

# **Stakeholders meeting on the Zimbabwe Equity Watch**

## **REPORT**



© UNICEF Zimbabwe

**February 23<sup>rd</sup> 2012, Harare, Zimbabwe**



**Ministry of Health and Child Welfare  
Training and Research Support Centre  
with  
Regional Network for Equity in Health in  
East and Southern Africa (EQUINET)**



**With support from IDRC Canada**

## Table of contents

<b>Executive Summary .....</b>	<b>2</b>
<b>1. Background .....</b>	<b>3</b>
<b>2. Opening .....</b>	<b>4</b>
<b>3. Trends and priorities for advancing equity.....</b>	<b>6</b>
3.1 Overview of the Zimbabwe Equity Watch .....	6
3.2 Economic trends and health equity .....	9
3.3 Health Sector Contributions to health equity .....	11
3.4 Discussion.....	12
<b>4. Enhancing universal coverage and equitable health financing .....</b>	<b>12</b>
4.1 Improving universal access to essential health services .....	12
4.2 Financing for equity and universal coverage.....	18
<b>5. Health in all policies on the social determinants of health.....</b>	<b>21</b>
5.1 Access to safe water and sanitation .....	21
5.1 Household food production and nutrition .....	23
5.3 Discussion.....	24
5.4 Strengthening health promoting production and trade.....	25
<b>6. Plenary review and next steps .....</b>	<b>26</b>
6.1 Report back from the parallel sessions .....	26
6.2 Institutionalising equity monitoring .....	29
<b>7. Closing.....</b>	<b>30</b>
<b>APPENDIX 1: Summary brief on the Zimbabwe Equity Watch.....</b>	<b>31</b>
<b>APPENDIX 1: Programme.....</b>	<b>35</b>
<b>APPENDIX 2: Delegate list.....</b>	<b>37</b>

**Cite as:** MoHCW, TARSC EQUINET (2012) Stakeholders meeting on the Zimbabwe Equity Watch Harare, Zimbabwe February 23 2012, EQUINET, Harare

Acknowledgement to Parliament of Zimbabwe Portfolio committee on Health, WHO Country office, EQUINET steering committee members: Community working Group on Health and SEATINI for their contribution to planning and roles in the meeting. Thanks to all the speakers, chairpersons, rapporteurs.

Thanks to IDRC Canada for support to the Equity Watch work and meeting and to KIT Netherlands for their contribution of a delegation from Netherlands to the meeting.

## Executive Summary

The Ministry of Health and Child Welfare and Training and Research Support Centre/ EQUINET hosted a one day meeting on Thursday 23rd February in Harare to report on and review the findings of the 2011 Zimbabwe Equity Watch; involve health and non health sector actors in identifying priorities and actions to strengthen equity in universal health coverage and action on the social determinants of health; and propose how to institutionalise health equity monitoring. The meeting involved 52 delegates from different sectors of government, parliament, civil society, private sector, technical institutions and international organisations. It was opened by the Hon Minister of Health and Child Welfare with eminent speakers from economic, health, water, food and nutrition, and trade sectors.

The meeting identified a number of recommendations and areas of follow up action flowing from the discussions on the Equity Watch report and the presentations in the plenary and parallel sessions. (The page of the report where more details can be found are shown).

Stakeholders endorsed equity as a guiding principle for UHC, as well as health in all policies. They called for strengthened consistent co-ordination of the institutions and agencies that influence the determinants of health and delivery on UHC.

Access to safe water, sanitation and food security were identified as priorities. Delegates proposed increased investments in water infrastructure, including through public private partnerships; involvement of rural communities in user maintenance groups; strengthened promotion and enforcement of by laws on environmental health and requirements for every new home to have a toilet. Urban agriculture should be encouraged; tariff and education measures used to promote traditional, local foods; and tax and tariff options used to discourage consumption of high sugar, high fat and other unhealthy foods (page 26).

Delegates proposed that greater link be made between trade and health, recognising the economic value of the health sector: Measures were proposed to revitalise the local production of pharmaceuticals; and to strengthen port health to prevent import of hazardous foods, products and medicines. It was proposed that there be active and early involvement of health officials in regional and multilateral trade negotiations (page 27).

The national stakeholder meeting proposed that the essential health service benefit/ entitlement made universally available to the whole population be updated, and include also community roles and the inputs of other sectors in primary health care. An updated benefit package should take into account the population health profile, views of communities and other sectors, and should cost the agreed benefit (p27).

Delegates agreed on principles of health financing: that financing should be progressive, should not burden the poor, and should take account of stakeholder perceptions. Progressive taxes should be the main source, linked to consumption, to high growth areas of the economy and to activities that generate health burdens. Options to be explored included shares of VAT, sin taxes (on spirits, beer, cigarettes, high sugar and high fat foods, road tolls) and earmarked taxes on areas of high economic growth. Prepayments by communities should replace user fees. These should not be used for essential health services, which should be covered from taxes, but for quality improvements, defined locally and with funds managed locally (p28).

It was proposed that the Equity Watch be institutionalized and repeated in future with the involvement of other sectors, with indicators also identified for annual monitoring in the routine information system. Specific additional areas for equity analysis were identified. (page 29).

## 1. Background

The Ministry of Health “National Health Strategy 2009-2013” raises universality, equity and quality as central principles. The principle of universality calls for measures that ensure that the population all have access to health interventions and services, while the principle of equity calls for measures to close avoidable inequalities in health and in access to the resources for health, allocated in relation to health need. Closing inequalities in health calls for action on the social determinants of health, to address the causes of ill health that exist in people’s living, working and community environments.

In 2008 and then again in 2011 Zimbabwe implemented an Equity Watch, to gather and organise evidence on progress in health equity and measures to improve equity, to promote dialogue on the findings and the implications for policies and actions to strengthen health equity. An Equity Watch is a means of monitoring progress on health equity by gathering, organizing, analysing, reporting and reviewing evidence on equity in health.

Equity Watch work is being implemented in countries in East and Southern Africa in line with national and regional policy commitments. In February 2010 the Regional Health Ministers Conference of the 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.

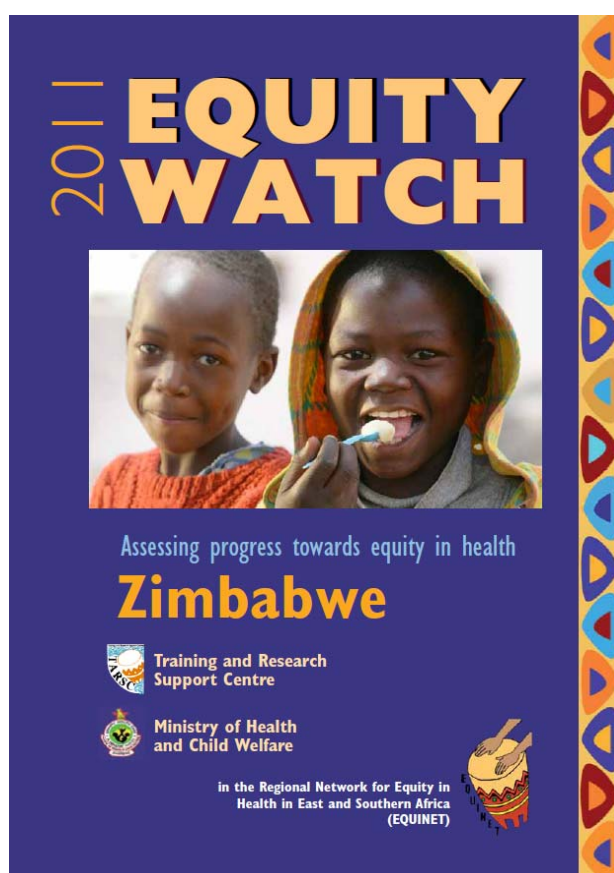
The 2011 Zimbabwe Equity Watch report was completed in November 2011 and updates the 2008 Equity Watch report. It shows past levels (1980–2005), current levels (most current data publicly available) of health, health services, social determinants of health in terms of the dimensions of inequality that need to be addressed and the progress in addressing them. It presents recommendations based on an analysis of information available.

A summary of the Equity Watch

findings is presented in Appendix 1, and the full report is available at

<http://www.equinetafrica.org/bibl/docs/Zimbabwe%20EW%20Nov2011%20lfs.pdf>.

