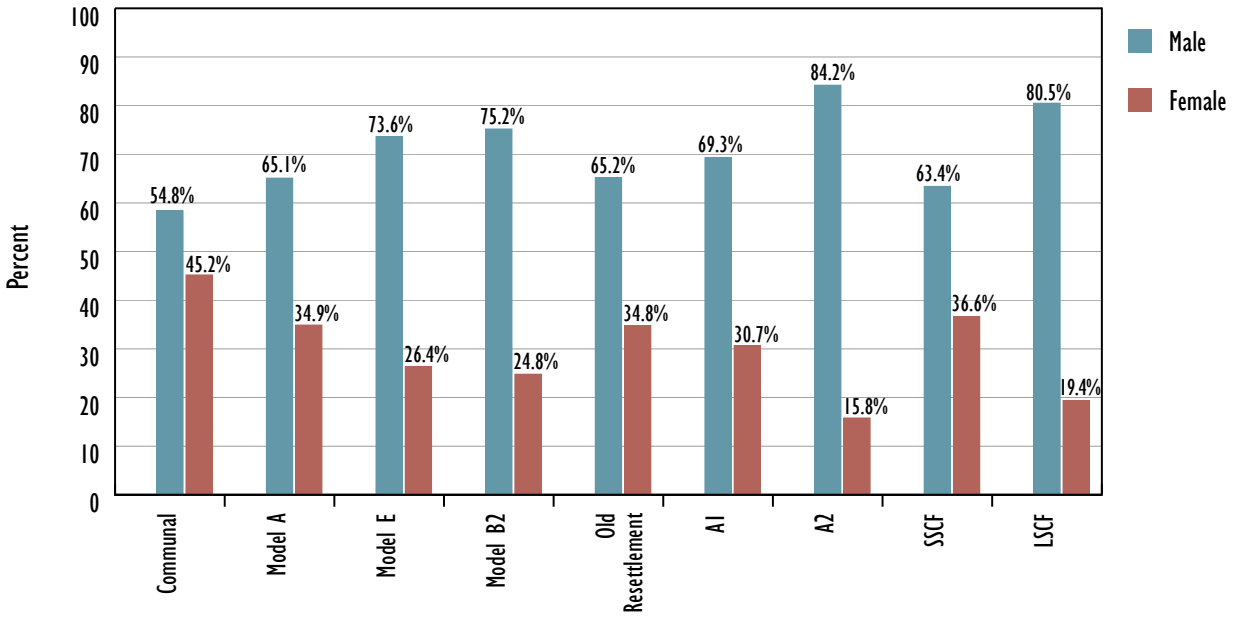
INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
Government spending on agriculture as a percent of total government expenditure	11 4 2 8 8	1990 1995 2000 2005 2007	3.4 2.5 3.8	2009 (*) 2010 (**) 2014

Source: AU/NEPAD 2007, MoFinance 2010,2012, 2014 (*) expenditure (**) budget estimate

Past levels: 1980 – 2008

- From an allocation of 11 per cent of the national budget in 1990, the budget to agriculture fell to 2% in 2000, rising sharply from 2001 to 2005, at a time of significant land reform and falling thereafter to 8 percent in 2007 (AU/NEPAD 2007). Household surveys between 1999 and 2005 showed a fall from 18% to 10% in women's employment in skilled non-agricultural employment in rural areas, suggesting greater reliance amongst women on smallholder farming (Loewenson, Shamu 2008).

Figure 6a: Distribution of farm owners by sex and land type 2010

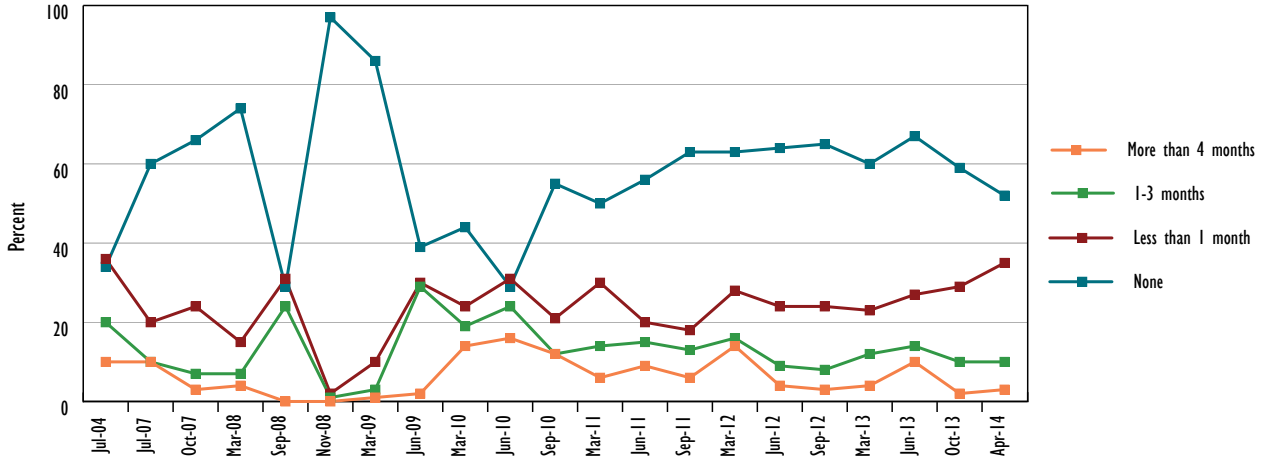


Source: GoZ 2013d SSCF = Small scale commercial farming LSCF = Large scale commercial farming

Current level: 2009-2014

- In 2009-13 the share of the budget to agriculture did not rise above 3.8 percent (see summary table). Investment in smallholder and female farming, especially for local food production has been found to improve health and nutrition, however farmers, especially women farmers, have not always accessed the inputs needed for this. Women had significantly lower ownership of land and access to draught power, credit and irrigation and only four percent of women farm owners secured loans compared to 12 percent of male farm owners (GoZ 2013d; *Figure 6a*; CMP 2013). The Grain Marketing Board owed farmers $6.1bn in 2014 for grain delivered and late payments were reported to discourage cereal production, together with shortages and rising prices of fertiliser (WFP and Vam 2014). Community monitoring reports indicated a relationship between levels of own produce and household food security. For example although food prices rose in 2014, a rise in average maize yields and in consumption from own production was associated with rising levels of food stocks (CMP 2014; *Figure 6b*).

Figure 6b: Reported level of food stocks, 2004 –2014



Source: CMP 2014

Progress

The evidence suggests that there are still further steps for the potential of land reform to translate into health equity and food security gains, particularly through investment in smallholder food production. These include improved support for inputs, timeliness of payments for cereal deliveries and overcoming gender inequalities in land ownership, and in access to capital and inputs.

EQUITY WATCH

© UNICEF Zimbabwe

Advancing equity in health

This section presents markers of progress in health equity, in terms of the values that underpin health equity and the progress in addressing social and geographical inequalities in health outcomes. With expectations of attainment of the Millennium Development Goals (MDGs) in 2015, this section reviews achievement in equity also in relation to the key health goals (MDG 4, 5 and 6). It adds a new category of trends and inequalities in chronic conditions, given the rising challenge posed by conditions such as hypertension, diabetes, heart and liver diseases, cancers, injuries and other disorders.

Formal recognition and social expression of equity and universal rights to health

Past levels: 1980-2008

- Zimbabwe's constitutional processes and amendments up to 2013 did not address the right to health or health care, although the country has been a signatory to the International Covenant on Economic, Social and Cultural Rights since 1991. National health policies have, however, consistently expressed equity and universalism as central principles, organizing health systems around Primary Health Care (PHC),

Current level: 2009-2014

- The Government National Health Strategy 2009-2013 raised universality, equity and quality as central principles and "the protection of health rights in the constitution" as a national priority (MoHCW 2010). With input from communities, stakeholders and policy makers, the 2013 Constitution for the first time guarantees the right to health care in section 76 providing that:
  - *(1) Every citizen and permanent resident has the right to access basic health care including reproductive health services*
  - *(2) Every person living with a chronic condition has the right to access basic services for the illness*
  - *(3) No person may be refused emergency medical treatment in any health-care institution*
  - *(4) The State must take responsible legislative and other measures, within limits of resources available to it, to achieve the progressive realization of the rights set out in this section (GoZ 2013c).*
- Rights to health determinants such as safe water were also included, as noted earlier. They were upheld by the High Court in May 2014 when it ruled that disconnecting water supplies of defaulting residents was unconstitutional without court approval (Nemukuyu 2014). Various processes have operationalised these rights. In 2012-2014 MoHCC reviewed the 1995 core health services package to identify entitlements to services, as described in a later progress marker. In 2011 to 2013, widespread consultations were held on the Public Health Act of 1924 led by the Advisory Board of Public Health (PHAB) and the MoHCC and a Public Health Bill prepared that adopted a rights based framework to promote health, address the social determinants of health and access to health care in a manner that "promotes justice, equity and gender equity" (PHAB MoHCW 2011). Zimbabwe signed the WHO Framework convention on tobacco control and has enforced greater compliance with tobacco advertising laws.
- At the same time there is a gap in knowledge of current public health law that suggests a need for wider promotion of and awareness on health laws for their implementation (TARSC, MoHCC 2013; TARSC 2014). This was drawn into focus by reports in January 2014 of the very high fees being taken by top executives at the country's biggest medical aid society, raising attention to the poor regulatory oversight of the 30 health private voluntary health insurance companies funding largely private health care services (Huruva 2014). In 2000 the Competition and Tariff Commission (CTC) had also raised concern that the growing monopolies of insurers and providers in Zimbabwe limited patient choice, and conflicted with the terms of the Medical Aid Societies Statutory Instrument 330 of 2000 (Shamu et al. 2010). While government has since appointed a senior official from MoHCC to regularise the operations of the specific medical aid society, the case has raised wider attention to the limitations on enforcement posed by shortages of personnel, ambiguities in the law, lack of reporting from societies and lack of awareness and advocacy by members (Huruva 2014). A nearly 100 percent increase in consultation fees for private doctors in May 2014 triggered a further demand that the state meet its constitutional duties to provide health care, given the cost escalation in the private for profit sector (Mathuthu 2014)

Progress

The inclusion of rights to health and health care in the 2013 Constitution is a key step in formally recognising equity and social justice in health, as have been the law reform, judicial and health sector processes that seek to operationalise it. Both state and civil society capacities need to be strengthened to implement these rights, including in relation to private sector services.

Eliminating differentials in maternal mortality, child mortality (neonatal, infant and under five) and child under-nutrition

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL Level	Year
Child mortality rate 1–5 yrs / 1000 (CMR)	23.0	1980	28.0	2009
	39.6	1999	29.0	2010/11
	24.0	2005/6	21.0	2014
• ratio rural : urban (number:1)	1.61	1999	1.63	2009
	1.22	2005/6	0.92	2010/11
• Ratio lowest to highest quintile	2.08	2005/6	2.91	2010/11
• lowest: highest mothers education ratio	2.31	2005/6	1.74	2010/11
• highest to lowest region ratio	2.91	2005/6	3.45	2010/11
Under 5 mortality rate / 1000 (U5MR)	102	1999	84	2010/11
	82	2005/6	90	2012
			75	2014
• ratio rural : urban (number:1)	1.60	1999	1.15	2009
	1.10	2005/6	0.99	2010/11
• Ratio lowest to highest wealth quintile	1.26	2005/6	1.47	2010/11
• lowest: highest mothers education ratio	1.21	2005/6	1.25	2010/11
• highest to lowest region ratio	2.22	2005/6	2.69	2010/11
Infant mortality rate / 1000 (IMR)	49	1980	67	2009
	65	1999	57	2010/11
	60	2005/6	56	2012
			55	2014
• ratio rural : urban (number:1)	1.38	1999	1.16	2009
	1.09	2005/6	1.04	2010/11
• Ratio lowest to highest wealth quintile	1.07	2005/6	1.15	2010/11
• lowest: highest mothers education ratio	0.91	2005/6	1.22	2010/11
• highest to lowest region ratio	2.22	2005/6	3.04	2010/11
Maternal mortality rate / 100 000	350	1999	960	2010-11
Household survey data	555	2006	525	2012
	725	2007	614	2014
Stunting in children < 5 years (height for age <2SD) - % total children	33.6	1999	35.2	2009
	34.6	2005/6	32.0	2010/11
			27.6	2014
• ratio rural : urban	1.32	2005/6	1.21	2010/11
• lowest: highest wealth quintile ratio	1.42	2005/6	1.55	2010/11
• lowest: highest mothers education ratio	1.14	2005/6	1.35	2010/11
• highest to lowest region ratio	1.48	2005/6	1.31	2010/11
Under-nutrition in children U5 years (weight for age<2SD) % total	10.3	1999	9.7	2010/11
	13.2	2005/6	3.3	2014
• ratio rural : urban	1.64	2005/6	1.26	2010/11
• lowest: highest wealth quintile ratio	2.58	2005/6	2.111	2010/11
• lowest: highest mothers education ratio	1.45	2005/6	1.22	2010/11
• highest to lowest region ratio	2.19	2005/6	2.22	2010/11

Sources: CSO Macro International. 1995; 2000; 2007; ZIMSTAT UNICEF 2009, ZIMSTAT ICF Macro 2010, 2012; MoHCW 2009 ; ZIMSTAT 2013; ZIMSTAT 2014. Note: 2007 MMR data and 2010 nutrition data used different analytic methods limiting comparison; maternal mortality; infant and child mortality differentials cover a 10 year period before the survey; maternal mortality for 2014 covers the 7 years before the survey

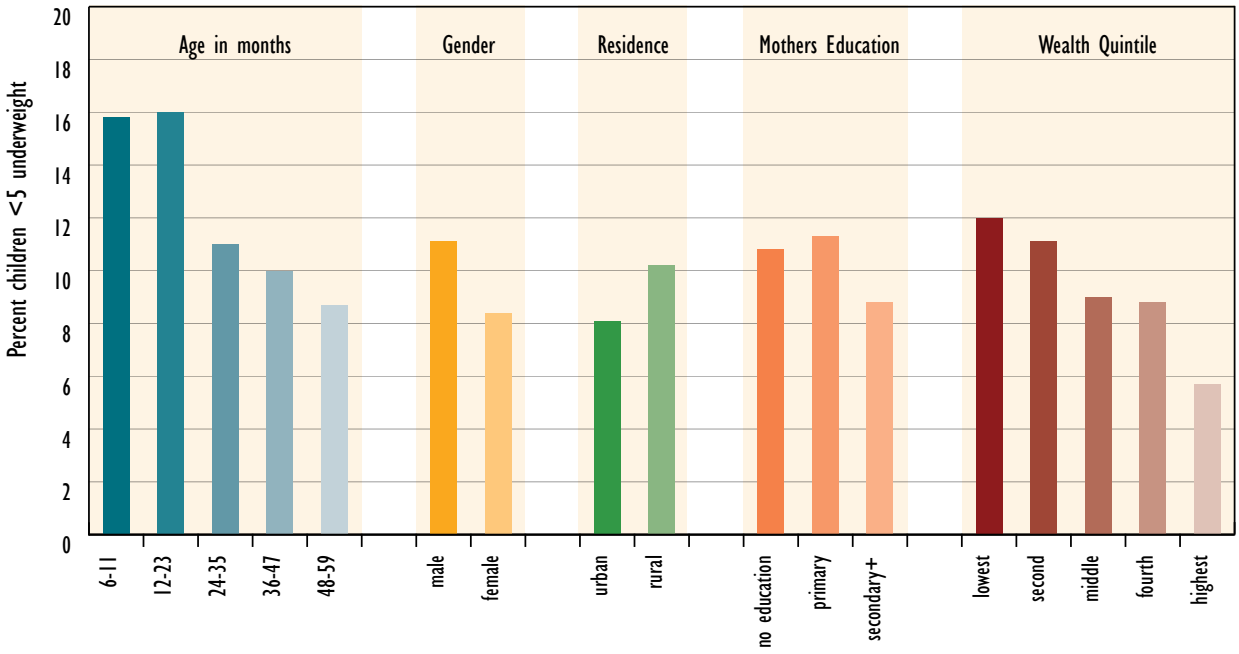
Past levels: 1980 – 2008

- Child and infant mortality fell between 1999 and 2005/6, while child undernutrition rose after 1994 (CSO; Macro Int 2000). Inequalities in child, under 5 year and infant mortality were higher across geographical regions than across wealth or mother's education (see summary table), although wealth related inequalities widened for child mortality. Nutrition, a key determinant of child survival, varied most widely by wealth and geographical region. Vulnerability was noted to begin at early ages, with low rates of exclusive breastfeeding in the first 6 months (GoZ and UNICEF 2007). A significant rise in maternal mortality in the period, shown in the summary table, related to service issues, such as limited availability of skilled birth attendants at first referral level; limited access to health facilities and transport; unwanted teenage pregnancies and abortion complications; social attitudes condoning violence against women and inadequate services to address gender violence (Parl of Zimbabwe 2008). While the median age at first birth rose in urban areas after 1999, it did not rise in rural areas, with half of young rural women pregnant in their teens (Loewenson, Shamu 2008).

Current level: 2009-2014

- The summary table indicates improvements in infant mortality from 2009 to 2010/11, with no further improvements to 2012, and improvements in child and under 5 year mortality between 2011 and 2014. There is some debate on whether the data for 2005/6 and 2010/11 is comparable due to sampling variability and reporting errors (ZIMSTAT and ICF 2012). Neonatal mortality also rose from 24/1000 in 2006 to 30/1000 in 2009 (ZIMSTAT UNICEF 2009). Differences by residence (rural:urban) fell for all three areas of mortality between 2006 and 2010/11. Other inequalities widened, particularly across geographical and wealth region, for all three areas of mortality, and less so by mother's education (see summary table). Under-5 mortality is highest in Manicaland (97 deaths per 1,000 births) and lowest in Matabeleland North (36 deaths per 1,000 births). Socio-economic inequalities in child survival also appear to become more significant as children grow older.
- While levels of wasting and overweight declined continuously since 1999, stunting did not (ZIMSTAT 2013b),with a small decline between 2010 and 2014 and increased child stunting in urban areas (ZIMSTAT and ICF Int 2007; 2012). Wealth and regional inequalities in undernutrition remained relatively high, with smaller gradients by mother's education (see summary table and *Figure 7a*). By 2010/11 nutritional outcomes were poorest in the first year of life (ZIMSTAT and UNICEF 2009; *Figure 7a*). There has been an increase in breastfeeding of children under 6 months, but only 31 percent of these children are exclusively breastfed, with over a quarter of infants also consuming water and complementary foods (ZIMSTAT and ICF Int 2012). Ensuring conditions for exclusive breastfeeding and nutritious weaning foods appears to be important to improve nutrition in infancy.

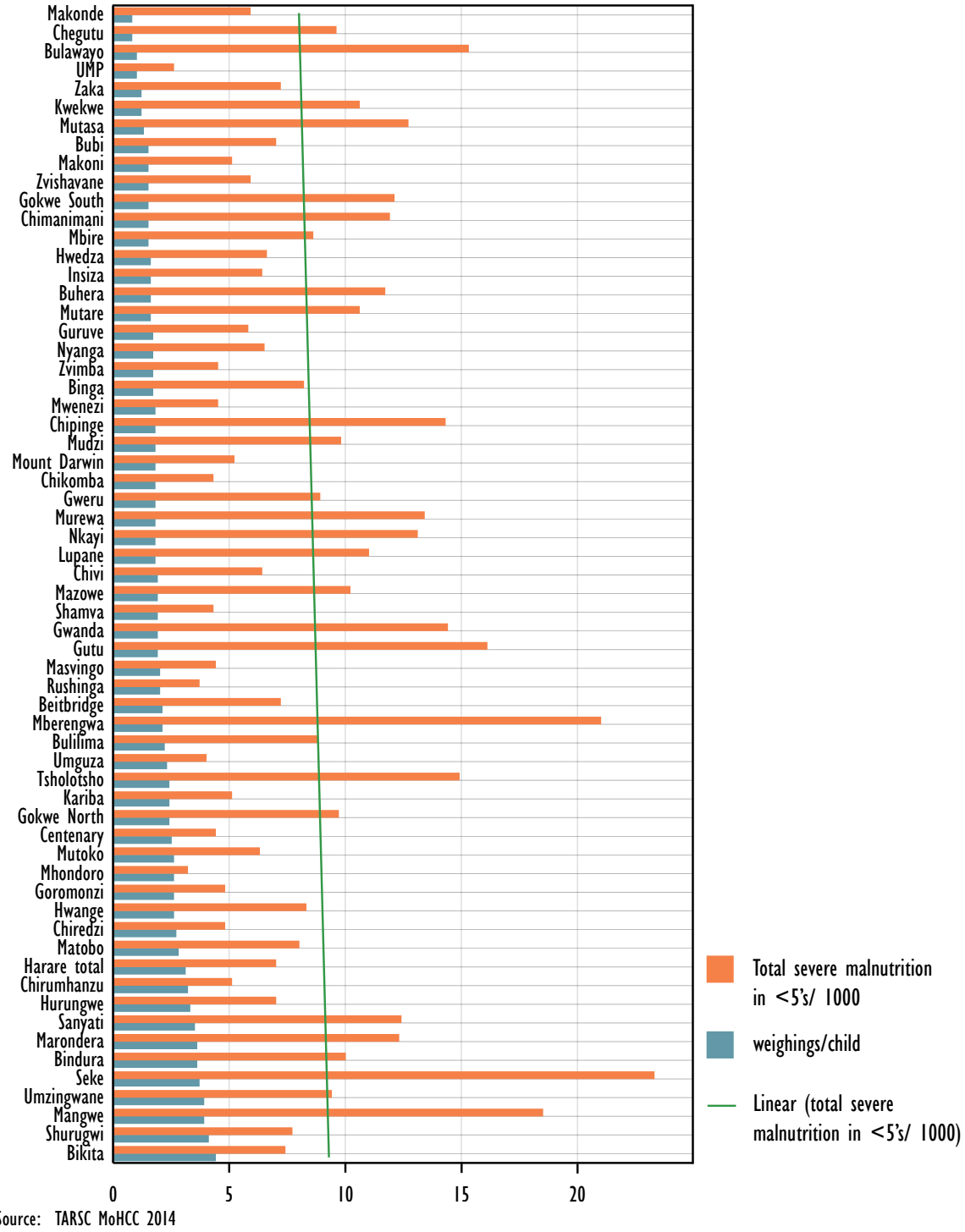
Figure 7a Differentials in child under-nutrition (weight for age) 2010/11



Source: ZIMSTAT and ICF Int 2012

- Monitoring their growth assists to identify children at risk of malnutrition. According to the MoHCC Health information system (HIS), each under 5 year old was weighed 2.4 times on average in 2013, (the same as in 2012) with no difference by gender. While there was some variation across districts in rates of growth monitoring it was not associated with the level of poverty and weakly associated with the reported level of severe malnutrition. (*Figure 7b*). This may mean that districts that are monitoring more are more able to detect and manage malnutrition, or that more children are brought for growth monitoring in areas where malnutrition is more common. On either basis the direct relationship is beneficial. The HIS evidence confirms household survey findings that districts with higher income, like Bulawayo and Mutare, also have high levels of child malnutrition. Within wealthier urban areas there are thus many vulnerable households and children that need to be identified.
- The summary table shows a significant aggregate rise in the maternal mortality rate (MMR) to 2011 and a fall thereafter to 614 in 2014. It is difficult to compare data across the period due to differences in analytic methods, and the wide confidence intervals for MMR estimates. Nevertheless the recorded rates are far from government's target of 70 maternal deaths / 100,000 live births by 2015. The upward trend suggests that maternal mortality has risen over the past two decades (ZIMSTAT and ICF 2012; MoHCW 2008b).
- Reproductive and maternal health services play a key role in preventing maternal mortality, further discussed in the next progress marker. The four main causes of death for 2010-11 were postpartum haemorrhage, sepsis, eclampsia and malaria. Of the deaths notified in 2010 and 2011, 70% were perceived as avoidable, with the majority attributed to delays in seeking and accessing care (GoZ and UNDP 2012).
- Although facilities report on maternal mortality, without population data on its distribution, it is difficult to track the distribution of need, including for allocation of resources. That there are such differentials is suggested by the lowest income groups having double the risk of adolescent pregnancy than the highest (ZIMSTAT UNICEF 2009). The Maternal Mortality Inter-Agency Group notes that, with the risk of maternal death rising significantly for deliveries outside institutions or by non-skilled persons, more attention needs to be given to access to and quality of these services (UN Zimbabwe 2013).

