2011

EQUITY WATCH

Assessing progress towards equity in health

Zimbabwe

Training and Research Support Centre

Ministry of Health and Child Welfare

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

Map of Zimbabwe showing provinces

Source: Zimstat, UNICEF 2009

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Foreword

It is with pleasure that the Ministry of Health and Child Welfare presents the second *Equity Watch* report for Zimbabwe, assessing the progress we are making in health equity. This report updates the 2008 Zimbabwe *Equity Watch* and is part of a regional programme of work with the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and in cooperation with the East, Central and Southern African Health Community. We are happy that this programme was first piloted in Zimbabwe and that we are now able to release this second report to track the changes between 2008 and 2011.

The 2008 *Equity Watch* report highlighted the need for investments in primary health care to revitalise the health system close to communities, to close gaps in access to services and to address the causes of ill health. Primary health care is central to the national health strategy for the 2009 to 2013 period. It is positive, therefore, that this 2011 *Equity Watch* indicates that improvements have been made in priority areas identified in the 2008 report, such as in primary education, in supplies of medicines and staff to primary care and district levels, in immunisation coverage, in access to antiretrovirals, and in recognition and support of community capacities for health. The report also points to improved health outcomes, such as reduced HIV prevalence, child mortality and under-nutrition.

Nevertheless, equity is still a concern. The report shows that poverty and inequality in wealth remain persistently high. Economic inequality affects access to key inputs to health, like improved incomes or safe water. It also affects the uptake of health services. It is disturbing to note, for example: that we continue to have wide differences between rural and urban areas in access to safe water and sanitation; that there is a new rise in urban food poverty; that children's nutritional levels continue to be strongly linked to their mothers' socio-economic and health situation; or that uptake of maternal health depends on women's wealth, education or place of residence. These are all basic conditions for human dignity and should not depend on wealth, residence or other social factors. We hope that future *Equity Watch* reports include analysis of inequities on the basis of race and ethnic group, and disaggregate evidence to district level, to better understand and address the social distribution of health and of the services that support health.

We have begun to address the concerns raised in the 2008 report by strengthening staffing levels and supplies to clinics and districts, negotiating incentives to retain staff and supporting village health workers. These investments have helped to reduce barriers to services in those people who need them most, helping to protect them against the impoverishing effect of ill health in vulnerable communities. The health sector needs adequate funding to widen delivery on these pro-poor investments and to tackle continuing barriers to access, such as user fees.

The report highlights the need for multi-sector action and a supportive global environment to achieve health equity. Differences in health outcomes arise due to inequalities in incomes, in access to safe water and sanitation and healthy food as well as to other conditions. These other sectors need to tackle these issues to ensure that people's health is not dependent on which community or family they are born into. The progress towards gender parity in education has been a considerable resource for health. We hope this report will stimulate discussion across a range of sectors and with development partners, civil society and parliament on the specific measures we can take to ensure that we close the gaps in access to the resources and services that people need for health.

Hon. Dr Henry Madzorera
Minister of Health and Child Welfare of Zimbabwe
Harare, October 2011

About the equity watch

An *Equity Watch* is a means of monitoring progress on health equity by gathering, organising, analysing, reporting and reviewing evidence on equity in health. Equity Watch work is being implemented in countries in eastern 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 (ECSA) Health Community 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. The aim is 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.

This report updates the 2008 Zimbabwe *Equity Watch* report using a framework developed by EQUINET in cooperation with the eastern, central and southern African health community and in consultation with WHO and UNICEF. The report introduces the context and the evidence within four major areas: equity in health, household access to the resources for health, equitable health systems and global justice. It shows past levels (1980–2005), current levels (most current data publicly available) and comments on the level of progress towards health equity with a coloured bar indicating broadly whether the situation is:


Improving


Static, mixed or uncertain


Worsening

The relationship to the average in the east and southern African region is also shown, where this is clear (and left blank where comparisons are difficult or uncertain):


Above the regional average

Below the regional average

EQUINET defines equity as:

> *'Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. Equity motivated interventions seek to allocate resources preferentially to those with the worst health status. This means understanding and influencing the redistribution of social and economic resources for equity-oriented interventions, and understanding and informing the power and ability people (and social groups) have to make choices over health inputs and to use these choices towards health' (EQUINET steering committee, 1998).*

We explore in particular 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. We also explore the governance of the health system, given that the distribution and exercise of power affects how resources are distributed and how strategies are designed and applied to ensure access to the resources for health.

Key areas

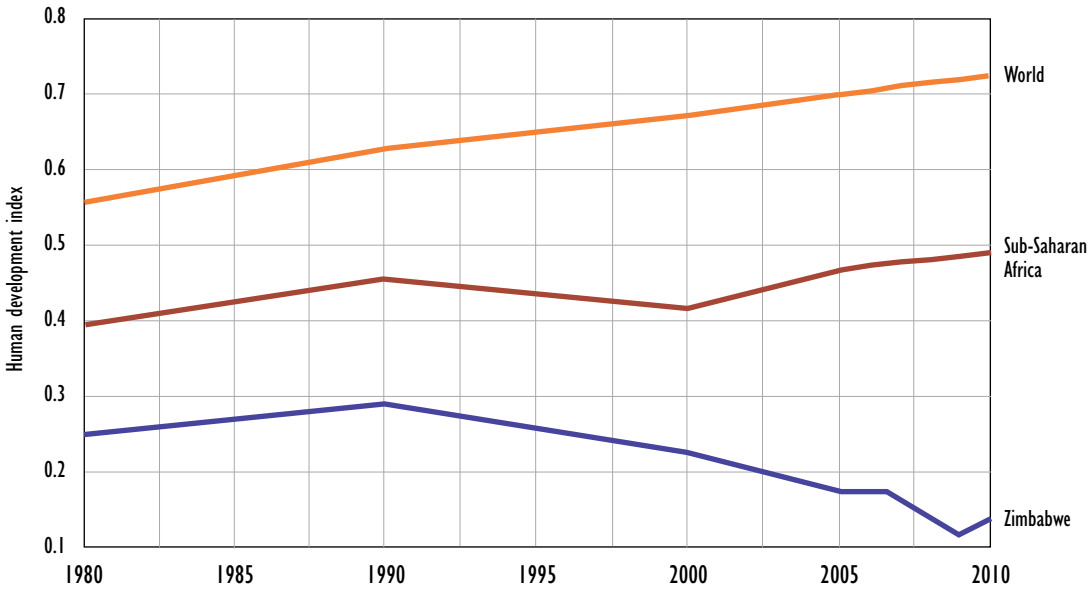
Introduction

EQUITY WATCH

Zimbabwe has a wealth of resources and potential. In 2007, out of the 12,4 million people, 47 per cent were urban and 53 per cent were rural (UNDP, 2008). Zimbabwe's population is highly literate and the country has rich natural, mineral and agricultural resources (UNDP, 2008). While the population has been one of the most affected by AIDS globally, adult HIV prevalence fell from 25.7 per cent in 2002 to 13.7 per cent in 2009 (Zimstat, UNICEF, 2009). After 2000, out-migration levels were significant and while return remittances bring new resources into the economy, 36 per cent of those migrating go to countries with low levels of income and human development (UNDP, 2008).

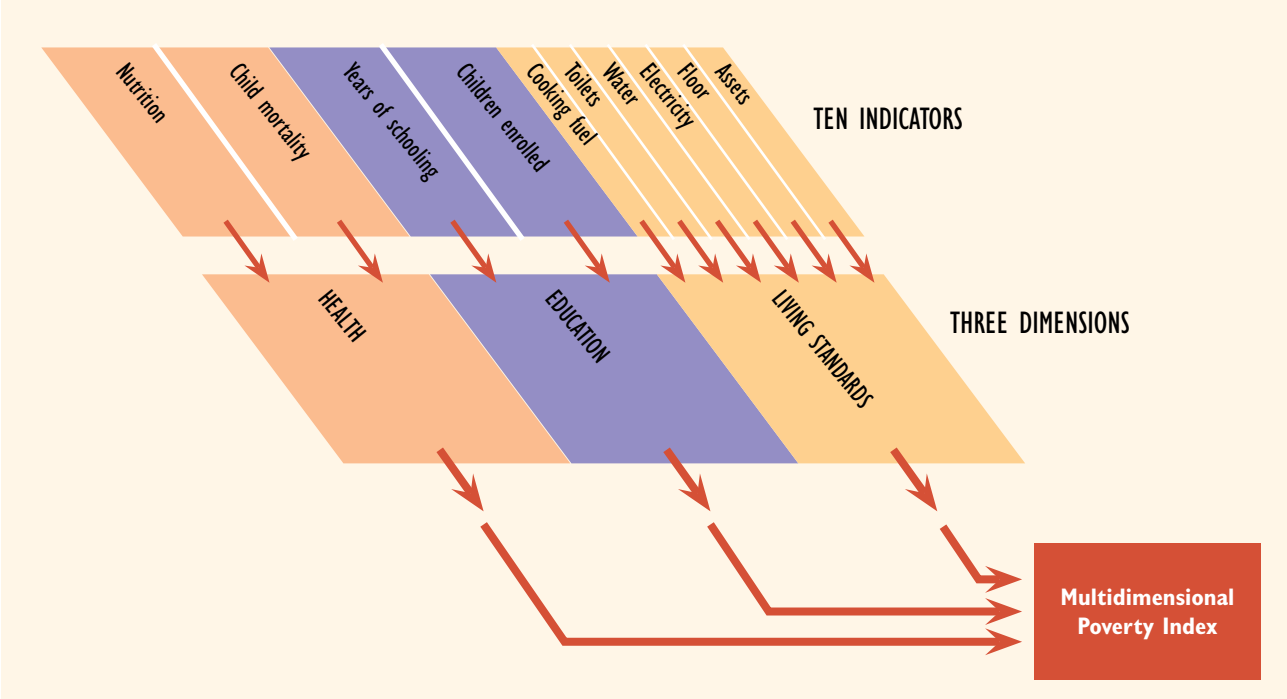
A sustained period of political conflict in the 2000s was associated with a 35 per cent decline in the gross domestic product (GDP) between 1999 and 2007 and an official year-on-year inflation rate in 2008 of 231 million per cent, the highest in the world (Zimstat, UNICEF, 2009). Since 2000, land reform has resulted in the transfer of around 8 million hectares of land across 4,500 farms to over 160,000 households, representing 20 per cent of Zimbabwe's total land area, according to official figures. While outcomes have been mixed, there is evidence that land reform has widened access to economic assets and strengthened local economies (Scoones *et al.*, 2010). However, economic decline brought hardship for the poor majority, with shortfalls in a range of basic needs and declining employment and income security. Since the 'inclusive government' was formed under a global political agreement in February 2009, there has been some recovery. Inflation has fallen, industrial capacity in the manufacturing sector has improved (from 10 per cent in 2008 to 30–50 per cent in 2010) and goods and services are more available.

Figure 1: Human development trends, Zimbabwe, 1980–2010



Source: UNDP, 2011

Figure 2: Components of the Multidimensional Poverty Index



Source: UNDP, 2011b

The GDP per capita fell from US$1086 in 1982 to $341 in 2008 but had risen to $449 by 2009 (World Bank, 2010). Between 2000 and 2008, 25 per cent of the population were identified as at risk of multidimensional poverty, an index assessed through components shown in Figure 2. Severe deprivation was found in at least one indicator of education in 15 per cent of the population while deprivation in health affected 30 per cent of the population. Living standards (assets, electricity, water, sanitation, energy) were unacceptable for 65 per cent of the population, a major contributor to poverty. A cholera outbreak in late 2008 reflected this decline in living conditions and affected around 100,000 people.

Zimbabwe's human development index (HDI) fell between 1980 and 2010, at a time when the rest of the sub-Saharan Africa region reflected an increase (UNDP, 2011; Figure 1). The small rise in 2010 suggests signs of recovery but it is too early to tell.

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The 2008 *Equity Watch* reported a 'testing context' and challenges. Since 2009, improved political and economic conditions have increased opportunities for better health. How equitably have these opportunities been distributed and with what impact on health?

This report assesses the changes since the 2008 *Equity Watch* report. In response to the question 'what progress are we making in equity in health?', it examines trends in health outcomes, in the social determinants of health, in redistributive health systems and in the returns to health from the global economy.

EQUITY WATCH

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Advancing equity in health

Progress markers

- Formally and publicly recognising and expressing equity and universal rights to health
- Achieving the Millennium Development Goal of reducing by half the number of people in poverty
- Eliminating differentials in maternal mortality, child mortality and under five year under-nutrition
- Eliminating differentials in immunisation, antenatal care and attendance by skilled personnel at birth
- Achieving universal access to prevention of vertical transmission programmes, condoms and antiretrovirals

EQUITY WATCH

Advancing equity in health

This section presents various markers of progress in health equity, in terms of the values that underpin it and the progress in addressing socio-economic and health inequalities.

Formally and publicly recognising and expressing a commitment to equity and universal rights to health

Past levels: 1980–2005

- Despite various constitutional processes and amendments since 1990, none of these addressed the right to health or health care and this right is not explicitly provided for in the Zimbabwe constitution. Zimbabwe is a signatory to the International Covenant on Economic and Social Rights in which Article 12 obligates member states to provide for the right to health. Zimbabwe is also signatory to various African charters and international conventions, as outlined in the 2008 *Equity Watch*. However, section 111b of the *Constitution of Zimbabwe* states that all international agreements require parliamentary approval before they are ratified and incorporated into domestic law and can take effect locally. These commitments to international agreements are thus not yet enforceable as they have not been domesticated in national law. A Patient's Charter, developed in 1996, provides information on the rights and responsibilities of patients and health providers but it has no formal legal status.
- *Planning for equity in health* (1980) and subsequent national policies have made equity a central policy principle, organising health systems around primary health care. They include measures to strengthen access and availability of public services and personnel and to redistribute resources to district services and underserved areas. Equity in access was encouraged by promoting health, deploying village health workers and offering 'free' services for those earning below Z$150 (then worth about US$220) (MoHCW, 1999).
- The Public Health Act (1924) is the major enabling law in health. While it has frequently been updated and amended to address new issues, gaps persist, for example on non-communicable diseases, maternal health, cross-border risks and new epidemics. Also, it is not rights-based and contains outdated terms like 'dirty and verminous persons' (Section 28). This does not reflect post-independence health policy, including in relation to primary health care and community involvement in health. It does, however, provide for local and central government powers to regulate nuisances to public health. The Medical Services Act (1998) and regulations were introduced to regulate health service standards, particularly in private sector services and voluntary medical aid societies. The Health Services Act (2004) created a specific board to employ health personnel. However, with economic decline, resource constraints and gaps in public sector personnel, there have been gaps in implementing these laws.

Current level: 2006-2010

- Reviewing the constitution has been an issue throughout the period, with a constitutional review process initiated after 2009. At the time of writing it was unclear how far this will address the right to health. Nevertheless, the desire to protect the right to health in the Zimbabwe constitution and law has been raised both by communities and policy makers. The government's *National health strategy 2009-2013* advocated for 'the protection of health rights in the constitution' as a national priority (MoHCW, 2009). In 2008, national civil society at the Community Working Group on Health 15th National Conference demanded that the right to health be included in the new constitution (CWGH, 2008). Communities also voiced this demand in public meetings during the 2010 national consultations on the new constitution.
- Recognising Zimbabwe's status as signatory to the International Covenant on Economic and Social Rights (ICESR) and the inclusion of the right to health in constitutions across the region, the Public Health Advisory Board, a national stakeholder body, proposed that the new constitution under debate includes:
  - a general right to the highest attainable standard of health for everyone;
  - the right to access health facilities, goods and services, including essential drugs, reproductive health care and emergency care;
  - the right to the social determinants of health (food, shelter sanitation and an adequate supply of safe water) and information;
  - freedom from discrimination or interference in achieving the right to health and provisions ensuring equity and protection of vulnerable groups;
  - prohibition of conduct injurious to health; and
  - principles for judging application of the rights and delivery of the state's obligations (PHAB, 2010).

  The constitutional process was still underway at the time of writing the report.
- The *National health strategy 2009-2013* raises universality, equity and quality as central principles (MoHCW, 2010). The strategy identifies three important objectives of Zimbabwe's health system:
  - to keep as many people as possible in good health in the community through health protection, health promotion and disease prevention strategies;
  - to provide appropriate quality services for those needing care in the community; and
  - to provide high quality hospital services at the appropriate level for those requiring that form of treatment and care.

  Government supported this strategy with the document, *Investment case,* which detailed the need to direct resources towards high priority areas, particularly primary health care (GoZ, MoHCW, 2010).
- In April 2010, the Ministry of Health and Child Welfare asked the Public Health Advisory Board to review the 1924 Public Health Act. Within the context of Zimbabwe's health policy, the Board carried out a technical and legal review and relatively wide stakeholder consultation in 2011. The Board drew public submissions through a white paper and held community and regional consultations and the final proposals were reviewed and adopted by stakeholders in July 2011 as proposals to government. The review identified the need for a rights-based framework that would, amongst other issues, promote health, address the social determinants of health and access to health care and do so in a manner that 'promotes justice, equity and gender equity' (PHAB, 2011).

Progress

Zimbabwe has instituted public debate on its constitution and a broad spectrum of stakeholders have articulated the need for the right to health and outlined what this signifies. The constitutional review process is still underway but awareness about the right to health is already more widespread. Proposals have been developed through wide consultation to strengthen the Public Health Act, the umbrella law in health. Principles of health equity continue to be articulated in policy and to guide the primary health care orientation described in the *National health strategy* and *Investment case* documents. The challenge remains to enact and implement these legal proposals and put the pro-equity policies and strategies in place. Civil society and stakeholders need to monitor this implementation.

Achieving the Millennium Development Goal of reducing by half the number of people in poverty (and living on less than US$1 per day)

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
% population living on less than US$1 a day (*PPP)	56.0	1990-2005	data not available	
% population living under the food poverty line	29	1995	data not available	
% population living under the total consumption poverty line	58	2003		
Rural: urban ratio for share below the total consumption poverty line	55	1995		
Multidimensional poverty index	72	2003	25.0	2000-2008**
Wealth quintiles	1.16	2003		
Rural				
– % in lowest quintile	29.3	2005	29.1	2009
– % in highest quintile	1.2	2005	1.4	2009
Urban				
– % in lowest quintile	0	2005	0.5	2009
– % in highest quintile	60.5	2005	59.9	2009

*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.

**The 2000-2008 data did not use the same measure as the 2003 data so the two cannot be compared.

Source: CSO Macro Int, 2007; MoPSLSW, 2006; GoZ/UNICEF, 2007, 2010; UNDP, 2008, 2011

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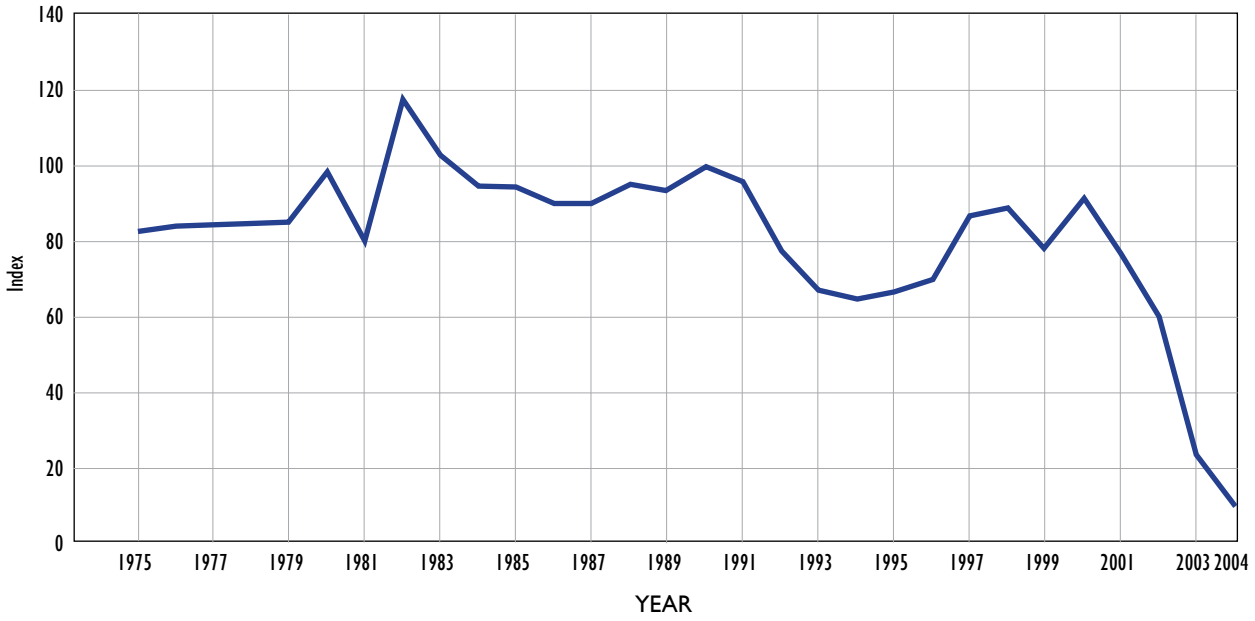
Past levels: 1980–2005

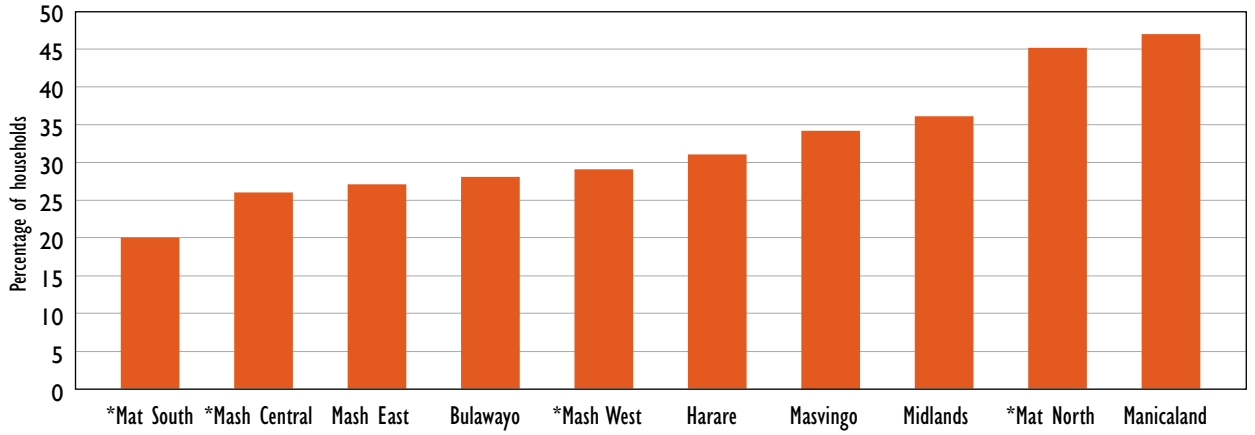
- Poverty increased between 1995 and 2003, both in terms of the food poverty line and the total consumption poverty line (see summary table). Total consumption poverty was higher in urban households than in rural households and in female-headed households than in male-headed households (MPSLSW, 2006). Between 1990 and 2005, 56 per cent of people were living on under US$1 a day and poverty tripled in Mashonaland Central, Bulawayo, Manicaland and Matabeleland South (GoZ/UNICEF, 2007).
- Figure 2a shows the significant drop in incomes after 2001. These figures may not capture all informal earnings but falling incomes, the impact of the AIDS epidemic and demand on community safety nets are likely to have contributed to poverty.
- Based on household surveys, the share of households with foster children rose between 1990 and 2005 from 11 to 25 per cent in urban areas and from 27 to 40 per cent in rural areas (Loewenson and Shamu, 2008).