The areas of progress and the gaps both point to the fact that the health sector has a key, but not sole role to play. To address inequalities in health the health sector needs to ‘get its own house in order’ to put in place or sustain implementation measures within the health sector for universal health coverage with equity. However many of the drivers of inequality in health demand policies and actions by other sectors. If these sectors do not act, the costs to the population, especially vulnerable groups, and to the health sector will become unsustainable. In June 2011, WHO and MoHCW held a meeting of government ministries on the social determinants of health.





To engage stakeholders in addressing these opportunities and challenges to improving equity in health Ministry of Health and Child Welfare and Training and Research Support Centre/ EQUINET hosted a one day meeting on Thursday 23rd February 830am-5pm at Bronte Hotel Harare. Input to the planning and the meeting was also made by the Parliament committee on health, EQUINET steering committee members (CWGH, SEATINI), WHO and PHAB members.

The one day stakeholder meeting aimed to

1. report on and review the findings of the 2011 Zimbabwe Equity Watch.
2. involve health and non health sector actors in identifying priorities and actions to strengthen equity in universal health coverage and action on the social determinants of health;
3. propose how to institutionalise health equity monitoring and reporting.

The programme for the meeting is shown in Appendix 2 and the delegate list in Appendix 2

## 2. Opening

Hon Dr David Parirenyatwa, Chair of the Parliament portfolio committee and Health and Dr Davies Dhlakama, Acting Permanent Secretary in the Ministry of Health and Child Welfare welcomed delegates and chaired the opening plenary.

The Hon. Minister of Health and Child Welfare Dr Henry Madzorera opened the meeting. He observed that over thirty years ago, the signatories to the Alma Ata declaration noted that health for all would contribute both to a better quality of life and to global peace and security. But more than thirty years later, the vision of health for all remains a pipe dream.



Minister of Health and Child Welfare Dr Madzorera opening the meeting

“More than thirty years later, our people are still dying of primitive infectious diseases like typhoid and cholera. More than thirty years later, 725 women are dying whenever 100 000 babies are delivered. The major problem is generalized poverty, gross inequities and lack of access to quality health care in its broadest sense to include health promotion, prevention and curative services, and rehabilitation, and a lack of prioritization of health care and health financing by our governments.”

The Minister welcomed delegates noting that equity in health is a central policy principle for government, and has been since 1980. Zimbabwe was the first country to implement the Equity Watch, producing the first pilot report in 2008. He observed that the 2011 Zimbabwe Equity Watch report, makes it possible to track progress since the first report of 2008. Minister Madzorera reported evidence of progress, particularly in 2010, in significant reductions in HIV prevalence; improved child mortality rates and decreasing levels of under nutrition; better immunisation coverage; and some improvement in assisted deliveries. This progress needs to be sustained.

He however observed some evidence of gaps and widening social differentials. Child stunting and mortality shows wide differences across mothers with different social and economic conditions. Maternal mortality levels are high, with wide wealth, education and provincial differences in antenatal care coverage and proportion of assisted deliveries. Women from wealthy households have double the level of deliveries assisted by a skilled health worker. There are social differentials in access to interventions for prevention and treatment of AIDS.

The minister pointed to the underlying causes in a highly unequal economy “By 2005 it was found that the richest 10 percent of people had 22 times the wealth of the poorest 10 percent”. He noted that these economic differences lead to differences in access to healthy living environments, diets, levels of exposure to disease and in people's vulnerability to illness. The 2011 Equity Watch “shows that if your mother had secondary education in 2009, you had half the risk of dying as a child and a third the level of stunting”.

He made clear that the health sector has a duty to ensure that every one should access to a basic level of health care. The Ministry has begun to strengthen staffing levels and supplies to clinics and districts, and to support services at community and clinic level. The recently launched Health Transition Fund aims to usher in a new era of free health care for pregnant mothers and children under five. The Ministry is fully aware of other barriers to access, particularly in remote rural areas but will work at these, one barrier at a time. He particularly looked forward to a time when we will be able to secure these kinds of gains with domestic financing’.

“We will not solve this overnight, but the journey of a thousand miles begins with one step. Your contribution today is a further step in defining the principles, mechanisms and options for generating improved adequate and sustainable funding, and translating this in to visible improvements in access to health care. Let us think outside the box and not allow present reality to stifle our imagination.”

The Minister drew attention to fee policies introduced in the structural adjustment programmes that despite promises of additional revenue, improved efficiency and improved access to care did not yield gains. *“The only lesson we learnt from 20 years of user fees is that taking money from the poor when they are sick is not a good idea. Policy flip flops have dragged Africa many centuries backwards, and I do hope this meeting will come up with evidence based policy recommendations to government”.*

“The Ministry of Health and child welfare is very clear that user fees must go. But we need sustainable domestic financing to realize that vision, and this is part of your homework today at this equity conference”.

The Minister noted that the Equity Watch has been useful for tracking our policy commitment to health equity and looked forward to suggestions on how we institutionalise equity monitoring and review in the future. He thanked TARSC, EQUINET, MoHCW, IDRC and all those who worked on the meeting and wishes the delegates productive deliberations.

Following the Ministers speech delegates introduced themselves. Dr Gibson Mhlanga, Director of Preventive Services. MoHCW also welcomed delegates and introduced the aims of the meeting as outlined earlier.

### 3. Trends and priorities for advancing equity

#### 3.1 Overview of the Zimbabwe Equity Watch

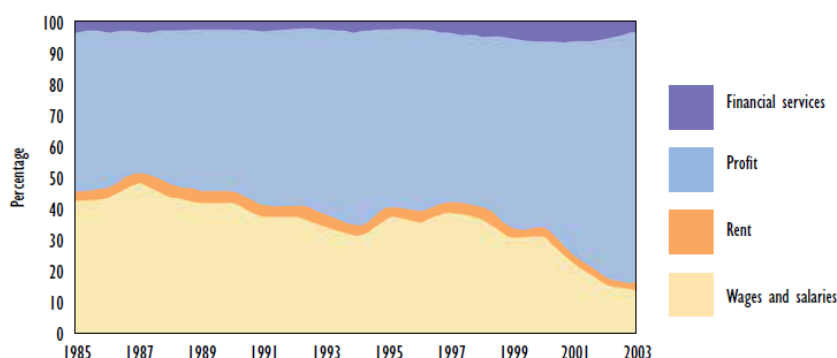
Dr Rene Loewenson, Director TARSC and cluster lead for the Equity Watch work in EQUINET introduced the Zimbabwe Equity Watch. The report was tabled with delegates at the meeting. In 2010 the Health Ministers in the ECSA Health Community in Resolution: ECSA/HMC50/R9 urged member states to report on evidence on health equity and on progress in addressing inequalities in health and called for strengthened capacities and measures to monitor and report on progress in addressing inequalities in health. The Equity Watch was initiated as a regional process by EQUINET in 2008. The first pilot report was done in Zimbabwe, who led the process in the region. The Equity Watch aims to

- Map and assess trends in inequalities in health, social determinants of health and health care and their causes
- Monitor progress on actions taken to improve health equity, particularly against commitments; and
- Share evidence for national dialogue on options for strengthening health equity, areas for research and regional exchange on challenges and promising practice;

The work has now been repeated in other countries in the region, a regional equity watch is being produced in 2012 and a regional meeting will be held to review the experience and proposals for developing the work further. Dr Loewenson acknowledged the role of government, technical institutions, civil society, parliaments, and UN agencies in advancing the work, including in planning the Zimbabwe stakeholder meeting.