Figure 7b: Levels of severe child malnutrition vs frequency of weighing by district, 2013



Source: TARSC MoHCC 2014

Progress

The levels of under five mortality (90/1000) and infant mortality (56/1000) are far from the MDG targets of 34/1000 and 22/1000 respectively, as is the level of child undernutrition. Socio-economic inequalities in child survival have widened and appear to become more significant as children grow older, so that the deficits on these MDG targets are likely to be even higher for children in poorer households. Health services can make some difference to this, including in immunisation and services for HIV, malaria and other prevalent conditions, but there is need to address the key determinants raised earlier – water, sanitation, food and shelter- to make stronger improvements in child mortality. The evidence suggests the need to create conditions for exclusive breastfeeding and the options for nutritious weaning foods, as well as to encourage growth monitoring, to identify and support children in vulnerable situations in both urban and rural areas and to address the gender inequalities in household food production raised earlier. While there are some signs of recent improvement, Zimbabwe's high level of maternal mortality, well above its MDG target, points to a need to improve service uptake and access, discussed later.

Eliminating income and urban/rural differentials in immunisation, antenatal care, attendance by skilled personnel at birth

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL Level	Year
Full immunization % coverage 12-23 months	80	1994	49.0	2009
	75	1999	64.3	2010
	53	2005/6	64.5	2010/11
			69.2	2014
• Urban: rural ratio	1.08	1994	1.44	2009
	1.15	1999	1.12	2010/11
	1.16	2005/6		
• Highest to lowest mothers education ratio	1.21	2005/6	1.61	2010/11
• Highest to lowest wealth quintile			1.34	2010/11
• Highest to lowest region ratio			1.79	2010/11
% pregnant women with at least one ANC visit	94.4	1994	93.0	2009
	94.5	1999	89.8	2010/11
	95.0	2005/6	93.7	2014
• Urban: rural ratio	1.01	2005/6	1.07	2009
			1.00	2010/11
• High:low mothers education ratio			1.11	2010/11
• Highest to lowest region ratio			1.11	2010/11
% pregnant women with 4 + ANC visits	74.0	1994	57.0	2009
	64.3	1999	64.8	2010/11
	71.1	2005/6	70.1	2014
• Urban: rural ratio			1.08	2009
			1.03	2010/11
• Highest to lowest mothers education ratio			1.71	2009
• Highest to lowest wealth quintile			1.26	2009
• Highest to lowest region ratio			1.24	2009
% births attended by skilled personnel	69.2	1994	52.0	2009
	72.5	1999	66.2	2010/11
	68.5	2005/6	80.0	2014
• Urban: rural ratio	1.70	2005/6	1.48	2010/11
• Highest to lowest wealth quintile ratio	2.07	2005/6	2.38	2010/11
• Highest to lowest mothers education ratio	2.85	2005/6	2.44	2010/11
• Highest to lowest region ratio	1.64	2005/6	1.72	2010/11

Sources: CSO Macro International 1996, 2000, 2007, ZIMSTAT UNICEF 2009; ZIMSTAT ICF 2012, ZIMSTAT 2014

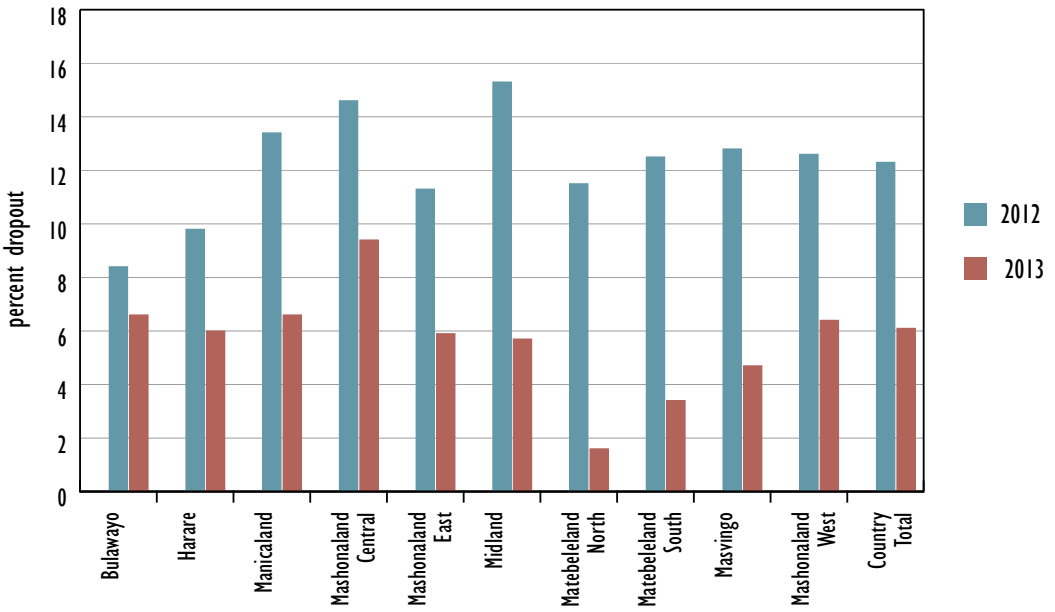
Past levels: 1980 – 2008

- Immunisation rates fell between 1994 to 2005/6 (see summary table). While some groups, such as the apostolic sects, oppose immunisation on religious grounds, the decline was mainly due to falling service delivery and outreach. Rural-urban inequalities grew as immunisation levels fell, with greater declines in rural coverage. An inverse relationship between immunisation and under 5 year mortality suggests that falling access to immunisation may have played a role in increased child mortality in the period. Village health workers (VHWs) who help improve uptake of such health services were reported to lack resources to do their work and were not present in newly settled areas (GoZ UNICEF 2007). After mid-2005, Child Health Day campaigns reached two million children biannually through a one-week national vaccination outreach and immunisation coverage increased to over 80% in 2007 (Singizi 2007). While antenatal care (ANC) attendance was relatively high between 1994 and 2005, the numbers of women attending four or more ANC visits and attended by a skilled birth attendant for deliveries decreased to 69% by 2005, attributed to shrinking incomes and increases in service charges (MoHCW, 2006, 2007). A number of barriers limited uptake of maternal health services, including failure to recognise danger signs, high fees at district hospitals, first use of traditional healer; and shortfalls in communication facilities, transport, medicine and skilled staff at primary care services (MoHCW 2009). not rise in rural areas, with half of young rural women pregnant in their teens (Loewenson, Shamu 2008).

Current level: 2009-2014

- Full immunisation coverage fell to 49% in 2009, but has since risen to 69% in 2014, still lower than levels in the early 1990s and below herd immunity levels (See summary table). Inequality in vaccination coverage fell as coverage rates rose after 2009, with widest inequalities by region. Pneumococcal conjugate vaccine (PCV 13) was introduced in July 2012 against pneumonia, meningitis, sepsis, and some forms of deafness (UNICEF 2012). Both the Health information system (HIS) in 2012 and 2013 and the 2010/11 DHS survey found Manicaland to have lowest level of immunisation and Matabeleland North to have the highest (TARSC MoHCC 2014). In Manicaland, where religious beliefs have been identified as barriers, immunisation coverage improved in 2013. The drop-out from pentavalent vaccine 1 to 3 gives an indication of the distribution of barriers to uptake. It has halved since 2012 to an average of 6% dropout in 2013, showing improved access. Children in Mashonaland Central were, however, nearly **three times** as likely to drop out of pentavalent than children in Matabeleland North (*Figure 8a*).

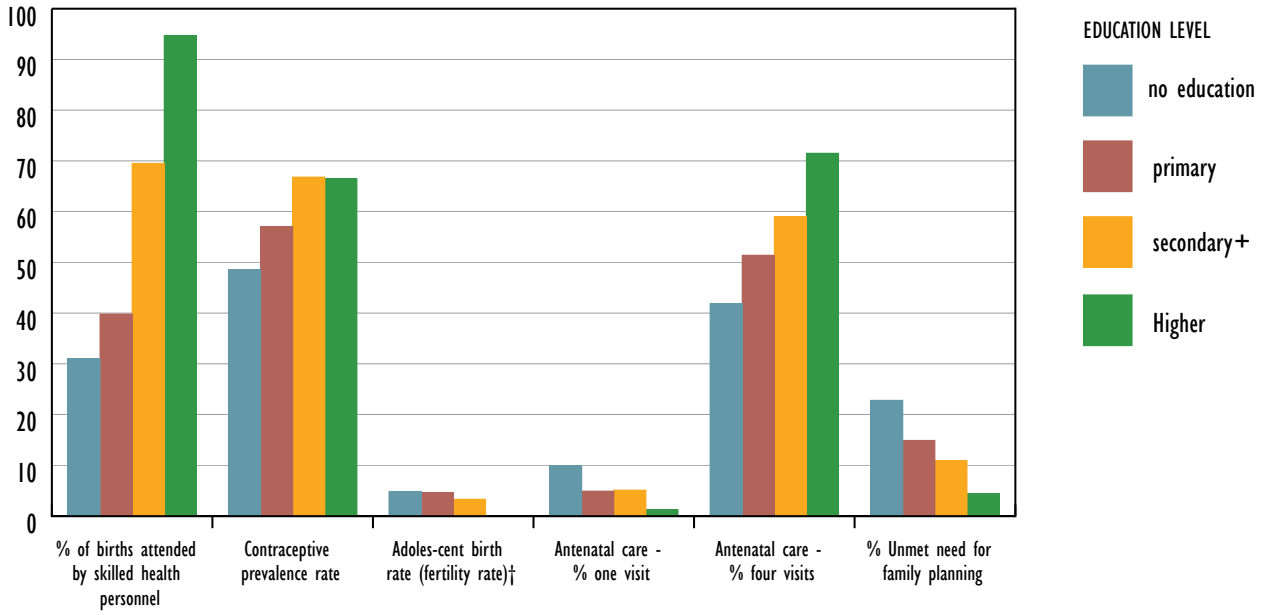
Figure 8a: Dropout from pentavalent 1 to 3 in children under one year old, 2012 and 2013



Source: TARSC MoHCC 2014 from HIS data

- Antenatal care (ANC) attendance of one visit has been at consistently high levels. Attendance of four ANC visits or more rose between 2010 and 2014, improving the opportunity for ensuring healthy pregnancy and delivery. It was still 23 percent points lower than that for one ANC visit by 2014, with wider inequalities by mother's education (See summary table), Attendance of births by skilled personnel also rose markedly in 2014, although with high differentials by wealth and mother's education (See summary table). The most significant social differential for coverage of maternal health services has consistently been mother's education (summary table; *Figure 8b*).

Figure 8b Maternal health data by mother's education 2009



Source: ZIMSTAT and UNICEF 2009

- Wealth and regional disparities in coverage of maternal health care were also high in 2009. A 2009 assessment of PHC found that nearly one in three deliveries were done outside the district of residence, as people search areas where there is better quality or more affordable care. Only 22% of facilities reported having a maternity waiting home to accommodate them (TARSC CWGH 2009). By 2011, 69% of doctor positions and 80% of nurse midwife positions were vacant (Beukes 2013). The social differentials in maternal health begin with the unmet need for family planning and exist at all stages of the reproductive process (ZIMSTAT and UNICEF 2009). This presents as a chain of disadvantage, where each stage acts as a filter to effective coverage for safe childbirth. While for each single intervention in the chain, the ratio of highest to lowest quintiles is between 1.2 and 2.7, in combination, women in the highest quintiles have *four times the delivery effectiveness* in accessing these key elements of effective maternal health care, shown below:

Table 3: Wealth quintile differences in accessing reproductive health services, 2008

	% contraceptive prevalence (a)	% ANC four visits (b)	births attended by skilled personnel (c)	Delivery effectiveness = a*b*c
Lowest quintile	.553	.519	.386	0.110
Highest quintile	.676	.656	.921	0.408

Source: Loewenson et al. 2010 using data from Zimstat and UNICEF 2009

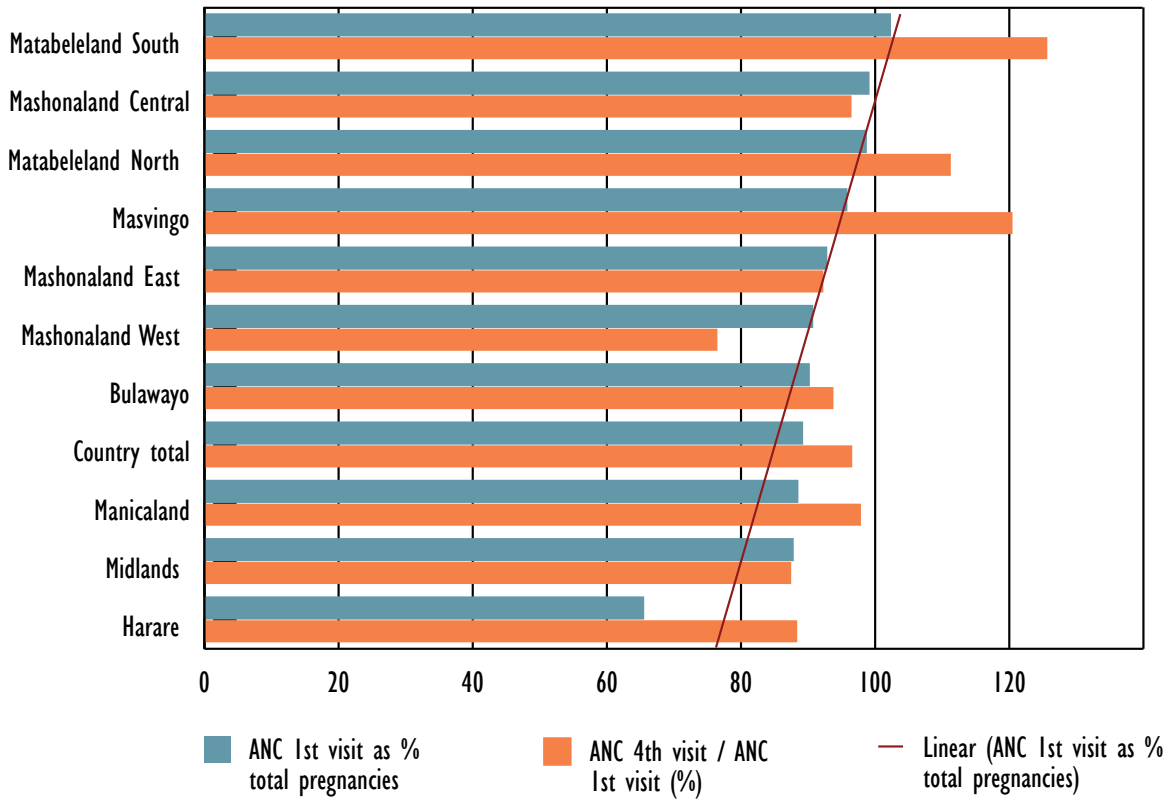
- Through the Health Transition Fund (HTF), the MoHCC has after 2011 lifted user fees for and invested in maternal and child health services. From 2009 to 2013, there was a 27 percent point rise in attendances and facilities offering free child care and an 18 percent point rise in attendances in facilities offering free full maternity care (CCORE and HTF 2013). HIS data showed that the level of *first* ANC visits, already at high levels, has changed little since 2012, but that the level of repeat ANC visits has improved across the country, as has the rate of facility based deliveries, although coverage has fallen in Harare (TARSC MoHCC 2014, See *Table 4*). There was a 69% difference in coverage of maternity services from Umguza at 30% to Marondera at 99%. The low levels in Umguza may be due to its proximity to Bulawayo and people preferring to use the urban services in Bulawayo.

Table 4: Rates of attendance at ANC (4th and 1st visit), 2012 (i)

	ANC 1st visit as % total pregnancies		ANC 4th+ visit / ANC 1st visit (%)		live births at facility as % total live births in population data	
	2012	2013	2012	2013	2012	2013
Bulawayo	86.6	90.1	69.3	93.7	102.2	117.4
Harare	71.5	65.4	90.2	88.3	86.6	74.0
Manicaland	91.8	88.4	95.2	97.8	69.3	71.6
Mashonaland Central	98.4	99.0	78.9	96.4	74.6	78.1
Mashonaland East	93.3	92.7	83.9	92.2	75.5	87.1
Midlands	95.0	87.7	70.8	87.4	68.5	74.5
Matabeleland North	102.9	98.6	121.0	111.2	90.7	89.1
Matabeleland South	105.5	102.2	99.2	125.5	29.3	85.2
Masvingo	98.0	95.7	122.2	120.4	82.6	86.4
Mashonaland West	88.7	90.6	62.9	76.4	64.7	109.0
Country total	90.9	89.1	88.5	96.5	74.9	83.1

Source: HIS data in TARSC, MoHCC 2014 (i) coverage rates of over 100% due to people using services in neighbouring districts and possible inaccuracies in denominator data due to population movements.

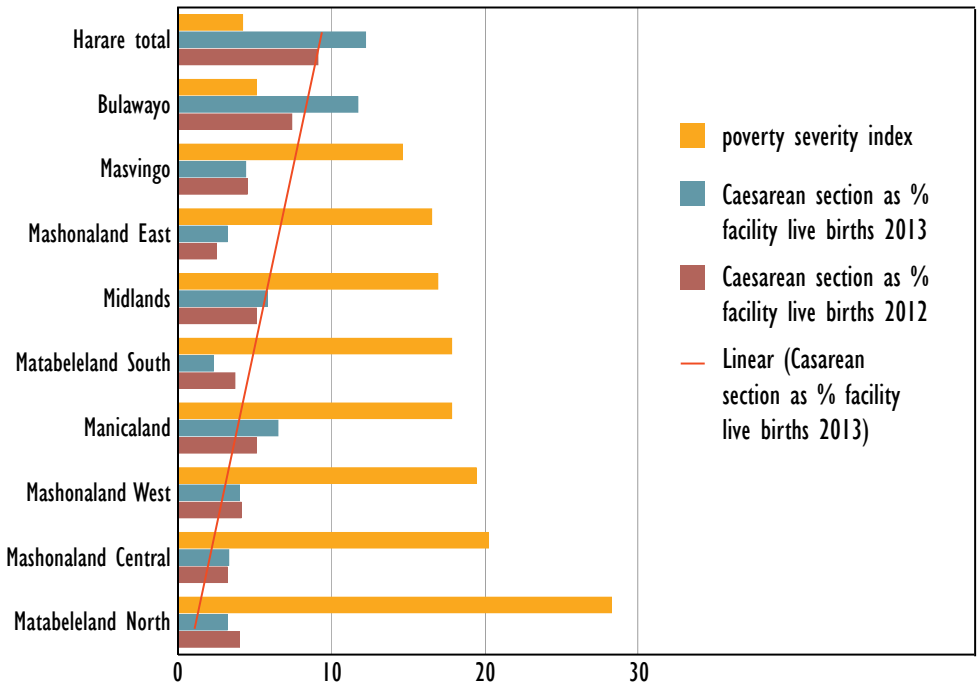
Figure 8c: ANC coverage percent and dropout 1st to 4th visit, 2013



Source: HIS data in TARSC, MoHCC 2014

- There are many indications that ensuring longitudinal continuity (ie sustaining contact with clients) in the delivery reproductive health services is important for equity. Women who attend four or more ANC visits have better pregnancy and delivery outcomes. The HIS shows that provinces that have a higher coverage of first visits for ANC also have less falloff in four or more ANC visits (*Figure 8c*). In 2012 there was a significant positive correlation between contraceptive uptake and assisted deliveries, (R^2 =.263 $p<0.05$) indicating that districts performing well on contraceptive uptake are also performing well on assisted deliveries and vice versa (TARSC MoHCC 2014).
- The access barriers may be both geographical and financial. For example, many women book at advanced stages in order to cut costs and so do not make two or more visits before delivery, especially in lower income households.
- The rate of Caesarean sections suggests complications in deliveries that may arise due to poor antenatal risk screening. It may also, in contrast, indicate better access to referral facilities when complications do occur. In 2013, cities had a higher rate of C- sections and districts with higher levels of poverty had significantly lower rates, suggesting that access to referral services may be the key factor affecting the distribution of this service (See *Figure 8d*)

Figure 8d: Caesarean section and poverty severity index by province, 2012 and 2013



Source: TARSC MoHCC 2014 from HIS data

Progress

After significant declines in coverage of immunisation and maternal health care to 2009, there have been equally significant improvements, albeit not yet to levels in the early 1990s or those set in MDGs. Social disparities and religious barriers appear to have reduced immunization coverage after 2011. However attention still needs to be given to factors affecting availability (cold chain, supplies, service outreach) in regions with low coverage.

In relation to maternal health services, there has also been a steady rise in coverage of ANC and deliveries assisted by a skilled attendant, with measures to reduce cost barriers and improve service delivery. The disparities by wealth and mother's education in service coverage appear to persist and add over the chain of sexual and reproductive health (SRH) services. The evidence suggests the need to intervene early in improving contraceptive uptake and adolescent reproductive health. It points to the need for continuity in SRH services, including in screening, in ensuring four or more ANC visits, and in ensuring referral continuity for complications to close differentials in delivery outcomes.