Figure 2a: Average real earnings, 1975–2004 (Index: 1990 = 100)



Source: CSO data (unpublished)

Figure 2b: Proportion of food insecure households by province, 2009



* Mat = Matabeleland Mash = Mashonaland

Source: ZIMVAC, 2009

Current level: 2006-2010

- Poverty levels have not been measured in household surveys since 2005. Nevertheless the significant economic problems after 2000, hyperinflation eroding purchasing power and periodic drought are reported to have deepened poverty, buffered to some extent by remittances from family members outside the country (Bracking and Sachikonye, 2006).
- There is evidence that urban poverty has increased. The 2009 ZimVAC urban food security assessment found 33 per cent of the assessed households to be food insecure compared to 24 per cent in November 2006, with highest reported food insecurity in Manicaland and Matabeleland North (ZIMVAC 2009, see Figure 2b). Nevertheless the 2009 Multi-Indicator Monitoring Survey (MIMS) showed that household wealth was still higher in urban than in rural areas, with 60 per cent of the urban population in the highest wealth quintile in contrast to one per cent in rural areas (GoZ/UNICEF, 2010).
- The state provides various forms of public assistance to deal with vulnerability, including the Basic Education Assistance Module (BEAM), which provides school-fee waivers, public works programmes, food relief and social welfare grants. These have all suffered limited funding, declining coverage and poor targeting of beneficiaries (UNDP Zimbabwe, 2008).
- For many households, remittances have been an important contributor to support social and economic costs, particularly food, school fees and health care costs (Table 1).

Table 1: Use of remittances, 2007

Remittance use	Frequency of use (%)
Food	98.8
*Fees	78.8
Medical expenses	65.0
Livestock	58.8
Building and consumer goods	53.8
Agricultural inputs	31.2
Business	10.0
Other	38.8

* fees for education and other services

Source: UNDP Zimbabwe, 2008

Progress

While there has not been a formal assessment of poverty levels in the country since 2005, there is related evidence suggesting that poverty levels have risen, formal safety nets have not adequately addressed vulnerability and remittances have buffered even deeper levels of poverty and contributed to essential needs. Rural–urban differentials persist in wealth, although evidence suggests that urban food poverty may have risen since 2009. Manicaland appears to have higher levels of poverty, including urban food poverty. An updated poverty survey is needed to build a more comprehensive framework for social protection.

Reducing the Gini coefficient to at least 0.4

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Gini coefficient	0.59 0.57-0.61	1995/6 2003	0.50 0.51	2005 2007
Wealth quintiles				
Rural				
– % in lowest quintile	29.3	2005	29.1	2009
– % in highest quintile	1.2	2005	1.4	2009
Urban				
– % in lowest quintile	0	2005	0.5	2009
– % in highest quintile	60.5	2005	59.9	2009

Note: The closer to zero the gini coefficient value is, the greater the equality in income distribution.

Source: MPSLSW, 2006; UNDP, 2005; 2008; CSO Macro Int., 2007; GoZ UNICEF, 2009

Past levels: 1980–2005

- The gini coefficient remained relatively stable between 1995 and 2003 but then fell up to 2005 (see summary table). Provinces with medium level poverty saw a reduction in inequality, particularly in Mashonaland Central and Mashonaland East for unclear reasons (MPSLSW, 2006). Over the 1999–2005 period the richest 10 per cent had 22 times the wealth of the poorest 10 per cent (UNDP, 2008). Using the Theil coefficient, the within-area (within rural and urban areas) contribution to inequality in Zimbabwe in 1995/1996 was at 72 per cent, more than double the contribution between urban and rural areas which stood at 28 per cent (World Bank, 2011).

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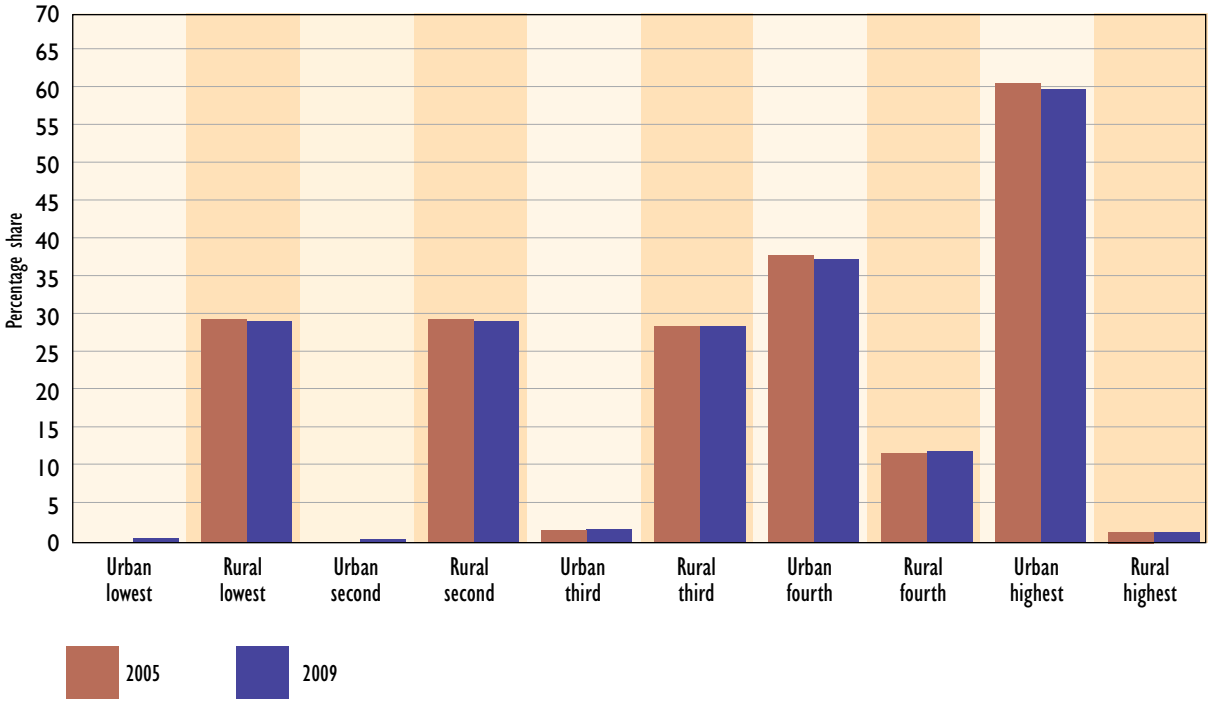
Current level: 2006-2010

- Gini coefficient estimates for 2007 suggest a small increase in inequality in wealth, but further data is needed to determine trends (see summary table). Comparing 2005 and 2009, it appears that while the greater share of poor households has continued to be in rural areas, there has been a small increase in urban households in lower wealth quintiles and in rural households in higher wealth quintiles (see Figure 3).
- There is no evidence to assess whether within-area inequality continues to predominate, as in the prior period. However there is some indication of the persistence of gender as a source of within-area inequality. Gender role stereotypes and division of labour persist, manifesting as low self esteem and lack of confidence among women. Women continue to perceive their role in the family as more important than all their other roles and yet lack support from the home as well as from the workplace (Chabaya *et al*., 2009).

Figure 3: Rural, urban shares in wealth quintiles, 2005 and 2009



Source: CSO Macro Int, 2007; GoZ UNICEF, 2009

Progress

While the gini coefficient fell between 2003 and 2005, it remained one of the highest in the region, with a small rise in inequality after 2005 and a small shift towards increased urban poor and increased rural wealth after 2005. Further evidence is needed to assess trends. The extremely high levels of inequality in wealth in Zimbabwe across the last three decades call for significant investments in redistributive systems.

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

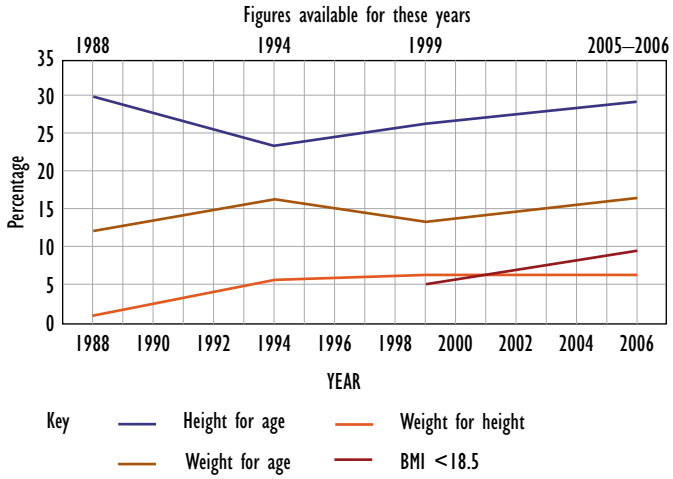
INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Child mortality rate 1–5 yrs / 1000 (CMR)	25.6 39.6 24.0	1994 1999 2005/6	28.0 29.0	2009 2010
– rural : urban ratio	1.61 1.22	1999 2005/6	1.63	2009
– lowest : highest quintile ratio	2.08	2005/6	2.00	2009
– lowest : highest mothers' education ratio	1.49 2.31	1999 2005/6	1.74	2009
– highest : lowest region ratio	2.83 2.91	1999 2005/6	2.38	2009
Under 5 mortality rate / 1000 (U5MR)	77.0 102.1 82.0	1994 1999 2005/6	86.0 84.0	2009 2010
– rural : urban ratio	1.60 1.10	1999 2005/6	1.15	2009
– lowest : highest quintile ratio	1.26	2005/6	1.41	2009
– lowest : highest mothers' education ratio	5.58 1.21	1999 2005/6	1.43	2009
– highest : lowest region ratio	2.20 2.22	1999 2005/6	1.84	2009
Infant mortality rate / 1000 (IMR)	53.0 65.0 60.0	1994 1999 2005/6	67.0 57.0	2009 2010
– rural : urban ratio	1.38 1.09	1999 2005/6	1.16	2009
– lowest : highest quintile ratio	1.07	2005/6	1.24	2009
– lowest : highest mothers' education ratio	1.46 0.91	1999 2005/6	1.33	2009
– highest : lowest region ratio	2.23 2.22	1999 2005/6	1.92	2009
Maternal mortality rate / 100 000 Household survey data Household survey data	 283 350	 1994 1999	 555 72	 2006 2007
Stunting in children under 5 years (height for age <2SD) – % total children	21 27 29.4	1994 1999 2005/6	35.2 31.9	2009 2010
– rural : urban ratio	1.42 1.64	1999 2005/6	1.24 1.21	2009 2010
– lowest : highest quintile ratio	1.46	2005/6	1.57	2009
– lowest : highest mothers' education ratio	2.61 2.80	1999 2005/6	3.42 2.19	2009 2010
– highest : lowest region ratio	2.17 1.46	1999 2005/6	1.68 1.31	2009 2010
Under-nutrition in children under 5 years (weight for age<2SD) % total	13.0 13.0 16.6	1994 1999 2005/6	11.8 9.7	2009 2010
– rural : urban ratio	2.08 1.63	1999 2005/6	1.43 1.26	2009 2010
– lowest : highest quintile ratio	2.23	2005/6	2.28	2009
– lowest : highest mothers' education ratio	2.15	1999	2.47	2009
– highest : lowest region ratio	12.63 16.1 2.19	2005/6 1999 2005/6	5.33 1.68 2.22	2010 2009 2010

Sources: CSO, MoH, Macro International. 1995, 2000, 2007; Zimstat, UNICEF, 2009; Zimstat, ICF Macro, 2010; GoZ MoHCW, 2009. Note: 2007 MMR data and 2010 nutrition data used different analytic methods which limits comparisons

Past levels: 1980–2005

- Child and infant mortality rates improved after 1980 then rose in the 1990s and fell again in the early 2000s (see summary table). AIDS was a major contributor to the increase in child mortality in the late 1990s but child under-nutrition and stunting also increased over that period (CSO, Macro Int, 2000) and up to 2005/6. Levels were higher than the 7 per cent of underweight children aimed at in the Millennium Development Goals. Rural areas had higher under-nutrition than urban areas (see summary table and Figure 4a).
- With the liberalisation of food markets in the 1990s, the economic challenges of the 2000s and rising inequality in wealth, food consumption among children declined by 34 per cent. Increased inequality in food consumption is further evidenced by a 48 per cent change in the negative Kakwani concentration index. The Kakwani index indicates whether payments for health are progressive (if positive) or regressive (if negative). A decomposition analysis showed that the increase in inequality in food consumption was associated with increased inequality in stunting and underweight by 11 per cent and 6 per cent respectively (Pimhidzai, 2009). Provincial inequalities were also wide. In 2003, Masvingo, Matabeleland North and Midlands had the highest share of households below the food poverty line. Rates of exclusive breastfeeding in the first six months were low (GoZ/UNICEF, 2007), indicating that vulnerability began at early ages.
- Maternal mortality doubled between 1994 and 1999 (see summary table). The determinants of this were identified as: inadequate skilled birth attendants at first referral level; limited access to 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 there was an overall decline in fertility between 1994 and 2006, after 1999 this decline was limited to the urban areas with fertility rates in rural areas remaining static. The median age at first birth consistently rose in urban areas but not in rural areas after 1999. This left young rural women vulnerable to pregnancy and maternal health problems at an earlier age and half of young rural women pregnant before they were out of their teens (Loewenson and Shamu, 2008).

Figure 4a: Trends in child and maternal nutrition, 1998–2006



Source: CSO Macro Int., 2007

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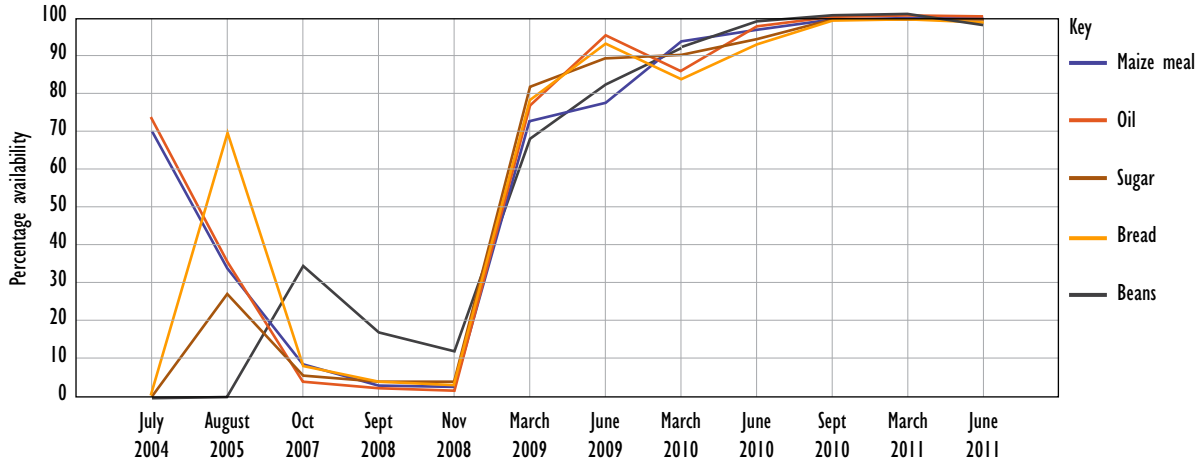
Current level: 2006-2010

- Between 2006 and 2009, infant, child and under five year mortality rates rose (see summary table). Neonatal mortality rates also rose from 24 to 30 per 1,000 live births and post neonatal mortality rose from 36 to 37 per 1,000 live births between 2006 and 2009 (Zimstat, UNICEF, 2009). Preliminary results of the 2010 demographic and health survey (DHS) indicate that infant mortality rates fell markedly in 2010, with a smaller decline in under five year mortality rates and a small rise in child mortality rates. As the mortality rates reflect the past five years, the infant mortality rate would be a more sensitive indicator of recent changes between 2009 and 2010.

Current level: 2006-2010 continued

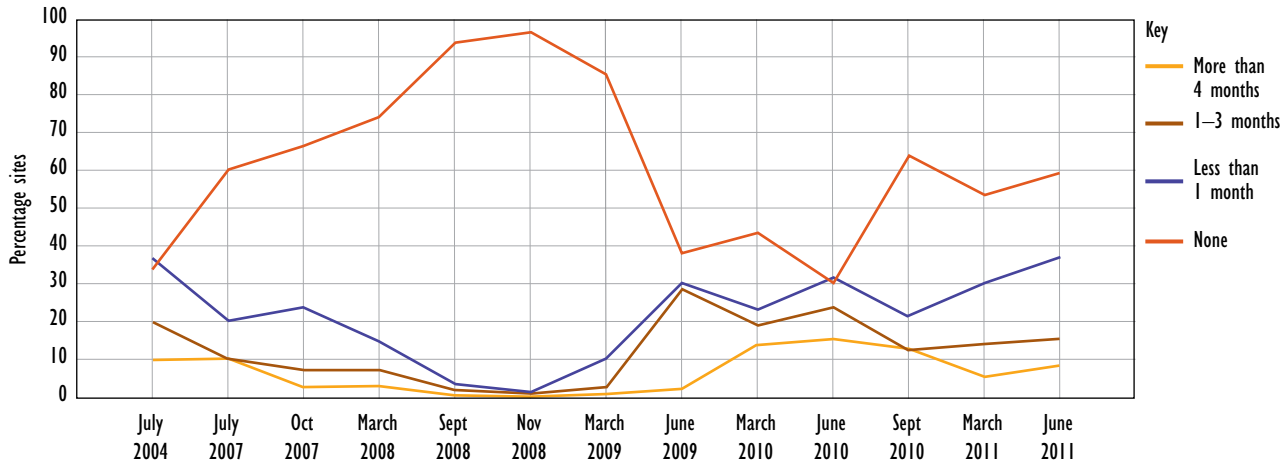
- As the summary table shows, the widest differentials in infant mortality were by province in 2006 and 2009, with relatively low differences by residence, wealth or mothers' education. However, differentials across these other dimensions widened for under five year and child mortality, particularly in the latter where wealth-related inequalities were as high as provincial inequalities. Provincial inequalities fell between 2006 and 2009 for infant, under five and child mortality rates and generally rose for other dimensions. This suggests that socio-economic drivers of inequality in child mortality became more significant in the period. In 2009, Mashonaland Central and East provinces had the highest childhood mortality rates while Matabeleland South province had the lowest. Mashonaland East had twice the infant mortality rate of Matabeleland South and the poorest households had a 30 per cent higher infant mortality rate than the wealthiest. In 2009, infant mortality rates unusually rose in the fourth quintile, before falling in the highest quintile. In 2006, the lower level of infant mortality in mothers with no education also contradicted the trend. This may be because the lowest income groups and mothers without education had higher levels of exclusive breastfeeding than those at higher levels (CSO and Macro Int, 2007; see Figure 4e).
- Community monitoring reports from sentinel sites in all districts reported better availability of basic foods from early in 2009 (Figure 4b). Increased prices after 2009 and lower levels of own produce from poor harvests were reported to have negatively affected household food security, with a rising share of sites reporting households with no food stocks in both urban and rural areas (see Figure 4c).

Figure 4b: Reported availability of food commodities, 2005–2011



Source: Community monitoring programme, 2010

Figure 4c: Reported level of food stocks, 2004–2011

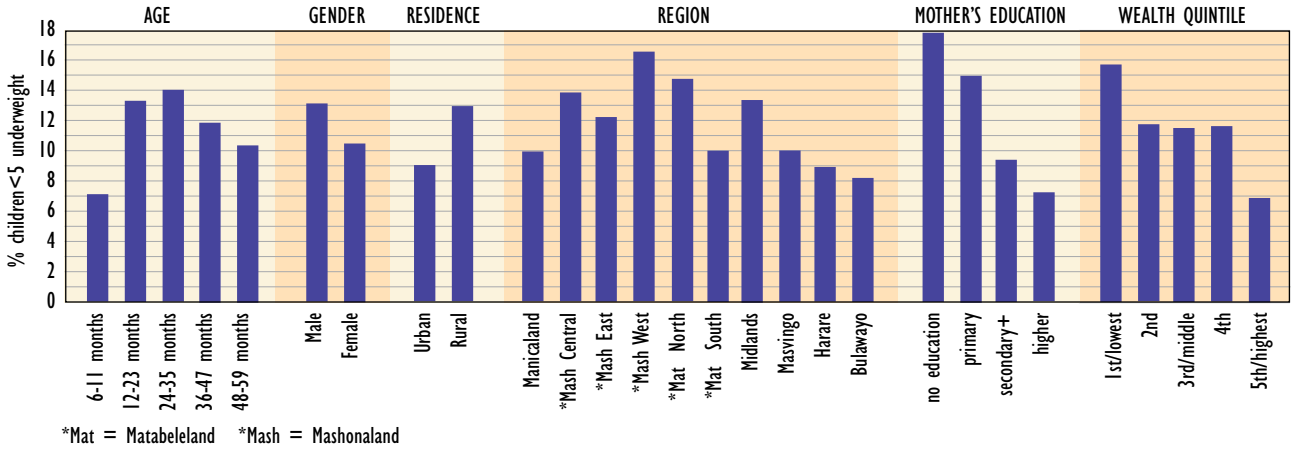


Source: Community monitoring programme, 2010

Current level: 2006-2010 continued

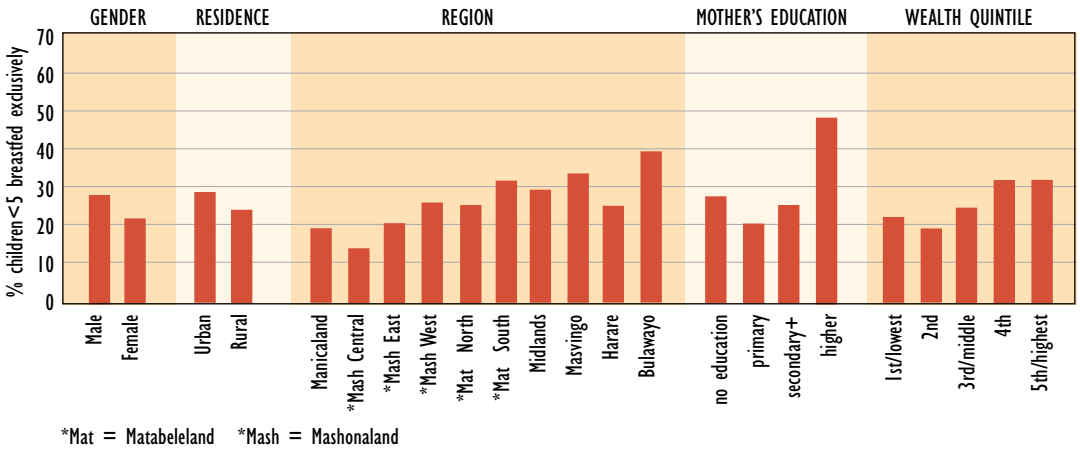
- While under-nutrition levels fell between 2006 and 2009, stunting did not. The 2009 data was collected during April and May in 2009, the agricultural harvesting season when food is generally more available and accessible. In 2009, differentials in low birth weight were relatively small and the social gradient in nutritional outcomes widened in early childhood (Zimstat, UNICEF, 2009). Under-nutrition was higher in children 24-35 months old and was concentrated in rural households, in children of mothers with no education and in the lowest income quintile. By 2010 both under-nutrition and stunting rates had improved.
- Analysis of the 2005/6 demographic and health data showed that low birth weight children were more likely to be stunted in early childhood and that higher maternal body mass index and birth spacing protected against stunting. The mother's education level appeared to be a strong determinant of child nutrition (see Figure 4d). In 2009 orphans and vulnerable children were more vulnerable to underweight and stunting than other children (Zimstat, UNICEF, 2009). These social differentials persisted in 2010 and while they narrowed for stunting, differentials by mother's education and region widened for under-nutrition (Zimstat, ICF, 2010).
- In 2005/6 no household, socio-economic or environmental characteristics were significantly associated with low birth weight and it appears that children's early opportunities for improved nutrition may be linked to their mothers' reproductive and nutritional health (Mbuya *et al.*, 2010).