She noted that the wider socio-political context for health has improved although challenges remain. *“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 health but also options for income-based social protection schemes, including health insurance”.*

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



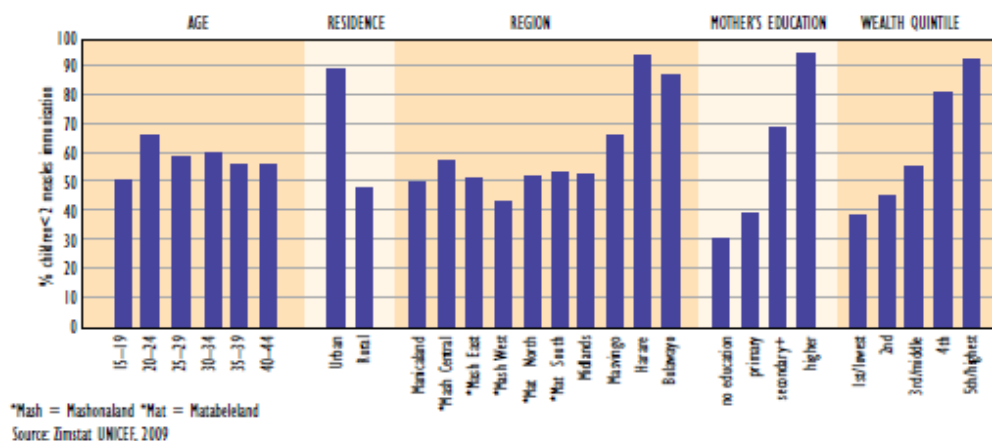
Source: CSO National Accounts in UNDP Zimbabwe, 2008

Source: Zimbabwe Equity Watch 2011

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. 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.

**Figure 6a: Births attended by skilled health personnel**



There are a number of barriers to households accessing the resources for health: While there has been improved school enrolment, and high gender parity, there has also been lower and more unequal completion rates and cost barriers at secondary school. Safe water is still inadequate in rural areas and costly in urban areas. Current rates of progress on safe water in Africa means that the MDG would only be reached by 2076. There has been falling rural and urban access to safe water with levels of access 80% higher in highest than lowest wealth group. Community monitoring suggests greater reliance for food on commercial supplies, while 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.

Dr Mhlanga outlined the findings of the report on health systems. Health systems that advance equity are organised to provide universal coverage and redistribute resources to needs. They have a primary health care orientation, preventing or ameliorating health damage caused by disadvantage through population health, intersectoral action and PHC. They empower people and involve them and their organisations in decisions and actions on health.

In relation to availability, Zimbabwe's physical infrastructure could support universal coverage. 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 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. He also noted the need for the sector to track expenditures by level of care, as is being done in other countries.

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.

Dr Mhlanga concluded by introducing the priorities raised by the report that would be discussed at the meeting, including

- safe water
- food security
- trade and health
- access to essential health services, and
- equitable health financing.

PROGRESS MARKER in <i>EquityWatch</i> reports of	2008	2011
<strong>EQUITY IN HEALTH</strong>		
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		
<strong>HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH</strong>		
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		
<strong>REDISTRIBUTIVE HEALTH SYSTEMS</strong>		
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		
<strong>A JUST RETURN FROM THE GLOBAL ECONOMY</strong>		
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		

### 3.2 Economic trends and health equity

Mr A Mushaniga, Executive Secretary of the National Economic Consultative Forum, presented an outline of the manner in which economic trends are affecting health equity.

Mr Mushaniga noted that the Zimbabwean lost its position within the SADC and globally and now faces the challenge to climb back. As already known, Zimbabwe's economy was the second most industrialised and second largest in the SADC region. Official 2010 GDP figures show the GDP as \$6.7 billion, less than 2.5% of South Africa's GDP and less than that of Zambia, Namibia, Botswana and Swaziland. The steps for recovery include creating a favourable investment climate, exploiting the quick wins in mining, agriculture and tourism in the short term, restoring manufacturing including rebuilding and boosting the pharmaceutical industry while exploiting economic integration in the medium term. The projections for the growth outcomes summarised below.



Mr Mushaniga NECF

Zimbabwe GDP Growth projections based on \$10 Billion in Year 0

Growth Rate	US\$ Billions						
	10 years	15 years	20 years	25 years	30 years	35 years	40 years
10%	25.94	41.77	67.27	108.34	174.5	281.02	45.26
12.5%	32.47	58.52	105.45	190.02	342.43	617.08	1111.20
15.0%	40.45	81.37	163.66	329.19	662.21	1331.75	2678.86
20.0%	61.92	154.07	383.37	953.96	1273.76	5906.67	14697.71

At an average 10% GDP growth it will take Zimbabwe 25 years i.e. up to 2036 to reach the \$108.34 Billion mark. Investment depends on a favourable investment climate and low country risk. leading to the summary table below of FDI inflows by country (US\$ Million). Zimbabwe and Malawi have lower levels of FDI in the region. Given that Namibia has discovered large offshore oil resources with exploration work by Delta and Enigma in progress, that Mozambique is going to the world's largest coal hub concentrated around Tete, Botswana is rapidly industrialising as Zimbabwe now has a trade shortfall against it and that Zambia has a Chinese funded \$2 Billion power project to boost the copper belt and industry in general, the economies of Zimbabwe and Malawi look likely to be further dwarfed in the next 3 to 5 years unless there is a deliberate decision to transform the economy. The diamonds which propelled Botswana do have a major role to play. However, energy is a restriction to growth. Local power generation can hardly deliver a consistent 1200 MW compared to South Africa's steady 40 000+MW. Zimbabwe's low energy content will not allow the growth of the economy with the current industry structure which requires lots of energy. Options include creating low energy diamond industries such as diamond polishing, chemical, textile and food industries; other low energy industries from food to textiles; becoming the centre of the south to north SADC transport hub with a dry port located in Harare and becoming the region's ICT centre by developing a Silicon Valley type structure at the Victoria Falls.

To advance the country needs

- one clear economic vision and an identified economic target
- clear time framed action plans

- restoration of business confidence by dealing with banking sector legacy issues(demonetization of the Zimbabwe Dollar and FCA balances); ensuring a culture of good corporate governance; ensuring policy consistency and predictability; incentivizing the saving public to return to formal sector banking by offering good interest returns and deposits guarantees and eliminating corruption
- resources to be channelled into infrastructure development, particularly power generation; rehabilitation of rail infrastructure, air transport, and the road trunk system, including through concessions/exemptions/PPP;
- to transform land from being dead capital to collateralized capital to revitalise agriculture and food security;
- to ensure that laws are investment friendly and base wage negotiation on labour productivity.
- to create a framework to bring investment for value addition plants in platinum, diamonds, cotton soya, leather, beverages from fruits , pharmaceuticals
- to promote growth of the economy by increasing participation of the previously disadvantaged.

He noted that it is important to work towards a holistic approach to empowerment and indigenization that will transform the economy by reducing poverty, promoting broad based/pro-poor economic empowerment and indigenization, creating massive employment; democratising the means of production and attracting FDI. This must also facilitate key social goals, like attaining the MDGs.

“The development of the economy should be cluster based underpinned by value and supply chains for equitable national growth. The clusters should be based on comparative and competitive advantage e.g. Mutare could be the diamond hub, Ngezi- Selous the platinum Hub, Gokwe the cotton hub, Mashonaland the tobacco hub,etc.

Collaboration can be built through economic blueprints, investment promotion, fiscal initiatives, infrastructure development and key national events, with national objectives going beyond partisan interests. Economic dialogue and think tanking is therefore very critical for any developmental process. The partnership between public and private sectors should be a natural phenomenon not an exception. Recent and current economic and financial crises in the world has further driven this point home”.

Mr Mushaninga noted that all these issues require healthy people and an ailing economy compromises health, health care, education and other assets. Health is also a productive sector. Zimbabwe up to 2004 had a pharmaceutical sector that was second only to South Africa in the whole of Africa manufacturing 80% of the local medicine requirements, health services that were a referral point for other countries and specialist personnel. Today user fees have been a barrier to local use of services, and funding is needed to rehabilitate services used the low income communities, but also for the whole health system. Primary health care is a primary focus given its role in bringing people into the system.

*“Given the challenges the economy is facing, it will be difficult to expect Zimbabwe to meet the Abuja commitment on 15% government budget to health. The inadequate per capita expenditure on health will be a feature for some foreseeable future until the economy has picked up. The resources from donors have to be properly managed so that the less fortunate have access to health services”.*

Mr Mushaninga called for a collective approach to rebuilding the economy and the health sector, so that it served all population groups, young, adult productive and elderly. While the older groups liberated the country politically, he noted it was the productive adults that now needed to ensure economic prosperity He proposed an agenda of ‘Economic prosperity for a healthy nation’, noting also that health is critical for any of the economic sectors to function.

### 3.3 Health Sector Contributions to health equity

Dr Davies Dhlakama, Acting Permanent Secretary in the Ministry of Health and Child Welfare presented an outline of how the health sector is contributing to health equity.