Achieving UN and WHO goals of universal access to antiretrovirals, condoms and prevention of vertical transmission

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL Level	Year
Adult HIV prevalence (%)	27.54 27.75 19.37 15.60	1995 2000 2005 2007	13.70 15.20 14.99	2009 2010/11 2013
• Urban: rural ratio	1.046	2005/6	1.46	2010/11
• Highest to lowest wealth quintile	0.97	2005/6	1.04	2010/11
% pregnant women having VCT as part of ANC	45.8 92.0	2005 2006	96.0 99.0	2009 2013
• Urban: rural ratio	1.59	2005/6	1.29	2009
• Highest to lowest mothers education ratio	6.49	2005/6	1.90	2009
• Highest to lowest wealth quintile	2.76	2005/6	1.52	2009
• Highest to lowest region ratio	2.07	2005/6	1.42	2009
% women attended VCT given an HIV test	67 72	2005 2006	59.1	2010/11
• Urban: rural ratio			1.17	2010/11
• Highest to lowest mothers education ratio			2.05	2010/11
• Highest to lowest wealth quintile			1.52	2010/11
• Highest to lowest region ratio			1.75	2010/11
Treatment on ART and in PMTCT	1.5	2004	62.0 **	2009
• % in need on ART *	16.0	2005	76.9 **	2013
• % Pregnant women in need on PMTCT *	60.0	2006	59.0 93.0	2009 2013
• % child in need on ART *	9.0 9.7	2006 2007	22.2 46.1	2009 2013
Female Condom use at last high risk sex 15 – 49 year age group				
• Urban: rural ratio			1:1.50	2009
• Highest to lowest wealth quintile			1:1.51	2009

Sources: CSO Macro International 2007, NAC et al. 2006; MoHCW 2006, 2006b, 2007, 2008b, ZIMSTAT UNICEF 2009, ZIMSTAT and ICF International 2012; GoZ 2014a
(*) in need refers to those with HIV and meeting criteria for treatment ** Adults, ART = antiretroviral therapy VCT = Voluntary counselling and testing

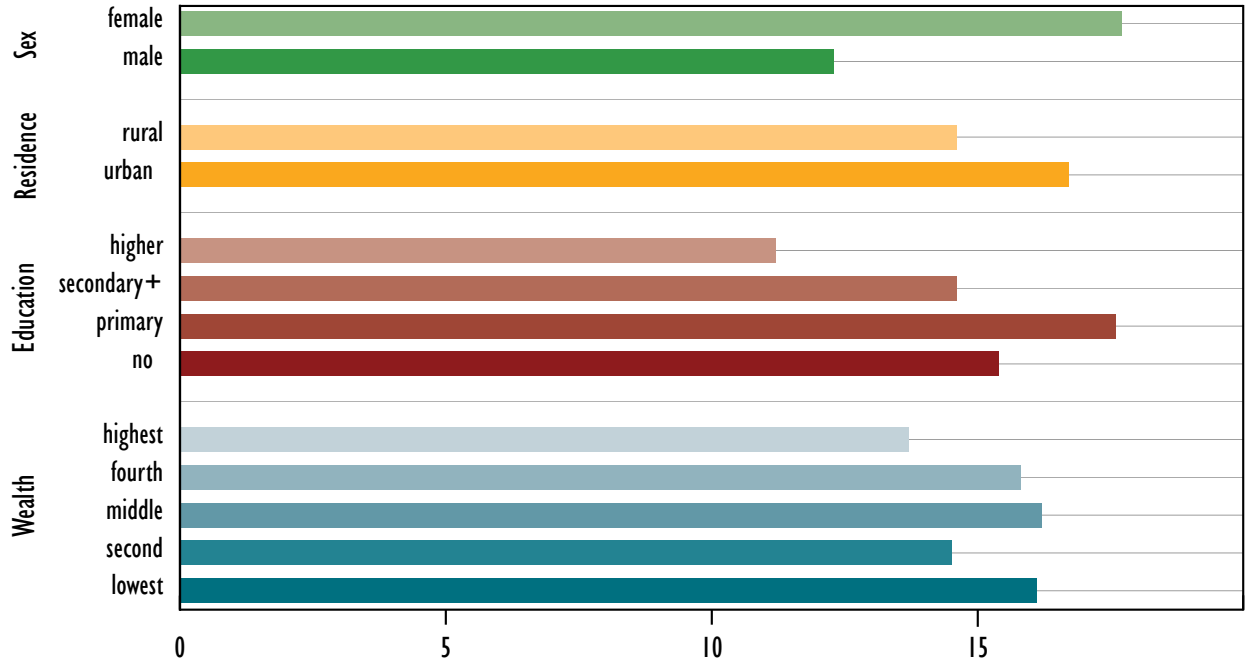
Past levels: 1980 – 2008

- HIV infection rose rapidly in the 1990s, rising with poverty, food insecurity, gender inequality, mobility and spousal separation. It fell thereafter to 2009, attributed to changing sexual behaviour among young people (MoHCW 2008). In 2002, government declared AIDS a national emergency and initiated the AIDS levy, an earmarked tax on income, to fund a National AIDS Trust Fund to implement prevention, treatment and care responses (NAC et al. 2006). VCT coverage rose rapidly and social differentials in access narrowed, although treatment access did not (MoHCW 2007, see summary table). While access to ART and prevention of vertical transmission rose between 2000 and 2005, it remained low up to 2009 (see summary table).

Current level: 2009-2014

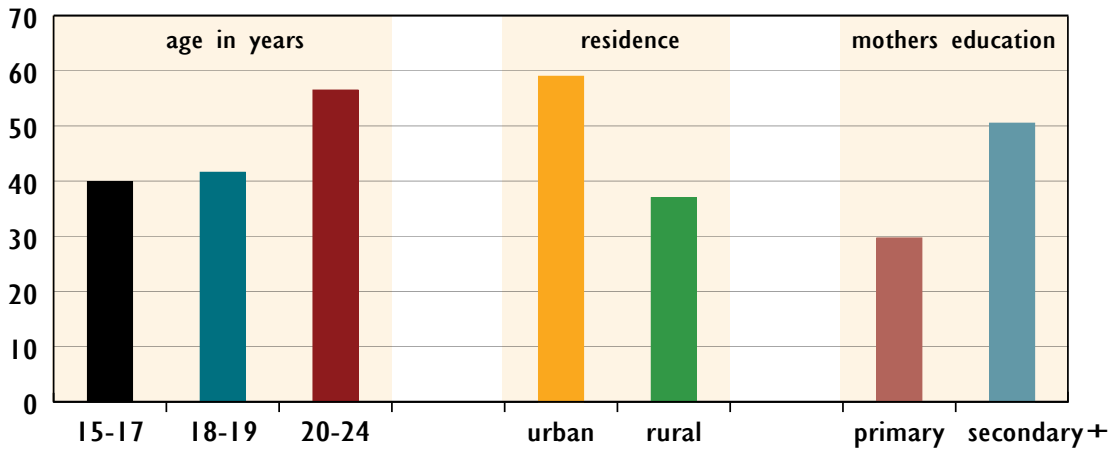
- The National HIV and AIDS Strategic Plan (ZNASP 2011-2015) set targets for 2015 to reduce HIV incidence by 50%, and among children to less than 5% (GoZ 2014a). In 2014, UNAIDS reported that the country is likely to achieve this and the other goals outlined in the plan. Adult HIV prevalence has remained at relatively stable levels (between 13 and 15 percent) but the rate of new HIV infections has fallen from a 1994 peak of 5.2 percent to 1.0 percent in 2013 (UNAIDS 2014). Zimbabwe was reported to have reversed the epidemic faster than any other country in east and southern Africa, contributed to by behaviour change, fewer sexual partners and high condom distribution (UNAIDS 2013). HIV prevalence does not vary widely by province but is higher in border towns, mining areas, growth points and resettlement areas.
- HIV prevalence in 15-24 year olds is 1.5 times higher in women than in men (GoZ 2014a). In addition to wide gender differentials in HIV, the prevalence is also higher in urban areas, and in people with primary education (*Figure 9a*). Wealth related differentials in HIV prevalence have remained fairly narrow since 2009.

Figure 9a: HIV prevalence (% total) 15-49 years, 2011



Source: ZIMSTAT and ICF Int 2012

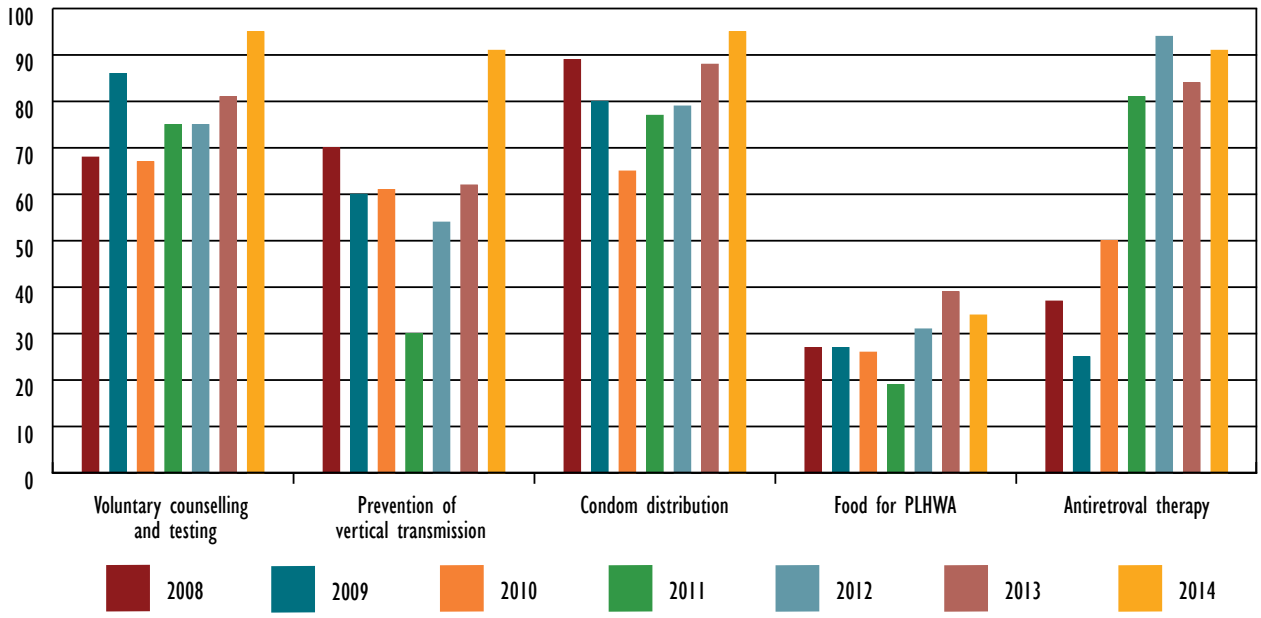
Figure 9b: Female condom use at last high risk sex 2011



Source: ZIMSTAT and ICF Int 2012

- There are wider differentials in access to HIV prevention interventions. HIV testing coverage is higher in rural (83%) than in urban areas (63%), with 32% points difference in coverage across provinces. Condom use was lowest among those who had primary education and in rural women, increasing the risk that HIV persists in poorer communities (ZIMSTAT and ICF International 2012, *Figure 9b*). After 2009, public sector services aimed to circumcise 1.2 million 15–29 year-old males by 2015. By 2014, 11 percent of men reported having been circumcised, or 14 percent of this target (ZIMSTAT 2014; GoZ 2014a).
- Patients are relatively dependent on public services for ART and report difficulties with affording drug prices in private pharmacies (MoHCW 2007). With funding from the AIDS levy (at $32 million in 2012) and external partners (UNAIDS 2013b), ART scale-up in 2012 reached 85% adult coverage under 2010 guidelines, although only 50% under the new WHO recommendations (UNAIDS 2013). The PMTCT programme expanded to all health facilities by 2010 (MoHCW 2010), although with shortfalls in medicine availability and barriers to uptake. In 2013, there were logistics and supply chain management challenges; stock outs of HIV test kits and medicines, inadequately decentralized paediatric ART services and ART initiation for children; unpredictable external funding; inadequate private sector reporting; and variability on the links with communities (GoZ 2014a). Community monitoring reports indicated improved availability of VCT, PMTCT, condoms and ARVs at primary care level by 2014, although there were also reports of medicine stockouts and limited availability of food for people living with HIV (CMP 2014).

Figure 9c: Reported availability of services for HIV, 2008-14



Source: CMP 2014; PLWHA = People living with HIV and AIDS

Progress

From amongst the highest HIV prevalences in the region, Zimbabwe's reversed the epidemic faster than any other country in east and southern Africa. High gender differentials in HIV suggest that social norms and behaviours continue to put young females at risk. There have been significant improvements in service availability, although with shortfalls in continuity of medicine supplies and differentials in coverage by wealth and education. These shortfalls need to be addressed together with access to food and gender inequality so that AIDS does not become a disease of poverty.

Detecting, preventing and managing chronic conditions

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
Prevalence (/1000)				
• Hypertension	10	1990	No comparable prevalence data available in this period	
	40	1997		
	250	2005		
• Diabetes	1.5	1990	See discussion for facility data from health information system	
	5.5	1997		
• Stroke	40.0	2005		
	5	1990		
	15	1997		

Sources: WHO 2011b; Mufunda et al. 2006; MoHCW et al. 2005;

Past level: 1980-2008

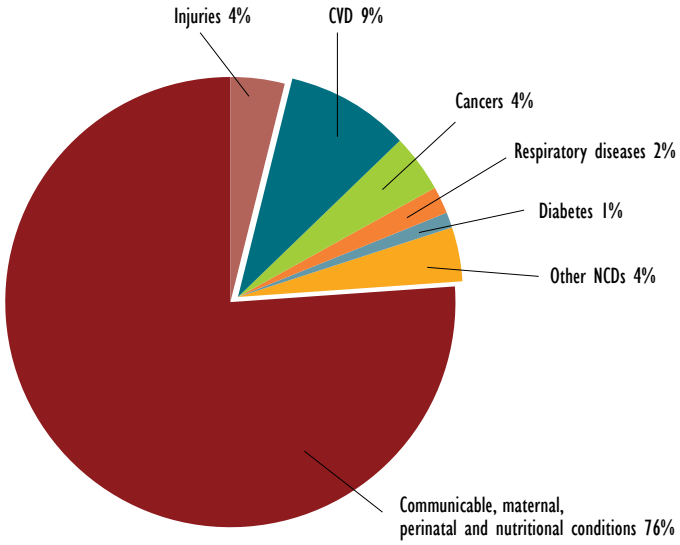
- Non communicable diseases (NCDs) or chronic conditions pose a substantial health and economic burden, and by 2008 both the risk factors and disease outcomes were noted to be high and rising in Zimbabwe, accounting for a fifth of all deaths, relatively equally distributed between men and women (WHO 2011, *Figure 10a*). In 2008, the prevalences of contributing factors were estimated at 39 percent of adults with high blood pressure, and 7 percent obese, with daily tobacco smoking at 9.6 percent and physical inactivity at 21.7 percent (WHO 2011b). The levels of NCDs appear to have risen rapidly (see summary table), although this may underestimate real levels, with a hidden larger share of people who are undiagnosed and may need higher cost care in later stages of disease. Poorer and more disadvantaged groups have a higher risk of NCDs and are more likely to have undetected problems and less resources for the costs of sustained care.

Current level: 2009-2014

- There was no available survey data for chronic conditions / NCDs post 2009. The most common NCDs leading to more years of life lost in Zimbabwe are reported to be hypertension; road traffic injury; stroke; congenital abnormalities; ischemic heart disease; liver cirrhosis; chronic kidney / renal disease; diabetes; chronic obstructive pulmonary disease (COPD); cervical cancer and mental disorders (WHO 2011b; IHME 2010). According to the HIS data for 2012 and 2013, there were a total of 21821 new hypertension cases and 9689 new diabetes cases in the public services in 2012. This incidence of about 3.3/1000 of adults for hypertension and 1.5/1000 of adults for diabetes compares with much higher *prevalence* rates from 2005 surveys of 23 to 29 percent for hypertension and 4

Figure 10a: Non communicable diseases in Zimbabwe 2008

Proportional mortality (percent deaths all ages)

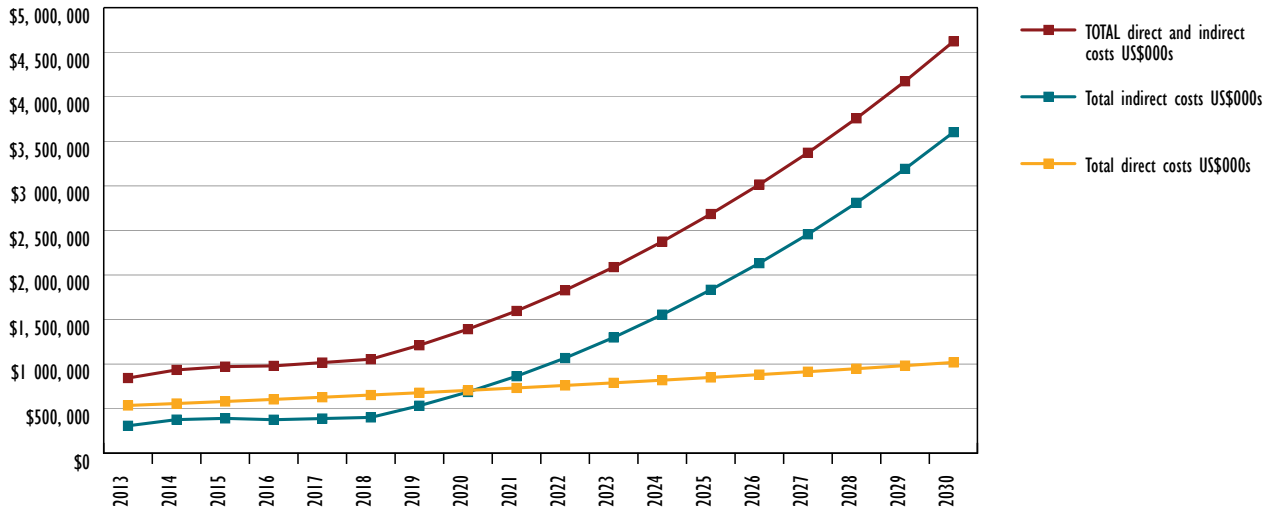


Source: WHO 2011b

percent for diabetes, suggesting that many with NCDs are not using services (MoHCW et al. 2005; TARSC and MoHCC 2014). There appear to be constraints in continuity of care for these chronic conditions. According to the HIS, attendance for hypertension follow up fell markedly in 2013 compared to 2012, while the follow up for diabetes rose markedly in the period, with women more likely to come for follow up treatment than men. Twenty nine percent of men 15-49 years drank alcohol in the month preceding the survey and 19 percent of this group smoked tobacco (ZIMSTAT 2014).

- By 2030 the top ten NCDs alone are projected to lead to over one million outpatient consultations and 27 000 inpatient admissions, with cervical cancer projected to be one of the most rapidly rising NCDs. Assuming no major intervention to prevent or control these top 10 NCDs, their annual direct per capita costs to the health sector and indirect costs to the economy and households are projected to rise by 2030 to $57.22 and $1bn respectively (Loewenson et al. 2013, *Figure 10b*). At the time of preparing this Equity Watch there was policy dialogue on a strategy for NCDs and launch of a pilot programme on vaccination for cervical cancer in school children.

Figure 10b: Projected DIRECT (health care) and INDIRECT (economic) annual costs in US$ 000s for top NCDs 2013-2030



Source: Loewenson et al. 2013; US$ at current exchange rate

Progress

There is some evidence of a rising level of NCDs/ chronic conditions in Zimbabwe that is not adequately being addressed through prevention or care. The absence of household survey information on NCDs is a sign of this oversight and a significant gap in planning, and calls for a risk factor and prevalence survey of NCDs to be implemented as soon as possible, or else inclusion of information on NCDs and the key risk factors in the next demographic and health survey, together with community level surveys of conditions such as hypertension. The projections of the cost to the economy, households and the health sector suggest that more attention be given to prevention and early management of NCDs. It is possible to act now to avoid such costs: to invest in proven cost effective measures for NCD prevention, detection and mitigation in the health sector, and new domestic resources can be mobilised for this, discussed in the next section. Interventions for NCDs include integration of healthy policies of other sectors (a health in all policies approach) to minimize exposure to risks, such as through environmental laws and measures, in road traffic systems and regulation of unhealthy marketing of food, tobacco and alcohol. It also calls for health promotion and public health measures reaching out to schools, communities and workplaces (MoHCC and WHO 2014). Zimbabwe has the unique opportunity of rebuilding its economy and health sector at a time when these costs are known, and when the technology and knowledge exists to address them and to prevent significant future burdens on households, on the health sector and on the economy.

EQUITY WATCH

© UNICEF Zimbabwe

Resourcing redistributive health systems

For health systems to promote health equity, they need to work with other sectors to improve household access to the resources for health, as discussed in the first section. Health systems also need to 'get their own house in order', to promote the features that enhance health equity. This section presents selected parameters of progress in this direction: in the benefits, entitlements and framework for building equitable, universal systems; in mobilizing adequate resources through fair, progressive funding; in allocating resources fairly on the basis of health need; and in investing in the central role of health workers, people and social action in health systems. The 2013 Constitution set commitments to universalism and equity and national strategies set commitments for Universal Health Coverage (UHC) that call for the gap to be closed between the need for quality services and the use of those services, for fair financing and financial protection against impoverishment in using services and to widen services that are person and community oriented and that involve people in decision making and in service delivery.

Achieving the Abuja commitment of 15% government spending on health

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
Government spending on health as a percent of total government expenditure (*)	17.0 7.4 8.9 8.7 12.2	1997 2000 2005 2007 2008	9.5 12.3 7.0 8.2	2009 2010 2013 2014
Total expenditure on health as a percent of GDP	10.8 8.9 8.9	1998 2005 2007	8.0	2010
Total public expenditure on health as a percent of total health expenditure	38	2001	18	2010
Total private expenditure on health as a percent of total health expenditure	62	2001	82	2010

Sources: Govender et al. 2008 ; WHO 2008b; 2011c, 2014; MoFin 2008, 2009, 2010, 2013,2014; Loewenson and Shamu 2006, MoHCW 2009, UNDP 2010; World Bank 2011; GoZ 2013e
Notes: (*) excluding external funding

Past level: 1980-2008

- After peaking in 1997, government expenditure on health fell in 2000, fluctuating thereafter and only rising again in 2008 (See summary table). Expenditure on health peaked in 1998 at 10.8 per cent of GDP and has not recovered to this level thereafter. Health maintained its ranking in the top five ministries in allocation of Government funding in the period (MoHCW 2009). Actual expenditures in 2006-8 were difficult to assess due to supplementary budgets and direct disbursements from the central bank (Shamu and Loewenson 2006).