Figure 4d: Social differentials in child under-nutrition, 2009 – under five year weight for age



Source: Zimstat UNICEF 2009

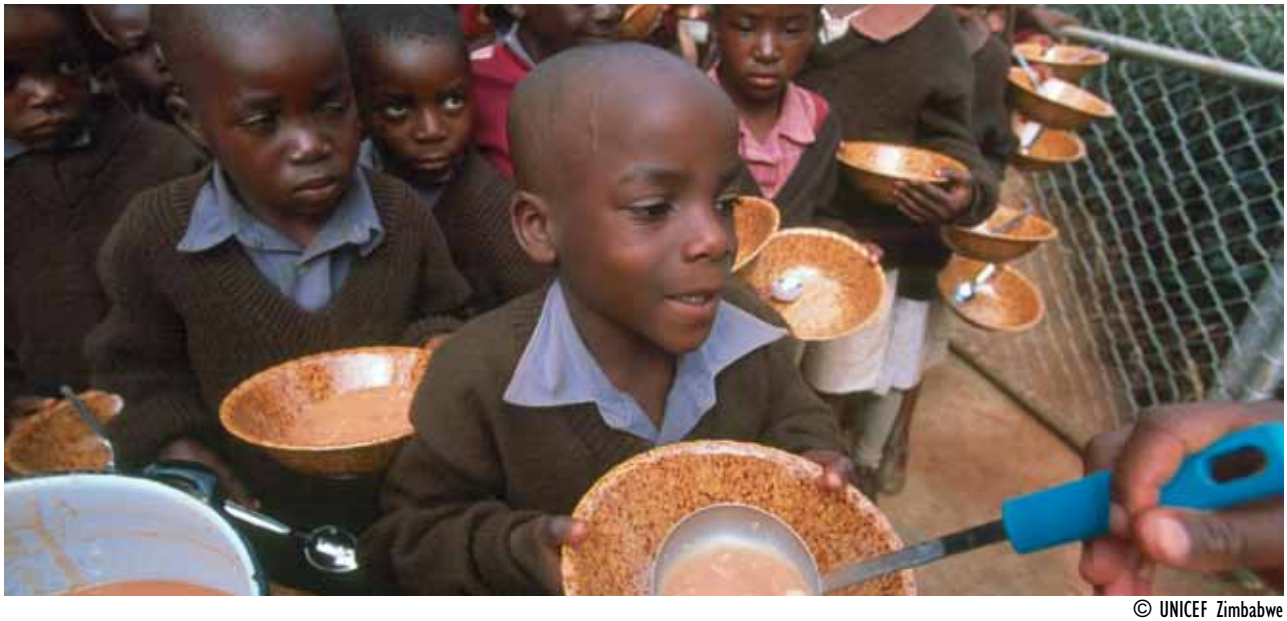
Figure 4e: Social differentials in child under-nutrition, 2009 – exclusive breastfeeding



Source: Zimstat UNICEF 2009

Current level: 2006-2010

- A child supplementary feeding programme has been in place since the early 1980s and has been resuscitated as and when needed. With the prolonged droughts of the 2000s, the feeding scheme has been almost continuous since 2002, although it might have been suspended at certain times of the year, such as immediately after the harvest. Community-based growth monitoring has been promoted in most feeding centres. The slight decrease in wasting observed in the Zimbabwe demographic and health survey of 2005/6 could be attributed to the feeding programme since districts that conducted the programme recorded lower levels of wasting (MoHCW, 2009).
- Social differentials in mothers appear to have a strong impact on health outcomes of young children. Maternal mortality is one indicator of women's health. By 2005 maternal mortality had risen to 555 per 100,000 and it rose again to 725 per 100,000 in 2007 (see summary table). It is difficult to compare 2005 and 2007 data as they are based on different analytic methods. Later data is still awaited from the 2011 demographic and health survey. However, there is a wide gap between these rates and government's target of 70 per 100,000 by 2015 (MoHCW, 2008b). The role of reproductive and maternal health services in improving maternal health is discussed in the next progress marker, as are the wide social differentials in access to these services. The lack of available data on the distribution of maternal mortality makes it difficult to track the distribution of progress or to ensure that resources reach those with highest mortality burdens. As one indication of these differentials, there is double the risk of adolescent pregnancy in the lowest income groups than in the highest income groups and in rural females compared to urban females (Zimstat, UNICEF, 2009).



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Progress

The 2009–2014 national health strategy aims to reduce maternal mortality to 300 deaths per 100,000 live births by 2015 and under five year mortality to 43 by 2013 (MoHCW, 2009). Infant and child mortality rates fell between 1999 and 2005 but then increased up to 2009 and fell again in 2010. Geographical inequalities in child mortality dominated up to 2005 but socio-economic drivers became more significant after that. Child under-nutrition improved after 2005 but stunting worsened, although again with improvements in 2010. Food insecurity after 2009 is more related to cost barriers and poor harvests than to the overall shortages noted previously. Child nutrition outcomes are associated with economic inequalities and particularly mothers' social and health situation, so that equity is an important issue in nutrition programmes. Zimbabwe has a relatively high and rising level of maternal mortality for its income level. Disaggregated information on maternal mortality would help identify those with highest risk. Programme targeting and general improvements in access to sexual and reproductive health services underway could then be complemented by more focused measures to address supply and uptake barriers to use of services in more vulnerable groups.

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

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Full immunisation % coverage 12–23 months	80 75 53	1994 1999 2005/6	49.0 64.3	2009 2010
– urban : rural ratio	1.08 1.15 1.16	1994 1999 2005/6	1.44 1.13	2009 2010
– highest : lowest mothers' education ratio	1.21 1.15 1.21	1994 1999 2005/6	2.00 1.62	2009 2010
– highest : lowest wealth quintile ratio			1.20	2009
– highest : lowest region ratio			1.90 1.83	2009 2010
% pregnant women with at least one antenatal care visit	94.4 94.5 95.0	1994 1999 2005/6	93.0 89.8	2009 2010
– urban : rural ratio	1.01	2005/6	1.07 1.00	2009 2010
– highest : lowest mothers' education ratio			1.11	2010
– highest : lowest region ratio			1.09 1.11	2009 2010
% pregnant women with 4 + antenatal care visits	74.0 64.3 71.1	1994 1999 2005/6	57.0	2009
– urban : rural ratio			1.08	2009
– highest : lowest mothers' education ratio			1.71	2009
– highest : lowest wealth quintile ratio			1.26	2009
– highest : lowest region ratio			1.24	2009
% births attended by skilled personnel	69.2 72.5 68.5	1994 1999 2005/6	52.0 66.2	2009 2010
– urban : rural ratio	1.70	2005/6	1.85 1.46	2009 2010
– highest : lowest wealth quintile ratio	2.07	2005/6	2.38	2009
– highest : lowest mothers education ratio	2.85	2005/6	3.05 2.44	2009 2010
– highest : lowest region ratio	1.64	2005/6	2.15 1.61	2009 2010

Sources: CSO, MoH, Macro International, 1996, 2001/2, 2007; Zimstat, UNICEF, 2009; Zimstat, ICF, 2010

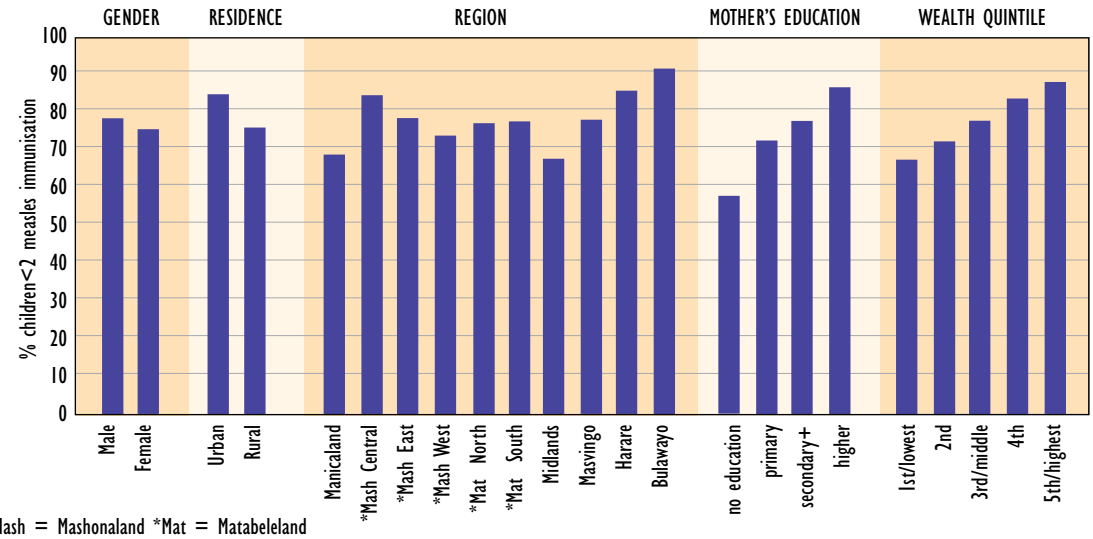
Past levels: 1980–2005

- Immunisation rates fell between1994 and 2005/6 (see summary table). Some groups, like the Apostolic sect, oppose immunisation on religious grounds but the decline was mainly due to a drop in service delivery and outreach. Rural–urban inequalities grew as immunisation levels fell, with greater declines in rural coverage. However, social differentials were wider than these differences by residence.
- Attendance at antenatal care (ANC) was relatively high between 1994 and 2005 but antenatal care bookings and numbers of women delivering at health facilities decreased by 30–50 per cent in 2005. This was attributed to shrinking incomes and increases in service fees (MoHCW, 2006, 2007). The share of women making four or more antenatal visits fell between 1994 and 1999 but recovered again by 2005 (see summary table).
- There was a significant increase in assistance by skilled birth attendants between 1994 and 1999, and a similarly significant decline between 1999 and 2005. By 2005, assisted deliveries were below the Millennium Development Goal target of 80 per cent, although this level had nearly been attained in 1999 (Loewenson and Shamu, 2008).

Current level: 2006-2010

- Immunisation coverage fell to 49 per cent in 2009 but has begun to rise and reached 64 per cent by 2010. The programme faced resource constraints and reduced outreach activities due to transport shortages, unreliable vehicles and lack of fuel. Gas supplies for refrigerators to maintain the cold chain were erratic (MoHCW, 2009). Investments in these areas have improved.
- Since mid-2005, Child Health Day campaigns have reached two million children biannually through a one-week national vaccination outreach. Consequently, overall immunisation coverage increased to over 80 per cent in 2007 (Singizi, 2007).
- While coverage rates have improved, they remain well below herd immunity levels and below levels achieved in 1994. Wide provincial differentials suggest a need for greater allocative efficiency. Masvingo had lowest coverage in 2009 (Zimstat, UNICEF, 2009).
- Measles immunisation coverage in 2009 in the 12-23 month age group showed a clear social gradient by area, education and wealth. In 2009 immunisation was significantly concentrated in wealthier households, with differences across wealth, province and education of mothers of up to 27 percentage points in immunisation coverage (see Figure 5).

Figure 5: Differentials in measles immunisation 12–23 months



*Mash = Mashonaland *Mat = Matabeleland

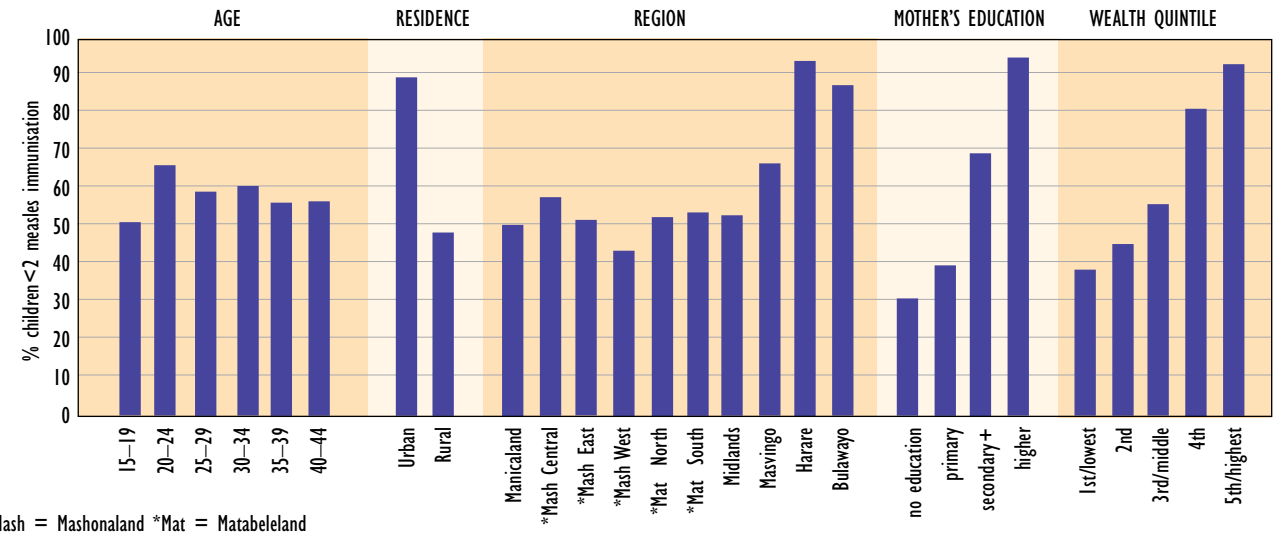
Source: Zimstat, UNICEF, 2009

Current level: 2006-2010 continued

- The inverse relationship between immunisation and under five year mortality suggests that inequities in access to immunisation (inverse to need) may have played a role in child mortality in the period. This was further indicated by an increase in measles epidemics in the period. Village health workers who help improve uptake of such health services were said to lack resources to do their work (GoZ/UNICEF, 2007).
- The share of women who had had a live birth in the preceding five years making at least one antenatal care visit fell between 2005 and 2010, as did the share of women making four or more antenatal care visits (see summary table).
- Attendance by a skilled person at birth fell in 2005/6, with a further significant fall in 2009 but an increase in 2010 (see summary table). The most significant social differential for coverage of maternal health services has consistently been mothers' education (see summary table and Figures 6a and 6b). Nevertheless wealth and provincial disparities in coverage of maternal health care are also high.
- The 2007 *Maternal and perinatal mortality study* found a number of barriers to access and uptake of maternal health services, including delayed reporting, failure to recognise danger signs, high fees at district hospitals, first use of traditional healers, service barriers (communication facilities, inadequate transport and communications, social barriers, lack of drugs and skilled staff shortage) (GoZ MoHCW, 2009). Among mobile and vulnerable pregnant women only 58 per cent reported being assisted by a skilled health worker (NEDICO, 2008).

Waiting at a PMTCT clinic: © DFiD, on Flikr.com

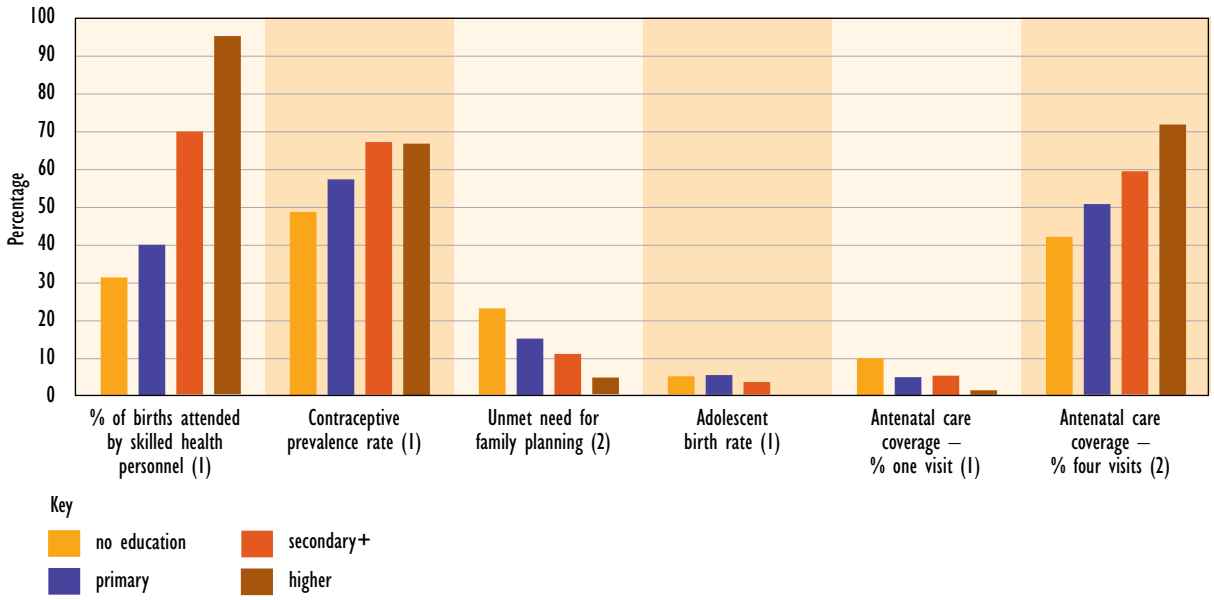
Figure 6a: Births attended by skilled health personnel



*Mash = Mashonaland *Mat = Matabeleland

Source: Zimstat UNICEF, 2009

Figure 6b: Maternal health data by mothers' education



Source: Zimstat, UNICEF, 2009

Current level: 2006-2010 continued

- A 2009 assessment of primary health care found that nearly one in three deliveries were done outside the district of residence, as people search areas where they have better quality or more affordable care, and only 22 pert cent of facilities reported having a maternity waiting home (TARSC, CWGH, 2009).
- The social differentials in maternal health begin with the unmet need for family planning and exist at all stages of the reproductive process (Zimstat, UNICEF, 2009).
- Social gradients apply across all maternal health indicators, as exemplified by trends in relation to mothers' education shown in Figure 6b. 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 (see table below).

	% contraceptive prevalence (a)	% antenatal care four visits (b)	% births attended by skilled personnel (c)	*Delivery effectiveness = a*b*c
Lowest quintile	55.3 .	51.9	38.6	0.110
Highest quintile	67.6	65.6	92.1	0.408

*Delivery effectiveness refers to the combined coverage for the three indicators of maternal health

Progress

From having among the highest levels of immunisation and maternal health care coverage in the region, Zimbabwe had fallen to among the lowest by 2005, with rising social and geographical differentials. While immunisation coverage has improved due to better supplies to facilities, the shortfall is still high and geographical differentials remain wide. Maternal health service coverage has fallen, with some improvement in assisted deliveries in 2010 but not in antenatal care, where levels fell below 1994 levels and wealth, education and provincial differentials widened. To achieve universal coverage, investment in immunisation needs to target resources that address differentials. Closing gaps in maternal health services demands intervention at all points of sexual and reproductive health services, from access to contraception to safe delivery. This relates to improving service availability and accessibility but also to addressing contexts of gender violence, poor community security and low levels of sexual and financial autonomy, particularly among young, mobile and vulnerable women.

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

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Adult HIV prevalence (%)	14.25 27.54 27.75 23.15 19.37	1990 1995 2000 2003 2005	17.45 15.60 13.70	2006 2007 2009
– urban : rural ratio	1.04	2005/6		
– highest : lowest wealth quintile ratio	0.97	2005/6		
% pregnant women having voluntary counselling and testing (VCT) as part of antenatal care	45.8	2005	92	2006
– urban : rural ratio	1.59	2005/6	1.29	2009
– highest : lowest mothers' education ratio	6.49	2005/6	1.90	2009
– highest : lowest wealth quintile ratio	2.76	2005/6	1.52	2009
– highest : lowest region ratio	2.07	2005/6	1.42	2009
% women attended VCT given an HIV test	67	2005	572	2006
– urban : rural ratio			1.12	2009
– highest : lowest mothers' education ratio			1.43	2009
– highest : lowest wealth quintile ratio			1.18	2009
– highest : lowest region ratio			1.15	2009
Treatment: on antiretroviral therapy (ART) and in prevention of transmission from mother to child programmes (PMTCT)				
– % in need* on ART	1.5	2004	16	2005
– % pregnant women in need* in PMTCT	54	2005	60	2006
– % child in need* on ART			9	2006
Female Condom use at last high risk sex 15–49 year age group				
– urban : rural ratio			1.50	2009
– highest : lowest wealth quintile ratio			1.51	2009

* 'in need' refers to those with HIV and meeting criteria for treatment

Sources: CSO Macro International, 2007, NAC et al., 2006; MoHCW, 2006, 2006b, 2007, 2008b; Zimstat, UNICEF, 2009

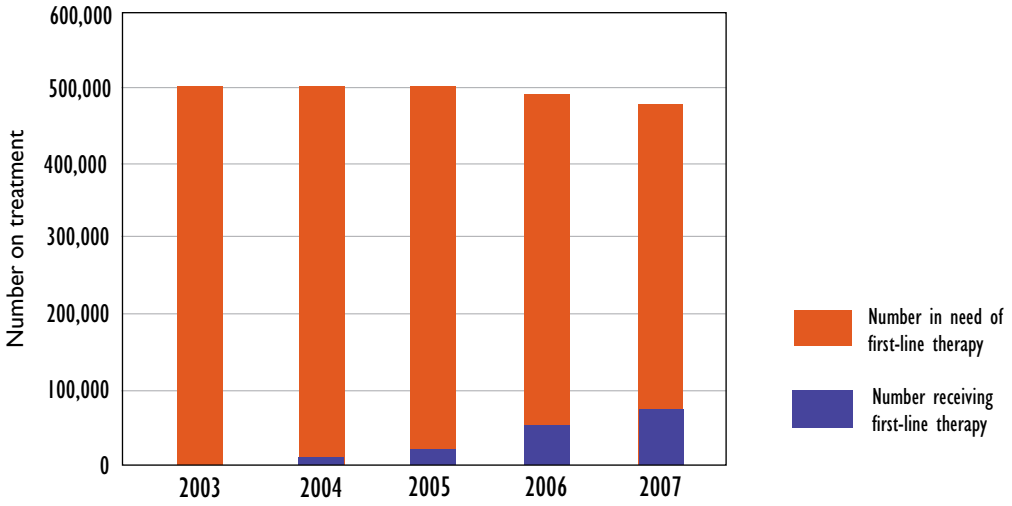
Past levels: 1980–2005

- HIV infection rose rapidly in the 1990s, increasing with poverty, food insecurity, gender inequality, mobility and spousal separation.
- A drop in adult HIV prevalence between 2003 and 2005 was attributed to changing sexual behaviour among young people (MoHCW, 2008).
- The AIDS levy and National AIDS Trust Fund were established in 1999 as a unique tax-based contribution to public spending on AIDS, although implying additional individual tax burdens (NAC *et al.*, 2006). In 2002, government declared AIDS a national emergency.

Past levels: 1980–2005 continued

- Voluntary counselling and testing services (VCT) expanded over 2003–2005, with mobile outreach to hard-to-reach populations. By 2005, 80 per cent of new antenatal care bookings were counselled, 67 per cent of those counselled were tested and 54 per cent of positive mothers and 51 per cent of HIV exposed babies received nevirapine (MoHCW, 2006b).
- Access to antiretroviral treatment (ART) and prevention of vertical transmission rose between 2000 and 2005 but remained low (see summary table).