He used the definition of equity in health provided by EQUINET, that implies addressing differences in health status that are unnecessary, avoidable and unfair. He observed that most of the events that lead to differences in health status and care are not within the health system, but that whatever the causes, those who fall sick end up with the health sector. Therefore the health sector has to find ways of addressing these differences. Policy documents show that Government has a commitment to addressing inequities, including Planning for Equity in Health (1980); the National Health Strategy for Zimbabwe 1997-2007: Working for Quality and Equity in Health and the National Health Strategy for Zimbabwe 2009–2013: Equity and Quality- A People's Right. In all Ministry Policy direction documents equity in health and health care is a central policy principle and core value.



Dr Dhlakama and Dr Mhlenga, MoHCW

Operationalizing this for the health sector implies a number of actions, including addressing inequitable access to services. The Ministry has a policy of no user fees for services for those earning below \$400, of reducing distance to health services so no-one is more than 10km to nearest health facility, backed by outreach services for those that live very far from health facilities. Waiting mothers homes have been built for pregnant mothers, and improved referral through provision of ambulance services. Inequitable access to quality care is also addressed by strategies to ensure that people get the right care at the right time from appropriately trained health provider, through a package of care defined for each level of care. Incentives are used to attract health workers to remote areas and outreach services include specialists, such as district doctors/ eye camps. In the current environment, Ministry is reinforcing the user fee policy, with special emphasis on under 5s, pregnant mothers and the elderly, and mobilizing resources to remove the excuse of charging fees at clinic level. A cellphone is provided for each clinic to strengthen referral and surveillance and provision of ambulances being improved. Ministry is using “quintile” data in DHS and other reports to target interventions. The Ministry is recommitting to Primary Health Care principles and community empowerment by strengthening Health Committees and the VHW programme.

Ministry is revisiting the core package of services for each level of care including data collecting tools, has reviewed the Public Health Act and reviewed the personnel

establishment to be in line with increased burden of disease. Health workers are also being trained in sign language to communicate with those with hearing disabilities. However Dr Dhlakama reiterated: *“The forces that produce health inequity are beyond MOHCW . The Ministry is and should work with other sector to address the social determinants that are leading to inequalities in exposure and vulnerability to disease, and thus the unequal health outcomes that are still found in Zimbabwe”*.

### **3.4 Discussion**

Hon Dr Parirenyatwa chaired the discussion. In the discussion, delegates observed that the speakers had presented policies that support equity, and evidence that suggests that these are not being applied, with consequences for equity. They questioned the extent of policy implementation.

For example there was a debate on the non application of the policy that user fees should not be charged at primary care level. Delegates pointed to reasons why the policy is not applied, such as the fact that local authorities are not getting grants to cover replacement of fee revenue. While Ministry of Health has provided staff and medicines, they note that there are other costs incurred. The issue of resourcing policies to support implementation was regarded as key. Ministry of Health is now using the Health Transition Fund and allocations from the Ministry of Finance to support the costs of maternal health services, so that deliveries and other services can be provided without charge. It was pointed out that rates have been used to fund health, and suggested that communities, local authorities, central government all have a duty to contribute to health, with local level mechanisms to identify those not able to pay. Other proposals were made to ensure policy implementation, such as to pass a regulation prohibiting fees. In the debate, issues were raised that needed follow up, such as defining and costing the health services that would be guaranteed. It was noted that the discussion would be taken forward in the parallel session.

One of the delegates raised that while services and institutions debated about resources, there is a deeper problem of resources and debt within the community. The build up of unpaid water charges is one example of this. It was noted that disconnecting the water supplies of those that owe money punishes vulnerable groups and pushes people to use unsafe alternatives for drinking water, leading to disease and costing even more than the unpaid bills.

These issues and others were carried forward as the meeting divided into two parallel sessions on advancing equity:

1. Enhancing universal health coverage and equitable health financing; and
2. Health in all policies on the social determinants of health.

## **4. Enhancing universal coverage and equitable health financing**

Mr Shepherd Shamu, University of Zimbabwe/ TARSC and Mr Itai Rusike Community Working Group on Health chaired the first session on improving universal access to essential health services.

### **4.1 Improving universal access to essential health services**

Dr L Mbengeranwa, Zimbabwe Health Services Board, gave a background to the current situation in health services, noting the inequitable health care delivery system inherited at Independence in 1980. Governments policy on Planning for Equity in Health in 1980 sought to respond to this and the Primary Health Care (PHC) approach was the main



means of delivery. PHC is “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self reliance and self determination”. PHC in Zimbabwe has been backed by a movement of health professionals and institutions, government and civil society organisations, researchers and grassroots organisations as the basis for improving universal access to essential health services. Reducing exclusion and social disparities in health is a central feature of this policy, organising health services around people's needs and expectations (service delivery reforms); integrating health into all sectors (public policy reforms); and pursuing collaborative models of policy dialogue (leadership reforms); including through increasing stakeholder participation. He thus observed that the main investments needed to support this are in

- Ensuring that primary care and other services are provided and accessed by all irrespective of their gender, age, caste, color, urban/rural location and social class.
- Involving communities
- Ensuring adequate numbers and distribution of trained medical staff.
- Using technology that is accessible, affordable, feasible and culturally acceptable to the community, such as refrigerators for vaccine cold storage.
- Recognising the many sectors that are equally important in promoting the health and self-reliance of communities e.g agriculture for food security and education, as was made clear in the National Stakeholder Workshop on Social Determinants of Health Report in June 2011.

Dr Mbengeranwa outlined the current organisation of health services in terms of the major stakeholders, the organisation and management of public health services at community and primary care clinic level; the secondary level district health services and team, the tertiary provincial health services and teams and the central hospitals with their management boards He outlined the services provided at each level, as shown in the box below:

<b>Services at primary, secondary tertiary and quaternary levels</b>	
<b>Primary Health Care Service</b>	
<b>i. Community Levels</b>	
<ul style="list-style-type: none"> <li>• Network of Community Health Centres and Community Health Workers</li> <li>• Link between community and local health service</li> <li>• Role fundamentally promotive, educative and preventive.</li> <li>• Treatment of simple disease conditions – malaria, diarrheal diseases.</li> <li>• Disease surveillance for enhancing information systems.</li> </ul>	
The effectiveness depends on: adequate numbers; well trained and motivated Village Health Workers / Health Promoters; with necessary supervision and Incentives and logistical support – drugs kits etc.	
<b>ii. Primary Rural Health Centres</b>	
<ul style="list-style-type: none"> <li>• Comprehensive promotive, preventive, curative and rehabilitative care concentrating on:</li> <li>• Maternal and Child Health;</li> <li>• Family planning;</li> <li>• Nutrition;</li> <li>• Routine immunisation;</li> <li>• Environmental sanitation – small scale water supplies and excreta disposal;</li> <li>• Control of communicable diseases;</li> <li>• Mental illness, eye diseases, physical and mental handicap;</li> <li>• General curative care, oral health</li> </ul>	
The effectiveness depends on: geographical access, ie within walking distance and available public transport; financial access – affordable fees, free service for under fives and those over 65 years, affordable maternity services; and adequate staffing with at least 2 nurses including a midwife.	

### **District Health Services**

Rural Health Centres refer to District Hospitals.

#### **iii. District Hospitals Provides:**

- Referral facilities for Rural Health Centres.
- Supervisory support to network of clinics and rural health centres
- Comprehensive preventive and curative services – medical and surgical
- Patients should have their first contact with a Doctor at this level.
- Most Rural District Hospitals are run by Missions. Some place more emphasis on curative care and less time devoted to preventive health programmes.
- Most Local Authorities have a mix of Primary Care and Maternity Clinics.

Large cities have no provision for District Hospitals due to funding constraints.

This poses a problem for the Tertiary Health Care Services which end up doing PHC work at the expense of very sick patients.

### **Provincial and Central Hospitals**

#### **iv. Provincial Hospitals** provide referral support to District Hospitals.

- ALL train Nurses and or Midwives
- Acute care for serious illnesses and injuries
- Hospital Emergencies
- Should provide for specialised care e.g Cardiology; Urology; Dermatology; Skilled attendance during child birth; Intensive care; Medical imaging services and **advanced** medical investigations and treatment
- Examples of Tertiary Care are: Cancer management; Plastic surgery; Advanced neonatal services and complex medical and surgical interventions.