Current level: 2009-2014

- The share of the government budget rose to 12.3% in 2010, but fell again thereafter to 8.2% in 2014. (See summary table). At 7% in 2013 *excluding* external funding and 10% *including* external funding, the share is significantly lower than the Abuja commitment. The 2013 budget statement projected a further fall to 5% in 2015 (MoF 2012), signalling low priority for domestic health financing in the projected budget. The shortfall is further compounded by a gap between budget and real allocation.

Progress

Zimbabwe has not yet met the Abuja commitment. Although it made some efforts to reverse the significant declines in the health share of the budget in 2008 and 2010, these increases were reversed in subsequent years. The share of GDP to health has been relatively high, but the overall level of public spending is low relative to need, as discussed in subsequent progress markers. While external funding contributes to the health sector, including through off budget funding, there is need for adequate domestic funding to the public health sector, on constitutional grounds, for public leadership in the health sector and to prevent fragmentation of the health system. That this is currently constrained is evident from evidence in 2010 that government contributed only 18% to the total health expenditures with the private sector, including employers (21%), households (39%) and external funders (19%) and other private (3%), contributing the remaining 82% (GoZ 2013e). Long term system and health needs like HIV and NCDs suggest a need to reprioritise domestic health financing, and to make effective use of these resources.

Achieving US$60 per capita public sector health expenditure

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
Per capita government expenditure on health US$ exchange rate	35 11 36	2000 2005 2007	16.50 19.39 15.17	2010 2013 2014
Per capita government expenditure on health PPP US$	14 10 9	2000 2005 2007	Not available	
Per capita total expenditure on health US$ at exchange rate	66 24 79	2000 2005 2007	Not available	
Per capita private expenditure on health US$ at exchange rate	31 13 43	2000 2005 2007	Not available	
Per capita private: public expenditure ratio	0.9:1 1.2:1 1.2:1	2000 2005 2007	Not available	

Sources: WHO 2008; 2008b, 2011b; MoFin 2008, Aitcheson et al 2013, GoZ 2013e In 2001 WHO estimated that US$34 per capita was needed for a package of priority health interventions (HIV, TB and malaria) excluding the systems costs, and $60 per capita to address the full health system costs (WHO 2001).

Past level: 1980-2008

- Total and government per capita health expenditure fell between 2000 to 2005 and both were below the $60 per capita estimated to meet health system costs (WHO, 2008). Private spending overtook public spending in 2005. By 2007, government spending was below US$60 per capita although total spending exceeded this level.

Current level: 2009-2014

- In 2009, of the budget allocation to health of US$7/capita, only US$2/capita was disbursed, and the health sector relied on external funding of US$100 million and US$180 million from the Global Fund Round 8 grants (MoHCW 2010). The 2009 MoHCC investment case identified that a further US$4.11/capita was needed for modest levels of intervention in the health sector and US$18.61/capita for a more comprehensive intervention (MoHCW 2010). The total government per capita allocation in 2010 of US$16.50 was below the WHO recommendation of US$34 (summary table). In 2013, the MoHCC received only $19.39/capita against its bid of US$46.38/capita, a 58% funding gap and far short of WHO recommended funding levels. Notwithstanding the need to effectively use resources, these deficits are significant: $388mn compared with the Abuja commitment, $199mn compared with the WHO MCH target and $332mn against the MoHCC budget bid (Atchison et al. 2013).

Progress

High poverty levels and wide use of public services by poor households means that improved equity depends on improving public sector spending. Current levels of public spending per capita are below levels required to fund a basic system, or for meeting MDG commitments, or to prevent future costs from chronic conditions. The shortfall limits public sector service provision, particularly in least resourced and most disadvantaged areas, with consequences for raised mortality, illness and reduced life opportunities in those areas. With government resources overshadowed by private and external funding, there is a significant challenge for the public sector to know of and align available funds from all sources towards national goals.

Establishing and ensuring a clear set of comprehensive health care entitlements for the population

Past level: 1980-2008

- The MoHCC defined its district core services in 1995 (MoHCW 1995). The National Health Strategy 1997-2007 stated a policy intention to set health care entitlements: 'To underpin future financing strategies, the country will need to guarantee its citizens access to a strategic package of core health services', but did not elaborate what these entitlements were and the 1995 package was used more as guidance than entitlement (MoHCW 1999). In the early 2000s the MoHCC 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). MoHCC identified core health services as those interventions for conditions treatable at the primary care level; environmental health and disease control measures; TB treatment and follow-up; antenatal care and uncomplicated deliveries; and health education within communities (Chihanga 2008).

Current level: 2009-2014

- In 2009, the National Health Strategy (2009-2013) included a commitment to reviewing the basic benefits package. Government noted the importance of setting entitlements and service targets as a basis for partnerships and contracting with non-state providers (MoHCW 2009; Sikhosana 2009). Civil society proposed that a package of essential services be defined and costed at primary level with priority being given to ensuring that this basic level of provision is funded and universally delivered by all providers of primary care clinics (central, local government, mission and other private) (TARSC, CWGH 2009). Wider stakeholders similarly endorsed the need to define, cost and raise awareness on comprehensive health care entitlements at the various levels of the health services (MoHCW, TARSC 2013). The inclusion of a right to health care in the 2013 Constitution, noted earlier, makes establishment of this entitlement even more important, not only for the state but for all health care providers. The District core services defined by MoHCC in 1995 were thus updated in 2013 -2014 as the Essential Health Benefit (EHB), drawing on epidemiological, costing, and community level evidence, including evidence from community level assessment of priority public health problems the EHB should address and services it should include (Gwati 2014; TARSC 2012). The draft package for primary and district services and its costing was under review at the time of writing this report. Preliminary estimates were tabled of a total average cost for the EHB of $16-$25 per capita at primary care level and of $40-$74 at district hospital level with a projection of total five year costs ranging from US$1.5bn to US$6.1bn (Vaughan 2014). This compares with a per capita public spending of $15.17 in 2013 noted in the prior progress marker.
- A falling level of public funds has weakened government's ability to set and implement the agreements with other providers on core services. While the RBF has, as noted earlier, enabled more outcome driven purchasing through incentives at primary care and district level, there is work underway to explore the purchasing measures and formal agreements that can be used to contract state and non-state providers on their service delivery commitments and outputs (Gwati 2014).

Progress

In response to policy, social, stakeholder and constitutional drivers, work has been done to update and cost comprehensive health care entitlements at primary care and district level. The difference between these costs and the current public budget allocations indicates that there will be shortfalls, raising questions on how current choices are made, how improved resource mobilization is achieved and what measures are put in place to ensure effective use of resources to show progressive realization in the delivery of the benefit. These are discussed in later progress markers.

Increasing progressive tax funding to health and reducing out of pocket financing in health

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
% Total Health Expenditure (THE) that is Government spending on health	53.0	2000	18.0	2010
	45.4	2005		
	46.3	2007		
Private spending on health	47.0	2000	82.0	2010
	54.6	2005		
	53.7	2007		
Social Health Insurance	0	2005	0	2010
Out of pocket spending as a percent of private spending	66.5	1995	48.1	2010
	45.5	2000		
	50.5	2005		
	50.4	2007		
External resources as %THE	1.3	2000	19.0	2010
	20.8	2005		
	0.2	2007		

Source: WHO 2011b; WHO, 2008; Shamu and Loewenson, 2006; World Bank 2011, GoZ 2013e

Past level: 1980-2008

- Zimbabwe collected 23 percent of its GDP in tax revenue in 2007, compared with 16 percent for low middle income countries generally. In 2007 direct income taxes contributed 47 percent of revenue and Value added taxes (VAT) 25 percent (UNDP Zimbabwe 2008). The country has had a largely tax funded national health service, albeit with relatively high levels of out of pocket spending. Public expenditure as a share of total health expenditure fell and private expenditure rose by 10 percentage points between 1995 and 2007 (See summary table; WHO 2011b). In the early 2000's, falling public spending, low external funding and relatively high out of pocket spending is likely to have reduced financial protection for poor communities. The AIDS levy added a new and rising share of revenue after 2001.

Current level: 2009-2014

- The sources of tax revenue in Zimbabwe in 2009-2012 are shown in *Table 5*. VAT on non-basic goods has the highest share, followed by income tax, corporate tax and excise duties.
- Measures to reduce out-of pocket spending by waiving user fees are discussed in the next progress marker. Sustaining these measures and avoiding informal charges depends on adequately funding services. Given the underfunding of the public health sector raised earlier, new tax options are being explored. Tax earmarking, or hypothecation, has already been applied in Zimbabwe as one way of improving health financing. The AIDS levy was the earliest earmarked tax. It shrunk in 2007/8 but rose after dollarization to about US $400 000 monthly, with 50% allocated by policy to ARVs (NAC 2011). The mining sector has been exempted from the AIDS Levy Fund and it has been argued that this exemption should be lifted (TARSC MoHCW 2013). Further earmarked tax options have been explored, proposed by the Parliamentary Portfolio Committee on Health in 2007 and by stakeholders reviewing the Public Health Act in 2013. The options reviewed have included earmarking a share of VAT; of excise taxes on cigarettes; fuel; alcohol, mobile phones; financial transactions; and mining taxes.

Table 5: Tax Revenue Contribution 2009 to 2012

Tax %contribution	2009	2010	2011	2012
VAT	39	39	35	32
PAYE	15	19	21	19
Customs Duty	26	16	12	11
Corporate Tax	4	10	13	13
Excise Duty	7	7	12	13
Other Taxes	9	9	7	12

Source: MoF 2012 in Atchison et al. 2013 VAT= Value added tax; PAYE= income tax

- The scale of shortfall on the essential health benefit, raised earlier, suggests the need for a meaningful level of resource mobilisation to meet it. Earmarking 1-2 percent of VAT is the option that comes closest to this, rising over time from US$154 mn in 2013 to $552 mn in 2032. This was calculated to cover total deficits on UHC of community, primary care and district services by 2030, based on projected MoHCC budgets. Earmarking a 25% increase on cigarette taxes, a 1% increase on fuel taxes (with a one of 5% additional in 2014 to raise the $13,7mn to rehabilitate capital equipment for emergency services), and a 5% increase on beer and wine and spirit taxes would yield a total revenue benefit for health of $12.2 in 2014 to $19.5mn in 2022, such as to fund effective promotion, prevention, detection and care interventions for NCDs (MoHCC, TARSC 2013). Consideration of these taxes has been included in the ZimAsset government plans for 2013-2018 (GoZ 2013).
- There have also been discussions of various forms of insurance. A social health insurance for formal sector workers was proposed by the National Social Security Authority (NSSA) in the early 2000s but rejected by parliament until the fiscal conditions and scale of formal employment would be more enabling. There are existing private voluntary insurance schemes covering only 10% of the population (GoZ 2013e). The number of private insurers grew in the 2000s, with numerous small schemes and there are concerns about quick start-ups to make fast money without established business plans or agreements to protect subscribers. There has been some indication that South African private insurers like Netcare have an interest in expanding into Zimbabwe (Foster 2012). Economic liberalisation, limited regulation and the challenges of the 2000s gave impetus and leeway for medical aid societies to acquire services. These managed care arrangements limited beneficiary choice and led to a high degree of vertical integration between funders and providers. Medical Aid Societies Statutory Instrument 330 of 2000 regulated this vertical integration but was poorly applied or monitored (Shamu et al. 2010). The attention raised by inflated salaries in the medical aid society described earlier has led to increased demand for regulation of voluntary insurance. Voluntary insurance is a less equitable form of health financing than tax financing and covers the wealthier social groups. Regulation of voluntary insurance can, however, assist to control cost escalation and ensure that insurance funding pays for services prioritised in national goals.

Progress

The 2010 World Health Report (WHO 2010b) unequivocally states that it is not feasible to achieve UHC through voluntary health insurance, and that these can only be supplementary to universal entitlements funded through mandatory pre-payment financing. Government has a responsibility for funding basic entitlements in health care. There has been a small shift towards reduced out of pocket spending. Any improvements in tax funding has proved volatile and has fluctuated. Earmarked tax revenue in the AIDS levy has proved relatively successful. Other earmarked taxes that are progressive (obtain revenue according to ability to pay) include direct taxes, mandatory (population wide) insurance and indirect taxes (such as VAT) in settings where there are higher levels of informal employment and markets as in Zimbabwe (Mills et al. 2012). Earmarking VAT is the only source that offers sufficient funds to meet gaps in the EHB, while various earmarked excise taxes offer some contribution to new demands from NCDs. Stakeholders have identified that any collections of such funds would need to be accompanied by measures to ensure equity, efficiency, transparency and accountability (MoHCW, TARSC 2013), discussed in a later progress marker.

Abolishing user fees from health systems backed up by measures to resource services

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
Out of Pocket (OOP) (*) spending as a percent of Total Health Expenditure (THE)	30.2 22.6 23.4 27.1	1995 2000 2005 2007	37.0	2010
Out of Pocket (OOP) spending as a percent of private Health expenditure	6.3 46.7 49.6 50.4	1996 2000 2005 2007	39.0	2010

Source: WHO 2011b, World Bank 2010, MoHCC 2014a (*) OOP spending covers health related household spending, including for health facilities, medicines, medical consultations and diagnostic services, estimated from public and private sector health facility revenue.

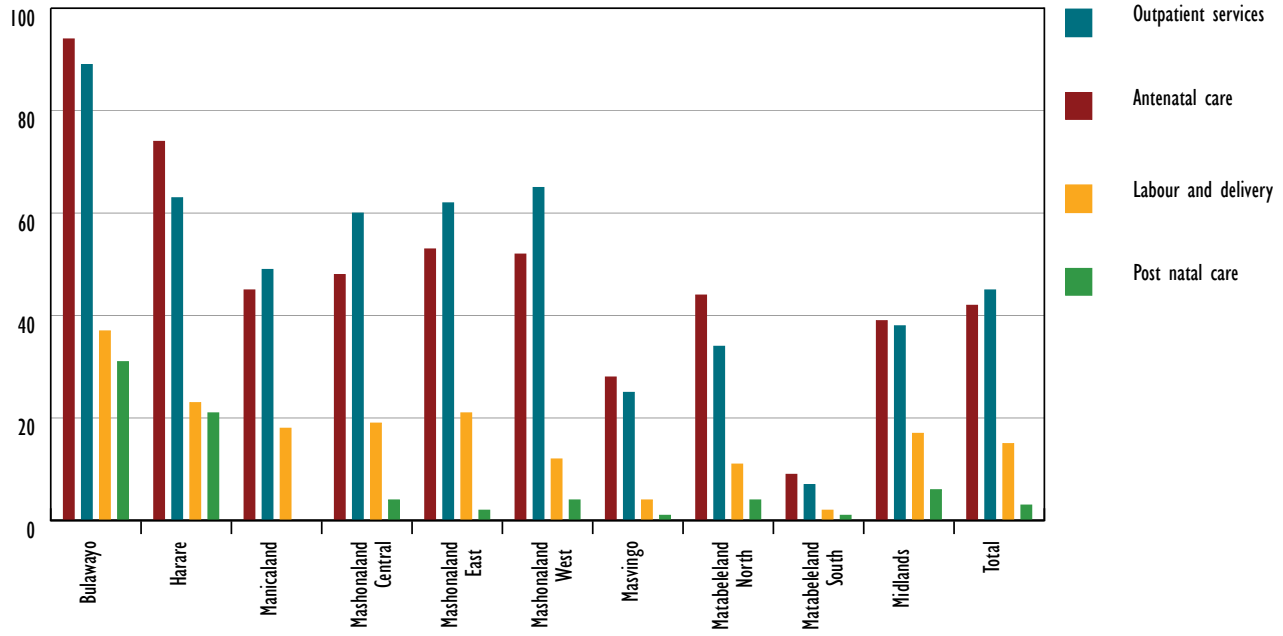
Past level: 1980-2008

- In 1980 free health care was introduced for those on low incomes (below Z$150; US$220). Despite this out of pocket spending was still moderately high at about a third of total health expenditure (summary table). Fee collections were introduced within the structural adjustment programme in 1990, but suspended in rural primary care services in 1995 after evidence of high dropout from services. The Medical Service Act (1998) gave the minister of health authority to fix fee levels at government and state-aided services. The 1997–2007 National health strategy proposed free treatment at primary care level (MoHCW 1999). Inconsistent implementation of this policy together with poorly functioning exemption schemes has meant that poor people faced a variety of cost barriers, including having to purchase medicines due to drug stockouts (MoHCW 1999). At the same time higher income earners obtained tax relief for medical insurance subscriptions and benefited from free services due to difficulties with determining earnings and a 'treat first, pay later' practice.

Current level: 2009-2014

- Despite policy intentions of free primary care, by 2009 the Maternal and Perinatal Mortality Study (2007), the Health Services Study (2008), and the Assessment of Primary Health Care in Zimbabwe (2009) all found that communities reported user fees to be unaffordable and to contribute to reduced access to services (MoHCW 2009). By 2011, outpatient fees were being charged in most urban primary care services and a large share of rural services, including for ANC, but much less so for deliveries and post- natal care (*Figure 11a*). The higher charges on ANC may be due to the booking fee being paid at this stage. As noted earlier this may have been a deterrent to attendance at ANC. User fees were the most commonly mentioned reason for lack of access, especially for maternal health services (MoHCW 2009). The National Health Strategy 2009-2013 proposed to review and abolish user fees at relevant levels and the ZimAsset included removal of user fees for selected population groups (MoHCW 2009; GoZ 2013). In March 2013 user fees at all rural health centres were eliminated for pregnant women, children under five years and those above 65 years of age, while complementing resources for these services through the Health Transition Fund. This policy seems to be having a positive effect, with communities reporting in 2014 a fall in average clinic fees from $4.88 in June 2012 to $2.95 in March 2014 (CMP 2012). However mothers with complications will be sent to referral hospitals where treatment may be costly and resources inadequate for both services and individuals.

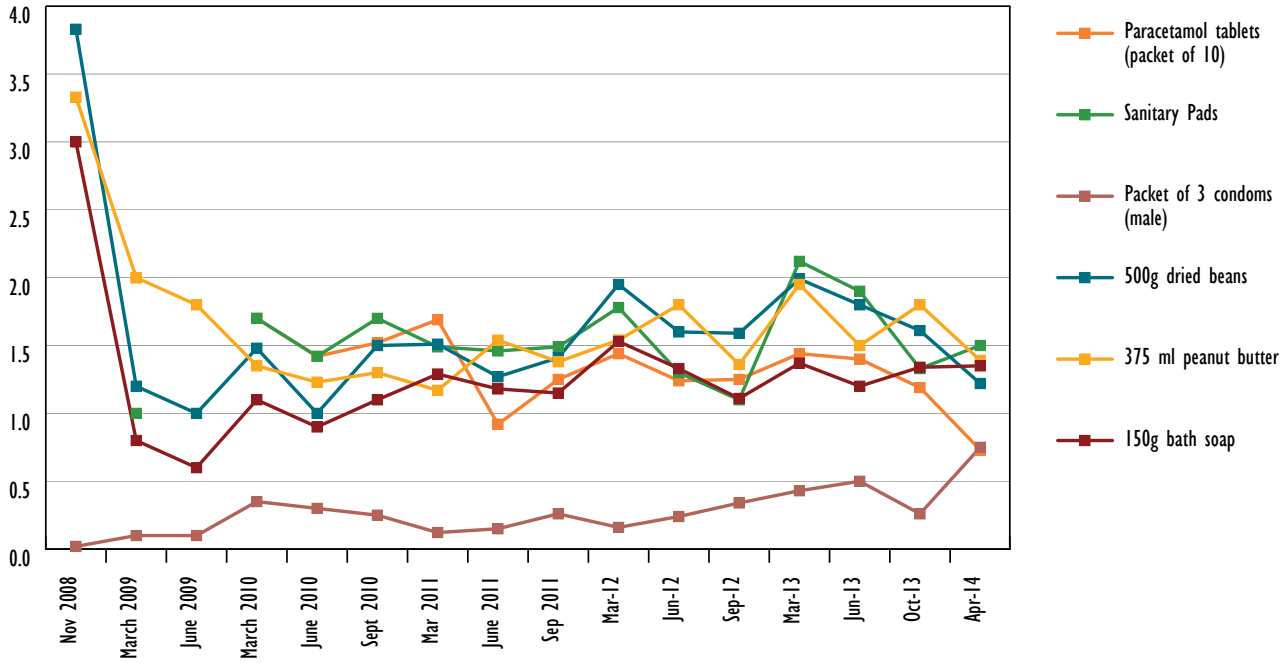
Figure 11a: Proportion of Level 1 (primary care) facilities charging user fees for select services by province, Dec 2011 (N= 1250)



Source: MoHCW 2012

- Fees in the private sector have risen. In 2014 the regulators set a 75 to 100 percent increase in private consultation fees, below provider demands, but considered by insurers to be too high, with limited beneficiary voice or input (Mathuthu 2014). There is no public domain evidence on the private sector's allocation of resources, on risk selection (leaving those most in need without insurance to be treated by the public sector); on overuse of care in those insured, or on drivers of cost escalation and their control. With high levels of segmentation in private funds implying low levels of cross subsidies across income groups and those with high and low health need (Shamu et al. 2010) cost escalation in the private sector is likely to increase inequity and reduce financial protections.