Figure 7: Access to antiretroviral treatment, 2003-2007

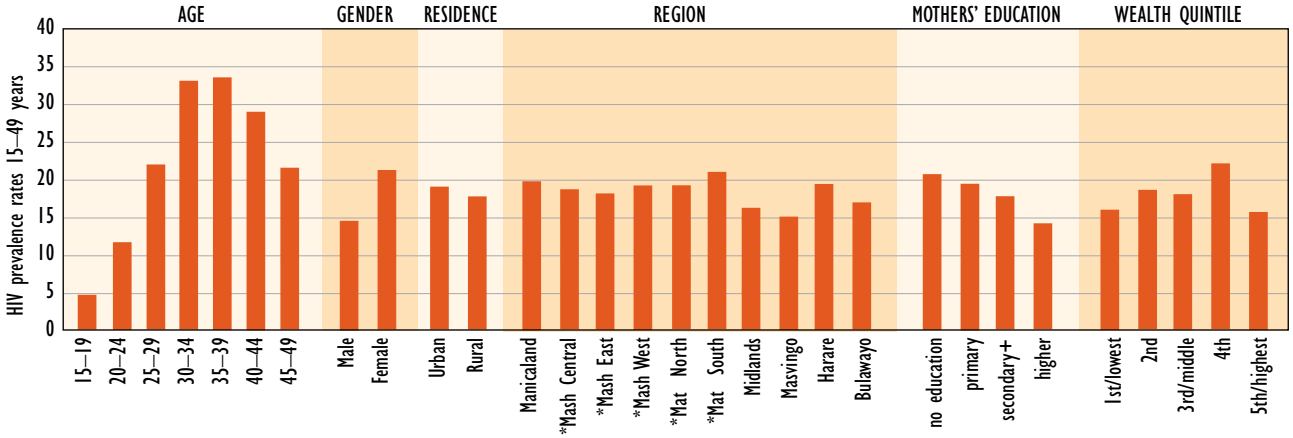


Source: MoHCW, 2008

Current level: 2006-2010

- HIV prevalence fell between 2006 and 2009. While there are some differences across wealth groups, the distribution of HIV prevalence does not show statistically significant differentials by gender, region, residence, education or wealth (Figure 8a). However, as shown in Figure 8b, there are social differentials in access to interventions to prevent HIV. The implications of lower use in rural, less well educated and poorer people for the future patterns of HIV would need to be further assessed but it suggests that HIV could persist in such communities as another 'preventable disease of poverty' after it has declined to negligible levels in wealthier, better educated communities.
- A national HIV/AIDS strategic plan for 2006–2010 included targets and guidelines in key areas of prevention, treatment and care. However, significant resource constraints limited implementation of the plan in the period. The national plan aimed for 85 per cent of people to know their HIV status by 2010. Voluntary counselling and testing was accessible to only 15–16 per cent of adults in 2007 but, as shown in the summary table, for women accessing antenatal care, access doubled, a significant improvement and beyond this target (NAC *et al.*, 2006; MoHCW, 2007, see summary table). Uptake of the service was much higher in women with higher education levels in 2005 but this education differential narrowed by 2009 as coverage improved. Nevertheless, the gradient in uptake by mothers' education was still wider than for other factors.
- In 2006, 92 per cent of pregnant women were pre-test counselled; 72 per cent of those counselled were tested, of whom 18 per cent were HIV positive; 60 per cent of these mothers were treated with nevirapine while 60 per cent of exposed children were treated (MoHCW, 2006). By 2009 the coverage figures were similar, suggesting limited improvement in prevention of mother to child transmission programmes. From the initial three pilot sites in 1999, these services have however expanded to more than 1,300 family and child health sites across the country, with a target of all health facilities (1,415) to be providing these services by 2010 (GoZ MoHCW, 2010). Services through accredited sites are thus widely available now, with some challenges in drug availability, while demand side factors that affect uptake may still need to be addressed.

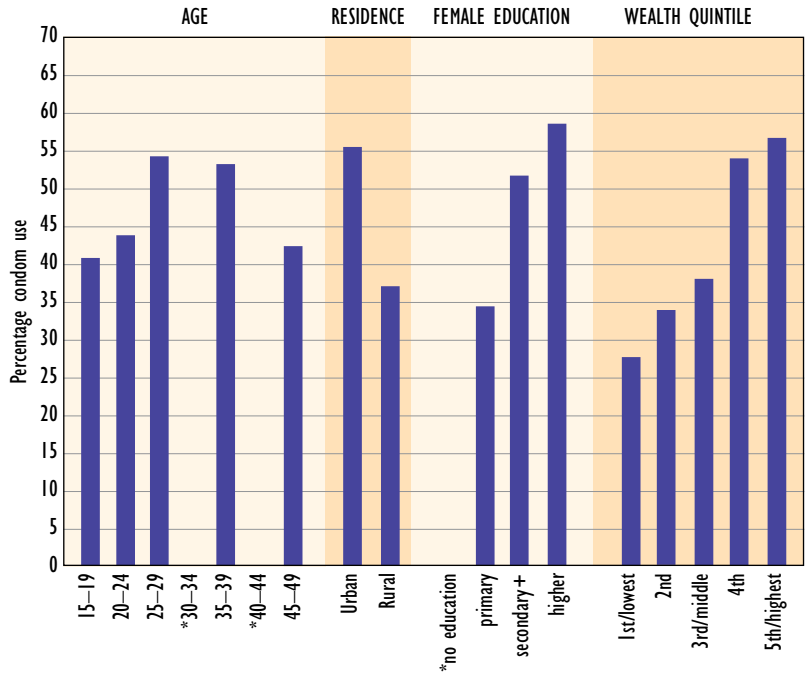
Figure 8a: Differentials in HIV prevalence 15-49 years, 2009



*Mash = Mashonaland *Mat = Matabeleland

Source: Zimstat, UNICEF, 2009

Figure 8b: Female condom use during last high-risk sex, 2009



* data not available

*Mash = Mashonaland *Mat = Matabeleland

Source: Zimstat, UNICEF, 2009

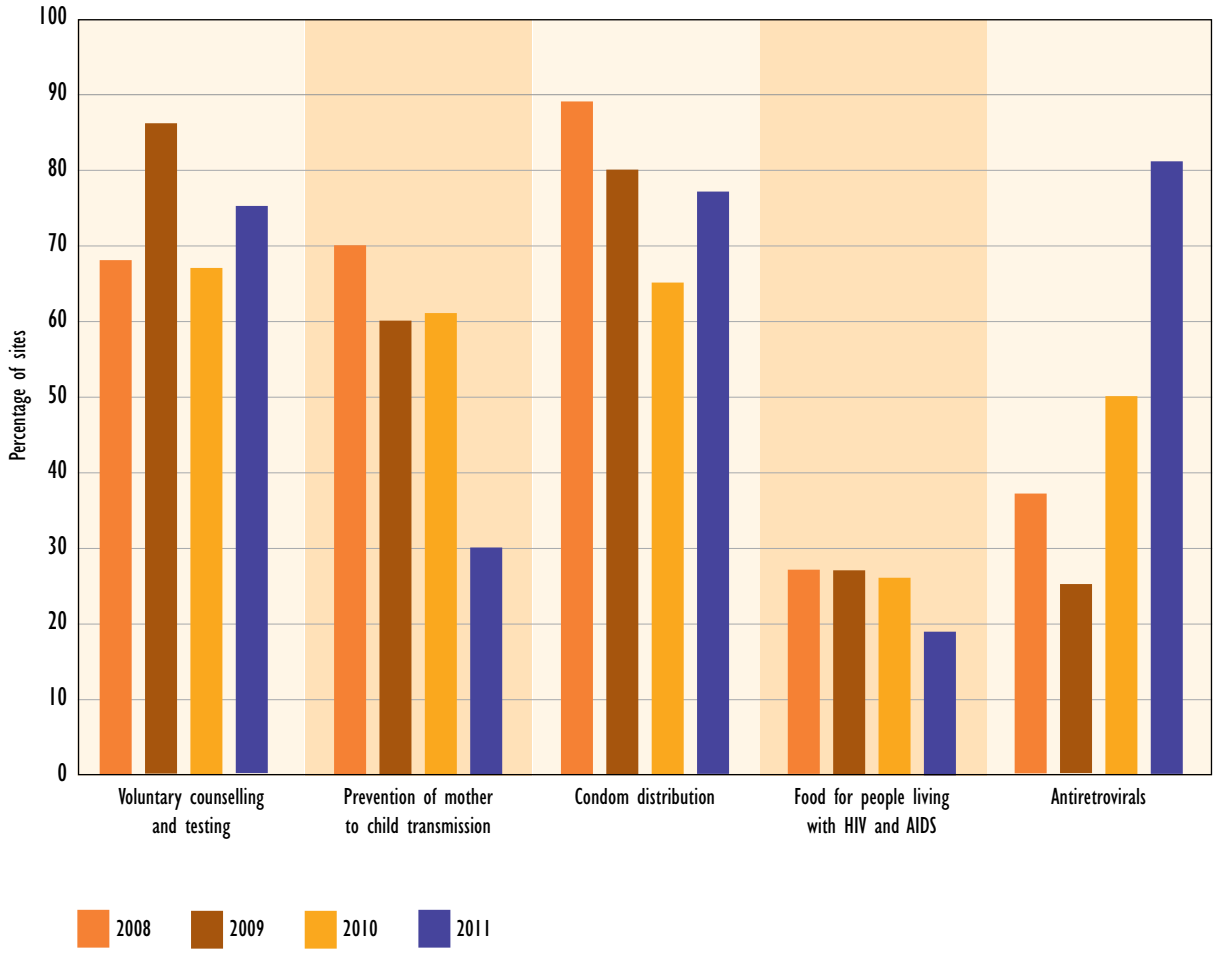
Current level: 2006-2010 continued

- In 2007 provider-initiated testing and counselling for all patients visiting health institutions was introduced (MoHCW, 2007). However coverage of first line antiretrovirals for those in need remained relatively low, with an estimated 394,000 people untreated in 2006 and even lower treatment coverage in children (MoHCW, 2008b, see summary table).
- Medicine shortages and stockouts, shortages of HIV test kits, staff attrition and low male participation are reported to have threatened programmes, including those for meningitis and TB. Patients have found it difficult to afford drug prices in private pharmacies (MoHCW, 2007).

Current level: 2006-2010 continued

- Community monitor reports in all districts on HIV and AIDS service availability at primary care level shown in Figure 9 indicate better availability of antiretrovirals but not of services for prevention of mother to child transmission. The latter contradicts evidence from the health information system cited earlier and needs to be further investigated to understand what lies behind this perception.

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



Source: Community Monitoring Programme, 2011

Progress

Zimbabwe had among the highest HIV sero-prevalence in the region but after 2002, levels fell and were down to 13.7 per cent of adults by 2009. This success story is attributed to a range of factors, including changes in sexual behaviour, particularly among youth. While HIV prevalence does not show marked social differentials, access to prevention and treatment interventions do. As shown by the closing of the wide social differentials (by mothers' education) in relation to voluntary counselling and testing in antenatal services, attaining near universal coverage significantly reduces such gaps. While the policies, institutions and programmes are in place to respond to these prevention, treatment and care needs, resources are still lacking for the scale up required. Additional measures are needed to promote uptake among vulnerable groups. Supply, cost and access barriers to paediatric treatment as well as barriers to treatment or to prevention of mother to child transmission services in rural, low income populations for whom service access is weaker and cost barriers higher, need to be addressed. Innovative measures such as the AIDS levy fund are discussed later.

EQUITY WATCH

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Household access to the national resources for health

Progress markers

- Achieving and closing gender differentials in attainment of universal primary and secondary education
- Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
- Increasing ratio of wages to gross domestic product
- Meeting standards of adequate provision of health workers and of vital and essential medicines at primary and district levels of health systems
- Abolishing user fees from health systems backed up by measures to resource services
- Overcoming the barriers that disadvantaged communities face in access to and use of essential health services

EQUITY WATCH

Household access to the national resources for health

The health inequalities and their determinants described in the previous section are addressed by households accessing resources for health through redistributive health systems and through wider national and global policies.
This section explores progress in selected parameters to assess whether households have access to the social determinants of health – the educational, environmental, income, health care and social protection resources – they need to improve their health. It also explores how far differentials in access to these determinants are being minimised. The parameters chosen are consistent with those identified by the WHO Commission on the Social Determinants of Health (WHO, CSDH, 2008).

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

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
% net enrolment in primary school of primary school age children	65.2	1999	89.9 91.4 91.0	2001-8 2005/6 2009
– male : female ratio	0.96 1.02	1999 2004	1.00 0.98	2005/6 2009
% net enrolment in secondary school of secondary school age children	76.6	1999	38.0 44.5 45.1	2001-8 2005/6 2009
– male : female ratio	1.11 1.10	1999 2004	0.98 1.01	2005/6 2009
Primary school completion rates % (overall)	73 68	2000 2004	42.6	2009
Secondary school completion rates % (overall)	78 73	2000 2004		
Primary school drop out rates – male : female ratio	1.04	2003		
Secondary school drop out rates – male : female ratio	0.89	2003		
% adult literacy (overall)	89	2003	91.4	2008
– males +15 years			94.4	2008
– females +15 years			88.8 87.3	2008 2009

Source: CSO and Macro Int, 1999; GoZ, UNICEF, 2007; MPSLSW, 2006; UNESCO, 2009; UNDP, 2010; Zimstat, UNICEF, 2009

Past levels: 1980–2005

- Primary and secondary school completion rates fell between 2000 and 2004, although gender equity improved (see summary table). Some districts had wider female to male gaps (Umguza, Bubi, Bullilima and Mangwe). Financial constraints accounted for 20 per cent of non-enrolments in primary school and 70 per cent of non-enrolments in secondary school in 2003. The government's Basic Education Assistance Module (BEAM), a welfare support programme for payment of school fees for vulnerable children, increased between 2001 and 2005. It supported nearly a million children but still did not meet the level of demand (GoZ, UNICEF, 2007).
- Primary school dropout rates were higher for boys while secondary school dropout rates were higher for girls. Girl children tend to leave school to care for sick parents or for younger siblings (MPSLSW, 2006).

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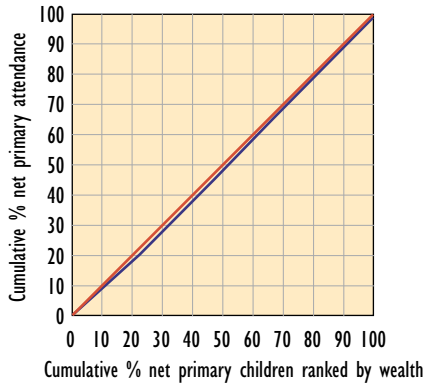
Current level: 2006-2010

- Primary and secondary school enrolment improved up to 2009, with negligible differences across social groups and a concentration curve for wealth differentials close to the equality line (see Figure 10). There is high gender and socio-economic parity in primary school attendance.
- The net primary completion rate was, however, only 42.6 per cent overall in 2009. Financial constraints were noted as the main reason for children not completing school (Figure 11). Some children were more vulnerable, such as children aged 10–14 years who had lost both parents, a situation that was reported to have deteriorated since 2005/6 (Zimstat, UNICEF, 2009).
- Education has been the biggest beneficiary of the national budget, most of this going to teachers' salaries, but falling real wages, poor conditions and political violence continue to affect adequacy of teachers (MPSLSW, 2006; Dugger, 2008).
- Education is not free and households were found to pay 85 per cent of the cost of primary education and 80 per cent of the cost of secondary education. Cost is a barrier for poor households. The BEAM programme does not meet the level of demand but a national girls' education strategic plan, launched in 2006, mobilised resources to keep girls, orphans and vulnerable children in school (UNICEF, 2006). Nevertheless cost remains a barrier, especially for secondary school access. Community sentinel site monitoring reported an increasing share of households having difficulty with meeting secondary school fees between March 2010 and March 2011, and difficulties in accessing BEAM (CMP, 2011).

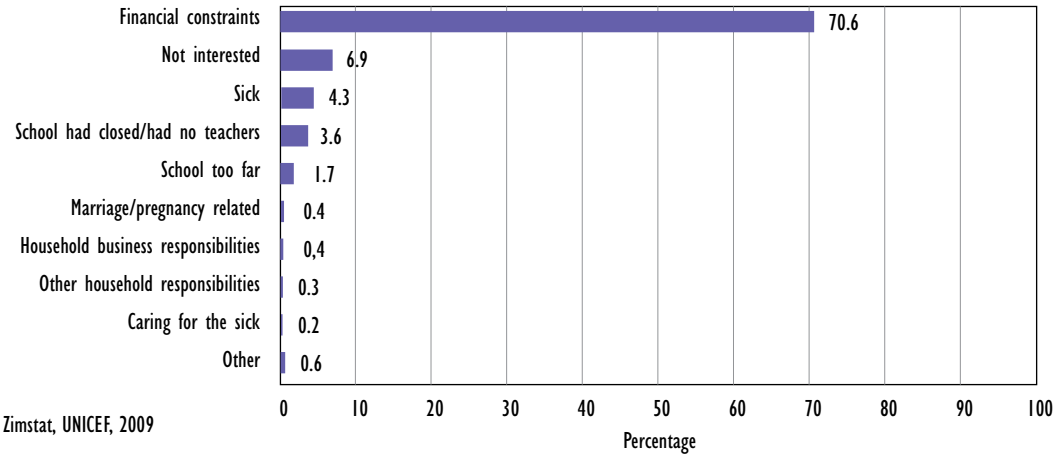
Figure 10: Concentration curve, net primary school attendance

Note:
The concentration curve shows how a factor (for example, primary school attendance) is distributed in different economic groups. If the curve is above the diagonal line, it is mainly found in poor people and if below it is mainly found in wealthy people. If it is on the line (as in the graph on the right) it means that it is equally distributed across income groups.



Source: Zimstat, UNICEF, 2009

Figure 11: Reasons for not attending primary school, 2009



Source: Zimstat, UNICEF, 2009

Progress

Zimbabwe's high net enrolment ratio and gender parity in education has contributed to health equity. Inadequate public sector resources and costs of education are, however, a barrier, with primary school completion rates falling, especially for low income households and marginal groups. Avoiding reversals calls for widening coverage of BEAM, measures to encourage female children to stay in school and making education affordable.

Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
% households using improved water source (overall)			78.2 73.0	2005/6 2009
– rural	75.1 66.5	1999 2004	67.1 75.0 61.0	2005/6 2008 2009
– urban	99 99	1999 2004	99.4 98.0	2005/6 2009
– urban: rural ratio	1.32 1.50	1999 2004	1.48 1.61	2005/6 2009
% households using improved sanitation (overall)			40.0 60.0	2005/6 2009
– rural	45	1999	30.5 43.0	2005/6 2009
– urban	99	1999	58.5 97.0	2005/6 2009
– urban: rural ratio	2.20	1999	1.92 2.26	2005/6 2009

Source: CSO, Macro Int., 2000, 2007; CSO, 2006; MoHCW, 2009

Past levels: 1980–2005

- Access to clean water was static between 1990 and 2000 and fell in rural areas between 2000 and 2004, widening the gap between rural and urban areas (see summary table). A far greater share of urban households had access to sanitation.
- However, water and sanitation, overcrowding of services and interruption of supplies was a problem even in urban areas.
- As an indicator of environmental risk, diarrhoea rates increased from 32 to 47 per 1,000 people between 2004 and 2005, with highest increases in Mashonaland West, Midlands, Harare and Chitungwiza (MoHCW *et al.*, 2004, 2005b).

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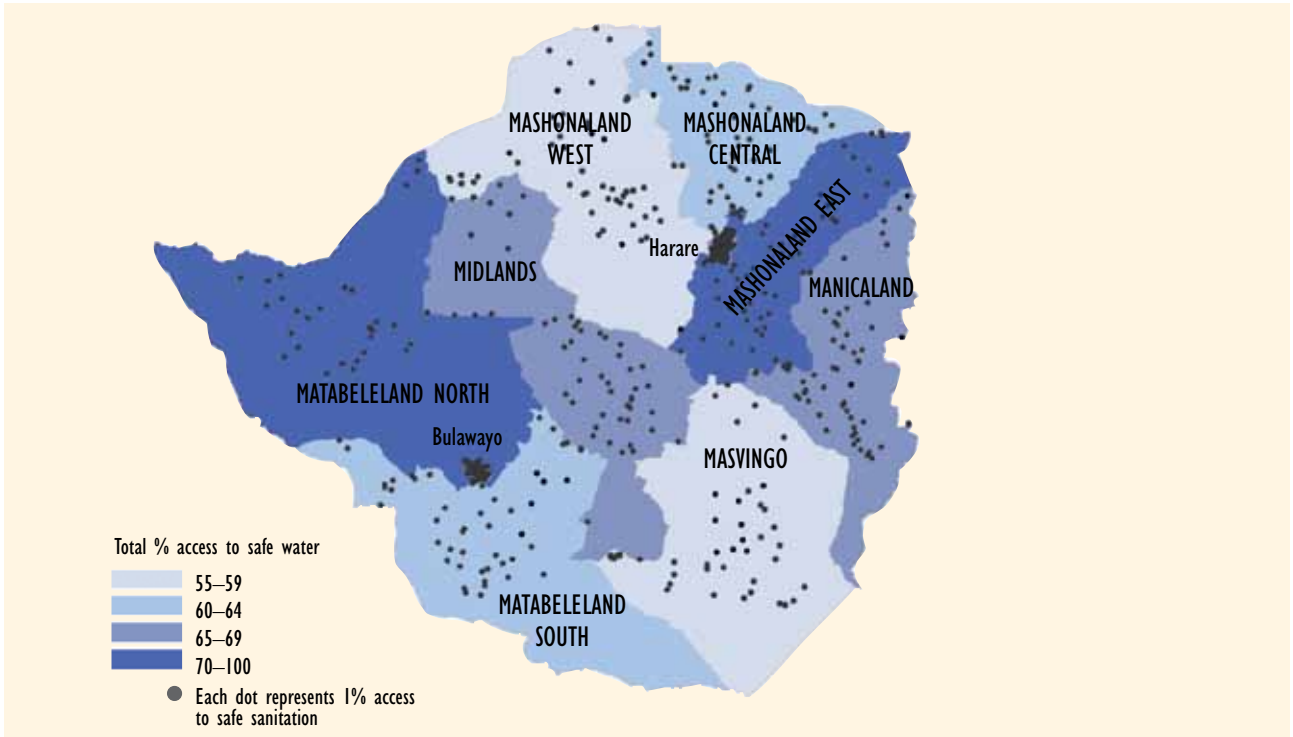
Current level: 2006-2010

- Between 2006 and 2009 the share of households using an improved water source fell and the urban to rural ratio rose primarily due to the bigger drop in rural areas (see summary table). Access to improved sanitation increased in both rural and urban areas between 2005 and 2009 although urban–rural differentials widened as the reported improvements were greater in urban areas. Wealth groups with highest access to safe water and sanitation have more than 80 percentage points higher levels of access than those with lowest levels. Use of improved sources of drinking water and sanitary means of excreta disposal increased with education of household heads (Zimstat, UNICEF, 2009). Inequalities were also high in access to safe water by province, with Bulawayo having 68 percentage points higher levels of safe sanitation than neighbouring Matabeleland North (see Figure 12).
- Interruption of water supplies, overcrowding of sanitation facilities and difficulties with urban waterborne sanitation during periods of water cuts meant that urban households were however also vulnerable to unhealthy environments. Authorities reported in 2008 that daily urban supply, limited by shortages of chemicals, was about 30 per cent of demand (ZINWA, 2008). Government, parliament and civil society reported a worsening situation in 2008, with a range of urban problems, including: aging and unrepaired sewer systems; waste put in sewers due to poor waste collection; illegal waste dumps; overflowing septic tanks; and frequent water and power cuts. A study on waste management commissioned by the Ministry of Health and Child Welfare in 2007 noted that most sewerage reticulation systems and treatment works were in a state of disrepair, raising the risk of diarrhoeal diseases, including cholera (MoHCW, 2009). While high density areas were particularly affected, these problems spilled into all areas with some long-term interruptions in supplies (USAID, 2008; CHRA, 2007; Parliament of Zimbabwe, 2008b).
- The same social differentials affected the ability to address the consequences of unsafe environments, leading to a significant equity gap. Increasing costs of water and basic hygiene items, such as soap, reduced their consumption in poor households. One resident of a high density area (Highfield, Harare) related, for example, the story of her five year old daughter's death due to fever and diarrhoea:
  'I took her back to the clinic three times,' she said, *'but every time they said that she would get better soon if I give her food and lots of water – that it was just the fever and there was nothing they could do because they had no drugs. I thought about taking her to the Harare Central hospital but it costs so much money and people said things are no better there. I just hoped'* (McGreal, 2008).

Figure 12: Provincial distribution of access to improved water and sanitation



Source: Zimstat, UNICEF, 2009

Current level: 2006-2010 continued

- A massive cholera epidemic in August 2008 led to a reported 4,269 deaths and 97,469 cases by April 2009 (MoHCW, 2009). It occurred in the context of frequent water and power cuts, and a breakdown of rubbish collection. Advice to boil water was difficult to follow during water and power cuts. The epidemic spread to all ten provinces. After 484 deaths and 11,735 cases, the government declared the outbreak a national disaster on 3 December 2008, opening the door to international help. A wide range of agencies working with government implemented health promotion, treated cases and carried out case tracing resulting in reduced case fatalities (Chambers, 2009).
- Longer term measures for water availability and treatment, and for sanitation, rubbish collection and hygiene activities were supported. Unsafe environments continue to be a health threat, particularly for poor households, although at a less severe level than in 2008 and more focused in rural areas, where significant gaps remain in access to safe water and sanitation.
- In February 2010, 14 out of 62 districts in the country were affected by another cholera outbreak and by May, the crude case fatality rate was 2.9 per cent. Rural areas accounted for 71.7 per cent of cases, compared to the pattern in 2009, where 46.8 per cent of the cases occurred in urban areas and 53.2 per cent in rural areas (WHO, MoHCW, 2010).