#### **v. Teaching Hospitals (Quaternary Services)**

- Sometimes an extension of tertiary care in reference to medicine of advanced levels not widely accessed.
- Experimental medicine and some types of uncommon diagnostic and surgical procedures only offered in a limited number e.g Parirenyatwa and Mpilo.

For an effective Tertiary and quaternary Care there is need for adequate number of specialists to cover all essential disciplines: Medicine, Anaesthetics, Surgery, Obstetrics, Paediatrics, Haematology, Pathology, Radiology, Physiotherapy. They can become dysfunctional due to lack of specialists such as in Mpilo Hospital

Dr Mbengeranwa identified the current challenges to universal access to essential health services as geographical, cultural, financial and logistic, ie in inadequate staff, continuity of staff, drug supplies, equipment and transport. He proposed some tentative solutions:

“In terms of geographical access, it would be important to ensure adequate numbers of Primary Care Clinics within walking distance, backed by a functional public transport system and a viable road network. In relation to financial access, there is need for a consistent policy on affordable free Primary Health Care, particularly for the vulnerable: for maternal and child health, for elderly people, and for chronic ailments such as diabetics, hypertension and HIV and AIDS”.

He noted that the manpower recruitment freeze in the face of inadequate staff establishment has led to inadequate manpower for all levels, including Community Health Workers – where there is need for better selection and better Incentives – at clinics, especially in terms of nurses trained in midwifery skills and environmental health workers; at district hospitals – where there is need to ensure adequate District Medical Officers, Government Medical Officers and midwives and at provincial and central hospitals in terms of the provision for specialists in all essential disciplines. However he also noted the ineffective use of personnel, such as when minor ailments are treated at central and provincial hospitals at the expense of critically ill patients.

He noted that in the early 2000s, the MoHCW conducted studies to identify and cost of core health services at the various levels of care to assess the viability of financially guaranteeing these services. The Ministry identified core health services as:

- Those interventions for conditions treatable at the primary care level;
- Environmental health and disease control measures;
- TB follow up treatment;
- Antenatal and uncomplicated deliveries; and
- Health education within communities

*“Unfortunately these entitlements are still to be defined. Civil Society through TARSC and CWGH proposed that a package of essential services and resources be defined and costed at Primary Health Care level and priority be given to funding these. There still need for a consensus on what these essential health services are. Communities should have a role in deciding what is essential.*



Delegates, Mr Mlilo CHRA, Dr Mbengeranwa, ZHSB, Mr Mujiri MoHCW

*To move forward there is a need for a consensus on what is essential health care. Communities should assist government in determining this. The decision on what is essential should also take disease trends into account. This analysis should be used to examine options for adequate budget and logistical support for these services, to reduce reliance on external funders. These services also need to be backed by skilled personnel, retained within the system through attractive salaries and conditions of service, supported by communities and with duties to report on their activities”.*

Mr Alexious Zindoga, National Council for Disabled Persons of Zimbabwe (NCDPZ) gave a dissuasive comment on the issue of access to health services.

He observed that universal access to essential health services means getting health care you want when you want it at a cost you can afford. However there are challenges to this. In Zimbabwe the unemployment rate is almost 70 -80%. Very few are people are on medical aid, the costs of which are exorbitant. The majority thus have to pay for services from out of pocket expenses. In rural areas some even trade the few animals like goats, cattle, chickens further impoverishing them, in order to access health

Ante-retrovirals (ARVs) have started at central levels but decentralization to local services is very slow. Although in principle the ARVs are free, very few people have money for transport to go and collect the medication. In the end they either do not access or get the medication for few months and default, causing drug resistance. This means most of the vulnerable populations do not have access to ARVs.



Mr Zindoga, NCDPZ,  
Mr Heijnen, KIT

*"In the Budget monitoring and expenditure tracking report from CWGH, focus group discussion participants in Tsholotsho indicated that at times they share tablets with neighbours when they cannot get the tablets. However they noticed that when the neighbour goes for review at times they come with new set of medication and it becomes difficult for them to share from new regime. They do all this out of desperation because they have no access to the life saving medication".*

There has been a challenge of reactive regimens of anti retrovirals that need to be replaced with regimens that have less side effects but this is taking too long to be addressed because of the unavailability of the alternative drug which is expensive for the government and the beneficiaries. The side effects are sometimes adverse that some people are being hospitalized for various ailments such as deep skin rashes. CD4 machines in Zimbabwe have had a record of being non functional (Chitungwiza from Dec 2011 to January 2012) and those that are working are overwhelmed with endless queues delaying putting many patients on ART, jeopardizing their health. Even the process of changing the drug regimens has become a challenge for there is now a need for CD4 count which requires payment. At an OI centre there is one doctor e.g. Chitungwiza who only attends to 20 patients per day. The delays the whole process of commencing people on ART.

Mr Zindoga pointed to the crisis of maternal mortality and the poor progress being made in addressing it. Although Health Committees in rural areas are embarking on initiatives to construct waiting mothers' shelters, he said that there are still challenges of mothers who are giving birth at home under the care of unqualified midwives. They are resorting to that because the maternity fees are unreachable. Some people have resorted to unauthorized traditional healers and herbalists for any kind of ailment including HIV and AIDS. The user fees have become prohibitive in as far as universal access to health services is concerned. He also noted that in rural areas while the distance from health facilities is recommended to be 8 km, some women are travelling much longer distances to be assisted by a midwife.

He expressed disappointment that the promise by the Ministry of Health and Child Welfare in 2003 at the National Congress of NCDPZ to have placed sign language interpreters at all provincial and district hospitals by August 2008 has not yet materialized.

"Most of the health infrastructure has been designed without persons with disabilities in mind and hence the environment becomes disabling worsening the situation and defeating the motive of universal access to health services at health centres. Provision of mobility appliance has become a two fold challenge, that is the costs of getting the appliances is very high and availability. Parirenyatwa Orthopaedic centre has had breakdown of equipment since October 2011. Further, most people with disabilities are not employed and cannot afford the user fees charged at health centres".

He raised other shortfalls in access including in access to public toilets in urban areas. However he suggested that most critical is the presence of legally recognised public accountability structures that are empowered to monitor local government. Health Centre Committees and Budget monitoring and tracking structures can be responsible for public accountability at health centres. They can be a bridge between the community and health workers to equitably distribute the resources and services at a particular health centre.

Mr Zindoga proposed that Zimbabwe intensify its efforts to meet the Abuja commitment and improve the overall level of public spending to meet commitments in AIDS, maternal and child health and other areas, integrating these services within health care and not as parallel programmes. This needs to be backed by health being recognised as a right in the constitution. The decentralisation of services and outreach to communities needs to be expanded. He further urged that municipalities need to resuscitate all the public toilets and make them accessible free of charge as it is the residents' right to have those services.

After the presentations participants discussed three questions relating to the issues raised:

- i. *What do we consider to be essential health services that should be universally available?*
- ii. *What are the key gaps in access that we need to address, for whom and how?*
- iii. *How should we regularly track, report and act on delivery of and equity in access to these services?*

The co-chairs observed the gaps in urban PHC, the over-reliance on external funders leading to programme rather than system development and the gaps in formalising community participation.

There was some discussion of fee charges, such as for urban toilets, that was referred to the next session. It was raised that we need to be clear what the essential services. The minute the local level, such as the clinic fails to provide the service and people start to look elsewhere for services, inequities become an issue. What are the things people should expect at each level?

In the discussion it was noted that while the Ministry has its understanding of the essential services, these need to be updated, community views need to be included and guided also by the pattern of health needs and the capacity of the system to deliver on these, not just through curative services but also through prevention and promotion services. We also need to define family and community roles. It should include an EHT in every health institution. The current 42% coverage is inadequate and ironic given that we have graduates that are not employed. Permission has so far only been given to employ 12 EHTs in the public sector, despite the massive need. We need to include the necessary services provided by other sectors for health and avoid short term remedies. For example it is necessary to comprehensively address the issue of safe drinking water and align external funder to this than to rely on providing aqua tablets for water treatment. Households need sugar, salt for ORT, not ORT packages from outside. The basic fundamentals need to be addressed.