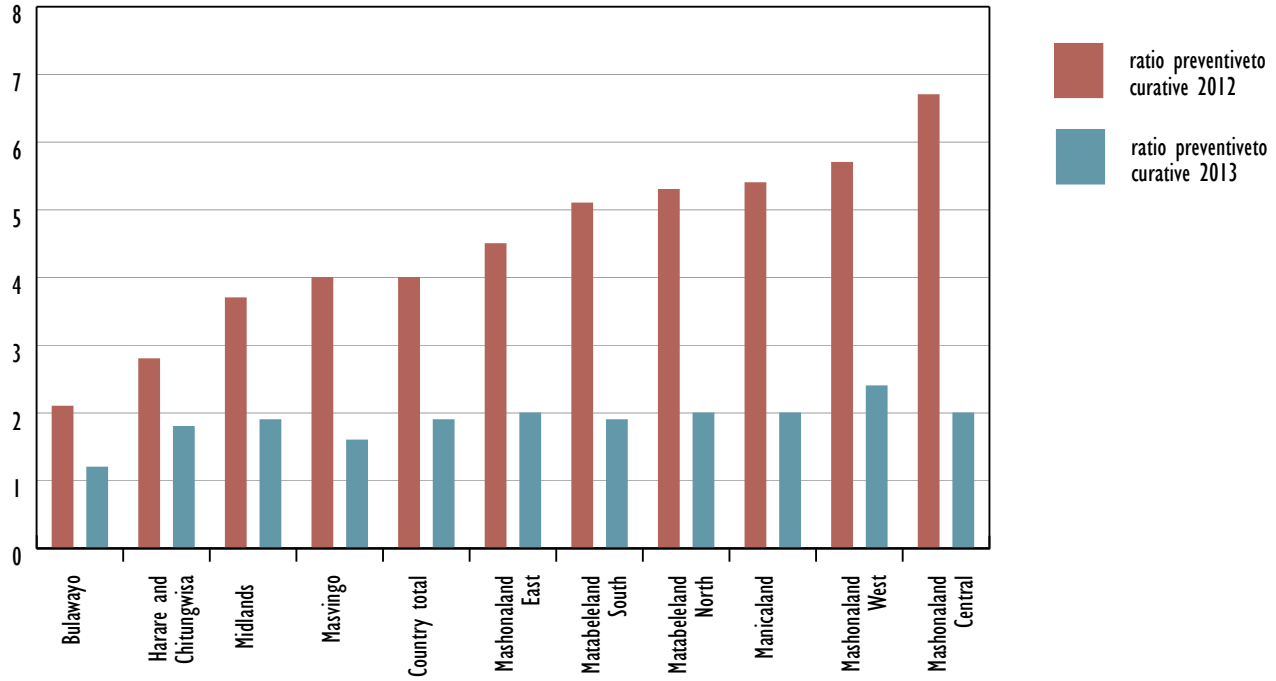
Figure 11b: US$ nominal monthly prices of indicator health goods: 2008-2014



Source: CMP 2014

- There are other determinants of financial protection. In addition to fee charges, communities pay for related costs of care. Taking a sample, the costs of such inputs have fallen from high levels in 2008, and have fluctuated around relatively stable levels to 2014, suggesting improving protection (CMP 2014; *Figure 11b*) Health services also provide financial protection when they ensure early detection and prevention of ill health, as this reduces the burden of paying for care on both households and services. MoHCC HIS data shows that between 2012 and 2013, while total attendances fell, curative attendances rose and preventive attendances fell markedly (*Figure 11c*). There was a significant association between this preventive: curative ratio and the poverty index across districts in 2012. (Pearsons R = 0.341 p<0.005). The higher ratio of preventive services in districts with higher poverty levels may be positive if services are indeed preventing avoidable illness in the poorer groups in these areas. When the level and share of preventive services fell in 2013, so too did the strength of this relationship with the poverty index (TARSC and MoHCC 2014).

Figure 11c: Curative and preventive attendances, health information system 2012 and 2013



Source: TARSC, MoHCC 2014

Progress

Zimbabwe has taken measures to fund and reinforce free care policies at clinic level and for pregnant women and children, with some evidence of a reduction in cost burdens to households. Its implementation needs to be monitored, to ensure that public sector service shortfalls do not lead to informal charges, and the charges and funding for referral services also addressed. More emphasis needs to be given to preventive services, especially when budgets decline. There is need to strengthen social accountability on cost escalation, efficiencies, risk cross subsidies and financial protection in private sector, through strengthened state monitoring, analysis, public domain reporting and regulation of costs and performance against national goals.

© ICRC, O. Moeckli, 2010

Harmonising the various health financing schemes into one framework for universal coverage

Past level: 1980-2008

- A unified health financing framework is critical for a universal health system. It has also been a challenge. 'Planning for equity in health' (1980) sought to provide universal health coverage through a public sector national health service that redistributes health resources towards health needs. Not-for-profit mission services were coordinated with government services through public grants. Health strategies in the 1990s emphasised partnerships, but falling public sector revenues limited the state's leverage to achieve this (MoHCW 1999). To boost revenues and universality, a 1991 government study concluded that a case existed for establishing a National Health Insurance Scheme (NHIS), and the 1997-2007 National Health Strategy proposed a NHIS to cover all citizens for basic health services and to improve equity in financing and provisioning. The NHIS devised in 2007 included a minimum benefits package financed from a 5 per cent levy on gross formal sector salaries to be administered by the National Social Security Authority (NSSA) (MoHCW 1999). The economic context affected both the tax funded public sector national health service and the NHIS. Concerns raised following a Parliament consultation led to postponement of the NHIS (Parliamentary Committee on Health 2007b).

Current level: 2009-2014

- Zimbabwe has continued to define a policy framework of a public sector led national health service in partnership with complementary nonstate actors as the basis for its universal system. However the segmentation of financing, limited cross subsidies across funding pools and low levels of domestic public financing, raised earlier, have weakened policy implementation and co-ordination across public, private and external financing. The significant funding flows and small population served in the private voluntary insurance sector described earlier, their variable size, internal segmentation, limited cross subsidies and the absence of a legally required basic package all raise challenges for harmonisation (Shamu et al. 2010). External funding rose after 2009, with a high share disbursed to programmes outside government expenditure frameworks (MoF 2010). Over time a range of health funds have emerged, some supported by external financing. The larger include the locally funded AIDS Levy Fund and the Health Services Fund (HSF), and the externally funded Health Transition Fund (HTF), which with the Global Fund for AIDS TB and Malaria managed US$30 to $100mn annually in 2012. Despite their different rules, these funds offer opportunities for co-ordination and alignment to national goals, particularly if their pooling, administrative and reporting systems are co-ordinated and synergised, that is also argued to reduce administrative costs and improve economies of scale (Chigumira et al. 2014a; MoHCW et al. 2013).
- Policy and stakeholder submissions have raised the need to strengthen domestic financing to set a framework for universal coverage, including to fund the contracts and other partnership mechanisms with non-state actors. The proposals for domestic financing have been discussed earlier, but beyond their technical coherence, stakeholders have raised the need to build public trust, information and communication, transparency and intolerance of corruption as vital for any new public funding. One option raised for this has been a semi-autonomous fund, similar to the National AIDS Council, under the Minister of Health (MoHCW et al. 2013).

Progress

Low public funding, various 'coping' strategies with external funder support and a fragmented private sector have weakened the framework for a universal system. Definition of the basic entitlement, improved domestic funding, improved tools for harmonised budgeting, planning and reporting and purchasing arrangements to align private funds to national goals are being explored to harmonise funding. Aligning key state and non state actors around a universal framework calls for a renewed (re)statement of and shared vision for a national health service; measures to ensure payments to public services from private insurers / medical aid and measures and capacities to effectively manage, allocate and report on the use of domestic and external funds.

Allocating at least 50 per cent of government spending on health to district health systems and 25 per cent to primary health care

Allocation head %	2002	2003	2005	2007	2009	2010	2011	2012	2013
Administration	5	7	8	1	16	12	14	15	8
Medical care (i)	78	81	82	81	76	80	74	74	83
Preventive services	16	11	9	6	7	7	9	9	7
Research	1	1	1	2	1	2	2	2	2

Source: Finance Department, MoHCW 2011; Ministry of Finance budget estimates 2002-2013 (i) The medical care budget allocation includes budget for preventive care supplies. The preventive services budget includes funding of the PMD office, and disease control programmes.

Past level: 1980-2008

- After the 1980s, government reallocated funds on the basis of health need, from central to district level. This was reversed in the later part of the decade and allocations continued to be mainly demand based (Loewenson and Chisvo, 1994). In 1994, central hospitals received 34 per cent of total funds, district hospitals and clinics 30 per cent, with 11 per cent allocated to prevention. Data was not disaggregated to health centre level (Euro Health Group 2005). After 2002, the administration, medical care and research shares rose, and the preventive services share fell, although some of the medical care services vote is used for prevention activities (see summary table). The Health Services Fund (HSF) set up in 1996 added external funds to fees retained by facilities, with 40 per cent held for community and disease control activities (Makuto 2007). Expenditure did not always follow these guidelines. The 1999 review commission in the health sector recommended that the allocation formula place more emphasis on population, poverty and referrals and, in 2001, a needs based resource allocation formula was developed (TARSC MoHCW 2002) but not implemented as the overall budget to the health sector fell markedly in the face of hyperinflation after 2002. However after external contributions to the HSF fell in the 2000s, Ministry of Finance provided an 'equalisation grant' for districts with low income (MoHCW 2008b). A 2005/06 survey noted the inadequacy of budget allocations to districts (MoHCW 2008b) with staff constraints affecting capacities to absorb funds (Mpofu et al. 2008).

Current level: 2009-2014

- Falling real public spending limited application of policy intentions to redirect resources from curative to prevention and promotion services, and to consistently apply needs based resource allocation (MoHCW 2009). The budget share to administration rose as overall real public budgets fell, with some improvement in 2013, and the share to medical care services rose while that to prevention fell (see summary table). Resource allocation continues to be demand driven based on 'budget bids', although some further work has been done to formulate a needs based resource allocation and to use analysis of gaps in delivery of key services in resource allocation (TARSC, Atchison, MoHCC 2014). Funds from the HTF, reported earlier, allocated through results based financing (RBF), have improved funding flows to district and primary care level, with evidence of improved service outputs and involvement of mechanisms such as health centre committees in accountability on funding flows and the use of funds for agreed workplans (MoHCC UNICEF et al. 2014).

Progress

Allocations are not broken down by primary, district and provincial levels, but the public finance management system reflects allocations and expenditures by institution, so this should be reported on in future. Work on needs based resource allocation shows that it is feasible and could be used to guide allocation of new resources so that no districts receive reduced funds. It can be applied together with measures to monitor service gaps (gap analysis) and to build capacities to absorb and effectively use funds. The investments made in the RBF have contributed to improvements in capacities to use funds for specific maternal and child services. It would be important to have a more accurate assessment, such as through a survey, of the real spending on prevention services, as a share of this is currently included in the curative budget.

Adequate provision of health workers and of vital and essential medicines in primary and district level services

INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009–2014) Level	Year
Total Doctors per 10,000 people	1.5 1.6	1992 2004	1.6 1.0	2009 2007-12
Nursing personnel per 10,000 people (registered and enrolled nurses)	11.8 7.2	1992 2004	7.2 13.0	2009 2007-12
Availability of medicines in facilities				
– % vital medicines	72 63	2000 2005		
– % essential medicines	56 21	2000 2005		
Availability of drugs at NATPharm	63	2004	42	2008
– % vital medicines	72 82	2005 2006		
– % essential medicines	21 56 62	2004 2005 2006	40	2008
% facilities with 80% essential medicines in stock			28.1 66.5 86.2 82.5	2009 2010 2011 2013

Source: MoHCW 1999; GoZ UNICEF 2007; WHO 2007, MoHCW 2009, World Bank 2014, CCORE and HTF 2013

Past level: 1980-2008

- In 1980, a range of measures were applied to produce, deploy and redistribute health workers, including training of new para-professional cadres. The density of doctors remained constant but that of nurses fell (see summary table). Doctors were distributed inverse to need, with most at central hospitals (64%) and in the private sector (54%) in urban areas and only 21 per cent at district level (MoHCW 1999). Bonding of newly qualified professionals was introduced in 2006, various incentives were used to address internal distribution, and nursing training was scaled up (HSB 2006). In the 2000s poor pay, low savings, poor living conditions, under-resourced health services, job stress and lack of confidence in their future led to out migration (UNICEF 2007b). In 2008, Government approved a retention package for all health workers, supported by development partners, and computerization of the health workforce information system facilitated improved planning and management of the workforce (MoHCC 2014b). An essential medicines programme in 1980 significantly improved management of medicines (MoHCW 1999), and medicine availability rose, although with more pronounced shortfalls at primary care services (MoHCW et al. 2004). In 2004- 2007, NatPharm received only 3% of the approximately US$65m it needed annually for the public sector (MoHCW 2009). Shortfalls in public services meant that people bought medicines privately, at prices that were reported to be higher than in neighbouring countries (EHG 2005).

Current level: 2009-2014

- By 2009, the overall density of 12.3 health personnel per 10 000 was well below the WHO recommended levels of at least 25 doctors, nurses and midwives per 10 000 (GoZ 2009). Poor pay and conditions of service, a harsh macro-environment and inadequate training led to an internal and external skills drain, particularly in terms of skilled personnel at district level, leaving many services understaffed (MoHCW 2009; Makuto 2007).

- In 2009 only 33 percent of villages countrywide were found to have access to facilities with nurses or midwives providing ANC according to national standards (MoHCW 2010). Health workers in post were not working at their best level, due to poor infrastructure and equipment, low salaries and limited supervision. Physician, nurse and Environmental health personnel numbers improved between 2009 and 2013, but the number of pharmacists, radiographers, oral health and health promotion personnel did not (shown in *Table 6*). The number of community health workers was increased (MoHCW 2011). Physician *density* fell to 2012, but nurse and midwife densities rose (see summary table). The 2014 total authorised establishment for MoHCC shown in *Table 6* has not been revised since 1980 and so does not adequately reflect population growth and movement. Even given this, 85 percent of the establishment was in post in 2013 (DFID HDRCC 2012).

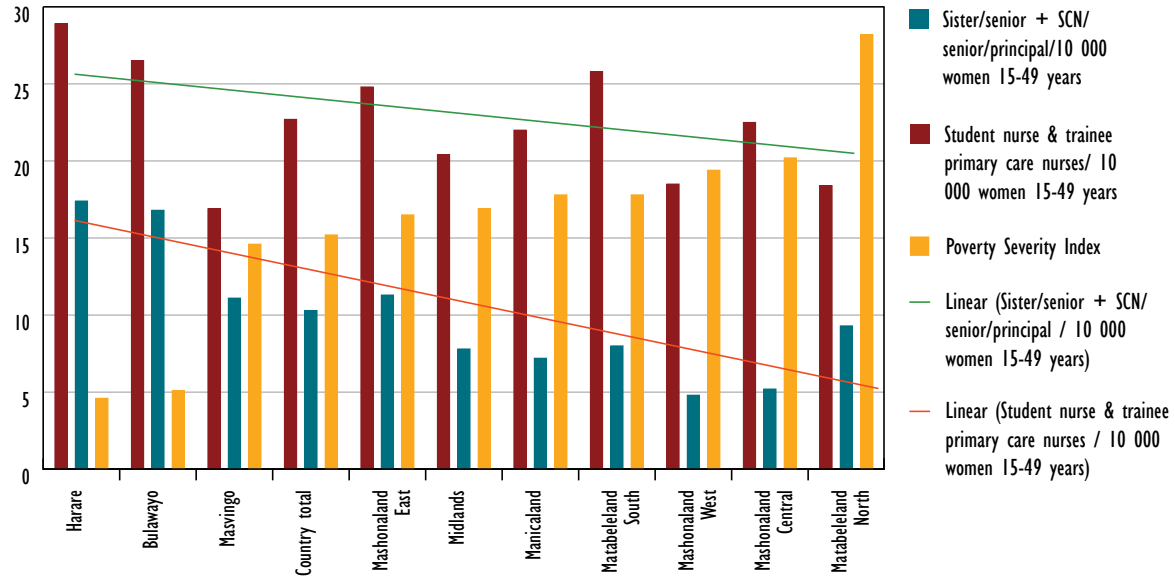
Table 6: Trends in selected health worker availability 2006 - 2011

Category	2006 Dec in Post	2007 Dec in Post	2008 June in post	2009 Dec in Post	2010 Dec in Post	2011 Dec in Post	2013 Dec in Post	Authorised Establishment for Critical Cadres
Top Management	7	13	16	42	42	45	47	83
Doctor	668	667	738	607	916	1 054	1 114	1 767
Nurses Grades	13 495	14 768	13 699	11 965	17 029	17 022	18 722	20 735
Environmental Health	1 293	1 220	1 157	1 031	1 433		1 885	2 495
Pharmacy	338	318	332	328	472	467	394	589
Radiography	158	154	261	242	206	241	239	471
Physiotherapy	374	355	368	316	377	378	419	472
Nutrition	783	761	787	778	905	858	845	980
Oral Health	195	192	181	172	239	255	236	327
Laboratory	324	320	317	184	417	433	349	644
Research officers	23	21	36	24	24	23	14	25
Health Information	93	100	145	115	166	165	187	227
Health Promotion	41	42	38	32	45	54	55	73
Administration General	6 708	6 207	5 879	6 096	6 105	5 347	5 334	6 049
Total	24 624	25 251	24 083	22 054	28 523	28 262	29 840	34 937

Source DFID HDRCC 2012, MoHCC 2015

- Increased training was a key strategy to counteract the brain and skills drain, although it also faced limits in the lack of lecturers and tutors across all fields. There was a vacancy rate for tutors of 68 percent (MoHCW 2009). The EU committed $2 million for an "Accelerated Midwifery Training" programme to ensure that 'at least 60% of nurses at any health facility are midwives' (Mwayera 2012). Training contributed to improved numbers. However there are geographical differences in their distribution, with a significant ($*p<0.05$) *inverse* association between nurse densities and the poverty index, and poorer districts having lower nurse densities (*Figure 12a*).
- There were a number of constraints external to the MoHCC in addressing the shortfalls. From June 2010 to September 2013, the Ministry of Finance (MoF) capped employment of new staff and froze recruitment, so that health workers leaving their post could not be replaced without approval from MoF. As a result, workforce shortages co-existed with a surplus of trained health cadres not able to work (Dieleman et al. 2012). Wage levels also acted as a deterrent to recruitment, with a strike for improved pay and better working conditions called by the Zimbabwe Hospital Doctors Association in October 2014. Notwithstanding these constraints communities reported improved availability of nurses in their local health centres, but pointed to an inadequacy of environmental health technicians (EHTs) (CMP 2014), with a 50% vacancy rate reported by MoHCC in this category (MoHCW 2010).

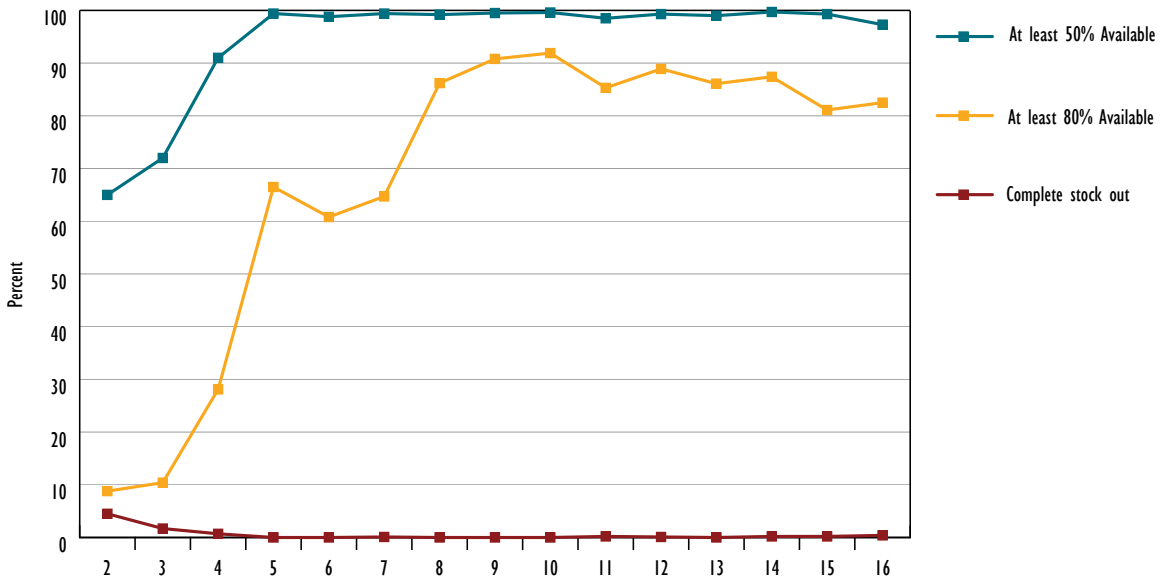
Figure 12a: Health worker densities and the poverty index, 2013



Source: HIS in TARSC MoHCC 2014

- In 2009, medicines and essential commodities were reported to be erratic in supply due to national shortages and an inadequate distribution capacity (MoHCW 2010). With support of international partners, essential medicines supplies improved for primary care and district services. The Vital Medicine Availability and Health Services Survey reported large increases from 2009 to 2011 in availability of selected essential medicines with levels remaining thereafter at about 80 percent to 2013, lower (73%) in the Midlands and higher (94%) in Mashonaland West. The frequency of stockouts fell (*Figure 12b*). There is now need to reduce dependency on external funding for these improvements at primary care and to improve availability at district hospitals.
- The pharmaceutical sector has been identified as a key area for investment, but has instead contracted, with low capacity utilisation; outdated equipment; no new product pipelines; and a decline of players entering the industry. Tariffs favour external imports from large corporations that are able to undercut the prices of local producers and raise costs on import of active ingredients, creating an unfavourable environment for domestic producers (SEATINI CEHURD 2014).

Figure 12b: Availability of selected essential medicines, 2009-2013



Source: CCORE and HTF 2013

Table 7: Distance to a health facility with staff and medicines reported by communities in sentinel sites

Province	No of sites	% sites reporting distance to health facility (km)		
		0-5 km	6-15 km	>15 km
April 2014	244	55	43	2
March 2013	240	58	36	7
March 2012	239	59	34	7
March 2011	237	58	40	2
March 2010	240	48	29	22
March 2009	182	54	27	19
March 2008	185	55	27	18
March 2007	160	62	24	14
March 2005	151	58	32	10

Source: CMP 2011; 2014

- Community monitoring surveys found improvements after 2010 in access to a facility with both medicines and personnel within 5km, plateauing thereafter to 2014 (*Table 7*). Communities reported wide availability of anti-malarials and antibiotics, but anti-hypertensive medicines at lower levels (CMP 2014). If people have to source medicines for chronic conditions from private pharmacies the cost can be a barrier to access (MoHCW 2009). It suggests that while there has been improvement in key medicines for maternal and child health, gaps in supply of medicines for chronic conditions may still pose a barrier to health in poor households

Progress

Co-operation between government and external partners has turned around the low levels of health workers and medicines in 2009 to an improved situation in 2014. There are continuing areas of concern in respect of: shortfalls in the distribution of personnel and medicines to the lowest income areas, gaps in personnel for public health and prevention; and shortfalls in medicines and supplies for managing chronic conditions. It is necessary to reduce dependency on external funders for these key inputs, such as through improving domestic financing, discussed earlier. There is also concern about a gap in public sector emergency transport (ambulances) and triage services. This may be addressed through earmarking a small share of the fuel levy or toll fee in one year, discussed earlier.

© UNICEF Zimbabwe

Implementing a mix of non–financial incentives for health workers

Past level: 1980-2008

- In the 1980s investments were made to train, deploy and reorient health workers around health policy priorities. Non-financial incentives contributed to high staff morale post-independence but declined in the 1990s, along with the purchasing power of salaries. In the early 2000s a series of strikes signalled rising discontent over pay and conditions in the public sector. A Health Service Board (HSB) was established in 2005 (Health Services Act No 28/2004) to address this situation (HSB 2005). A range of measures were introduced after 2005: a Public Service Skills Retention Fund; a scheme for training primary care nurses; bonding after basic training; formalising of labour relations in the HSB and provision of antiretroviral prophylaxis after occupational exposure; and access to ART (MoHCW 2007). Economic conditions still created powerful push factors: strikes for better wages in the health sector took place at five different times in 2007 and the HSB had limited authority and funds to implement many of its recommendations (HSB2007).