Progress

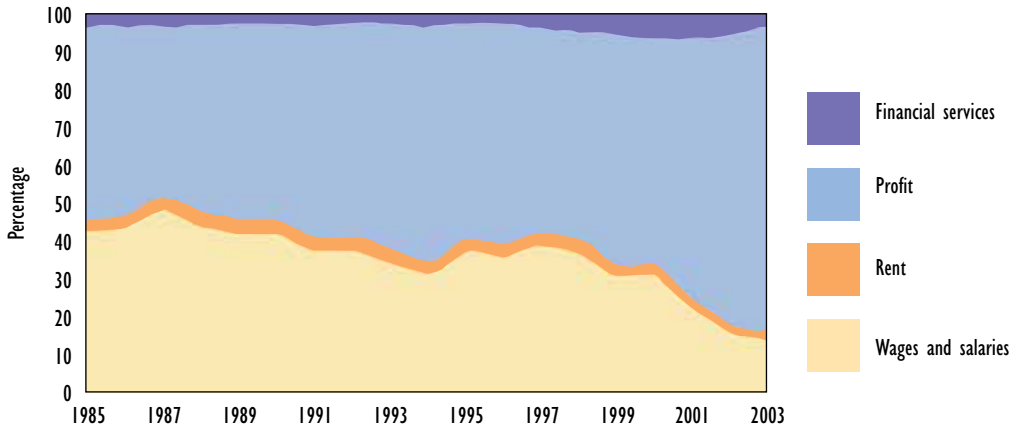
Closing rural to urban differentials in access to safe water and sanitation is a priority in meeting Millennium Development Goal targets. The situation on the ground indicates that while infrastructures exist, they are old and malfunctioning and tariff structures are needed to protect poor households' access. The cholera epidemic was a marker of the need for investment in this area, particularly in rural areas, and residents and parliament have called for safe water to be given higher priority (this would exclude it from load shedding and prioritise the related chemical procurement).

Increasing ratio of wages to gross domestic product (GDP)

Past levels: 1980–2005

- Growth in formal employment from 1980 to1990 was relatively low, at 1.8 per cent, declining to 1.6 per cent in the 1990–1994 period (Chitiga, 2004). While there was some growth in formal employment in the public sector in the early 1980s, the structural adjustment reforms in the 1990s were associated with a planned reduction in public sector employment and a drop in real wages.
- As shown in Figure 13, the wages and salaries share of gross domestic income (GDI) fell between 1987 and 1995, and again between 1997 and 2003, while the profits share increased. The wages and salaries' share declined from an average of 49 per cent during the pre-structural adjustment period to 41.5 per cent, and dropped even further to 29.9 per cent during the crisis period of 1997–2003 (Figure 13). Profits, on the other hand, increased in the same periods from an average of 50 per cent to 58.4 per cent and then to 73 per cent (UNDP Zimbabwe, 2008). The wage share fell in a period of higher poverty levels from 1995 to 2003, noted in an earlier progress marker. The increased profit share, on the other hand, was not associated with increased investment, due to macroeconomic instability. It did not lead to job creation and may thus have been a driver of widening inequality.

Figure 13: Gross domestic income at current prices by factor (%)



Source: CSO National Accounts in UNDP Zimbabwe, 2008

Current level: 2006-2010

- Due to a substantial shift towards earnings and profits within informal markets and through remittances it is difficult to track real changes in this indicator through formal data sets. The percentage of the population aged 15–64 years employed fell from 70.1 per cent in 1991 to 64.9 percent in 2008 (UNDP, 2010). In the 2000–2008 period, women made up only 38 per cent of total employment and 62 per cent was classified as 'vulnerable employment', suggesting that secure employment is limited and has fallen.
- Based on a recent all-industry salary survey using a Paterson job evaluation system, top (E5) executives in Zimbabwe were found to earn an annual median total package 100 times higher than that of lowest grade workers, compared to a ratio of 21 in Botswana. This suggests significantly wider executive to worker wage gaps in Zimbabwe than in neighbouring countries, primarily driven by the low real wages of ordinary workers, a matter that the Zimbabwe Congress of Trade Unions has protested about (Chulu, 2011).

Progress

Falling real wages and job insecurity indicate that employment has been a poor vehicle for households to access national resources. It appears that the share to profits has grown but has not translated into investment for new jobs. A high level of vulnerable employment has implications for the design of social protection schemes.

Meeting standards of adequate provision of health workers and of vital and essential medicines at primary and district levels of health systems

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Total doctors per 10,000 people	1.5 1.6	1992 2004	1.6	2009
Nursing personnel per 10,000 people (registered and enrolled nurses)	11.8 7.2	1992 2004	7.2	2009
Availability of medicines in facilities				
– % vital medicines	72 63	2000 2005	63 21	2005 2005
– % essential medicines	56 21	2000 2005		
Availability of drugs at NATPharm				
– % vital medicines	63 72	2004 2005	82 42	2006 2008
– % essential medicines	21 56	2004 2005	62 40	2006 2008

Source: MoHCW, 1999; GoZ UNICEF 2007; WHO, 2007, MoHCW, 2009

Past levels: 1980–2005

- In 1980, government applied a range of measures to produce, deploy and redistribute health workers, including by training new para-professional cadres. Adequacy and internal migration were the main constraints. The density of doctors remained constant but that of nurses fell (see summary table). In 1992, only 46 per cent of registered doctors practised in the public sector, with 64 per cent of these at central hospitals and only 21 per cent at district level. Almost all private sector doctors worked in urban areas. For nurses the respective figures were 45 per cent at central level and 33 per cent at district level (MoHCW, 1999; Normand *et al.*, 2006).
- In the 2000s, external migration of health workers rose due to poor pay, low savings, poor living conditions, under-resourced health services, job stress and workers' lack of confidence in their future (Awases *et al.*, 2004). Staff vacancies rose between 2001 and 2003: from 40 to 80 per cent for pharmacists, from 10 to 60 per cent for doctors and from 10 to 20 per cent for nurses (UNICEF, 2007b).
- An essential medicines programme in 1980 significantly improved medicine management (MoHCW, 1999). As shown in the summary table, medicine became less available between 2004 and 2005 (GoZ, UNICEF, 2007), with shortfalls more pronounced at primary care services used mainly by poorest communities. In 2004 medicine availability was at 82 per cent at central hospitals, 80 per cent at district hospitals and 60 per cent at rural health centres (MoHCW *et al.*, 2004).

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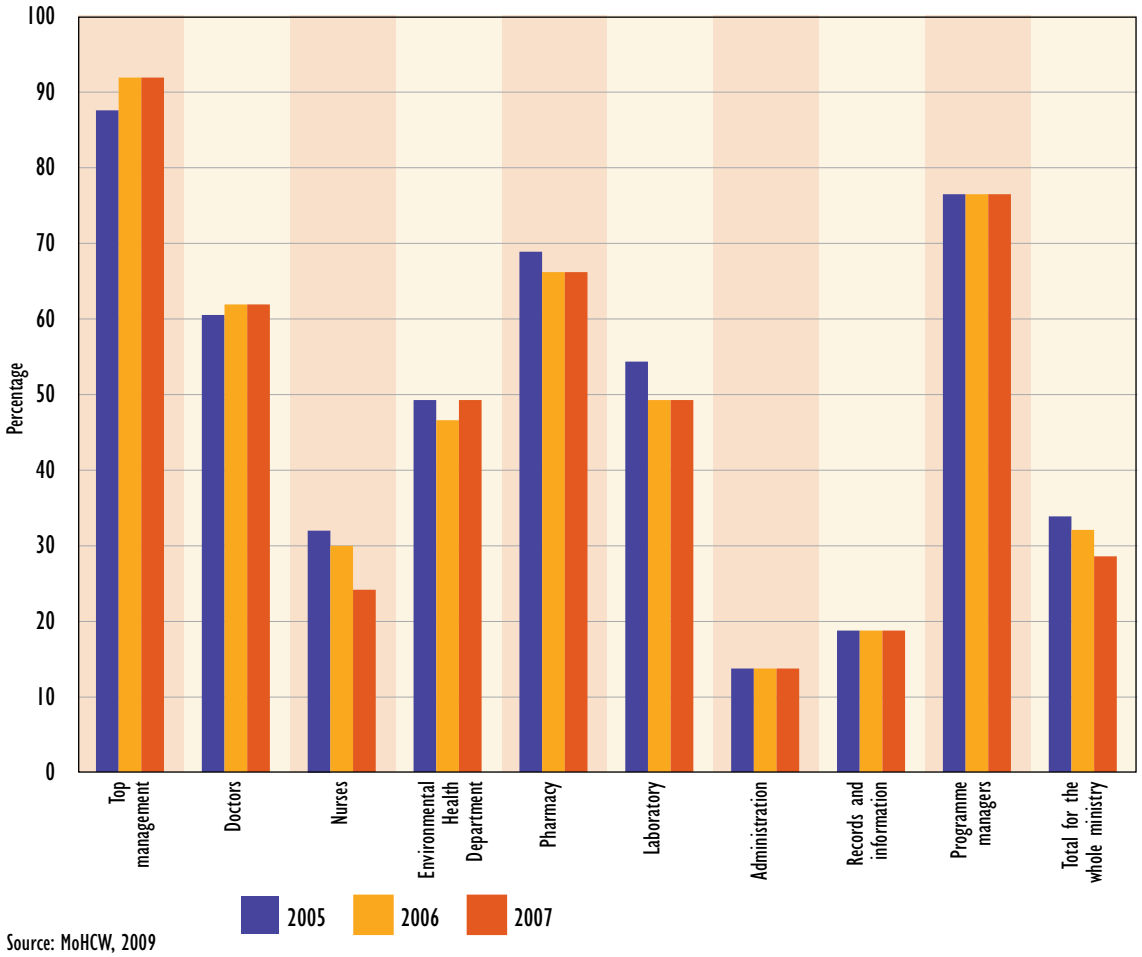
Current level: 2006-2010

- The policy targets in 2007 were to achieve 80 per cent coverage of essential health personnel and to reduce vacancy rates to 10 per cent (HSB, 2007). Between 2005 and 2007, vacancy rates fell overall but rose for pharmacists and environmental health personnel (see Figure 14). In 2009 physician and nurse density was no better than it had been in 2004, with an overall density of 12.3 health staff per 10,000. The WHO recommended levels are at least 25 doctors, nurses and midwives per 10, 000 (GoZ, 2009). A massive internal and external brain and skills drain has led to a loss of experienced, qualified health professionals from the public health sector. Some institutions, particularly at district level, were found to be staffed by untrained or junior cadres (MoHCW, 2009; Makuto, 2007).
- Deployment to rural, peripheral areas continued to be a problem although 2008 saw some improvement in deployment of doctors to rural services and in 2009 the number of trained nurses at rural health centres had reached the approved establishment levels. The high vacancy rates in the public health sector (shown in Figure 14) have led to the remaining health workers being thinly spread, overworked and less motivated (GoZ, 2009). Push factors were reported to be financial (pay, cost of living) and welfare (lack of accommodation, inadequate supervision) (HSB, 2007; MoHCW 2008b).
- In 2006, various incentives were used to address internal distribution, including more favourable bonding policies in district hospitals, a primary care nursing programme and scaling up nursing training (HSB, 2006). Increased training has been the main strategy to counteract the brain and skills drain but it has faced constraints in the lack of lecturers and tutors across all fields. The vacancy rate for tutors was 68 per cent (MoHCW, 2009). Nevertheless gaps remained. Only 33 per cent of villages countrywide were found to have access to facilities with nurses or midwives providing antenatal care according to national standards. Poor pay and conditions of service, a harsh macro-environment and inadequate training capacity continue to limit this area (GoZ MoHCW, 2010).

Figure 14: Vacancy status of health workers, 2005–2007



Source: MoHCW, 2009

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Current level: 2006-2010 continued

- Medicine availability appears to have worsened between 2006 and 2008 (see summary table). In October 2009, availability of essential commodities for the expanded immunisation programme was reported to be erratic due to national shortages, inadequate distribution capacity and lack of or poorly maintained cold chain equipment. Supplies of rapid HIV test kits and antiretrovirals for prevention of transmission from mother to child programmes were erratic due to inadequate funding and weak distribution capacity (GoZ MoHCW, 2010). Medicine was apparently less available in rural areas and at primary care services. While medicine availability at central, district and clinic levels was reported as constant in 2006, rural health centres were still experiencing problems (MoHCW *et al.,* 2006b). In the last quarter of 2009, 60 per cent of clinics compared to 17 per cent of hospitals had a stockout of perinatal kits (GoZ MoHCW, 2010).

  A number of factors were identified as leading to this situation, including lack of foreign currency, inadequate funding, leakages in the system, weak supply chain management and limited or no buffer stocks of many medicines (GoZ MoHCW, 2010). In the 2004–2007 period, for example, NatPharm received only 3 per cent of the approximately US$65 million it needs annually for the public sector, leading to the shortfalls between 2006 and 2008 shown in the summary table (MoHCW, 2009). Foreign currency shortages also impacted negatively on local pharmaceutical production (GoZ, 2009) and medicine prices in Zimbabwe were reported to be higher than in neighbouring countries (Euro Health Group, 2005).

- Cognisant of these availability issues, a specific focus with international partners on supply of essential medicines to districts in 2009 meant that the number of clinics with at least 50 per cent of essential drugs rose from 39 per cent in 2009 to 99 per cent in 2010, a significant increase found across all provinces (UNICEF CCORE 2009, 2010).

- In 2008 most people (72 per cent) were accessing their medicines from health centres and the remainder (27 per cent) were using private pharmacies. Non-availability of medicines at public institutions meant that households were forced to pay more than the highly subsidised fee at public institutions to buy medicines privately. However even the public sector cost was noted in one study to be too high, with 50 per cent of clients reporting going home without prescribed medicines as they could not afford them (MoHCW, 2009). Rural communities report greater difficulty than urban communities in affording the additional costs of drugs (Makuto, 2007). There is some evidence that this situation has improved since 2010. In community monitoring, a larger share of households reported they had access to a health facility within 5 kms with both medicines and staff.

Table 2: Distance to a health facility with staff and medicines reported by communities in sentinel sites

Year	No of sites	% sites reporting distance to health facility (kms)		
		0-5 km	6-15 km	>15 km
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: Community Monitoring Programme, 2011

Progress

Zimbabwe has had to address nearly a decade of negative effects from external migration and financial constraints on health worker availability. The country also suffered financial constraints and high costs of medicines which affected access to drugs, especially for low income and rural communities. Policies, strategies and some resources are now in place to address these issues, as outlined, for example, in the *Human resources for health strategic plan 2010-2014* (HSB MoHCW, 2010). The 2009–2014 national health strategy is committed to improving medicine availability in all health institutions to 100 and 80 per cent for vital and essential medicines respectively (MoHCW, 2009). Recent reports suggest improved deployment of doctors and nurses to rural facilities and a significant increase in availability of essential medicines at primary care levels. Sustaining this calls for a sustained focus on improving supplies and staffing in the public sector at clinic and district level, and monitoring by public authorities and communities. Bottlenecks need to be addressed, such as tutor capacities for midwifery training and deployment of pharmacy and environmental health cadres. Medicine supplies, finances, leakages and supply chain management. need constant monitoring.

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

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
*Out of pocket spending as a percentage of total health expenditure	30.2 33.2 22.6 31.0	1995 1998 2000 2001	23.4 25.8 27.1	2005 2006 2007
Out of pocket spending as a percentage of private health expenditure	66.3 75.2 46.7 51.3	1996 1998 2000 2002	49.6 50.3 50.4	2005 2006 2007

*Out of pocket spending covers health-related household spending, including for health facilities, drugs, medical consultations and diagnostic services, estimated from public and private sector health facility revenue.

Source: WHO, 2011b; World Bank, 2010

Past levels: 1980–2005

- In 1980 free health care was introduced for those on low incomes (below Z150, then worth US$220). The policy position on user fees has been that those who can afford to pay for services should do so but implementation of the principle has been mixed. Out of pocket funding has thus been moderately high at about a third of total health expenditure and at its lowest in 2000 (see summary table). Managing exemption from fees has been difficult and costly, with some consequent injustices in who was exempted.
- In 1990, emphasis was placed on fee collection. However, after evidence of high dropout rates from services, user fees in rural primary care services were suspended in 1995. The Medical Service Act (1998) gave the minister the authority to fix fee or no fee levels at government and state-aided hospitals.
- The *National health strategy for Zimbabwe 1997–2007* aimed at free treatment for the majority but also stated that the policy of free health 'creates a disincentive for people to join medical insurance schemes'. While consultation was officially free at rural health clinics, this was implemented inconsistently, with different fee levels being charged for drugs and consultations by the same types of facilities in different provinces (Euro Health Group, 2005).
- Poor people thus faced a variety of *de facto* cost barriers: the falling real value of the threshold for free care; transport costs; private purchases of medicines due to drug stockouts; and poorly functioning exemption schemes (MoHCW, 1999). 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' approach.

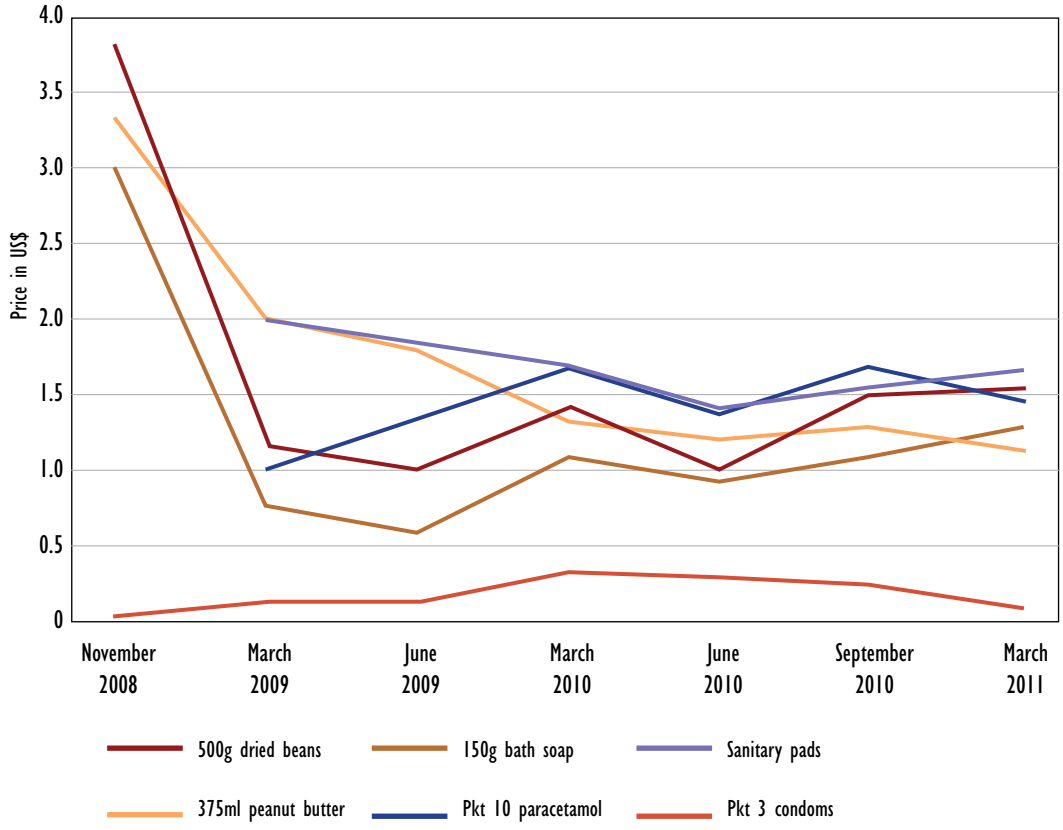
Current level: 2006-2010

- The policy of free public sector care at rural clinics is still in force, although most mission and local authority clinics do not follow it due to inadequate grants from central government. Pregnant mothers, children under five years and adults over 65 years are also exempt from fees up to district level. Despite this, in 2008, 59 per cent of respondents were found to have been charged for health care services, especially in urban, large-scale farming and mining areas. Of these, 36 per cent reported being unable to pay the fees (Makuto and James, 2007; Parl. of Zimbabwe, 2007).

Current level: 2006-2010 continued

- While the medical consumer price index has been lower than the 'all items' consumer price index, private sector medical fees have risen sharply and government has not succeeded in regulating them, despite the requirement for ministerial approval. As a result, recent surveys such as the *Maternal and perinatal mortality study* (2007), the *Health services study* (2008) and the *Assessment of primary health care in Zimbabwe* (2009) all report that communities considered user fees for services unaffordable. This contributed to reduced access to services, especially for poor and vulnerable communities (MoHCW, 2009). User fees were the most commonly mentioned reason for lack of access, especially for maternal health services (MoHCW, 2009).
- In addition to the direct costs of health services, communities have been monitoring the prices of a basket of goods related to health ('a health basket' including foods, medicines, safe water and hygiene products) since 2005. Taking a sample of items from this health basket, costs have generally fallen since the very high levels of 2008 but an upward trend was evident again in 2011 (CMP, 2010; see Figure 15).

Figure 15: US$ nominal monthly prices of indicator health goods, 2008-2011



Source: Community Monitoring Programme 2010

Progress

Zimbabwe has both geographical and income level fee exemption policies. The Ministry of Health and Child Welfare policy of free care at clinic level has not been applied uniformly by local government and mission clinics. Together with informal charges, fees have raised cost barriers for poor households. Communities reported that user fees were unaffordable, contributing to reduced services use, especially for poor and vulnerable households. Equity gains would be possible if government were able to enforce the user fee abolition policy at primary care level and fee abolition for specified essential services at district level, including in urban areas. However, this needs to be accompanied by increased funding to services, investment in supply side issues, heightened community awareness to prevent informal charges and community outreach programmes to promote uptake in the lowest income groups.

Overcoming the barriers that disadvantaged communities face in accessing and using essential health services

Past levels: 1980–2005

- The *National health strategy 1997–2007* aimed at all households being less than 10 kms from a health centre. Health infrastructure planning and development aimed to ensure one rural health centre per 10, 000 population, one district hospital per 140, 000 population and one provincial hospital per province. By 1997, 85 per cent of the population lived within 8 kms of a primary care facility (MoHCW, 2009).
- However, by 2003, 25 per cent of all households and 30 per cent of the poorest households were further than 10 kms from facilities (MPSLSW, 2006). The population movements in the land redistribution exercise meant that more people moved into the previous large-scale farming areas, where health facilities were more distant. Nevertheless there was evidence of improving access as reported use of facilities for illness rose from 62 to 71 per cent between 1994 and 2004 in both urban and rural areas.
- In 2004, 23 per cent of those not visiting services when they needed to cited cost as the reason (CSO, 2006).
- Use of private sector facilities was higher in urban than in rural areas in 1994 (with 25 percentage points difference) and 1999 (with 18 percentage points difference) but fell significantly by 2004 (to 9 percentage points difference) with cost a barrier for urban users.
- While cost has thus been a commonly cited barrier to access, some groups such as orphans and vulnerable children have also faced social barriers in accessing health services, including lack of information on services they are entitled to, lack of confidence to use services, poor communication with health workers and perceptions of stigma (UNICEF, 2005).