Making the services clear and costing them also calls for diagnostics and medicines and thus the revival of the pharmaceutical industry for local production of generic medicines. This must be a key element of universal health coverage with equity as medicines costs are a big driver of charges and a burden in poor communities.

Delegates cautioned that we need to recognise that we are in transition, and to provide for what priorities we will guarantee in the short, medium and longer term, within a stipulated period. The current strategic plan expires in 2013 and was developed soon after the crisis as a strategy to resuscitate the health sector. It is likely to be extended to 2015 to align it to other national policy documents, but will be reviewed in 2012 and the essential services and longer term steps brought into this review, prioritising the community, primary and district levels. The Ministry of Health pointed out that the district core health services handbook spells out what should be available at each level of care to district level including equipment and human resources. This needs to be reviewed and new developments captured. We can include provincial hospitals later.

In terms of tracking equity in universal access to services the Equity Watch was identified as a good initiative, and that within it we can define and track the areas of universal access that are prioritised. Delegates thus advocated for the process to be taken forward. Indicators can be reviewed to capture the diversity of issues that we have been discussed at the stakeholders meeting, such as access to energy sources. It was noted that noted that ZIMSTAT gathers community level indicators through household surveys; MoHCW tracks parameters within the health system through the health information system. Specific surveys at community level can also be implemented. Delegates endorsed that leadership should come from MoHCW.



Finally it was noted that inequities are a result of issues outside the health sector. It's the role of the MoHCW to sensitise other sectors in the causes of causes and to work with the relevant sectors to define what is the minimum each ministry should do to ensure health.

In summary it was concluded that there is a framework for the essential package in the MoHCW that can be the basis for review. The public health burden, community perceptions and roles and the roles and inputs of other sectors key to health and of the private health sector should also be factored in reviewing the framework. The package should be defined at each level of care with steps and deliverables (timelines). Gaps in infrastructure, medicines, health workers, transport and environmental health need to be looked at. Services defined as essential should be domestically funded. The MoHCW can continue to use the Equity Watch to track equity in universal access to services, working with Zimstat and others, as well as to link equity tracking to national health information system.

## 4.2 Financing for equity and universal coverage

Dr Gibson Mhlanga MoHCW, Dr Rene Loewenson TARSC/EQUINET chaired the session on health financing.

Mr Shepherd Shamu, University of Zimbabwe/ TARSC gave an input on priorities, principles and options for equitable health financing. He noted that there is evidence in the Equity Watch that households have very different capacities to contribute to health, with the ratio of salaries/wages to GDP has going down from 49% in the pre-ESAP to 29.9% for the period 1997-2003, large wage differentials (100:1) between top executives and the lowest paid worker and socioeconomic (wealth, education) differentials rising relative to geographic in service coverage.

He raised the key questions as

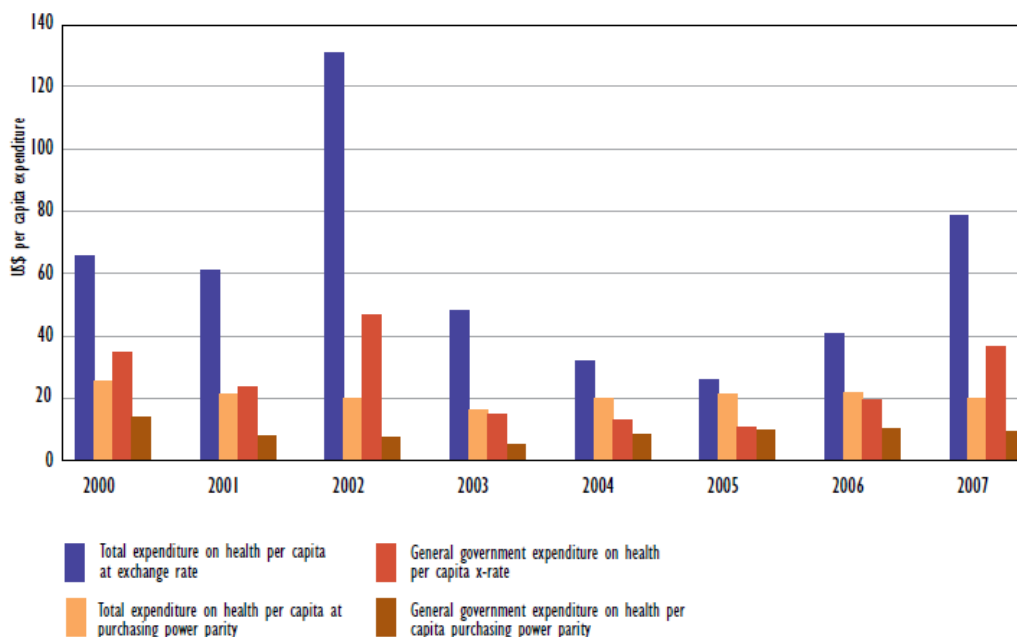
- Is public financing progressive and adequate to lead UHC?
- Are funds pooled to allow for cross subsidies?
- Is there harmonisation of funds?
- Are the funds reaching those with greatest health need?
- Are there cost barriers to care? Is there financial protection?
- How are we tracking and reporting on equity in financing?



Mr Shamu, UZ DCM /TARSC,  
Mrs Goliati ZNFU

In answer to each of these he noted that the MOHCW allocation as a percent of the national budget has improved but remains below the Abuja target of 15% after peaking at 17% in 1997. The share of health in the GDP has stayed above 5%, but public per capita expenditure remains below the minimum expected of US\$60 (including system costs). As noted earlier, allocating 50% to districts and 25% to primary care is difficult to track. The AIDS levy although not progressive as a flat tax, is increasing and covering the gap left by Global Fund. However there are high out-of-pocket payments that are regressive, with poor people paying more, including through medical aid co-payments.

Figure showing different sources of health funding 2000-2007



Source: Zimbabwe Equity Watch 2011

He noted that financing remains largely fragmented, with private health insurance covering less than 1% of population through many small, segmented schemes as well as the declining grants to not for profit mission and local government services. The high level of off budget external funding, limited cross subsidies across the different funding pools and no progress on national insurance also limits progressive financing. The absence of a clear set of costed entitlements makes it difficult to see what funds are needed and the fact expenditures not reported by level of care makes it difficult to assess the benefit incidence of expenditures at the different levels.

The policy position on user fees is very clear, but implementation is mixed. Mission hospitals and local authority clinics still receive inadequate grants from central government. Pregnant women, under 5 years and over 65yrs are exempt from fees up to district level but a recent study shows 59% to be charged especially in urban, peri-urban, mining areas and large commercial farms. Managing exemptions from fees is difficult and costly, and sometimes results in injustices. There is high inflation in user fees in the private sector and limited success in regulation. In addition there are 'defacto' cost barriers: transport, cost of medication from private sources. This has led to increased private and out-pocket expenditures.

*"To move forward we need adequate and sustainable domestic financing, for example through sin taxes and earmarked taxes on spirits, beer, fuel, cigarettes, high sugar foods, high saturated fat foods and road toll fees that are collected in a public health fund. We should explore a share of VAT going to health. To support any new revenue flows, we need to cost the basic entitlement for health care".*

He observed that enforcing the user fee policy is necessary, as well as ensuring that other barriers to access are reduced with, like transport costs or stigma. For resource allocation to be equitable, it needs to be more based on need than demand, at least in terms of the populations served. The next National Health Accounts should specifically include a focus on equity and allocations and spending be reported by level and area. In particular

disaggregated spending on primary care, district, and higher levels will facilitate study of who benefits from the distribution of spending by level of service.

After the presentations participants discussed three questions relating to the issues raised:

- i. *What options to ensure that financing is adequate and sustainable for essential health services?*
- ii. *What measures to ensure that there is financial protection and that resources are distributed according to need?*
- iii. *How should we regularly track and report on equity in health financing?*

In the subsequent discussion delegates observed that the Abuja commitment is only an indication of prioritisation of health in the budget, and that the per capita amount was also important so both are used in budget advocacy. We should do a proper costing and build a strong case on funds needed to maintain the essential services, and to check why our services such as those in the private sector seem to be more expensive than those provided in neighbours such as South Africa.