Current level: 2009-2014

- By 2009, efforts made in the 2000s to improve incentives were eroded by inflation and wider insecurity (Chimbari et al. 2008). Physicians had a high rate of dual practice (41 percent), although less than 10% of other categories of personnel did this (Gupta Dal Poz 2009). After dollarization in 2009, earnings stabilised and health workers salaries were topped up by external funders as a tax free top-up, conditional on attendance at work (or on authorised leave) and dependent on grade and location of work. It has been subject to modification over time as lower grade cadres and city council health workers no longer receive the top-up. The additional incentive reduced losses and attracted some who had resigned to rejoin service and appears to have had positive effect on personnel numbers and retention, as noted in the previous section. External support for these incentives was, however, high, totalling US$70m by 2012. The Global Fund stressed the need for the government to continue to pay these retention allowances despite a gap of US$4 million in 2013 and US$22 million in 2014 from the phase-out of Global Fund support for the Health Retention Scheme to prevent a loss of the gains registered in this area in previous years (Global Fund 2013). From 2011 the retention fund was administered independently by the HSB and its phase out began in 2013, with government supposed to take over the payments going forward (Dieleman et al. 2012).
- The current pay for health workers thus includes a basic salary according to grade, a housing and a transport allowance. Most critical cadres get at least one health sector specific allowance, such as night duty, on call, uniform, rural, psychiatric and/or residence allowance for junior doctors and a representation allowance for deputy directors and others in that grade. However, the wider problem of the high share of payment for health worker salaries crowding out other expenditures and the underfunding of the sector as a whole has limited the ability to sustain competitive levels of pay. By April 2014, junior doctors in the public sector were reported to earn monthly a basic salary of $329 a month, an on call allowance of $82, a transport allowance of $100 and a housing allowance of $129, or a total package of $640 excluding any retention allowance, at a time when the poverty datum line was $511 (HSB 2014). In October 2014 the Zimbabwe Hospital Doctors Association called for a strike over a review of their basic monthly salary to US $1200, exclusive of allowances, and occupational protections in the event of an Ebola outbreak (ZHDA 2014).

Progress

A range of steps have been taken to better manage and respond to health worker issues, institutionally, through the Health Service Board, through more inclusive negotiating mechanisms and through incentives that have improved retention. These have, however, depended on external funding, and both the wider economic conditions and the lack of adequate resources and authority in the HSB to fully implement its recommendations raises challenges to sustain these incentives. This raises the need to explore further incentives for health worker retention and to track levels of dual practice, informal work and other strategies that workers used to boost incomes, including for their impact on service delivery.

Formal recognition of and support for mechanisms for direct public participation in all levels of health systems

Past level: 1980-2008

- Community participation has been central to health policy since 1980. Village and ward health teams were supported by community health workers, although in the 1990s these mechanisms became less active as PHC services declined (Loewenson et al. 2004). The National Health Strategy 1997-2007 sought to strengthen participation to improve efficiency and accountability in resource use in the health sector and established hospital management boards, although financial authority and management remained centralised (MoHCW 1999). New forms of community involvement emerged, such as the 35 member Community Working Group on Health (CWGH), formed in 1998, to support participation in the health sector. The Advisory Board of Public Health (PHAB) and a range of committees and boards at different levels of services provide advisory mechanisms, and 1999 parliamentary reforms strengthened public engagement with the Parliamentary Portfolio Committee on Health and Child Welfare. Participation at local level was, however, variable. A 2007 survey found community participation in health activities in only half or fewer communities, and Village and Ward Development Committees (VIDCOs and WADCOs) were found in many districts to be meeting irregularly or to have been disbanded. Health Centre Committees (HCCs) did not always have the skills or resources for their roles (MoHCW 2008b). Community Health Councils and the Patients' Charter as formal mechanisms for community voice were weakened by the declining performance of the health system and the wider political environment, and by 2009 only five districts were reported to have functional Councils with the public largely unaware of their existence (MoHCW 2009). A 2009 community assessment highlighted community and local health workers' desire for greater involvement in planning (TARSC CWGH 2009).

Current level: 2009-2014

- The 2009-2013 National Health Strategy made inclusion and participation a central element (MoHCW 2009). The village health worker programme became a ministry priority in 2008 and 14 percent of the preventive services budget was allocated to it (MoHCW 2009). Community views have been gathered and integrated in review of the Public Health Law, of the essential health benefit and of financing strategies. Since 2009, civil society and MoHCC have supported health centre committees (HCCs) to be more actively involved in health planning (MoHCW 2010). Proposals for their legal recognition have been made by the PHAB, within wider proposals for strengthened participation in the review of the Public Health Act. A survey found that HCCs were present in 30% of all health districts, with some meeting as frequently as four times annually. The National Health Strategy called for further investment in these groups to assist communities to prioritize health needs and plans (TARSC et al. 2014; MoHCW 2009). HCC training was expanded and they have played a role in reviewing plans, expenditures and health service outputs in the RBF programme. An RBF evaluation found an increase in the number of HCC meetings in RBF districts (2.7 more per year) and a 34 % increase in presence of a facility work plan (Chigumira et al. 2014b). While these processes are strengthening participation in the public sector, as noted earlier, beneficiaries are poorly informed and play weak roles in decisions and management of schemes in the private for profit health sector.

Progress

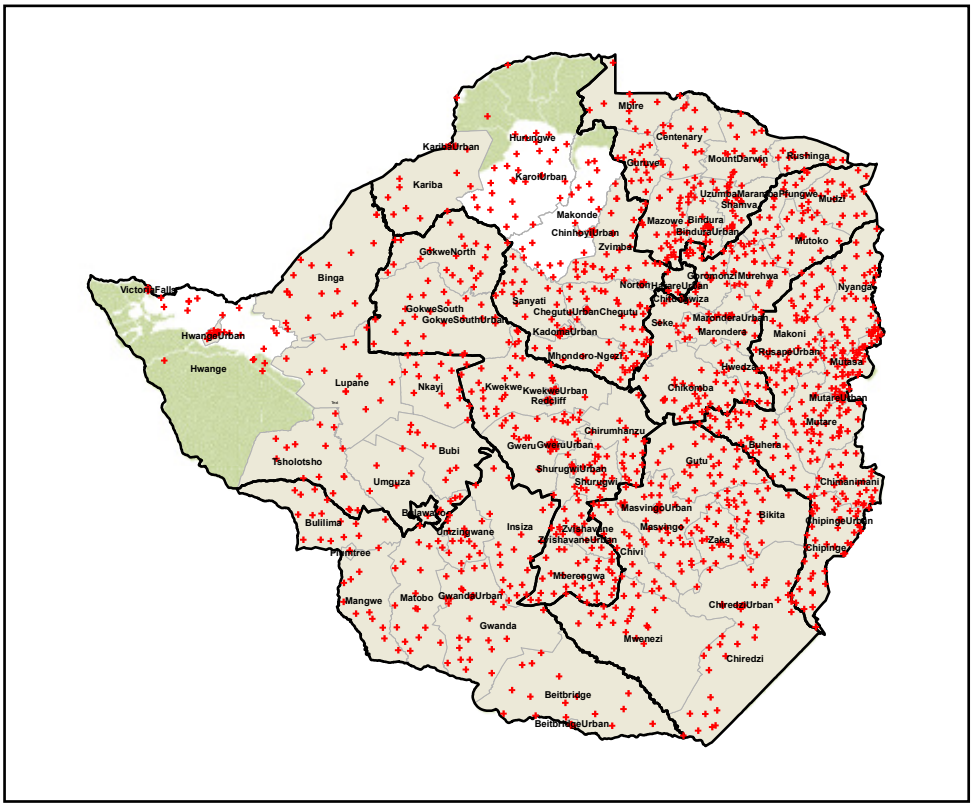
High adult literacy, an active civil society and parliament, legal and institutional provisions for joint planning, revival of village health worker programmes, revival of boards and policy recognition of the role of participation in health have revitalised participation in health, with increased policy support and activity from local to national level. While HCCs have been given a wider role, recognition and capacity support, they need to be formalised in law, and public information, involvement and accountability measures need to be strengthened in the private health sector.

Overcoming the barriers that disadvantaged communities face in access and utilisation of essential health services

Past level: 1980-2008

- All households should be less than 10 kms from a health centre and there should be one rural health centre per 10 000 people; one district hospital per 140 000 population and one provincial hospital per province (MoHCW 2009). By 1997, 85% of the population lived within 8 km of a primary care facility, although by 2003, 30 per cent of the poorest households were further than 10 km from facilities (MPSLSW 2006). The population movements in the land redistribution meant that people moved into the previous large scale farming areas, where health facilities were more distant, raising geographical barriers. Efforts were made to convert farm houses into health centres and to organise immunisation outreach. For urban areas the barriers differed. While there was evidence of a 7 percent points rise in uptake of services between 1994 and 2004 in both urban and rural areas, 23 percent of those not visiting services in 2004 cited cost as the reason (CSO 2006). Use of private sector facilities was higher in urban than in rural areas in 1994 and 1999, but fell significantly by 2004 with cost cited as the barrier for urban users. Cost was thus a commonly cited urban barrier to access. Financial barriers were higher for women in the lowest income quintile (ZIMSTAT and ICF Int 2012; CSO Macro Int 2007). By 2007, rural and peri-urban areas faced new barriers, as shortages of medicines, ambulances, water, electricity and sanitation at health institutions noted in earlier progress markers were found to lead people to use more distant facilities, raising transport, medicine and fee costs for households (Makuto and James 2007).

Figure 13a: Distribution of Zimbabwe's Health Facilities 2011

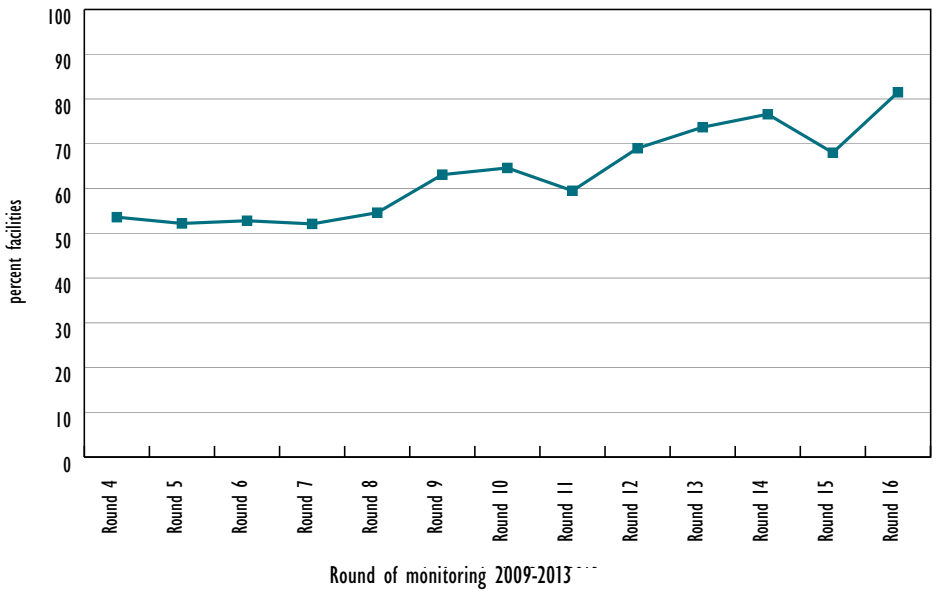


Source: UNICEF 2013

Current level: 2009-2014

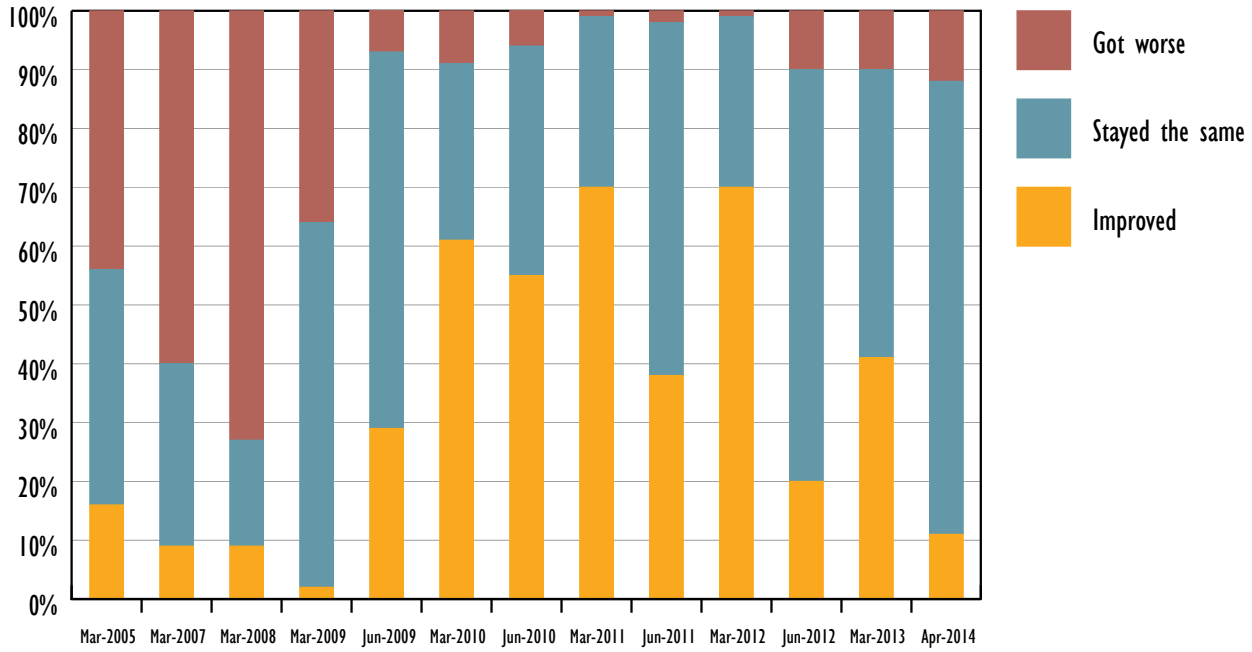
- The health service infrastructure in Zimbabwe is relatively well developed (See *Figure 13a*), with more limited infrastructure in Matabeleland North and South and Masvingo South. While these provinces have lower populations and less dense land use, their inhabitants also have to move further to access services. As noted in the prior period, the land reform has meant that in some areas people are newly settled without adequate facilities. However in this period availability of physical infrastructure services was less of a barrier than other factors, including the deficits in staff and inputs discussed in an earlier progress marker. The referral chain was, for example, reported to be largely dysfunctional due to a critical shortage of ambulances at district level (MoHCW 2010). In 2009, disruptions in communications and supplies were reported to have limited outreach and contributed to adverse outcomes in maternity, acute and emergency care (GoZ 2009). Improvements in supplies noted in earlier progress markers were thus important facilitators of improved service uptake. In 2011, the most important factor determining the choice of visiting a health facility was the availability of medicines (17 percent), while other enabling factors were close proximity (16 percent), positive staff attitudes (14 percent), low waiting times and no charges (11 percent for both) (GoZ 2013d). As the HTF programme was implemented, fee barriers for maternal health services were also addressed in an increasing number of services (*Figure 13b*). National community sentinel site monitoring also reported improved quality of services by 2012, with a preference for use of public clinics for ill health, and a fall in use of hospitals and private clinics as public services improved (CMP 2014; *Figure 13c*).
- While supply side barriers were thus addressed post 2009, there continues to be demand side barriers. By 2010/11, the demographic and health survey found that social and economic differentials in health and in access to health care had widened relative to geographical differentials across a number of reproductive, maternal and child health indicators (ZIMSTAT and ICF Int 2012). As noted in the discussion of previous progress markers, social and economic barriers affected both access and uptake, with factors such as knowledge of services, religious and cultural barriers, user fees and poor male involvement affecting uptake (MoHCW 2010). For people with disabilities, for example, stigma, marginalisation, intolerance and sexual abuse were reported to be barriers to access, while a fall in the real value of the state disability allowance made assistive devices (wheelchairs, crutches) unavailable or unaffordable (Loeb 2009).

Figure 13b: Facilities offering free full maternity services 2009-2013



Source: CCORE and HTF 2013

Figure 13c: Share of sites reporting changes in quality of health services-2007-2014



Source: CMP 2014

- These barriers relate in part to economic conditions and a call for wider social protection measures. For example the Child Protection Fund has provided regular cash transfers to the 55,000 poorest and most vulnerable households in 2013 to support child wellbeing (UNICEF Ministry of Labour 2010). At the same time limited government funding has meant that the social welfare ministry has not provided funds to MoHCC to meet the costs of patients that it refers to government hospitals for free treatment. This raises a question of how such mitigatory measures can reach all households in need, given the larger number of poor and vulnerable households in both rural and urban areas, raised in the earlier progress markers. They also relate to social factors. For example households were found in 2009 to lack the information, resources and support they needed to effectively participate in health (TARSC CWGH 2009). An expanding health literacy programme by civil society and increased public investment in village health workers, both initiated in 2009, have begun to address social barriers, as have measures to re-vitalize and strengthen the role of the village health worker (VHWs) (GoZ 2009). For example 150 VHWs in Tsholotsho District held 3552 health information sessions in their communities in 2012, helping to link women to facilities and increase demand for ANC and PMTCT, supporting referrals for and following up on people returning from health facilities (Muchedzi et al. 2013). These enablers within the community will become even more critical in ensuring continuity of services to address chronic conditions and multiple morbidities that often co-occur in low income communities. Yet, despite their importance and the policy commitment to this programme, in 2010 only 19 percent of villages countrywide were estimated to have active VHWs (MoHCW 2010).

Progress

Zimbabwe's health service infrastructure supports universal access, although gaps need to be addressed in new resettlement areas. There has been improvement in availability of medicines, staff and other supplies, with improved perceived quality of care in local services reducing costly measures for households to travel outside their areas for services or use private care. Ensuring commodity supplies (medicines and equipment) and staffing in primary care services has thus played an important role in improved equity. However social and economic barriers still need to be addressed, including through widening health literacy and support to VHWs, and training VHWs for newly settled areas.

EQUITY WATCH

A more just return from the global economy

Household access to the resources for health and the promotion of equitable health systems are both increasingly influenced by policies, institutions and resources at the global level. The final section examines selected parameters of the policy space and support for health equity at global level. These include the debt burden on health, the use of flexibilities in world trade agreements, the support from international institutions for health worker incentives, the protections for women smallholders' food production in trade policies and the inclusion of health officials and health protection in trade negotiations and agreements.

Reducing debt as a burden on health

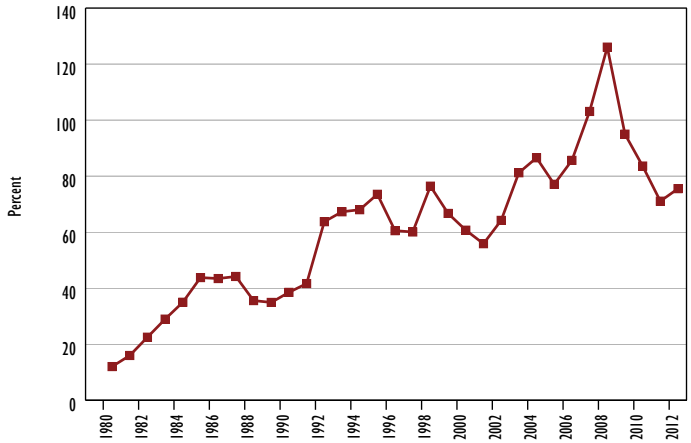
INDICATOR	PAST LEVELS (1980–2008) Level	Year	CURRENT LEVEL (2009-2014) Level	Year
External debt as a % GDP	78 68 72	1998 2000 2006	192	2009

Source: UNDP Zimbabwe 2008, IMF 2011

Past level: 1980-2008

- Debt repayments have been documented to deplete domestic resources that could be applied to health and other services, for both capital and recurrent investments. High debt levels can also weaken the value of local currencies. In Zimbabwe, total external debt fell between 1998 and 2000, but rose steadily as a share of Gross National Income from 1980 to 2008 (See *Figure 14*). In 2000 about a quarter of the revenue from the export of goods and services was used to service debt and the total debt exceeded earnings from exports and imports (IMF 2001). External debt rose to about US$4 billion by 2008 (IMF 2011).

Figure 14: External debt stocks as a share of Gross National Income 1980-2012



Source: World Bank 2014c

Current level: 2009-2014

- By 2009, debt was reported to have risen to 192% of GDP (IMF 2011). It continued to rise to US$7.3bn by 2013 (IMF 2014), with arrears to the IMF and the Bank amounting to US$124 million and US$1,007 million, respectively (IMF 2013) and 17 percent of the debt due to penalty charges (GoZ 2013). The real extent of external indebtedness is unknown, with guarantees used for offshore loans and loans from non-OECD countries not in the public domain (UNDP Zimbabwe 2008).
- Whatever the actual level, the external debt is noted to be unsustainable without debt relief (UNDP Zimbabwe 2008). In November 2010 a Zimbabwe Accelerated Arrears Clearance Debt and Development Strategy (ZAADDS) was approved to pave the way for negotiating the clearance of arrears and debt relief for the country, together with a re-engagement with the international community for the removal of sanctions and negotiation with creditors and development partners for arrears clearance, debt relief and new financing (GoZ 2013b). The plan also included leveraging Zimbabwe's natural resources in pursuit of debt relief (GoZ 2013b), raising concern over the implications for sustainable longer term resource planning and use.

Progress

Zimbabwe has a high and unsustainable level of debt. While there have been measures to negotiate debt relief, there is also concern that leveraging natural resources for debt relief may affect future resources needed to address social determinants of health, including employment, income, infrastructures and environments.

Ensuring health goals in trade agreements

Past level: 1980-2008

- Zimbabwe made no commitment to the World Trade Organisation (WTO) General Agreement on Trade in Services (GATS) and included all WTO TRIPS flexibilities in its laws. The country applies an essential drugs list and promotes prescribing generic drugs across public and private sectors. 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 authorised 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. The Zimbabwe National HIV and AIDS Strategic Plan 2006-2010 acknowledged the need to review trade barriers and strengthening local production of pharmaceuticals (NAC et al. 2006).