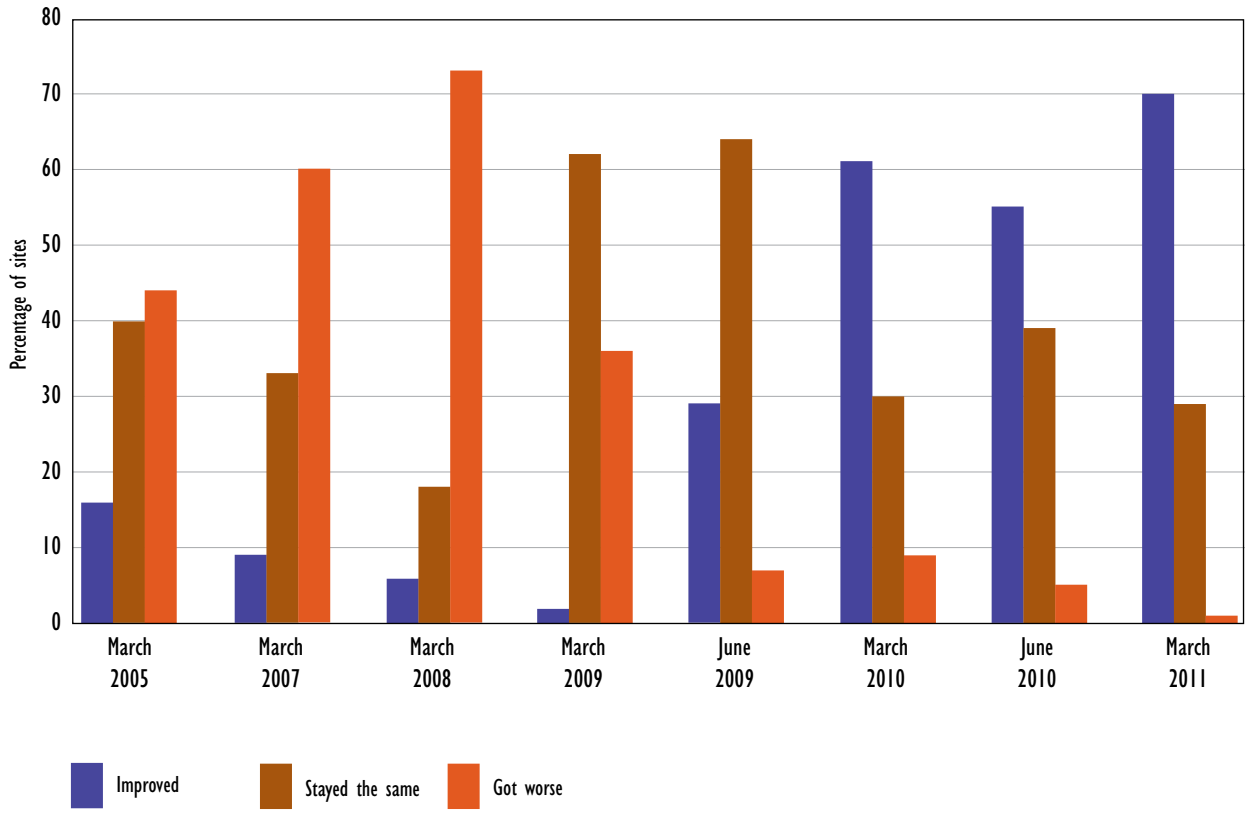
Current level: 2006-2010

- Efforts to improve service supply are noted in previous progress markers. Further efforts also included: converting farmhouses into health centres; immunisation outreach; staff incentives to accept district posts; and institutionalising traditional medicine.
- The share of households more than 10 kms from a facility had reduced to 17 per cent by 2007, although 40 per cent were still more than 5 kms away. However population movement, as a result of the agrarian reform programme and natural population growth, reduced geographic access in some parts of the country (MoHCW, 2009).
- In 2007, shortages of medicines, ambulances, water, electricity and sanitation at health institutions led to people using more distant facilities, increasing household transport, medicine and fee costs (Makuto and James, 2007).
- In 2009, disruptions in communications and supplies were reported to have limited outreach activities and contributed to adverse outcomes, particularly for maternity care, acute care and emergencies (GoZ, 2009). The referral chain was reported to be largely dysfunctional due to a critical shortage of ambulances at district level (GoZ MoHCW, 2010).
- These supply constraints reportedly affected particular groups more. Women were more affected by numerous barriers, including treatment fees, drug availability, transport and distance to facilities (CSO, Macro Int., 2007). People with disabilities faced particular problems as economic conditions and health services declined after 2000. Hyperinflation eroded the value of the state disability allowance, assistive devices (wheelchairs, crutches,) were unavailable or unaffordable and special schools struggled to function (Loeb, 2009).
- However, even where there is availability, there are access barriers. Financial barriers were cited by 75 per cent of women in the lowest income quintile compared to 35 per cent in the highest income quintile (CSO; Macro Int., 2007). For people with disabilities, stigma, marginalisation, intolerance and sexual abuse were reported to be barriers to access (Loeb, 2009).

Current level: 2006-2010 continued

- The low use of clinic services amongst some social groups has been attributed in national planning to lack of knowledge, religious and cultural barriers, user fees and poor male involvement (GoZ MoHCW, 2010). Civil society and community health worker activities have been found to play a role in addressing these factors by promoting health service uptake in vulnerable communities.
- In 2010, however, only 19 per cent of villages countrywide were estimated to have active village health workers, due to a cessation of the training programme in most districts as well as poor and uncoordinated remuneration across programmes (GoZ MoHCW, 2010). In one community survey of 25 districts, less than half of households reported having a health worker in their wards and the village health workers reported that they were not supplied with basic medicines.
- Outreach activities in communities (malaria spraying, TB contact tracing, immunisation outreach) were low due to limited resources and shortfalls in environmental health technicians.
- Households were also found to lack the information, resources and support they needed to effectively participate in health (TARSC, CWGH, 2009). Nevertheless, an expanding health literacy programme by civil society and increased public investment in village health workers were both initiated in 2009.
- On balance, while these challenges exist, there are some positive trends since 2010, with national community sentinel site monitors reporting a marked increase in the use of public clinics and less use of hospitals and private clinics (Table 3; CMP, 2011). Nearly three quarters of sites reported improved quality of services in March 2011, a significant increase since March 2005 (Figure 16).

Figure 16: Share of sites reporting changes in quality of health services



Source: CMP 2011

Table 3: Share of community monitoring sites reporting preferred facility used when people fall ill

Year	No of sites	Percentage of sites reporting response				
		Hospital	Public clinic	Private clinic	Home	*Other
March 2011	237	9	85	3	3	0
March 2010	240	25	61	6	6	2
March 2009	182	17	67	11	3	2
March 2008	185	21	73	0	4	2
March 2007	160	22	71	0	4	3
March 2005	151	28	72	0	0	0

*Includes traditional medicine

Source: CMP, 2011

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Progress

Zimbabwe's health service infrastructure could support universal access, although gaps need to be addressed in new resettlement areas. Improved uptake of services depends on overcoming shortages of drugs, staff and other supplies, as well as barriers to uptake. These include charges for services and medicines, as well as social factors. Civil society outreach, health literacy and support to village health workers need to be extended nationally to address such barriers. Community reports suggest that after some decline, the past year has seen improved use and satisfaction with services. Further disaggregated information is needed to see who is benefiting from service improvements and outreach and whether vulnerable groups are being reached.

EQUITY WATCH

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Resourcing redistributive health systems

Progress markers

- Achieving the Abuja commitment of 15 per cent government spending on health
- Achieving US$60 per capita public sector health expenditure
- Increasing progressive tax funding to health and reducing out of pocket financing in health
- Harmonising the various health financing schemes into one framework for universal coverage
- Establishing and ensuring a clear set of comprehensive health care entitlements for the population
- Allocating at least 50 per cent of government spending on health to district health systems (including level 1 hospitals) and 25 per cent of government spending on primary health care
- Implementing a mix of non–financial incentives for health workers
- Formally recognising and supporting mechanisms for direct public participation in all levels of health systems

EQUITY WATCH

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 (for example, safe water and education) discussed in the previous 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, for example: in the benefits, entitlements and framework for achieving universal coverage; in mobilising 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.

Achieving the Abuja commitment of 15 per cent government spending on health

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
*Government spending on health as a percentage of total government expenditure	17.0 7.4 9.2 8.9	1997 2000 2003 2005	8.7 12.2 9.5 12.3	2007 2008 2009 2010
Total expenditure on health as a percentage of GDP	10.8 7.6 8.9	1998 2003 2005	9.3 8.9	2006 2007

*excluding external funding

Sources: Govender et al 2008 ; WHO 2008c; MoFin 2008, 2009, 2010; Loewenson and Shamu, 2006, MoHCW 2009, UNDP 2010; World Bank 2011; WHO 2011b,

Past levels: 1980–2005

- After peaking at 17 per cent in 1997, government expenditure on health had fallen to just 7.4 per cent by 2000. It rose slightly in 2003 (see summary table) but the increase was not sustained. Total expenditure on health as a percentage of gross domestic product was at 10.8 per cent in 1998 but fell again thereafter.

Current level: 2006-2010

- During the period of a functional economy, the Zimbabwe government has always given priority to the social sectors. Though the budget allocation to the health sector has been below the levels required for the delivery of quality health services, health has maintained its ranking in the top five ministries in allocation of government funding (MoHCW, 2009).
- In the 2006–2008 period, actual expenditures were difficult to assess due to the practice of supplementary budgets and direct disbursements from the central bank (Shamu and Loewenson, 2006). Over the 2006–2010 period, however, there is evidence that the health share of government budget spending recovered, although with some fluctuations.
- Health spending returned to double digits in two of the four years reported on in this period (in 2008 and 2010) which was last achieved in the late 1990s (see summary table).

Progress

Zimbabwe has not yet met the Abuja commitment although it has reversed significant declines in the health share of the budget and the share to health of gross domestic product has been relatively high. Despite this, the real value of this spending fell due to high inflation prior to dollarisation. While government has shown signs of reprioritising health, the overall level of public spending is still low relative to need. Health thus needs to continue to be prioritised and the share of gross domestic product needs to be maintained.

Achieving US$60 per capita public sector health expenditure

In addition to the Abuja commitment, in 2001 WHO estimated that US$34 per capita was needed for a package of priority health interventions for sub-Saharan Africa, excluding the wider systems costs, and US$60 per capita including these costs (WHO, 2001).

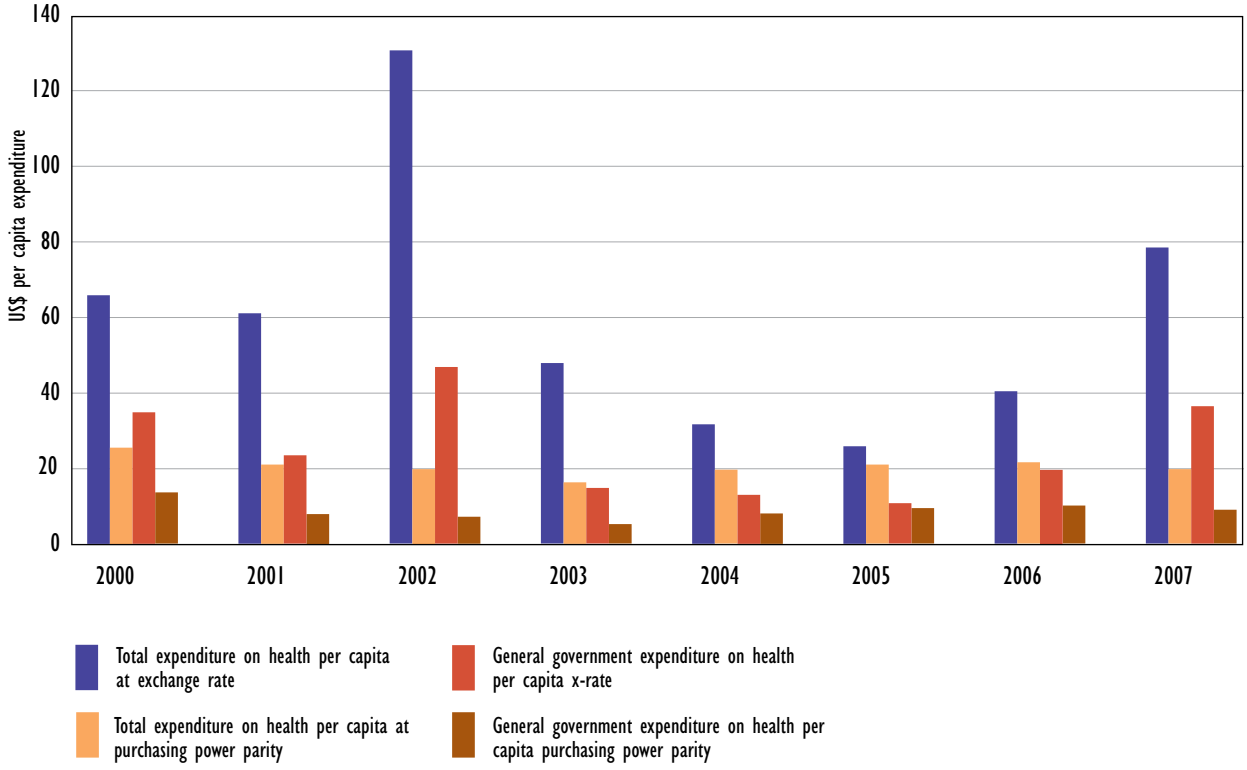
INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Per capita government expenditure on health US$ exchange rate	35 15 11	2000 2003 2005	20 36	2006 2007
Per capita government expenditure on health PPP US$	14 05 10	2000 2003 2005	10 09	2006 2007
Per capita total expenditure on health US$ at exchange rate	66 48 24	2000 2003 2005	40 79	2006 2007

Sources: WHO, 2008, 2008c, 2011b; MoFin, 2008

Past levels: 1980–2005

- Total and government per capita health expenditure fell between 2000 and 2005, although not in 2002. Both were generally below the US$60 per capita considered necessary for a basic health system to function (WHO, 2008).

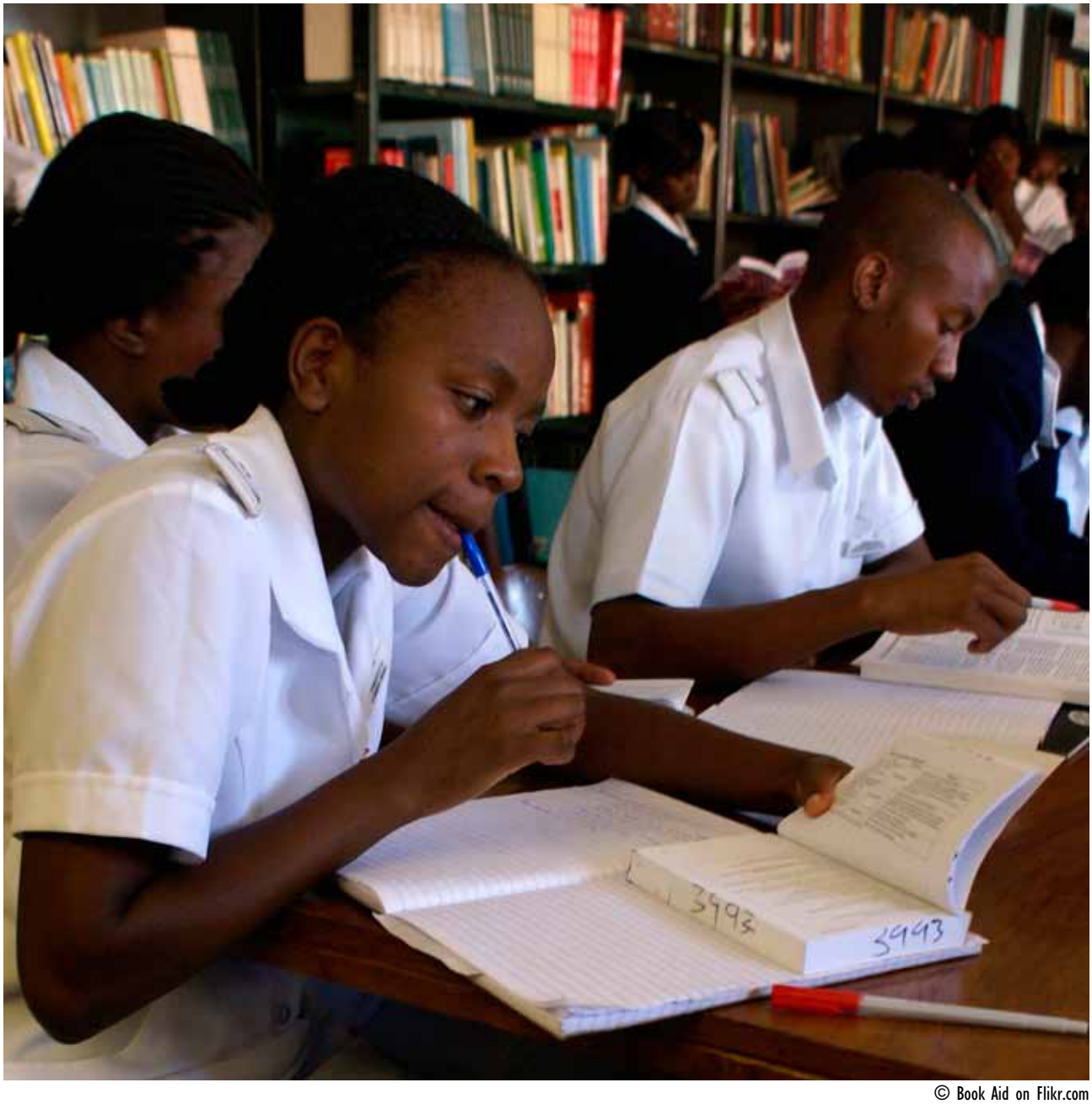
Figure 17: Health expenditure data



Source: WHO, 2010

Current level: 2006-2010

- Assessing spending over the 2006-2008 period was complicated by the Reserve Bank of Zimbabwe's extra-budgetary spending but total and government per capita expenditure apparently rose after 2005. Government spending is below US$60 per capita but total spending is above it (US$ at exchange rate). The public health sector is underfunded so off-budget external funding has apparently increased. While this may support the public sector, it is not captured within sector-wide funding or budget support.



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Progress

Despite improvements, public sector health expenditure has not risen enough to revive the health sector or to provide domestic resources to address the shortfalls noted in earlier progress markers. A large share of spending appears to be off-budget and in the private sector. With high poverty levels and wide use of public services by poor households, improved equity appears to depend on improving public sector spending. Sector-wide funding or budget support measures are needed to ensure external funds are known and aligned to the national investment plan.

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

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
% Total health expenditure that is government spending on health	54.6 53.0 45.4	1995 2000 2005	48.7 46.3	2006 2007
Private spending on health	45.4 47.0 54.6	1995 2000 2005	51.3 53.7 0	2006 2007 2006
Social health insurance	0 0	1995 2005	0	2007
Out of pocket spending as a % private spending	66.5 45.5 50.5	1995 2000 2005	50.3 50.4	2006 2007
External resources as % total health expenditure	1.3 20.8	2000 2005	17.3 0.2	2006 2007

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

Past levels: 1980–2005

- Public expenditure as a share of total health expenditure fell while private expenditure rose by 10 percentage points between 1995 and 2005. Out of pocket spending as a share of private spending fell and then rose, as the private insurance share rose and fell. More people dropped out of private prepayment schemes, in part due to company closures (see Figure 18). With a trend towards increased private and out of pocket spending in the period, health financing became more regressive.

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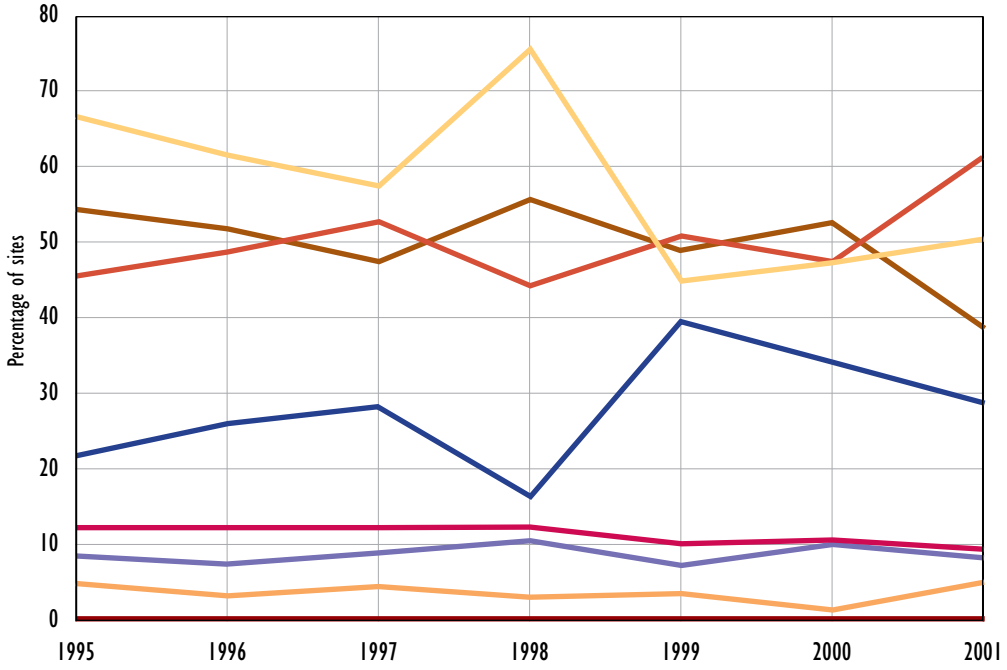
Figure 18: Sources of health expenditure, 1995-2001



Key

- Total expenditure on health as % of gross domestic product
- External resources on health as % of total health expenditure
- General government health expenditure as % of total health expenditure
- Private health expenditure as% of total health expenditure
- General government health expenditure as % of general government expenditure
- Social security funds as % of general government health expenditure
- Private insurance as % of private health expenditure
- Out of pocket expenditure as % of private health expenditure

Source: WHO, 2011b

Past levels: 1980–2005 continued

- A reduction in public spending and in private insurance coverage in 2001 is likely to have reduced financial protection, especially of poor communities. With the relatively low contribution of external funds, households were compelled to meet the gap through out of pocket spending.
- The AIDS levy added a new source of revenue in 2001, with real revenue rising from $59 million in 2001 to $75 million in 2005 (GoZ, UNICEF, 2007). This did not meet the gap left by a reduction in external funding after 2000, with annual donor spending per HIV-infected person in Zimbabwe at US$4, compared to a country average of US$74 in southern Africa (GoZ/UNICEF, 2007).

Current level: 2006-2010

- Zimbabwe is a high-tax state, collecting 22.7 per cent of gross domestic product in tax revenue compared with 12.9 per cent for low income countries as a whole and 16 per cent for low middle income countries. The country relies on direct income taxes for 47 per cent of revenue.
- In 2007, 25 per cent of tax was from VAT (UNDP Zimbabwe, 2008) but this grew to 39 per cent by 2010, with 19 per cent from PAYE and only 10 per cent from corporate taxes (Afrodad, 2011). Being payable by everyone, VAT is not redistributive and while the VAT Act exempts or zero rates certain goods and services, this benefits all consumers. The 2011 budget suggested that to improve collection local authorities should collect taxes, including from small enterprises, and keep 10 per cent (Afrodad, 2011).
- Collections through the AIDS levy, which had shrunk in 2007/8, rose after dollarisation to about US$400,000 monthly, with 50 per cent allocated by policy to antiretrovirals (NAC, 2011).
- Public spending on health rose after 2006 and private and out of pocket spending fell (see summary table). Nevertheless tax funding of the health sector remains low and private and out of pocket spending high. No health accounts data are available after 2007. Government funding, estimated from the 2010 health budget in the government budget estimates, assumed that US$156 million allocated to the ministry in 2010 would be availed. However, only 10 per cent of the allocation in 2009 was actually disbursed.
- After 2008, government spending also included US$100 million annual donor inflows and US$180 million from the Global Fund Round 8 grants (GoZ MoHCW, 2010).
- To reduce out of pocket spending, various tax funding options have been suggested. In 2007 the Parliamentary Portfolio Committee on Health proposed a 'sin tax' on luxury items that negatively affect health such as liquor and tobacco. In reviewing the Public Health Act, stakeholders suggested ways to improve public financing, including: levies charged as a tax on income tax for specific funds for health challenges or to fund prepaid health services; hypothecated or earmarked taxes for particular programmes or uses, where the taxpayer knows what the state will spend the money on; taxes or levies on activities or products that increase particular public health burdens (cigarettes, alcohol, road traffic, high sugar products) to be allocated to health promotion and prevention activities; taxes on financial currency transactions, airline tickets, cell-phone charges, spent against budget lines for priority public health programmes, such as maternal health and immunisation; and various grants, fees and penalties related to the Act.
- Social health insurance could reduce out of pocket spending. Proposals to implement it under the National Social Security Authority were made and reviewed but concerns discussed in the next progress marker mean the proposals are not implemented as yet.