It was suggested that tax revenue should be linked to sectors where the economy is projected to grow more rapidly (eg mining, tourism, agriculture) as waiting for 30 years to domestically finance essential health services is not acceptable in terms of lost life. It was noted that the very low tax base makes tax options not likely to yield significant shares in the immediate, but that the principle is important and a transition to domestic financing needs to link health financing with areas of economic growth. A number of more immediate resource options were identified, such as giving tax incentives be given to those who contribute to public health services, and community share trusts resourcing some of the health entitlements within community and primary care levels.

The Minister of Health has already advocated for a share of funds from road tolls, and carbon taxes to fund reliable ambulance services for road traffic accidents. There may be resistance to such proposals so we need a good case for this. External funders also have a role to play in the short term. The investment case has outlined gaps and the Health Transition fund is coming in to fill some of these gaps.



Parallel session  
discussions

The informal sector needs to be tapped into. Delegates proposed a small share of VAT for health, since everyone pays VAT even those not formally employed. It was noted that while there may be resistance, Ghana used VAT to finance National Health Insurance and that studies show that it is not always regressive. We need to study who how the burden of VAT in Zimbabwe is distributed across different wealth groups and if it is not regressive, as one delegate put it “VAT will be the elephant that will grow. Lets not be reactive. Lets start things now and as the economy grow, so does the revenue”.

The principles were agreed, that financing should be progressive, should not burden the poor, and should take account of stakeholder perceptions. More technical work needs to be done on the options for the short and long term.

In terms of user fees, after some debate it was noted that those who can should pay for health services, but that payment at the point of having the service leads to poor people paying more (in percentage terms) than the rich and is a barrier to use of services in those who need them most.

Delegates this agreed on prepayment as a principle. If there are any collections for health, these should not be for the basic entitlements and essential health services, which should be covered from tax or other funding but for quality improvements defined locally, with funds managed locally. These principles were proposed and it was suggested that the steps towards moving from the current situation to this goal would be explored further technically.

The principle of the essential services tax funded and improvements funded through prepayments should also apply in local authorities and mission services. Delegates felt that local authorities do have funds and need to manage these, supplement them with local collections such as from statutory licensing and inspection fees and orient their priorities towards including the health of their communities.

Delegates concurred that the National Health Accounts should specifically include a focus on equity and allocations and spending should be reported by level and area to facilitate tracking of who benefits from the distribution of health spending. It was also proposed that referrals made by clinics to hospitals should be costed to check the cost burdens incurred by inappropriate use of the referral system.

## **5. Health in all policies on the social determinants of health**

Dr Lincoln Charimari, WHO, and Mr Rangarirai Machemedze SEATINI chaired the session on safe water, sanitation and food security.

### **5.1 Access to safe water and sanitation**

Mr T Mutazu Chair of the National Action Committee, Ministry of Water Development presented on access to safe water and sanitation. Until the inception of the Inclusive Government, access to safe water and sanitation had declined over the years, leading to the 2008-2009 cholera outbreak (98,531 cases; 4,232 deaths) - a red flag indicator on the poor state of water supply and sanitation (WASH).



Flowing Sewage in urban areas



Contaminated water supplies

T Mutazu 2012

After rapid assessments, there has been urban infrastructural rehabilitation, with the urban sector since February 2010 benefitting from over US\$20 million dollars for rehabilitation and further on-going resource mobilisation. Rural WASH rehabilitation has not received much attention yet, and there needs to be sustained promotion of hygiene education for behaviour change. This was seen to call for a holistically coordinated sector covering urban, rural and overall water resources management to minimize risk to human health and environmental damage, through improved access to safe water and sanitation services and positive behaviour practices. The sector is slowly rebuilding itself over the past 3 years, but needs continued financing and technical assistance, especially given its role in facilitating health and economic activities.

There is low capacity to utilize stored water; weak institutional capacity; absence of an independent regulator and aged water storage structures. The rural sector also faces weak strategies and capacities, weak community self reliance systems, low sector capacity and limited supply chains. In urban areas there is aged and overloaded infrastructure, low water tariffs and a weak urban revenue base, weak strategic engagement of the private sector; low human and financial capacity; weak water demand management measures and weak enforcement of pollution regulations.

MWRDM assumed full leadership of the sector in the National Action Committee (chaired by MWRDM), with three sub-committees: rural (chaired by MTCID), urban (chaired by MLGRUD), and water resources (chaired by MWRDM). A WASH Sector Working Group was set up to strengthen liaison and joint planning with sector donors. No comprehensive sector policy existed. A Rural policy background paper was developed, based on a 2004 draft, a water resources policy background paper and an urban water supply policy background paper are both under development, coordinated by the sub-committees of the NAC. The first drafts were presented to the NAC in February, 2012 and a comprehensive policy should be in place by mid-year.

There is been rehabilitation of water and/or wastewater treatment plants, with UNICEF support. Little is being done on the reticulation systems, and Harare has 29% water losses due to pipe bursts, leakages, etc. Support for water treatment chemicals in 20 urban local authorities and all ZINWA stations will come to an end in March 2012, and strategies are being worked out for local authorities to be self sufficient. Water supplies have improved, from half a day per week supply in 2009 to four and half days per week on average in 2012.. No major rural rehabilitation programme has been undertaken to-date except in 6 districts through the PSIP, and UNICEF is mobilizing resources to cover a further 30 districts in 5 provinces. Access is however significantly compromised by poor maintenance.

Sector financing is a major challenge. The African Development Bank estimated that \$14.2 billion was needed for infrastructure (2011 to 2020) of which 50% should come from government. Of this \$4.2bn was needed for water and sanitation. Current investment is significantly lower with: Public Sector Investment Programme at \$230 mln in 2011; external funders providing \$600 mln in 2011, and 'Zim-Fund' committing \$80 mln for energy and water. Water sales are not able to fully fund the sub-sector and the blend pricing policy, while important for equity, is a disincentive to local water resource development.

*"There is thus need to develop a program to repair and rehabilitate rural water supplies and give responsibility and asset ownership of RWS to RDCs. The needs of resettled Zimbabweans also need to be addressed. In urban areas, there needs to be a financing strategy to replace aging infrastructure, and the tariff policy needs to be updated to enhance viability while protecting water access in poor households. A specific budget line is needed for rural sanitation in both local and national budgets and advocacy is needed for sanitation behaviour change through community led strategies. For urban areas city-by-laws on environmental and public health need to be better enforced".*

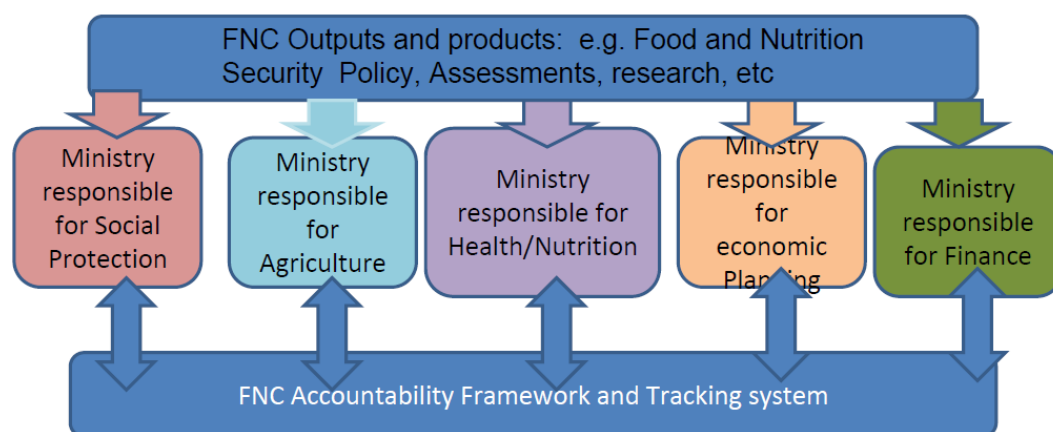


## 5.1 Household food production and nutrition

Ms K Mukadota, Programme officer in the Food and nutrition council presented on household food production and nutrition.

In 1995, Government of Zimbabwe established Task Force to recommend solutions to persistent and growing problem of hunger and malnutrition. This informed the establishment of Food and Nutrition Council (FNC) and reinforced need for multi-sectoral approach. In 1998, Cabinet agreed to a national consultative process to transform Policy Framework into a national Food and Nutrition Security Policy led by FNC. Since, Zimbabwe food and nutrition situation has deteriorated due to national economic and socio-political challenges, although food and nutrition is recognised as central to development, multi-sectoral in nature and a policy priority across all political levels and groups.