Current level: 2009-2014

- While Zimbabwe has protected health in formal positions at WTO, the liberalisation of the economy and increase in imported goods has raised the risk of import of products harmful to health. For example an assessment of cigarette sales in 5 urban areas found low compliance with health warning labelling regulations, particularly in the 15 imported brands being marketed (Loewenson 2010). The commercialisation of public services and growth of the private for profit sector makes Zimbabwe open to liberalisation of its health service sector. There has been some discussion of medical tourism but to date Zimbabwe has made no further commitments of its health sector under GATS. In relation to TRIPS, in 2010 Varichem Pharmaceuticals a local pharmaceutical provider had achieved prequalification status for ARVs. Zimbabwe has a sound legal framework and a strong regulatory body on medicines (the Medicines Control Authority of Zimbabwe) (Zimtrade 2009).
- According to UNIDO's assessment, the country's four generic manufacturers could easily account for 90% of the secondary pharmaceutical manufacturing (formulation) business in the country (UNIDO, 2011). However in 2011, the chairman of the Pharmaceutical Manufacturers' Association reported in a workshop on the state of the pharmaceutical industry in Zimbabwe that the industry was collapsing (Mujuru 2011), with production challenges noted in an earlier progress marker and competition from imported and donated medicines, declining domestic spending on medicines, prolonged registration times (about 24 months), and power shortages undermining the industry (SEATINI and CEHURD 2014). ZimAsset calls for the 'resuscitation and recapitalisation of the local industry' including improved supply of locally produced drugs (GoZ 2013). While both trade and health policies have raised support for development of the pharmaceutical sector, in practice the industry has faced high import tariffs on their raw material inputs, while imported finished pharmaceutical products have enjoyed a tariff free import status (UNIDO 2011). This contradiction calls for improved consistency between policy goals and measures.

Progress

Zimbabwe has preserved its flexibilities in relation to World Trade Organisation agreements, prequalified a local producer of medicines and has been cautious in protecting health against trade pressures. However policy support for local pharmaceutical production has been inconsistently carried through in trade practices and the sector is declining. Relatively wide commercialisation of services, charges at point of care and private insurers purchasing and running for profit services and pharmaceutical companies makes the sector vulnerable to wider liberalisation. Widening trade liberalisation in the economy has also led to unregulated import of products harmful to health. The convening of intersectoral dialogue by MoHCC offers opportunities to raise the profile of health in all policies, including in trade, particularly if backed by wider social awareness and advocacy.

Bilateral and multilateral agreements to fund health worker training and retention

Past level: 1980-2008

- Zimbabwe was 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 played a leading role in the African caucus motivating the discussion of health worker migration at the World Health Assembly and remained actively involved in the policy dialogue on health worker migration. In this period, international partners provided some foreign currency contributions to support retention (Midzi 2008).

Current level: 2009-2014

- Zimbabwe continues to have agreements with longstanding partners, such as an agreement with Cuba to send doctors to the country (Dambisya et al. 2013). The country has had a number of bilateral agreements for funding health worker training, including: with WHO on technical support, the International Association for Educational Assessment (IAEA) and EU for scholarships, and with international partners (DfID, CIDA, UNFPA, UNICEF, Expanded Support Programme) on retention incentives and GFATM on salaries. These agreements are reported to have had positive effect on health worker availability and retention (MoHCW 2008b).
- In 2009, the Harmonized Health Worker Retention Scheme (HHWRS) described earlier, provided for co-operation between government and development partners to reverse the out-migration of health personnel, and address staff vacancies. The HHWRS was a joint initiative between MoHCC, Health Services Board, College of Health Science, Harare City Council and development partners, including the Global Fund, European Commission, Expanded Support Programme of HIV AID, DfID, UNICEF, WHO, and UNFPA. The Global Fund pledged over $74 million between 2010-2014. The funds resourced allowances in a retention scheme, including to community home-based caregivers to deliver community programs along with assistance to integrate monitoring and evaluation systems for HIV/AIDS, TB, and malaria in the national health information system. From 2011 government has progressively taken over administration and funding of the scheme, more so since 2013 (Dieleman et al. 2012). The HHRWS was found to have a positive impact on outpatient attendance and skilled birth attendance, with improvements in these outcomes associated with improvements in reduced vacancy rates in nurses.
- In relation to the WHO Code on the international recruitment of health personnel, Zimbabwe discussed the WHO Code with the ministries of foreign affairs, finance, education, labour, and the health services board and has set up an implementation committee to monitor and report on its implementation. (Dambisya et al. 2013).

Progress

There have been numerous international co-operation agreements supporting training and retention of personnel in the period, with positive impact on personnel retention and associated improvements in service coverage. Government is taking over the funding of these incentives, although with a high share of health budget expenditure going to personnel, this raises concern at the possible crowding out of non-wage and capital expenditures, with negative implications for service delivery and for personnel working at optimum levels.

Health officials included in trade negotiations

Past level: 1980-2008

- Many negotiations on trade and investment have implications for health. WTO agreements on services, intellectual property, biodiversity, sanitary measures and other areas, and economic partnership agreements can have profound impact on the supply of goods and services in health or impact on health. Civil society in Zimbabwe campaigned in the 2000s for greater recognition of health in trade and investment policies: *'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'* (CWGH 2004:3). Health sector officials were not directly involved in trade negotiations, which were led by the trade ministry. However health officials were consulted by the Ministry of Industry and Trade, and as noted in the prior progress marker on GATS and TRIPS, the positions taken by Zimbabwe generally protected the public sector in health.

Current level: 2009-2014

- The review of the Public Health Act in 2011 made proposals for general duties to avoid harm to health and requirements for health impact assessments that also establish obligations in trade.
- The country has had a senior and experienced diplomat on health in Geneva and actively participates in and leads processes within the work of the Africa Group in health diplomacy. Greater focus has been given in this period to global health diplomacy, including through capacity building. Involvement of health officials in international negotiations is co-ordinated through the offices of the Permanent Secretary in the MoHCC. There has been increased focus on preparation for international negotiations, such as the World Health Assembly and related forums where health and trade may be under discussion. The frameworks for negotiations are found in government policy documents. Regularly, the Top Management Team of the MoHCC and members of the planning pool engage in exercises to review international and regional resolutions, conventions and treaties and make recommendations for country, regional & international positions (Mhlanga 2013). Prior to negotiations preparatory meetings are held with top management personnel to review issues, and members assigned to study specific topics. Briefings are obtained from relevant expertise, such as from WHO, intergovernmental organizations, SADC and from diplomatic missions. Meetings may also be held with bilateral partners on issues to be discussed. The health team also consults with relevant arms of government on certain specific matters, for direction or advice, and may include officers from those departments in the delegation (Mhlanga 2013). Following negotiations, the teams report to the Minister, and through the Minister to cabinet and relevant government agencies.
- Zimbabwe has also participated in regional preparatory meetings prior to the World Health Assembly and in the Africa Group that co-ordinates across African countries. The Africa Group has built a unique level of unity around shared positions in GHD, on issues such as access to essential medicines, strategies on AIDS, or global recruitment of skilled African health workers. Shared policies across the region have also been built through the policy harmonisation processes taking place in African regional community initiatives, as in the cross border collaboration on malaria, TB and HIV and AIDS control or in the establishment of the SADC HIV and AIDS Trust Fund to implement cross border HIV and AIDS programmes (SADC 2009).

Progress

There has been increasing attention to the role of health in foreign policy, including in trade agreements. Zimbabwe has recognised diplomatic capacities in this area, and has further developed capacities in the MoHCC and strengthened processes for preparation for negotiations and follow-up actions. Various factors are identified as contributing to improved outcomes, including: effective composition and capacity of the delegations; assigned responsibility to individuals or units within the ministry who are accountable for their roles; clarity in preparations and on potential follow up; communication with other government departments and strengthened regional engagement. It would be timely to build on this with clear goals for foreign policy on health, and to hold wider national dialogue and consultation to raise awareness and draw input on protection of health in trade.

Bibliography

1. Advisory Board of Public Health (PHAB) (2010) The right to health in the Constitution and Public Health Law in Zimbabwe, Harare.
2. Advisory Board of Public Health (PHAB), MoHCW (2011) Proposals and principles for the Review of the Public Health Act, Mimeo Harare.
3. African Development Bank Group (AfDB) (2011) Infrustructure and Growth in Zimbabwe: An action plan for stained strong economic growth, ADB, Addis.
4. AfDB (2013) Zimbabwe Multi-Donor Trust Fund (ZimFund) launches flagship infrastructure development project, accessed 20 Oct 2014 at: http://www.afdb.org/en/news-and-events/article/zimbabwe-multi-donor-trust-fund-zimfund-launches-flagship-infrastructure-development-project-11674/.
5. African Forum on Debt and Development (AFRODAD) (2011) What Has Tax Got To Do With Development: A Critical Look At Zimbabwe's Tax System AFRODAD Harare.
6. African Union, NEPAD (2007) Comprehensive Africa Agriculture Development Programme: Country report Zimbabwe accessed September 2008 at: http://www.sa.resakss.org/country/Zimbabwe.asp 3.
7. African Union (2008) 10 per cent National Budget Allocation to Agriculture, Development AU brief, accessed September 2008 at: http://www.imf.org/external/np/sec/pn/2002/PN0264.HTM.
8. African Union, NEPAD (2007) Comprehensive Africa Agriculture Development Programme: Country report Zimbabwe accessed September 2008 at: http://www.sa.resakss.org/country/Zimbabwe.asp 3.
9. Atchison Actuaries &Consultants, TARSC, MoHCW (2013) Projections for the use of Earmarked Value Added Tax for health financing in Zimbabwe, Atchison Actuaries, TARSC, MoHCW, Harare.
10. Beukes SM (2013) Zimbabwe, 12 July 2013: Transition fund breathes new life into Zimbabwe's health system, accessed 15 Jan 2015 at: http://www.unicef.org/esaro/5440_13039.html
11. Central Statistics Office (CSO) and Macro International Inc. (1995) *Zimbabwe demographic and health survey 1994*, CSO and Macro International Inc., Calverton, MD.
12. CSO (2006) *2004 labour force survey*, Government of Zimbabwe, Government Printers Harare.
13. CSO (2008) Consumer Price Index tables, Mimeo, Harare.
14. CSO and Macro International Inc. (2000) Zimbabwe demographic and health survey 1999, CSO and Macro International Inc.: Calverton, MD.
15. CSO and Macro International Inc. (2007) Zimbabwe demographic and health survey 2005-06, CSO and Macro International Inc., Calverton, MD.
16. Chabaya 0, Rembe S, Wadesango N (2009) The persistence of gender inequality in Zimbabwe: factors that impede the advancement of women into leadership positions in primary schools South African Jo Education 29:235-251.
17. Chigumira G, Matsika W, Nyamadzawo J, Chiwunze G (2014a) Review of financing of semi-autonomous health institutions in Zimbabwe, ZEPARU for TARSc and MoHCC in the Rebuild programme, Harare.
18. Chigumira G, Chiwunze G, Nyamadzawo J, Matsika W, Kok M, Toonen J (2014b). Report of a field study on the sources, systems and channels of funding health from central to operational level in Zimbabwe, ZEPARU and KIT, for TARSC and MoHCC in the Rebuild programme, Harare
19. Chihanga S (2008) Ministry of Health and Child Welfare, Director of Policy and Planning, Personal communication 14 August 2008.
20. Chimbari MJ, D. Madhina, F. Nyamangara, H. Mtandwa, V. Damba (2008) *Retention incentives for health workers in Zimbabwe*, EQUINET Discussion Paper Series 65. NUST/ UNAM, U Limpopo, ECSA-HC, EQUINET, Harare.
21. Chitiga M (2004) *Trade policies and poverty in Zimbabwe*, mimeo, Poverty and Economic Policy Research Network, South Africa.
22. Chulu B (2011) Zimbabwean executives not overpaid, Independent, 28 April 2011 http://www.theindependent.co.zw/business/30790-brett-chulu-zimbabwean-executives-not-overpaid-.html.
23. Collaborating Centre for Operational Research and Education (CCORE) and the Health Transition Fund (2013) Vital Medicines Availability and Health Services Survey, CCORE, Harare.
24. Combined Harare Residents Association. (CHRA) (2007) 'ZINWA bill scandal to be exposed' 14 November 2007, accessed 9 July 2008 at: www.kubatana.net/html/archive/locgov/071114chra.asp?sector=WATSAN&year=2007&range_start=1.
25. Community Monitoring Programme (CMP) (2011) Quarterly Community Assessment of the Socio-economic Situation in Zimbabwe: Health and Education March 2011, Mimeo, Harare
26. CMP (2012) Quarterly Community Assessment of the Socio-economic Situation in Zimbabwe: Income and Employment June 2012, Mimeo Harare.
27. CMP (2013) Quarterly Community Assessment of the Socio-economic Situation in Zimbabwe: Health and Education April 2013, Mimeo, Harare.
28. CMP (2014) Quarterly Community Assessment of the Socio-economic Situation in Zimbabwe: Health and Education April 2014, Mimeo, Harare.
29. Dambisya YM, N Malema, C Dulo, S Matinhure, P Kadama (2013) 'The engagement of east and southern African countries on the WHO Code of Practice on the International Recruitment of Health Personnel and its implementation', EQUINET Discussion paper 103, EQUINET, Harare.
30. DFID Human Development Resource Centre (2012) An Impact Assessment of the Zimbabwe HHWRS, DFID, Harare.
31. Dieleman M, Watson M and Sisimayi, C (2012) Impact assessment of the Zimbabwe Health Worker Retention Scheme, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213900/Impact-assess-zimb-health-workers-retention-schemeFinal_20Report_20.pdf.
32. ECSA Health Community (2013) Report of the ECSA-HC Directors' Joint Consultative Committee Pre-Conference on Global Health Diplomacy, Ngurdoto Mountain Lodge Arusha, Tanzania, 11 August 2013.

33. Euro Health Group (EHG) (2005) 'Health Sector Support Programme Zimbabwe: Medicines survey public sector: Essential drug survey 2004 – public sector', Euro Health Group, Søborg, Denmark.
34. EQUINET Steering Committee (2007) Reclaiming the resources for health: A regional analysis of equity in health in east and southern Africa, EQUINET in association with Weaver Press (Zimbabwe), Fountain Publishers (Uganda), and Jacana (South Africa), Harare, Kampala and Cape Town.
35. Foster N (2012) Private sector involvement in health services in East and Southern Africa: country profiles, EQUINET Discussion Paper 89 Health Economics Unit (UCT), EQUINET, Harare.
36. Global Fund (2013) Audit of Global Fund Grants to Zimbabwe, accessed 23 Oct 2014 at: http://www.theglobalfund.org/en/oig/reports/.
37. Govender V., D. McIntyre, R. Loewenson (2008), Progress towards the Abuja target for government spending on health care in east and southern Africa, EQUINET Discussion Paper 60, EQUINET, Harare.
38. Government of Zimbabwe (GoZ) (1924) Public Health Act Ch 15:09, GoZ, Harare.
39. GoZ (2004) Zimbabwe Millennium Development Goals 2004 progress report, UNDP Zimbabwe, Harare.
40. GoZ (2004b) Population Census 2002, accessed 17 October 2014 at: http://www.ZIMSTAT.co.zw/.
41. GoZ (2009) Getting the Health Care System Moving again: 100 day plan GoZ Harare.
42. GoZ (2010) Mid-term Fiscal Policy Review, Government Printers, Harare.
43. GoZ (2011) *Strategy to Accelerate Access to Sanitation and Hygiene July 2011-June 2015*, accessed 10 July 2014 at: http://www.wsscc.org/sites/default/files/sanitation_and_hygiene_strategy_-final_draft-20sept2011.pdf.
44. GoZ (2013) Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset): Toward an Empowered Society and a Growing Economy" October 2013-December 2018, accessed on 16 Oct 2014 at; http://www.zimtreasury.gov.zw/zim-asset.
45. GoZ (2013b) The 2014 National Budget Statement: Towards an Empowered Society and a Growing Economy, GoZ, Harare
46. GoZ (2013c) Constitution of Zimbabwe Amendment 20, Government of Zimbabwe, Harare.
47. GoZ (2013d) Women and Men in Zimbabwe Report 2012, accessed 23 Oct 2014 at; http://www.ZIMSTAT.co.zw/dmdocuments/Gender/Report2012.pdf.
48. GoZ (2013e) National Health Accounts 2010, MoHCC, Harare.
49. GoZ (2014a) *Global AIDS Response Progress Report: Zimbabwe 2014*, accessed 5 June 2014 at: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/ZWE_narrative_report_2014.pdf.
50. GoZ (2014b) The 2014 Mid-Year Fiscal Policy Review Statement: 'Towards an Empowered Society and a Growing Economy,' accessed 20 Oct 2014 at: http://www.techzim.co.zw/wp-content/uploads/2014/09/2014-Mid-Term-Fiscal-Policy-Review.pdf.
51. GoZ and United Nations Development Programme (UNDP) (2012) Zimbabwe Millennium Development Goals Progress Report, UN, Harare.
52. GoZ and UNICEF (2007) World fit for children mid-decade progress report, Zimbabwe 2002-2006, UNICEF, Harare.
53. GoZ, EMCOZ, ZCTU (2007) Zimbabwe national strategic framework for the private sector response to HIV and AIDS 2007-2010, Government Printers, Harare.
54. Gupta N, Dal Poz M (2009) Assessment of human resources for health using cross-national comparison of facility surveys in six countries Human Resources for Health 2009, 7:22.
55. Gwati G MoHCC (2013) Desk Review for Purchasing Arrangements for Public Health Services in Zimbabwe November, Harare, MoHCC, with TARSC, Zimbabwe.
56. Health Service Board (2005) Draft strategic plan 2005-2010, Health Service Board, Harare.
57. HSB (2006) Health Service Board annual report 2006, Health Service Board, Harare.
58. HSB (2007) Health Service Board annual report 2007, Health Service Board, Harare.
59. HSB (2014) Information provided by Health Service Board, Mimeo, Harare.
60. HSB, MoHCW (2010) Human Resources For Health Strategic Plan 2010-2014, HSB, Harare
61. Human Rights Watch (HRW) (2013) *Troubled Water: Burst Pipes, Contaminated Wells, and Open Defecation in Zimbabwe's Capital*, accessed 5 June 2014 at: http://www.hrw.org/sites/default/files/reports/zimbabwe1113_forUpload_1.pdf.
62. Huruva S (2014) Salary scandals in Zimbabwe's medical insurance - crisis or opportunity for accountability? EQUINET Newsletter 159 May 2014.
63. International monetary Fund (IMF) (2001) Public information notice (PIN) No. 02/64 accessed September 2008 at http://www.imf.org/external/np/sec/pn/2002/PN0264.HTM.
64. IMF (2011) Zimbabwe: Article IV Consultation 2011 IMF Country Report No. 11/135 IMF, New York, http://www.imf.org/external/pubs/ft/scr/2011/cr11135.pdf.
65. IMF (2013) Heavily indebted poor countries (HIPC) initiative and multilateral debt relief initiative (MDRI) – Statistical update, accessed 13 July 2014 at: http://www.imf.org/external/np/pp/eng/2013/121913.pdf.
66. IMF (2014) World economic outlook database, October 2014, accessed 17 Jan 2015 at: http://www.imf.org/external/pubs/ft/weo/2014/02/weodata/index.aspx
67. Inst for Health Metrics and Evaluation (IHME) (2010) Global Burden of Disease Profile Zimbabwe, IHME, Seattle
68. Jamasmie C (2014) 'Massive diamond fields discovered in Zimbabwe to save the country's industry' accessed 5 Jan 2015 at: http://www.mining.com/massive-diamond-fields-discovered-in-zimbabwe-to-save-the-countrys-industry-35693/.
69. Loewenson R., M. Chisvo (1994) *Transforming social development: The experience of Zimbabwe*, UNICEF, Harare.
70. Loewenson R, Masotya M (2008) Equity Watch: assessing progress towards equity in health. Zimbabwe. EQUINET, Harare.

71. Loewenson R, I. Rusike, M. Zulu (2004) *Assessing the impact of health centre committees on health system performance and health resource allocation*, EQUINET Discussion Paper 18, EQUINET, Harare.
72. Loewenson R, Shamu S (2008) Population and health trends in Zimbabwe: Trend analysis of the Zimbabwe demographic health surveys 1994 – 2006, Training and Research Support Centre (TARSC), Harare.
73. Loewenson R, Kadungure A, Makandwa M, Mushawatu C, Macheka S, Chikara S, Marima S. (2010) Assessment of the implementation of the Public Health (Control of Tobacco) regulations 2002: TARSC, Harare.
74. Loewenson R, Chuma J, Shamu S (2010) Analysis of equity in meeting the health Millennium Development Goals in Eastern and southern Africa, UNICEF ESARO, Nairobi.
75. Loewenson R, Chituku T, Masuka N (2013) Costing of non communicable diseases in Zimbabwe, Mimeo, Harare.
76. Loewenson R, Machingura F, Kaim B, Rusike I (2014) 'Health centre committees as a vehicle for social participation in health systems in east and southern Africa' EQUINET discussion paper 101, TARSC with CWGH and Medico, EQUINET: Harare.
77. Loeb ME, (2009) The Effect of Failed States on the Well-Being and Lives of People with Disabilities, Chapter 2 pp13- 30 in Maclachlan, M and Swartz, L (eds) Disability and International Development: Towards Inclusive Global Health, Springer New York Mabika A. (July 2008) Health desk, SEATINI, Personal communication, Harare.
78. Makuto D., V. James V (2007) *Study on access to health care services in Zimbabwe*, European Union, ECORYS Nederland BV.
79. Mathuthu M (2014) 'Medical consultation fees increased by 100 percent,' SW Radio Africa 26 May 2014, accessed on 24 Oct 2014 at: http://www.swradioafrica.com/2014/05/26/medical-consultation-fees-increased-by-100-percent/.
80. McIntyre D., B. Chitah , L. Mabandi, F. Masiye, T. Mbeeli, S. Shamu (2007) *Progress toward equitable health care resource allocation in east and Southern Africa*, EQUINET Discussion Paper 52. EQUINET, Harare.
81. Mhlanga G (2013) Zimbabwe's experience in preparation, attendance and post attendance activities related to Global Health Diplomacy, Presentation at the ECSA – HC 23rd DJCC & 7th Best Practices Forum 12 August 2013.
82. Midzi S. (2008) personal communication, July 2008.
83. Mills A et al (2012) Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage Lancet May 15 2012 DOI:10.1016/S0140-6736(12)60357-2.
84. Ministry of Finance (MoF) (2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2012, 2013, 2014) *National budget estimates*, Government printers, Harare.
85. Ministry of Health and Child Care (MoHCC) (2013) National Health Accounts Draft Report, MoHCC , Harare
86. MoHCC (2014a) National health accounts, Government of Zimbabwe, Harare.
87. MoHCC (2014b) Rebuilding Health Services after a Health Workforce Crisis in Zimbabwe, accessed 5 June 2014 at: http://www.who.int/workforcealliance/forum/2011/hrhawardscs18/en/.
88. MoHCC and WHO (2014) Social Determinants of Health Working Group (SDHWG) Orientation meeting report 19 February 2014 Harare, Zimbabwe.
89. MoHCC, UNICEF et al (2014) Health Transition Fund joint report, MoHCC, Harare
90. Ministry of Health and Child Welfare (MOHCW) (1995). District Core Health Services. Harare: MOHCW.
91. MoHCW (1999) *National health strategy for Zimbabwe 1997-2007: Working for quality and equity in health*, Government of Zimbabwe, Government Printers, Harare.
92. MoHCW (2001) National health accounts, Government of Zimbabwe, Harare.MoHCW (2005a) 'Zimbabwe national health profile 2002', MoHCW, Harare.
93. MoHCW (2005b) 'Zimbabwe national health profile 2005', MoHCW, HarareMoHCW (2006) *PMTCT and paediatric HIV prevention, treatment and care national plan 2006-2010*, Government of Zimbabwe, Harare.
94. MoHCW (2006b) Zimbabwe National Health Profile 2006.MoHCW, Harare.MoHCW (2007) *AIDS and TB programmes annual report 2006*, Government of Zimbabwe, Harare.
95. MoHCW (2007b) *The Zimbabwe Programme for Prevention of Mother to Child Transmission of HIV (MPTCT) 2006 annual report*, Government of Zimbabwe, Harare.
96. MoHCW (2008) Zimbabwe National HIV/AIDS estimates, 2007, MoHCW, Harare.
97. MoHCW (2008b) 'Working consultative document: Developing a national health strategy 2008-2012' mimeo, Harare.
98. MoHCW (2009) The National Health Strategy For Zimbabwe (2009 – 2013) Equity And Quality In Health: A People's Right, Government of Zimbabwe, Harare.
99. MoHCW (2010) Health Sector Investment Case (2010-2012) , MoHCW, Harare.
100. MoHCW (2011) 'Rebuilding Health Services after a Health Workforce Crisis in Zimbabwe" accessed 20 Oct 2014 at: http://www.who.int/workforcealliance/forum/2011/hrhawardscs18/en/.
101. MoHCW (2011b) Health Transition Fund: A Multi-donor Pooled Transition Fund for Health in Zimbabwe, accessed 20 Oct 2014 at http://www.unicef.org/zimbabwe/ZIM_resources_htfoutline.pdf.
102. MoHCW (2012) National Integrated Health Facility Assessment Report, Ministry of Health and Child Care, Harare.
103. MoHCW (2015) Summary of human resources estimates, MoHCW, Harare.
104. MoHCW and WHO (2011) National Stakeholders workshop on social determinants of health: report , June 29-30 2011, Harare
105. MoHCW, National Information & Surveillance Unit, CSO (2004) Zimbabwe national health information system data, MoHCW, Harare.
106. MoHCW, TARSC (2013) Report on Stakeholder Review of options for Domestic health Financing, 16 August, Bronte Hotel, Harare, MoHCW, TARSC/ EQUINET Zimbabwe.
107. MoHCW, TARSC, KIT (2013) Report on meeting to

review institutional options for management of earmarked funds for Health, 11 April, Bronte Hotel, Harare, MoHCW, TARSC/ EQUINET Zimbabwe.