Progress

There has been a small shift towards increased public financing from taxes and reduced private and out of pocket spending. More equitable taxes need to be identified. There is debate on options for improving tax revenue and domestic progressive financing for health, including through social health insurance and community health insurance. The financing incidence – who bears what burden of funding health services – of the different funding proposals needs to be assessed.

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

Past levels: 1980–2005

- Achieving a unified health financing framework has been a challenge. *Planning for equity in health* (1980) sought to provide universal health coverage, strengthen the public sector and redistribute health resources towards health needs. Not-for-profit mission services were coordinated with government services through public grants. In the 1990s, falling public sector revenues limited the state's leverage to achieve this.
- Health strategy in the 1990s emphasised partnership between public and private sectors to widen the base for providing and financing health care (MoHCW, 1999). A 1991 study commissioned by government concluded that a case existed for establishing a national health insurance scheme. The 1997–2007 national health strategy confirmed this intention to introduce national social health insurance to cover all citizens for basic health services and to improve equity in financing and provisioning (MoHCW, 1999).

Current level: 2006-2010

- While public and not-for profit mission services continue to coordinate provision, financing remains segmented between different providers, with limited cross subsidies across funding pools. Hyperinflation and related devaluation of public funds over the 2005–2008 period left the public sector relatively weak, although, as noted earlier, public financing improved in 2010.
- The share of external funding rose after 2009 but the $35 million made available for health by October 2009 and the $84 million in October the following year were disbursed directly to programmes and projects, outside of government budget expenditure frameworks (MoF, 2010, 2011).
- Private health insurance, largely through medical aid societies, covers less than 1 per cent of the population, provides 80 per cent of income for private health care providers and represents about 20 per cent of total health expenditure (Shamu *et al*., 2010). There are many small medical aid societies that are internally segmented with limited cross subsidies and no legally required basic package. Medical aid societies have encouraged the growth of urban private hospital services for employed and wealthier groups. The economic liberalisation in the 1990s and the economic decline in the 2000s led medical aid societies to acquire health services and pharmacies, despite regulations prohibiting this. By 2009 their clients were making high co-payments (compulsory top-up payments to providers above their payments to medical aid societies) and faced restrictions on which providers they could use (Shamu *et al*., 2010).
- In 2007 government devised a national health insurance scheme, including a minimum benefits package, to be financed from a 5 per cent levy on gross formal sector salaries and administered by the National Social Security Authority. Parliament raised concerns about transparency in managing the fund, the make-up of the suggested benefits package (which excluded antiretroviral treatment), the tax burden on formal employees and what measures would ensure service quality (Parliamentary Committee on Health, 2007b). The introduction of the scheme was subsequently postponed.

Progress

Despite a stated policy goal of universal health coverage, health financing in Zimbabwe remains largely segmented. Public grants and agreements exist with local government and missions, a national health insurance scheme has been proposed and external funding has increased. However, low public funding, lack of a defined basic entitlement and almost all external funding being outside budget frameworks have weakened public leadership towards a universal framework. Relatively unregulated, segmented private funding, largely for higher income urban groups, further segments health financing. Public leadership towards universal coverage calls for improved public financing, a set of basic entitlements, tighter private sector regulation and increased sector-wide pooling of external funds.

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

Past levels: 1980–2005

- 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' (MoHCW, 1999). There was no public document in the period that elaborated what these entitlements were.

Current level: 2006-2010

- One of the reasons often cited for the huge financing gap is the provision of what, to all intents and purposes, is an unlimited package of free services, while the financing base has continued to shrink to levels where it is impossible to sustain this. In the early 2000s the Ministry of Health and Child Welfare 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). The ministry 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).
- By 2009, a further policy statement was made in the *National health strategy 2009–2014* to review the provision of a basic benefits package. This was also proposed in an assessment of primary health care in Zimbabwe (2009) from civil society. This proposed that a package of essential services and resources be defined and costed at primary level and that priority be 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). However as yet this set of entitlements is still to be defined.

Progress

While policy commitments have been made to defining comprehensive health care entitlements, technical and policy dialogue (including with parliament and civil society) is needed to establish, cost and raise awareness on a clear set of comprehensive health care entitlements for the population at the various levels of the health services.

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

Past levels: 1980–2005

- After the 1980s, government reallocated funds, on the basis of health need, from central to district level and to rural services. This was reversed later in the decade (Loewenson and Chisvo, 1994). Needs-based resource allocation was explored but, with falling real funding, allocation was mainly demand based.
- In 1994 central hospitals received 34 per cent of total funds, district hospitals and clinics 30 per cent, with 11 per cent for 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. The optimum amount of spending on prevention within the medical care vote would need to be determined through a study.
- The Health Services Fund, set up in 1996, added external funds to fees retained at clinic and hospital level, with 40 per cent held for community and disease control activities (Makuto, 2007). Expenditure did not always follow these guidelines. After external contributions to the fund fell in the 2000s, the Ministry of Finance provided an 'equalisation grant' for low-income districts (MoHCW, 2008b).
- The AIDS levy fund provided equal shares to all districts, with allocations to provincial and district levels rising from 46 per cent in 2002 to 75 per cent in 2005 (GoZ, UNICEF, 2007).

Table 4: Budget allocations by area, health sector

Budget line %	2002	2003	2005	2006	2007	2008	2009	2010
Administration	5	7	8	10	11	9	16	12
Medical care	78	81	82	79	81	81	76	80
Preventive services	16	11	9	9	6	10	7	7
Research	1	1	1	2	2	1	1	2

Source: Finance Department, Ministry of Health and Child Welfare, 2011

Current level: 2006-2010

- Currently, resource allocation continues to be demand driven based on 'budget bids'. 'Blue book' budget 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 information could be publicly reported on in future.
- A 2005/06 district health survey noted the inadequacy of budget allocations to districts (MoHCW, 2008b) but staff shortfalls also led to constraints in the capacity to absorb funds in some districts (Mpofu *et al.*, 2008). Between 2005 and 2010 the budget shares to the sub-votes remained relatively constant.
- While noting the limits in the lack of evidence disaggregated by level or on expenditure on prevention and promotion activities in hospital settings, it appears that reduced real public spending from the late 1990s has constrained policy intentions to redirect resources from curative to preventative and promotional services and to apply needs based resource allocation (MoHCW, 2009). Several resource allocation formulae have been piloted to improve equity and alignment to policy goals but they have not been consistently applied (MoHCW, 2009).

Progress

Routine reporting on allocations by level and a specific study on spending on primary health care and prevention by curative services is needed to properly track this progress marker. Funds such as the AIDS levy fund disburse commodities and not cash. Coverage inequities noted earlier suggest that further measures are needed to promote needs-based financing and the capacity to demand and use resources at lower levels. Civil society and parliament can play a role in monitoring resource flows to district and primary health care levels.

Implementing a mix of non–financial incentives for health workers

Past levels: 1980–2005

- In the 1980s investments were made to train, deploy and re-orient health workers around health policy priorities. *The National health strategy 1997–2007* noted that the non-monetary rewards that contributed to high staff morale in early periods of post-independence, such as housing, transport, education and recreational activities, had declined in the 1990s, along with the purchasing power of salaries. This undermined efforts to retain personnel in peripheral services. In the late 1990s and early 2000s a series of industrial actions signalled rising discontent over pay and conditions of service in the public sector.
- A Health Service Board was established in 2005 (Health Services Act No 28 of 2004) to address this situation, including the 'brain drain', discussed earlier (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 for nurses, doctors and other cadres; provision of antiretroviral prophylaxis after occupational exposure; and access to antiretroviral treatment (MoHCW, 2007a). Salaries and conditions were negotiated in a bipartite negotiating panel consisting of six employer and six employee representatives, chaired by an independent expert in labour matters (HSB, 2006). While this arrangement formalised labour relations in the sector, it did not cover all health workers. For example, junior doctors were not included in 2006 and neither were clinical staff in training institutions.

Current level: 2006-2010

- The public sector offered various incentives to retain personnel in the 2000s, including: salary reviews, dual practice, part-time work, housing, uniforms, night duty, on call and call out pay, post-basic qualification and rural allowances, training opportunities and work environment improvements (EQUINET SC, 2007).
- Strikes for better wages in the health sector took place five times in 2007 and the bipartite negotiating panel met thirteen times to negotiate salaries and conditions of service (HSB, 2007). However, the Health Service Board has faced constraints in its authority and the funds to implement many of its recommendations (HSB, 2007).
- Efforts made to improve incentives in the 2000s were eroded by inflation and wider insecurity, while variable application of allowances and current bonding arrangements were reported as a source of frustration (Chimbari *et al*., 2008). For highly skilled workers, such as public sector physicians, there was a high rate of dual practice (41 per cent of physicians), although with rates of 10 per cent or less dual practice in other categories of personnel (Gupta, Dal Poz, 2009).
- After 2009, dollarisation stabilised earnings and health workers received additional payments from external funders, such as DfID, European Union, CIDA, UNICEF and the Global Fund for AIDS, TB and Malaria. The dollarisation and top-up scheme had an immediate effect in stopping the 2008 strike and retaining health workers, with some who had resigned rejoining the service.
- The incentives and improved conditions appear to have had positive effects as vacancy rates stabilised or fell for most categories of personnel. The impact of the retention scheme was being assessed at the time of writing the report.

Progress

A range of steps have been taken to better manage and respond to health worker issues, institutionally, through the Health Service Board and more inclusive negotiating mechanisms, and through the incentives offered. However, the Health Service Board lacks adequate resources and authority to fully implement its recommendations. A range of incentives have been applied and with dollarisation appear to have supported retention as vacancy rates have fallen. External funders have made a critical contribution while also raising issues of sustainability.

Formally recognising and supporting mechanisms for direct public participation in all levels of health systems

Past levels: 1980–2005

- Community participation has been central to health policy since 1980. Village and ward health teams were supported by community health workers. In the 1990s these mechanisms became less active as primary health care services declined, with evidence of mutually reinforcing links between mechanisms for participation and the strength of primary health care services (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 through self-managing entities. The Health Services Act (24/2004) established hospital management boards although financial authority remained at ministry headquarters and management was centralised (MoHCW, 1999).
- A growth in civil society action brought new forms of community involvement in health, such as the 35-member Community Working Group on Health (CWGH), formed in 1998, to support participation in the health sector and outreach to vulnerable groups and to capacitate mechanisms for joint planning in health. The Advisory Board on Public Health and a range of committees and boards at different levels of services provided advisory mechanisms but many became dormant during the early 2000s.
- Reforms in 1999 led to the establishment of the Parliamentary Portfolio Committee on Health and Child Welfare which held public hearings and engaged stakeholders on health.

Current level: 2006-2010

- A 2007 survey found community participation in health activities in only half or fewer communities. Village and ward development committees in many districts were meeting irregularly or had been disbanded. Health centre committees did not always have the skills or resources for their roles (MoHCW, 2008b). Community health councils and a patients' charter were meant to provide formal mechanisms for community voices but were weakened by the declining performance of the health system and the wider political environment.
- 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 worker desire for greater involvement in planning but also inadequate formal guidelines, recognition or resources to support these roles (TARSC, CWGH, 2009; MoHCW, 2009).
- The 2009–2014 national health strategy made inclusion and participation a central element (MoHCW, 2009). Since 2009, civil society and the Ministry of Health and Child Welfare have supported health centre committees in being more actively involved in health planning (GoZ MoHCW, 2010) while proposals for their legal recognition have been made by the Public Health Advisory Board.
- The village health worker programme, which declined in the 1990s and was reintroduced in 2001, became a ministry priority in 2008, with 14 per cent of the preventive services budget in 2008 allocated to this programme (MoHCW, 2009).
- Policy accountability at national level has been strengthened by revival of the Public Health Advisory Board and activities of the Parliamentary Portfolio Committee on Health (MoHCW, 2008b: 2009).

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 up to national level. Mechanisms at primary care level need legal recognition. Guidelines are needed to support participation, and adequate resources need to be allocated to support participation mechanisms.

EQUITY WATCH

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A more just return from the global economy

Progress markers

- Reducing debt as a burden on health
- Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers
- Ensuring health goals in trade agreements, with no new health service commitments to GATS and inclusion of TRIPS flexibilities in national laws
- Bilateral and multilateral agreements to fund health worker training and retention
- Health officials included in trade negotiations

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, protecting women smallholders' food production in trade policies and including health officials and health protection in trade negotiations and agreements.

Reducing debt as a burden on health

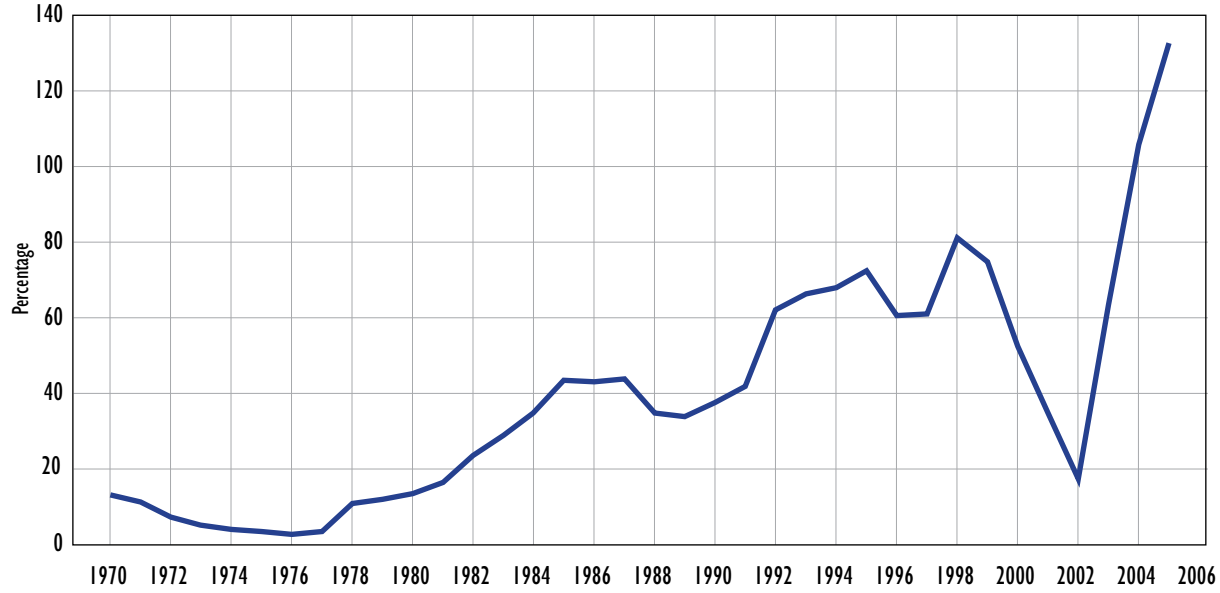
INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
External debt as a % gross domestic product	78 68	1998 2000	72 192	2006 2009

Source: UNDP Zimbabwe 2008, IMF 2009, 2011

Past levels: 1980–2005

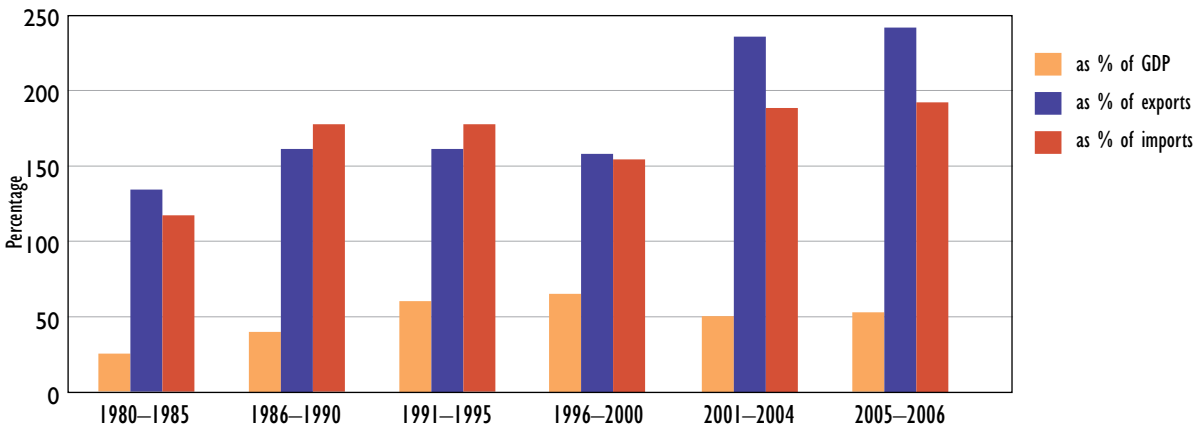
- Total external debt fell between 1998 and 2000. However, it rose as a share of gross national income between 1990 and 1995, fluctuating and then falling between 1998 and 2003. Levels rose to over 100 per cent in 2005 (See Figure 19a).
- In 2000 about a quarter of the revenue from the export of goods and services was used to service this debt (IMF, 2001). The total debt exceeded earnings from exports and imports (see Figure 19b).
- Zimbabwe was not among the 14 African nations that received debt cancellation in 2005 and was not listed among countries eligible for debt relief.

Figure 19a: External debt stocks as a share of gross national income, 1970–2005



Source: World Bank, 2010

Figure 19b: Zimbabwe's external debt structure, 1980–2006

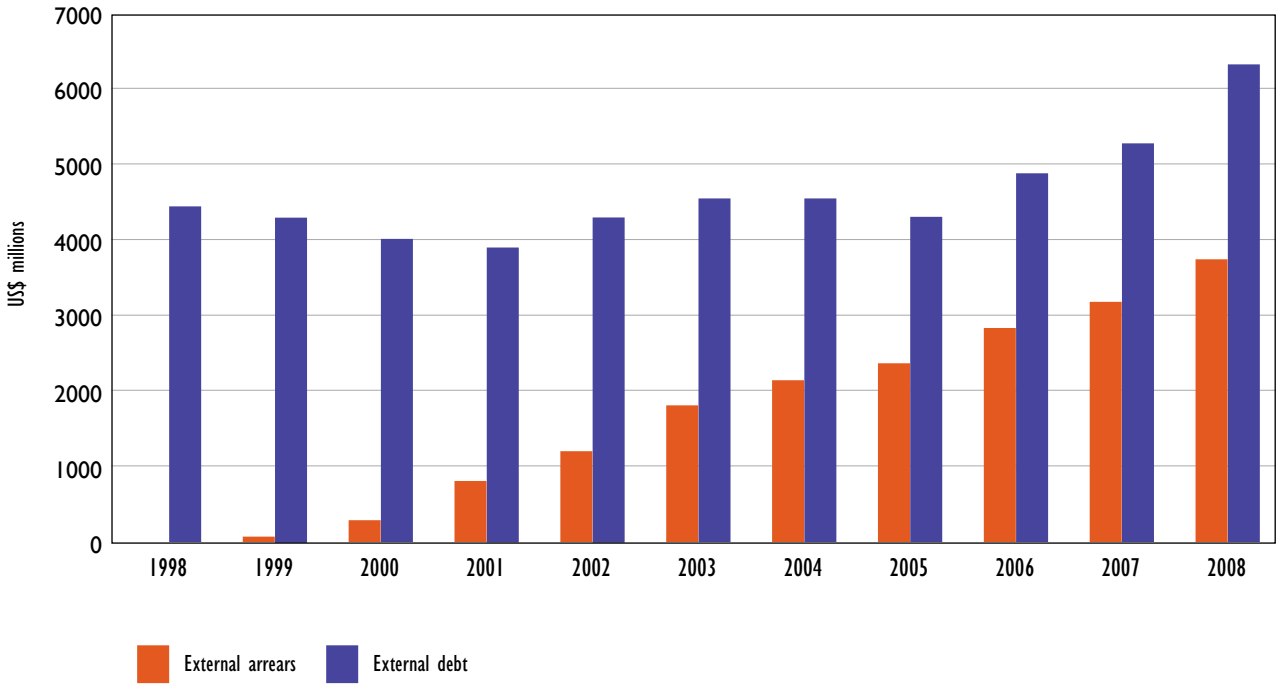


Source: World Bank database in UNDP Zimbabwe, 2008

Current level: 2006-2010

- By 2006, Zimbabwe's external debt had risen to 72 per cent of gross domestic product, with 94 per cent of this owed to multilateral and bilateral creditors (SADC Bankers, 2007). By 2009, the debt was reported to have risen to 192 per cent of gross domestic product (IMF, 2011). The external debt profile deteriorated rapidly and the country ran up arrears in excess of US$3 billion, including the 'pipeline' of current transfer payments for the year 2007 alone of US$450 million and rising to over US$6 billion by 2008.
- The real extent of external indebtedness is unknown, partly because of the contingency liabilities of the government and the central bank in relation to offshore loans for which they have provided guarantees, partly because the full extent of the current payments pipeline is unknown and because details of loans from non-OECD countries such as China, India, Iran and Venezuela are not in the public domain (UNDP Zimbabwe, 2008). Whatever the actual level, the external debt is not sustainable without debt relief (UNDP Zimbabwe, 2008).

Figure 20: External debt, 1998-2008



Source: IMF, 2011

Progress

Zimbabwe has a high and unsustainable level of debt. It has not received debt relief and despite high poverty levels, would not be eligible for debt relief under the HIPC scheme (the Enhanced Heavily Indebted Poor Countries Initiative) due to its classification as middle income. Any payments to debt servicing using the economic resources from minerals and any recovery in domestic manufacturing would withdraw critical resources needed to address the significant shortfalls in employment, income, infrastructure, environment and services, highlighted in this report.

Allocating at least 10 per cent of budget resources to agriculture, particularly for investments in smallholder and women producers

INDICATOR	PAST LEVELS (1980–2005) Level	Year	CURRENT LEVEL (most recent data) Level	Year
Government spending on agriculture as a percent of total government expenditure	11	1990	8.0	2007
	4	1995	3.4	2009*
	2	2000	2.5	2010**
	8	2005		

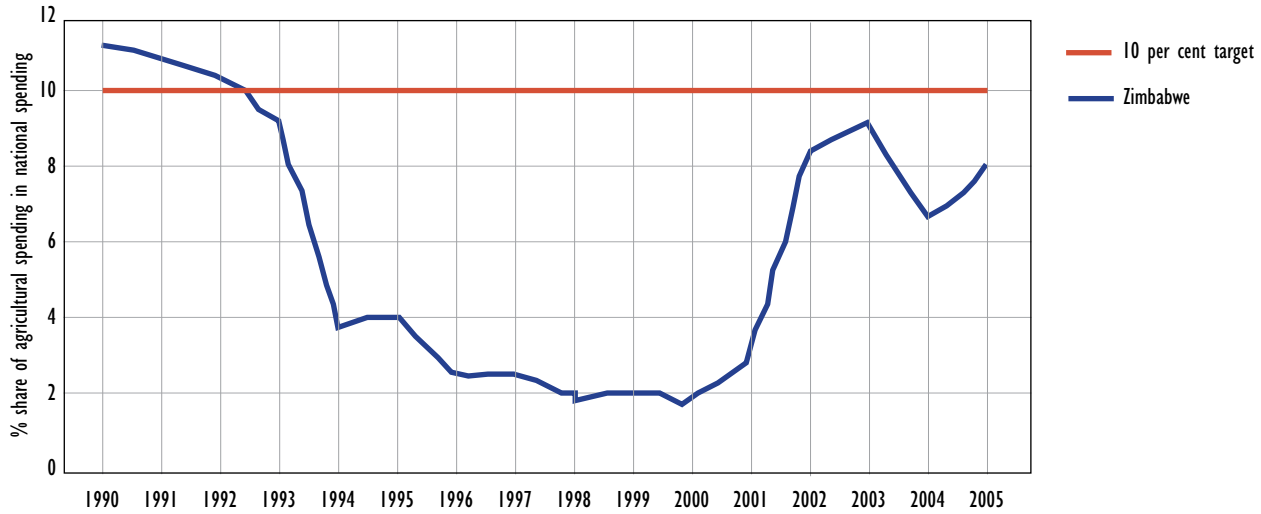
* expenditure **budget estimate

Source: AU/NEPAD, 2007, MoFPED, 2010

Past levels: 1980–2005

- Agriculture was allocated 11 per cent of the national budget in 1990 (AU/NEPAD, 2007). It fell thereafter until 2000 and rose sharply as a share of the budget over the 2001 to 2005 period (see Figure 21).
- The most significant measure in the period was the land reform programme from 2000 onwards, which had stated policy aims of redistributing large-scale land to smallholder farmers, improving access to land for smallholder farmers.
- Household surveys showed a downward trend between 1999 and 2005 in the percentage of women in skilled non-agricultural employment in rural areas (18.4 per cent to 9.6 per cent), suggesting women' rely more heavily on smallholder farming (Loewenson and Shamu, 2008).