108. MoHCW, University of Zimbabwe, WHO, UNICEF (2005) National Survey Zimbabwe Non-Communicable Disease Risk Factors, MoHCW, Harare.

109. Ministry of Public Service, Labour and Social Welfare (MPSLSW) (2006) 2003 *Poverty assessment study survey, final main report,* Government of Zimbabwe, Harare.

110. Mufunda J, Chatora R, Ndambakuwa Y, Nyarango P, Chifamba J, Kosia A, Sparks HV. (2006) Prevalence of noncommunicable diseases in Zimbabwe: results from analysis of data from the National Central Registry and Urban Survey. Ethn Dis;16(3):718-22.

111. Mpofu A. and Nyahoda P (2008) *National health financing in Zimbabwe 2005: Contribution of the National AIDS Levy to national health care support,* EQUINET Discussion Paper 54, EQUINET, Harare.

112. Muchedzi A, Chadambuka A, Musarandega R, Machekano R, Woelk G (2014) Improving demand and retention in PMTCT programs through support to the Village Health Worker (VHW) Program in Tsholotsho District, Zimbabwe, accessed 20 Oct 2014 at: http://www.pedaids.org/page/-/uploads/conferences/IAS%202014/ZimVWH_IAS2014.pdf

113. Munjanganja LE and Machawira MS (2014) Education for all 2015 National Review Report: Zimbabwe, accessed 15 Jan 2015 at: http://unesdoc.unesco.org/images/0023/002304/230412e.pdf

114. Mujuru E (2011) 'The state of the pharmaceutical Industry in Zimbabwe' (unpublished) Presentation at a workshop, 8 October 2011.

115. Mwayera L (2012) EU $2 million fund for midwifery training, accessed 15 Jan 2015 at: http://www.thezimbabwean.co/news/zimbabwe-news/58107/eu-2-million-fund-for.html

116. Mzumara M (2014) 'Zim diamonds not forever?' accessed 15 Jan 2015 at: http://www.financialgazette.co.zw/zim-diamonds-not-forever/

117. National AIDS Council (NAC), MoHCW, UNAIDS (2006) *Zimbabwe national HIV and AIDS strategic plan (ZNASP) 2006-2010*, NAC, Harare.

118. NAC (2011) *Zimbabwe National AIDS Support Programme*, NAC, Harare

119. Nemukuyu, D (2014) 'Water disconnections unconstitutional: Court, The Herald 3 May 2014, accessed 22 Oct 2014 at: http://www.herald.co.zw/water-disconnections-unconstitutional-court/.

120. NGO Human rights Forum (2014) CSOs' Mid-Term Report of the Universal Periodic Review Process (2014) accessed 25 Oct 2014 at: www.hrforumzim.org/news/zim-civil-society-organisations-mid-term-report-of-the-universal-periodic-review-process.

121. Oxford Poverty and Human Development Initiative (OPHI) (2013) Zimbabwe: Country Briefing 2013, Oxford UK.

123. Parliament of Zimbabwe (2008) Draft report of the portfolio committee on Local Government on the provision of water and sewer services by ZINWA and its impact on public health, mimeo, Portfolio Committee on Local Government, Harare.

123. Republic of Zimbabwe (1981) Constitution of the Republic of Zimbabwe 1981, GoZ, Harare.

124. Southern Africa Development Community (SADC) (2009). Round 9 Proposal. HIV Cross Border Initiative. 10 June., SADC, Botswana.

125. Scoones I, Marongwe N, Mavedzenge B, Murimbarimba F, Mahenehene J Sukume C (2010) Zimbabwe's Land Reform: Myths and Realities, James Currey, UK.

126. SEATINI, CEHURD (2014) Medicines production and procurement in east and southern Africa and the role of south-south co-operation, EQUINET Discussion paper 104, EQUINET, Harare.

127. Shamu S., R. Loewenson (2006) *Zimbabwe national health sector budget analysis and equity issues 2000–2006*, Equinet Discussion Paper 43, EQUINET, Harare.

128. Shamu S., R. Loewenson (2008) Zimbabwe health budget analysis, 2008, TARSC Monograph, Harare.

129. Shamu S, Loewenson R, Machemedze R and Mabika A (2010) 'Capital flows through Medical Aid Societies in Zimbabwe's health sector,' *EQUINET Discussion Paper Series 82*. Training and Research Support Centre, SEATINI, Rhodes University, EQUINET, Harare.

130. Shamu (2012) 'Resource mobilization for health under the Zimbabwe Investment Case 2010-2012,' EQUINET Discussion Paper Series 94. Training and Research Support Centre, EQUINET, Harare.

131. Shamu, S, TARSC (2013) Literature Review on Needs based Resource Allocation TARSC, MoHCC, Harare

132. Sibanda M and Makore G (2013) Tracking the trends: An assessment of diamond mining sector tax contributions to treasury with particular reference to Marange diamond fields, accessed 15 Jan 2015 at: http://publishwhatyoupay.org/sites/publishwhatyoupay.org/files/Tracking%20the%20Trends%20(2).pdf.

133. Sikhosana P (2009) Getting the Zimbabwe Health System moving again. MoHCW, Harare.

134. Singizi T (2007) *Zimbabwe's Child Health Days help to reduce measles and boost child survival,* dated 29 November 2007, accessed 21 July 2008 at: http://www.unicef.org/infobycountry/zimbabwe_41970.html.

135. Smith H, Chiroro P, and Musker P (2012) Process and Impact Evaluation of the Basic Education Assistance Module (BEAM) in Zimbabwe Final Evaluation Report, accessed 20 Oct 2014 at: http://www.unicef.org/evaldatabase/files/BEAM_Evaluation_Final_Report.pdf.

136. Taruvinga M (2014) 'Availability of essential drugs improves,' accessed 24 Oct 2014 at: http://www.thezimmail.co.zw/2014/06/26/availability-of-essential-drugs-improves/.

137. Training and Research Support Centre (TARSC) (2012) Community view on the essential health benefit in Zimbabwe. TARSC, Harare.

138. TARSC (2013) An assessment of Zimbabwe's Health Services Fund (HSF), TARSC Harare.

139. TARSC (2014) Compliance with provisions of food and infant formula labelling regulations in Zimbabwe February 2014: TARSC CBRT, Harare.

140. TARSC, CWGH (2009) Health where it matters most: An assessment of Primary Health Care in Zimbabwe March 2009 Report of a community based assessment: TARSC Harare.

141. TARSC, MoHCW (2002) Report of a study on inclusion of equity indicators in the resource allocation formula for Ministry of Health Funds in Zimbabwe, Equity Gauge Monograph,TARSC, Harare.

142. TARSC, MoHCW (2011) Equity Watch: assessing progress towards equity in health in Zimbabwe, EQUINET Harare

143. TARSC MoHCW with PHAB (2013) Implementers workshop on the Public Health Act, Harare, September 16-18 2013, Harare.

144. TARSC, Atchison Actuaries (2014) Proposals for resource allocation to support equity and universal coverage in Zimbabwe, paper produced in the Rebuild Consortium, TARSC, MoHCC, EQUINET; Harare.

145. TARSC, Community Based Researchers (2014) Assessment of the funding, accounting, and monitoring of Zimbabwe's Health Services Fund, TARSC, Harare.

146. TARSC MoHCW with PHAB (2013) Implementers workshop on the Public Health Act, Harare, September 16-18 2013, Harare.

147. TARSC, MoHCC (2014) How well are we doing on equity and universal coverage of health services in Zimbabwe? Analysis of 2012 and 2013 Health Information System data, TARSC, MoHCC, Harare.

148. UNAIDS (2013) Case Study 2013: Zimbabwe An AIDS Strategy Focused and Aligned with Our Vision and the United Nations targets for 2015, accessed 11 July 2014 at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/2013CaseStudyZimbabwe_en.pdf.

149. UNAIDS (2013b) Zimbabwe's sustained progress toward "Getting to Zero," accessed 11 July 2014 at: http://www.unaids.org/en/resources/presscentre/featurestories/2013/may/20130514zimbabwe/

150. UNAIDS (2014) Global AIDS Response Country Report: Zimbabwe 2014, accessed 5 Dec 2014 at: http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2014.pdf.

151. UNIDO (2011) 'Pharmaceutical sector profile: Zimbabwe', UNIDO: Vienna. Available at: http://apps.who.int/medicinedocs/documents/s18701en/s18701en.pdf.

152. UN Zimbabwe (2013) Issue Paper Series: Maternal Mortality in Zimbabwe Evidence, Costs, and Implications, accessed 1 June 2014 at http://www.zw.one.un.org/sites/default/files/UN-ZW_IssuePaperSeries-1_MMR_June2013.pdf.

153. UNDP (2005) *Human development report 2005 – International cooperation at a crossroads: Aid, trade and security in an unequal world*, Oxford University Press, New York.

154. UNDP (2008) *Human development report 2007/2008*, UNDP, New York.

155. UNDP (2009) Human Development Report 2009, UNDP, New York.

156. UNDP (2010): The Human Development Report. 2010, UNDP, New York.

157. UNDP (2010b): The Human Development Report 2010. Excel Data Spreadsheets: http://www.hdr.undp.org/org.

158. UNDP (2011) Worldwide Trends in the Human Development Index 1970-2010, accessed July 2011 at http://hdrstats.undp.org/en/countries/profiles/ZWE.html.

159. UNDP (2011b) Multidimensional Poverty Index accessed July 2011 at http://hdr.undp.org/en/statistics/mpi/

160. UNDP (2014) Human Development Report 2014 Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience: Explanatory note on the 2014 Human Development Report UNDP, New York.

161. UNDP (2014b) In Zimbabwe better clinics lead to better healthcare, accessed 20 Oct 2014 at: http://www.undp.org/content/undp/en/home/ourwork/hiv-aids/successstories/in-zimbabwe--improving-clinics---helps-improve-healthcare

162. UNDP Zimbabwe (2008) Comprehensive Economic Recovery in Zimbabwe A Discussion Document, UNDP, Harare.

163. UNESCO(2009) UIS Statistics in brief Zimbabwe, UNESCO, Paris.

164. United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (2008) 'Zimbabwe election period', *OCHA Weekly Situation Report*, Issue No 10, 2–13 Jun 2008, 13 June 2008.

165. UNICEF (2006) *Zimbabwe's ground-breaking plan for girls and orphans and vulnerable children's education*, dated 18 October 2006, accessed 21 July 2008 at: http://www.unicef.org/media/media_36452.html.

166. UNICEF (2007) *Zimbabwe's HIV infection rate continues to fall*, dated 31 October 2007, accessed 17 June 2008 at: http://www.unicef.org/infobycountry/media_41603.html.

167. UNICEF (2007b) 'World fit for children – mid-decade progress report: Zimbabwe 2002-2006' UNICEF, Harare.

168. UNICEF (2012) Pneumococcal vaccine launched in Zimbabwe, accessed 5 June 2014 at: http://www.unicef.org/infobycountry/zimbabwe_65459.html.

169. UNICEF (2013) UNICEF Annual Report 2013: Zimbabwe, UNICEF, Harare

170. UNICEF (2013) Zimbabwe: WHO and UNICEF estimates of immunization coverage: 2012 revision, UNICEF, Harare

171. UNICEF and Ministry of Labour and Social Services (2010) Child Protection Fund: In support of the National Action Plan for Orphans and Vulnerable Children, accessed 26 Oct 2014 at: http://www.unicef.org/zimbabwe/ZIM_resources_childprotfundstratconcept.pdf.

172. UNICEF Zimbabwe and the Transition Fund (2011) Education in Emergencies and Post-Crisis Transition: 2010 Report Evaluation, UNICEF, Harare.

173. United Nations Office for the Co-ordination of Humanitarian Affairs (2008) 'Daily cholera update 18 December 2008', Zimbabwe UN OCHA, Harare.

174. United States Agency for International Development (USAID) (2008) *Humanitarian assistance*, accessed 9 July 2008 at: http://www.usaid.gov/zw/hum_assistance.html.

175. Vaughan K (2014) Costing Zimbabwe's Essential Health Benefit: Draft Costing Findings, KIT, Netherlands

176. VVOB education for development (2015) The challenges of ECD teacher development in Zimbabwe, accessed 18 Jan 2015 at: http://www.vvob.be/zimbabwe/news/the-challenges-of-ecd-teacher-development-in-zimbabwe.

177. Water and Sanitation program (WSP), African Development Bank (AfDB) United Nations Children's

Fund (UNICEF) and Government of Zimbabwe (GoZ) (2011) *Water Supply and Sanitation in Zimbabwe: Turning Finance into Services for 2015 and Beyond*. Available online at: http://www.wsp.org/sites/wsp.org/files/publications/CSO-Zimbabwe.pdf

178. United States Agency for International Development (USAID) (2008) *Humanitarian assistance*, accessed 9 July 2008 at: http://www.usaid.gov/zw/hum_assistance.html

179. World Bank (2010) Country data Zimbabwe sourced from world development indicators database. Available at http://data.worldbank.org/country/zimbabwe

180. World Bank (2011) Analyzing Inequality, World Bank, at http://go.worldbank.org/5PI4DL3WD1

181. World Bank (2014) World Development Indicators: Health Systems, accessed 13 July 2014 at: http://wdi.worldbank.org/table/2.15.

182. World Bank (2014) Global Economic Prospects: Country and region specific forecasts and data, accessed 16 Oct 2014 at: http://www.worldbank.org/en/publication/global-economic-prospects/data?region=SST

183. World Bank (2014b) World Development Indicators: Health Systems, accessed 13 July 2014 at: http://wdi.worldbank.org/table/2.15.

184. World Bank (2014c) Data: external debt stocks accessed 20 Oct 2014 at: http://data.worldbank.org/indicator/DT.DOD.DECT.GN.ZS.

185. World Food Programme (WFP) and Vam food security analysis (2014) Zimbabwe Food Security Outlook, January – March 2013 accessed 22 Oct 2014 at: http://www.wfp.org.

186. World Health Organization (WHO) (2001) Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health. World Health Organisation. Geneva

187. WHO (2007) *Working together for health: The world health report 2006*, WHO: Geneva.

188. WHO (2008) World health statistics 2008, WHO, accessed 9 June 2008 at: www.who.int/whosis/whostat/2008/en/index.html.

189. WHO (2008b) *Zimbabwe national expenditure on health*, National health accounts series, 15 May 2008, accessed 15 July 2008 at: http://www.who.int/nha/country/zwe.pdf.

190. WHO (2010) *World health statistics, 2010*, Available at http://www.who.int/gho/database/WHS2010 (accessed 1 August 2010).

191. WHO (2010b). 'Health systems financing: The path to universal coverage,' World Health Report. WHO: Geneva.

192. WHO (2011) World Health statistics, Core Health Indicators Database 2011. WHO: Geneva, available at: http://www.who.int/whosis/en/.

193. WHO (2011b) NCD Country Profiles, 2011: Zimbabwe, WHO, Geneva.

194. WHO (2011c) National Health Accounts Database 2011. accessed at www.who.int/nha/en/ August 2011.

195. WHO (2014) World Health statistics 2014, Global Health Observatory (GHO). WHO: Geneva, available at: http://www.who.int/gho/publications/world_health_statistics/2014/en/.

196. WHO, MoHCW (2010) Epidemiological Bulletin Number 57 Week 17 (week ending 2 May 2010), Mimeo Harare

197. ZEPARU, TARSC, MoHCW, UCT HEU (2013) Review of health financing in Zimbabwe: Inception report for the Financing studies, TARSC, MoHCW with GHNE and EQUINET, Harare.

198. ZEPARU, TARSC, MoHCW (2013) Feasibility and projections of selected earmarked taxes as a source of health financing, ZEPARU, TARSC, MoHCW, Harare.

199. ZEPARU (2014) Desk Review of institutional arrangements for health financing in Zimbabwe, ZEPARU, TARSC, MoHCC, EQUINET in the ReBUILD project, Harare.

200. Zimbabwe Hospital Doctors Association (ZHDA) Executive Committee(2014) Press Statement 20 October 2014, accessed at: http://www.kubatana.net/2014/10/21/3467/doctors-strike-zimbabwe

201. Zimbabwe Mail (2014) Government sets $6,000 salary cap for parastatals' (2014) Zimbabwe Mail, 18 March 2014, accessed 3 November at: http://thezimbabwemail.com/government-sets-6000-salary-cap-for-parastatals/.

202. Zimbabwe National Statistics Agency (ZIMSTAT), UNICEF (2009) Multiple Indicator Monitoring Survey (MIMS) Preliminary Report, Harare.

203. ZIMSTAT (2011) *Labour Force Survey,* ZIMSTAT, Harare.

204. ZIMSTAT (2013) *Census 2012 National Report*, ZIMSTAT, Harare.

205. ZIMSTAT (2013b) *Poverty and Poverty Datum Line Analysis in Zimbabwe 2011/2012*, ZIMSTAT, Harare.

206. ZIMSTAT (2013c) Poverty Income Consumption and Expenditure Survey 2011/12 Report, ZIMSTAT, Harare.

207. ZIMSTAT (2014) Multiple Indicator Cluster Survey 2014, Key Findings. Harare, Zimbabwe: ZIMSTAT, accessed 23 Oct 2014 at: http://reliefweb.int/sites/reliefweb.int/files/resources/multiple_indicator_cluster_survey_2014_en.pdf.

208. ZIMSTAT and ICF International (2012) *Zimbabwe Demographic and Health Survey 2010-11*, Calverton, Maryland: ZIMSTAT and ICF International Inc.

209. ZIMSTAT and UNICEF (2009) Multiple Indicator Monitoring Survey (MIMS) Preliminary Report, Harare.

210. Zimtrade (2009) 'Pharmaceuticals Zimbabwe', Zimtrade: Harare. Available at: http://www.zimtrade.co.zw/pdf/sector%20right-ups/Pharmaceuticals.pdf

211. Zimbabwe Vulnerability Assessment Committee (ZimVAC) (2009) Urban Food Security Assessment January 2009 National Report, ZIMVAC, Harare.

212. ZimVAC) (2013) Rural Livelihoods Assessment January 2013 National Report, ZIMVAC, Harare

213. Zimbabwe Vulnerability Assessment Committee (ZimVAC) (2014) Rural Livelihoods Assessment, National Report, ZIMVAC, Harare

EQUITY WATCH

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. It is achieved through the distribution of societal resources for health, including but not only through the actions of the health sector.

This report of the Zimbabwe Equity Watch has been produced by Training and Research Support Centre and Ministry of Health and Child Care Zimbabwe working with EQUINET. The summary table below shows the progress markers that were assessed, the trends, with green for improving progress, red for worsening trends and yellow for uncertain or mixed trends. The report provides the evidence on these trends and proposes areas for action.

PROGRESS MARKER in Equity Watch report of	2008	2011	2014
HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH			
Halving the number of people living on US$1 per day			
Reducing the gini coefficient of inequality			
Increased ratio of wages to gross domestic product			
Closing gender differentials in access to education			
Halving the proportion of people with no safe drinking water and sanitation			
Allocate resources to agriculture and women smallholder farmers			
EQUITY IN HEALTH			
Formal recognition of equity and health rights			
Eliminating differentials in child, infant and maternal mortality and under nutrition			
Eliminating differentials in access to immunization, ante-natal care, skilled deliveries			
Universal access to prevention and treatment for HIV/AIDS			
Detecting preventing and managing chronic conditions			
REDISTRIBUTIVE HEALTH SYSTEMS			
Achieving the Abuja commitment			
Achieving US$60 per capita funding for health			
Establish and ensure clear health care entitlements			
Improve tax funding and reduce out of pocket spending to health			
Abolish user fees			
Harmonize health financing into a framework for universal coverage			
Allocate at least 50% public funding to districts and 25% to PHC			
Provide adequate health workers, medicines at primary, district levels			
Implement non-financial incentives for health workers			
Recognition of and support for mechanisms for public participation in health systems			
Overcoming barriers to access and use of services			
A JUST RETURN FROM THE GLOBAL ECONOMY			
Reducing the debt burden			
Ensure health goals in trade agreements			
Bilateral and multilateral agreements to fund health worker training			
Health officials included in trade negotiations			