Figure 21: Share of agriculture in the budget against the target of 10 per cent, 1990-2005



Source: AU/NEPAD, 2007

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Current level: 2006-2010

- The share of the budget allocated to agriculture fell to 8 per cent in 2007 (AU/NEPAD, 2007) and even lower to 3.4 per cent by 2009. It is difficult to assess whether the improvement in public spending on agriculture before 2005 or the fall after 2005, affected smallholders or women farmers as data on the number of smallholder beneficiaries by gender is not publicly available and government spending on agriculture is not disaggregated by producer level or by gender.
- A vote of credit from external funders in 2010 included funds for procurement of seed and fertiliser, with pledges of US$100.3 million but disbursements by end of June 2010 were only up to US$9.3 million (GoZ, 2010).

Progress

Zimbabwe's current allocation of 3.4 per cent is well below the 10 per cent target or the African Union average of 6.6 per cent reported in 2007 (AU/NEPAD, 2007). The extent to which funds reach poor households and women farmers particularly needs to be further assessed. However, the low levels of household food stocks reported earlier in 2010 suggest that greater investment is needed in women smallholders, particularly those growing food.

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Ensuring health goals in trade agreements, with no new health service commitments to GATS and inclusion of TRIPS flexibilities in national laws

Past levels: 1980–2005

- Zimbabwe made no commitment to the General Agreement on Trade in Services (GATS) and included all World Trade Organisation trade-related aspects of intellectual property rights (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 a period of emergency (due to the HIV/AIDS situation) 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.
- In 2003 Varichem Pharmaceuticals (Pvt) Ltd was granted authority to produce HIV-related drugs and supply 75 per cent of its product to public health institutions at fixed prices. By October 2003, it had marketed seven generic antiretroviral medicines (Khor, 2007).

Current level: 2006-2010

- Zimbabwe has made no commitment to GATS and its laws include all TRIPS flexibilities. The commercialisation of public services and growth of the private for profit sector make Zimbabwe open to liberalisation of its health service sector. A limiting factor is the poor purchasing power of consumers due to the current economic environment and the falling consumption of private for profit services (referred to earlier).
- Zimbabwe's *National HIV and AIDS strategic plan 2006-2010* acknowledges the need for affordable AIDS treatment and draws attention to the review of trade barriers and tariffs and the further strengthening of local production of pharmaceuticals with the aim of 'facilitating local companies to prequalify according to WHO and other standards' (MoHCW *et al.*, 2006). By 2010 Varichem Pharmaceuticals (Pvt) Ltd had achieved prequalification status for antiretrovirals.
- While Zimbabwe has protected health in formal positions at the World Trade Organisation, the liberalisation of the economy and increase in imported goods has led, *de facto*, to importing products harmful to health and not in line with national law. For example, an assessment of cigarette sales in five urban areas found low compliance with health warning labelling regulations, particularly in the 15 imported brands being marketed (Loewenson, 2010). Communities are concerned about importation and sale of unsafe foods, cosmetics and other products (TARSC *et al.*, 2011).

Progress

Zimbabwe has preserved its flexibilities in relation to World Trade Organisation agreements, prequalified a local producer of medicines and carefully protected health against trade pressures. Relatively wide commercialisation of services through medical aid societies purchasing providers and pharmaceutical companies, makes it vulnerable to wider liberalisation of the health service sector. Furthermore, wider trade liberalisation has led to unregulated imports of products harmful to health. Parliament and civil society can play a role in promoting dialogue across sectors to raise the profile of health in trade, to advocate for health-promoting trade and domestic industries supporting the health sector and to protect against the import of products harmful to health due to wider liberalisation.

Bilateral and multilateral agreements to fund health worker training and retention

Past levels: 1980–2005

- In the period, 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 was part of the African ministers caucus motivating the discussion on health worker migration at the World Health Assembly and remained actively involved in the policy dialogue on the topic. Zimbabwe participated in the Southern African Development Community dialogue and agreement on the management of migration of skilled health workers within the region.

Current level: 2006-2010

- Falling real wages in the public sector have been a push factor for out-migration and industrial action and efforts to provide incentives have not matched the pull of competitive wages in other countries (HSB, 2007).
- As discussed in the earlier progress markers, international partners provide foreign currency contributions to retention incentives for government, mission and local authority health personnel, while the Global Fund for AIDS, TB and Malaria paid salaries in 26 districts for district medical officers, district laboratory scientists and pharmacists or pharmacist technicians. UNFPA and the European Union also provided support for salaries or top-up incentives for selected provincial and district personnel (Midzi, 2008).

Progress

A number of bilateral agreements for funding health worker training are in place, including those with the following organisations: WHO on technical support, the International Association for Educational Assessment and European Union on scholarships, international partners (DfID, CIDA, UNFPA, UNICEF, Expanded Support Programme) on retention incentives and the Global Fund to Fight AIDS, Tuberculosis and Malaria on salaries (MoHCW, 2008b). As discussed earlier these agreements appear to have had a positive effect on health worker availability and retention, and impact assessment was underway at the time of writing this report. The negotiation of agreements around retention incentives could be widened to address other dimensions of the incentive regime developed by the Health Services Board and pooling resources would avoid internal tensions caused by selective incentives offered to particular categories of personnel.

Health officials included in trade negotiations

Past levels: 1980–2005

- 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: 2006-2010

- Health sector officials are not directly involved in trade negotiations which are led by the trade ministry but they are consulted by the Ministry of Industry and Trade. However, trade negotiations are having an increasing impact on health, such as in the economic partnership agreement with the European Union and negotiations on services.
- The Parliamentary Committee on Health and civil society have raised trade and health issues but these were poorly defined in health advocacy earlier in the period (Mabika, 2008).
- Greater focus has been given to global health diplomacy, including through capacity building, and the country has a senior and experienced diplomat on health in Geneva. It actively participates in and leads processes within the work of the Africa Group in health diplomacy.
- 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.

Progress

There is scope for a greater audit and more protection of health in trade agreements. There has been growing attention to this area in both law review and capacity development. Zimbabwe has recognised diplomatic capacities in this area.

PROGRESS MARKERS	STATUS AND TRENDS	PRIORITY AREAS FOR ACTION
EQUITY IN HEALTH		
Formal recognition of equity and health rights	Public debate on the constitution has raised awareness and support for the right to health. The Public Health Act was reviewed to update it and health equity is articulated in policy and in the 'National health strategy' and 'Investment case' documents.	The challenge remains in enacting legal proposals and implementing pro-equity policies and strategies. Civil society and stakeholders need to monitor implementation.
Halve the number living on less than a dollar per day	Poverty levels have risen, with continued rural–urban differentials, but also a rise in urban food poverty. Formal safety nets are weak but remittances have buffered deeper poverty.	There is need to carry out an updated poverty survey and build a more comprehensive framework for social protection.
Reduce the gini coefficient	The gini coefficient fell between 2003 and 2005 but is high in the region, with a small rise in inequality after 2005 and a small shift towards increased urban poverty and increased rural wealth after 2005.	Further evidence is needed to assess trends. High inequality in the last three decades calls for redistributive systems.
Eliminate differentials in child, infant and maternal mortality and undernutrition	Child mortality shows widening socio-economic differentials. Child under-nutrition improved after 2005 but stunting worsened, with food prices and poor harvests affecting food security. Child nutrition is associated with mothers' social and health situation.	Disaggregated information on maternal mortality is needed to identify highest risk and better target resources and measures to address supply and uptake barriers in more vulnerable groups.
Eliminate differentials in access to immunisation, antenatal care and skilled deliveries	Immunisation and maternal health care coverage fell up to 2005 and social, geographical differentials rose. Immunisation coverage had improved by 2010 but wide geographical differentials persisted. Maternal health service cover is below 1994 levels, with wide wealth, education and provincial differentials.	Sustain investment in immunisation. Interventions are needed at all points of sexual and reproductive health services, both in improving service availability and accessibility, and addressing social contexts.
Universal access to PMTCT, ART, condom uptake	HIV prevalence has fallen since 2002. It does not show social differentials but access to prevention and treatment interventions do. Attaining near universal coverage reduces such gaps. Resources are lacking for scale up, particularly for PMTCT.	Additional measures are needed to address supply, cost and access barriers to paediatric treatment, to ART treatment and to PMTCT in rural, low income populations.
HOUSEHOLD ACCESS TO RESOURCES FOR HEALTH		
Close gender differential in education	High net enrolment and gender parity is challenged by inadequate public sector resources and education costs, with falling primary school completion rates.	Need for BEAM to expand, measures to avoid female drop out and to ensure costs are affordable.
Halve the share without safe water and sanitation	Rural–urban differentials in access to safe water and sanitation remain wide. While infrastructures exist, they are old and malfunctioning and tariff structures are needed to protect poor households' access.	Investment needed in rural areas and safe water to be given higher priority.
Increase ratio of wages to GDP	Falling real wages and job insecurity. Higher profit share has not translated into investment in new jobs.	Employment, labour and wage policies and social protection schemes need to take into account high levels of insecure income.
Adequate health workers and drugs at primary level	Improved deployment of doctors and nurses to rural facilities, and significantly improved medicine supply in 2010. Inadequate tutor capacities and pharmacy and environmental health vacancies. Cost barriers, funding and management gaps affect medicine access.	Public authorities and communities need to monitor availability of personnel and of affordable medicines within primary and secondary levels.
Abolish user fees	Fee exemption policies in place but application mixed. User fees perceived as unaffordable by communities, reducing access to services, especially for poor and vulnerable households.	Enforce the user fee abolition policy at primary care level and for specified district services. Invest in services and outreach to promote uptake.
Overcoming barriers to use of services	Availability has improved but shortages of staff and supplies are most felt by vulnerable groups. Costs, information and stigma limit access but uptake and satisfaction has improved in the past year.	Outreach, health literacy, village health workers need to be extended nationally. Disaggregated information is needed on service coverage.

PROGRESS MARKERS	STATUS AND TRENDS	PRIORITY AREAS FOR ACTION
REDISTRIBUTIVE HEALTH SYSTEMS		
Achieving 15 per cent government spending on health	Efforts made to reverse significant declines in the health share of the budget now at 12 per cent but still low real value relative to need.	Continue to reprioritise health in the budget towards the 15 per cent target and at 8–9 per cent share of GDP.
Achieving US$60 per capita health funding	Per capita expenditure on health has not risen to match health sector needs, a large share is in the private sector or off budget external funds, weakening public sector leadership for equity.	Increase domestic funding to public health sector and strengthen sector-wide alignment of external funds and private sector resources.
Improve tax funding and reduce out of pocket funding for health	There has been a small shift towards increased tax funding and reduced private and out of pocket spending. No data available after 2007. Debates underway on options for domestic funding but options already identified not yet implemented.	More equitable taxes need to be identified. The benefit incidence of the different funding proposals being debated need to be assessed and options introduced.
Harmonise financing into a framework for universal access	Health financing remains segmented due to low public funding, lack of a defined basic entitlement, concerns about funding transparency and a relatively unregulated, segmented private sector largely serving higher income urban groups.	Need for improved public financing, setting basic entitlements, strengthened private sector regulation and increased sector-wide pooling of external funds.
Establish and ensure clear health care entitlements	Policy commitments have been made to define health care entitlements and while some technical work has been done on this, no defined set exists. This undermines costing, financing and regulation.	Policy dialogue is needed to establish, cost and raise awareness on a clear set of entitlements at the various levels of health services.
Allocate at least 50 per cent of public finances to districts, 25 per cent to primary health care	Relatively unchanged budget shares over 2005–2010. Various funds for districts but still limited needs-based financing (mainly demand-based) and capacity constraints to absorb resources at lower levels. Data not publicly reported by level of spending.	Need for reporting on allocations by level and spending on primary health care and prevention by curative services. Need to strengthen and monitor allocation based on health need.
Implement incentives for health personnel	Establishing a Health Service Board has improved response to health worker issues. International support for incentives has reduced vacancies.	Incentives funded by external funders need to be sustained and sector-wide incentives applied.
Recognise and support mechanisms for public participation	High adult literacy, active civil society and parliament, revival of village health worker programmes of boards and policy recognition of the role of participation have revitalised participation of communities in health from local to national level.	Health centre committees need legal recognition. Guidelines needed to support participation and resources allocated to health literacy and to support functioning of mechanisms for participation.
A JUST RETURN FROM THE GLOBAL ECONOMY		
Reduce the debt burden	Zimbabwe has a high and unsustainable level of debt and is not eligible for debt relief under the HIPC.	Debt relief would release resources critical to meet wide social deficits.
Allocate resources to agriculture and women smallholders	Zimbabwe's current allocation of 3.4 per cent is well below the 10 per cent target and the extent to which funds reach poor households, particularly women farmers, needs to be further assessed.	The low levels of household food stocks reported in 2010 suggest that greater investment may be needed in women smallholders, particularly those growing food.
Ensure health goals in trade agreements	Zimbabwe has prequalified local drug production and protected health in trade agreements but liberalisation is also opening trade in harmful products.	Ensure service commercialisation does not weaken public health and control import of harmful products.
Bilateral and multilateral health worker agreements	Key bilateral agreements for funding health worker training and incentives negotiated with UN and international agencies. Internal tensions caused by selective incentives to particular personnel.	Negotiate agreements on incentives that support the incentive regime developed by the Health Services Board and encourage external support to be in pooled funds.
Include health workers in trade negotiations	There has been growing attention to this area in both law review and capacity development. Zimbabwe has recognised diplomatic capacities in this area.	Sustain efforts to widen health diplomacy capacities; audit and protect health in trade law and strengthen public health law.

KEY Improving; Static, mixed or uncertain; Worsening

NOTE: In one case green is blended with yellow as the picture has a general direction of improving or worsening but with some mixed results.

Conclusions

Zimbabwe has a wealth of resources and potential for health – a highly literate population and rich natural, mineral and agricultural resources. It has also faced numerous challenges in the recent decade, including the continued effects of AIDS, a sustained period of political conflict, significant levels of out-migration of skilled people, a significant decline in the gross domestic product, an inflation rate in 2008 that was the highest globally, shortfalls in basic goods and a quarter of the population at risk of poverty, particularly in relation to deprivation in living standards. These conditions all threaten health, as was most visible in the 2008/9 cholera epidemic that affected around 100,000 people.

After the February 2009 'inclusive government' under a global political agreement, there are signs of recovery. Inflation has fallen, industrial capacity in the manufacturing sector has improved, goods and services are more available, and the gross domestic product per capita has risen. Early evidence suggests that land reform has widened access to economic assets and strengthened local economies. The human development index which fell markedly between 1980 and 2009 showed a small rise in 2010.

In 2008, the *Equity Watch* report spoke of a 'testing context' and challenges for health. Discussion of the 2008 report led to a demand from members of parliament and communities for the right to health to be protected and for investments in primary health care to revitalise the health system close to communities and address the causes of ill health.

This 2011 *Equity Watch* report was carried out in a more positive context. The report assesses progress made in addressing the issues raised in 2008 and in advancing equity in health. It examines trends in health outcomes, in the social determinants of health, in redistributive health systems and in the returns to health from the global economy.

Unfortunately, 2010 data are not available for many progress markers, so the trends after 2009 are not yet clear on many indicators. A 2010 household survey and other monitoring surveys suggest substantial improvements since 2009. Some of these improvements are in priorities identified in the 2008 report – primary education, medicine supplies and staffing at primary care and district levels, access to antiretrovirals and recognition and support for community capacities for health.

The 2011 report suggests areas where further research or analysis are needed to understand how changes are affecting different population groups, including:

- an updated poverty survey to inform comprehensive social protection;
- national and provincial trends in a measure of inequality, like the gini coefficient;
- social and geographical disaggregation of maternal mortality ratios;
- disaggregated information on service coverage to assess who is benefiting from better availability and whether vulnerable groups are being reached;
- the financing incidence of different options for domestic resource mobilisation;
- spending on prevention within medical care services;
- spending by level of the health system and on prevention by curative services; and
- the extent to which public resources for agriculture reach poor households and particularly women farmers.

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The wider socio-political context for health has improved although challenges remain. At a policy level, a new national health strategy that promotes equity, primary health care and the right to health reflects the policy aspirations raised in the light of the 2008 report.

Constitutional debate has raised awareness and opened up space for the right to health as has consultation to strengthen the umbrella Public Health Act. Social participation and action in health has been revitalised by high adult literacy, an active civil society and parliament, institutional mechanisms for joint planning, revived village health worker programmes and health boards as well as by policy recognition of the role of participation in health. A high net enrolment ratio and gender parity in education are key contributors to health equity.

At the same time some economic conditions and trends in social determinants threaten health equity. The evidence suggests that poverty levels have increased and inequalities in wealth remain persistently high. Although rural wealth has improved, urban food poverty has increased. Low household food stocks in 2010 suggest that greater investment may be needed in women smallholders, particularly those growing food. Further, while the share of national income to profits has grown, it has not translated into investment for new jobs, leaving many in vulnerable employment. This weakens household resources for heath but also options for income-based social protection schemes, including health insurance. Barriers to safe motherhood are evident in low levels of sexual and financial autonomy, particularly among young, mobile and vulnerable women.

Costs of education are an increasing barrier for households, leading to falling primary school completion rates for low income households and marginal groups. Social protection programmes do not have adequate resources to meet the level of demand created by these cost barriers. A decline in local industry and wide trade liberalisation have led to imports of some products that are harmful to health – cosmetics, alcohol, food, drugs and tobacco.

Safe water, a major issue in the 2008 report, hampered by old and malfunctioning infrastructure, is still inadequate in rural areas and costly in urban areas. Poverty, debt and access to safe water remain areas of poor process.

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There is evidence of progress in health outcomes, particularly in 2010 data: significant reductions in HIV prevalence; improved child mortality and under-nutrition; better immunisation coverage; and an improvement in assisted deliveries, although still below 1994 levels. The progress is recent and needs to be sustained.

There is also evidence of gaps and widening social differentials. While geographical inequalities dominated in child mortality up to 2005, socio-economic drivers became more significant after that. Child stunting remains high, with cost of food replacing supply as the major barrier after 2009, and poor child nutrition associated with economic inequalities, particularly in mothers' social and health situation. Maternal mortality levels are high and rising, and wealth, education and provincial differentials in antenatal care coverage and assisted deliveries are wide, indicating that vulnerable groups face supply, access and acceptability barriers to using sexual and reproductive services. There are social differentials in access to interventions for prevention and treatment of AIDS.

The report suggests that while improving the distribution of wealth would assist in closing these gaps, inequalities can also be closed by public sector measures to reach universal coverage, as demonstrated with primary school enrolment or voluntary testing and counselling coverage.

The health sector has a key but not a sole role to play. Many issues affecting health – such as living conditions, marketing of harmful products, employment creation, support for food production or the price of food – demand action by other sectors. If these sectors do not act, the costs to the population, especially to vulnerable groups and to the health sector, will become unsustainable. The level of debt makes debt relief important, to ensure that debt servicing does not withdraw resources from investing in this social recovery. The report suggests growing awareness of the need for wider responsibility for public health. There is some evidence that the Ministry of Health and Child Welfare is building its own capacities to facilitate this wider inter-sectoral action in its efforts to build capacities, establish partnerships, review laws and take action at primary health care level. However, limited regulatory capacities, high vacancy rates for environmental health officers and a persistently low share of expenditure on preventive services suggests that this role is still not well appreciated or supported by all within the ministry. A redistributive health sector is also vital to address the inequities noted in access to services.

In relation to availability, Zimbabwe's physical infrastructure could support universal access. The country has to address nearly a decade of negative effects from external migration and financial constraints on health worker availability and on other supplies. Service gaps still need to be addressed in new resettlement areas but concerns raised in the 2008 report about strengthening staffing and supplies to clinics and districts and negotiating incentives to retain staff have begun to be addressed. With high poverty levels and wide use of public services by poor households, public sector measures to improve availability have contributed to better coverage and reduced barriers to services in groups most needing them. Bottlenecks, such as tutor capacities for midwifery, training and deployment of pharmacy and environmental health cadres and finances, leakages and supply chain management for medicines need thus to be addressed.

This implies increased budget commitments and domestic funding. Zimbabwe has not yet met the Abuja commitment but has made some progress towards it. The overall and government per capita expenditure on health is too low to revive the health sector. Total spending on health has risen faster than government spending, indicating increased private and external funding. The report suggests that vulnerable groups depend on a stronger public sector in health and that this calls for strengthened regulation of the private sector and increased sector-wide pooling of external funds. However, even where services are available, access barriers exist – the two most commonly identified being costs of medicines and user fees, especially for low income and rural communities. Fee exemption policies have had mixed application, with informal charges and consequent cost barriers for poor households. Communities perceive user fees as unaffordable. Equity gains would arise from total enforcement of the user fee abolition policy at primary care level and for specified essential services at district level, including in urban areas. This would need to be accompanied by increased funding to services used by poor communities and in community outreach to promote uptake.

Raising the revenue for this means continuing the recent trends to increase public financing from taxes, identify further equitable taxes, define the basic entitlement and show the resources required and to address concerns about financial accountability.

Fewer barriers exist to acceptability of services with increasing information and awareness but stigma, women's lack of autonomy, religious beliefs and negative attitudes still block uptake of some services. Community reports suggest improved use and satisfaction with services in the past year. Civil society outreach, health literacy, village health worker support and health centre committees appear to have reduced such barriers and need to cover all districts, backed by legal recognition, guidelines and resources.

There is strong policy support for health equity. The major challenge is to ensure that resources from increasing wealth reach those with highest health need. Those with high health need, profiled in this report, often have the least voice. Issues raised by parliament and civil society in the last *Equity Watch* report have begun to be addressed although progress is variable. Similarly, parliament and civil society need to profile and monitor the issues raised in this report so that they remain high priority concerns, not just for the health sector but for the country as a whole.

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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. All countries in eastern and southern Africa have policy commitments to health equity, as do the regional organisations, the Southern African Development Community and the East, Central and Southern African Health Community. In February 2010, the ECSA Regional Health Ministers resolved to track and report on evidence on health equity and progress in addressing inequalities in health. EQUINET is working with countries and the regional organisations to implement the *Equity Watch*, to monitor progress on health equity by gathering, organising, analysing, reporting and discussing evidence on equity in health at national and regional level.

This Zimbabwe Equity Watch report was produced by Training and Research Support Centre and Ministry of Health and Child Welfare 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* reports of	2008	2011
EQUITY IN HEALTH		
Formally recognising equity and health rights		
Halving the number of people living on US$1 per day		
Reducing the gini coefficient of inequality		
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 of vertical transmission, antiretroviral therapy and condoms		
HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH		
Closing gender differentials in access to education		
Halving the proportion of people with no safe drinking water and sanitation		
Increased ratio of wages to gross domestic product		
Provide adequate health workers and drugs at primary, district levels		
Abolish user fees		
Overcoming barriers to access and use of services		
REDISTRIBUTIVE HEALTH SYSTEMS		
Achieving the Abuja commitment		
Achieving US$60 per capita funding for health		
Improve tax funding and reduce out of pocket spending to health		
Harmonize health financing into a framework for universal coverage		
Establish and ensure clear health care entitlements		
Allocate at least 50% public funding to districts and 25% to primary health care		
Implement non-financial incentives for health workers		
Formal recognition of and support for mechanisms for public participation in health systems		
A JUST RETURN FROM THE GLOBAL ECONOMY		
Reducing the debt burden		
Allocate resources to agriculture and women smallholder farmers		
Ensure health goals in World Trade Organisation (TRIPS, GATS) agreements		
Bilateral and multilateral agreements to fund health worker training		
Health officials included in trade negotiations		