The conceptual framework places nutrition and food security within broader economic and livelihoods framework. Nutrition and food security analysis is integrated within different sectors through ZIMVAC, consortium of Government, UN agencies, NGOs and other International Organisations led and regulated by Government. All relevant sectors are thus involved in national nutrition surveys and in specific assessments, such as the regular urban assessments. The Food and Nutrition Security Policy was also developed through a consultative approach and is being implemented collaboratively, centrally, and through decentralized capacities at provincial, district and sub-district level.

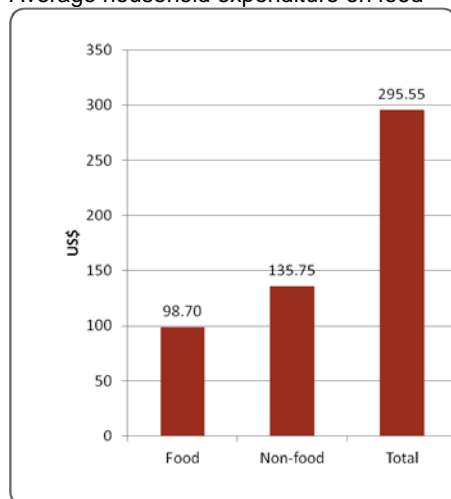


The food poverty datum line (FPL) represents the minimum consumption expenditure necessary to ensure that each household member can (if all expenditures were devoted to food) consume a minimum food basket representing 2 100 kilo calories. An individual whose total consumption expenditure does not exceed the food poverty line is deemed to be very poor. In Zimbabwe, 15 % of interviewed households were found to be living below the food poverty line. Mashonaland Central (26%) had the highest percentage of household who were living below the FPL, while Harare (6%) had the lowest percentage.

The total consumption(TCL) is a sum of the FPL and minimum acceptable expenditure on essential non- Food household goods and services. Household with incomes below the TCL are considered to be poor. In surveys, 70% of interviewed households were living below the TCL, therefore considered to be poor. Matabeleland North had the highest proportion of households living below TCL at 89%, and even Harare, at the lowest level of 55%, had high levels.

The average household monthly expenditure on food was USD99 for surveyed households. Households in Harare spent the most on food while the household in Mashonaland Central

Average household expenditure on food



K Mukadota 2012

spent the least. On average sampled households were eating more than two meals a day. Children were eating more meals than adults. Most households (89%) had access to an acceptable diet. Households in peri-urban areas had a poorer diet than those living in high density areas.

The highest proportions of food insecure households were found in Mashonaland Central (23%) followed by Bulawayo (16%) and Matabeleland North (16%). The lowest proportions were found in Harare (5%) followed by Matabeleland South (7%).

*“Households headed by women, with widows, by less educated,*

*unemployed or chronically ill members, were more food insecure than others, as were households with arrears or debt or that had experienced a shock. About 29% of the surveyed households in 2010 reported practising some urban agriculture, a significant drop compared to the 2006 Assessment results that show 64% practicing urban agriculture. Households face pressure to choose between food and basic non food needs- rental, medical bills and utility bills – as they cannot afford both. This makes employment critical, including in urban agriculture”.*

### 5.3 Discussion

After the two presentations participants discussed two questions relating to the issues raised:

- i. *What are the key gaps in access to safe water and sanitation that we need to address, for whom and how?*
- ii. *What are the priority areas for action in which communities to close gaps in nutrition, healthy diets and household food security?*

In the discussion it was noted that people need education and motivation in ensuring safe water and proper waste management. This needs to be backed by a re-focus in services from reactive to proactive approaches, and support for appropriate technologies such as for biogas and recycling. In rural areas communities need to be empowered to maintain rural water points, and in urban areas a rehabilitation of supplies calls for ringfencing of revenue collected from water for this investment. Delegates proposed that all new houses should by law be required to have a toilet.

It was noted that political commitment exists but that policies may not be in place or implemented. The necessary activities and those to reduce pollution of water sources, encourage safe waste disposal, enforce by laws and expand water supplies, including through partnerships, call for a more coordinated approach within and across ministries, and with other stakeholders. There is need to complement public investments with

community involvement and ownership, and increased funding through improved private/public partnerships.

Food and nutrition security should be mainstreamed into all sectoral programmes, with greater attention to food safety, to promoting traditional foods and to the promotion of urban agriculture and community gardens to teach and encourage healthy eating. Supportive environments for better practices need to be created, such as through tariffs to protect local foods, higher taxes on high sugar and high fat foods to discourage their consumption and enforcement of by laws to ensure waste collection. There is need for increased use of post-harvest technologies and management to increase the availability of food.

## **5.4 Strengthening health promoting production and trade**

Dr Portia Manangazira MoHCW and Mr Rangarirai Machemedze SEATINI chaired the session on strengthening health promoting production and trade

Mr T Chifamba, Ministry of Regional Integration, presented on ensuring healthy production and trade. He noted That the health sector remains a priority for the Zimbabwe government. Health services however falls under the social services sector and are not fully positioned as a tradeable service (they cannot only be delivered through the market as they are a right and essential for survival). Access to essential drugs and other healthcare products/services remains a challenge particularly in face of HIV/AIDS, malaria and tuberculosis. Despite considerable inflows from cooperating partners and the fiscus, there are still shortfalls in financing of these health related commodities and services.

*“There are significant opportunities in health as economic sector, given the record of quality service in our institutions, therapeutic climatic conditions, an underused medicines production sector and regional markets”.*

However, from a trade and production perspective, the sector faces deficiencies in infrastructure, capacity underutilization, unavailability of specialist services prompting patients to import these services, limited investment in medical schools, loss of skilled workers and import of hazardous products and counterfeit drugs.

Cooperating partners are sourcing medicines predominantly from outside the country despite the underused capacity in the country. The Industrial Development Policy has thus prioritized the pharmaceutical sector. Zimbabwe amended its patent act, Patent Act (Chapter 26:03) Revised Edition of 1996, through the Patent Amendment Act of 2002 in line with its obligations under the TRIPS Agreement, and has the flexibilities for parallel importation, compulsory licencing and the Bolar provision allowing advance production of generics.

He noted that hazardous substances such as tobacco and kenge are getting into the country. The complex regulatory environment means that Port Health Officials are not allowed to break seals, and foreign products have different languages.

*“The smuggling in of harmful products is a concern. All major ports of entry and exit have Port Health personnel, but port health facilities are poorly equipped. New approaches being used are however likely to increase security at the main ports.”*

Broader stakeholder consultation is needed in policy formulation and involvement in regional , plurilateral and multilateral negotiations remains key, with health officials included in trade discussions. Production and trade policies (related to health sector) should be supportive, consistent and coherent.

*“There is need for investment in research and development, backed by a deliberate policy on local procurement, a strengthened national regulatory framework and PPPs for training, infrastructure development and production of pharmaceuticals”.*

Finally he noted that an inter-ministerial Committee in Bilateral Agreements exists but that consultations, especially relating to health issues, is weak. There is need for consultations and dialogue on health issues in trade negotiations.

After the presentation participants discussed two questions relating to the issues raised:

- i. *What are the priority areas and measures to promote health through production and trade?*
- ii. *What are the priority areas for attention and measures to avoid trade and production that may be harmful to health?*

Delegates noted that Zimbabwe has capacity to produce for the health sector, but that the biggest client, government, may not presently have financial resources to procure. External funding comes with strings attached, such as a preference to buy from suppliers abroad. There is need for a paradigm shift, that strengthens co-operation across sectors, builds domestic public and private partnership, through development of a deliberate policy and strategy on local production. This can be done within the current regulatory environment that provides for TRIPS flexibilities and will assist to limit counterfeits and other imported problems.

Health personnel should be brought early into dialogue on trade agreements and the potential for trade and production within the health sector better explored, such as in relation to the returns from qualified personnel produced. Port health personnel should be given conducive working conditions, and the barriers to effective monitoring and control of hazardous imports addressed.

## **6. Plenary review and next steps**

Dr Stanely Midzi, World Health Organisation and Hon Blessing Chebundo Parliament Portfolio Committee on Health chaired the final session.

### **6.1 Report back from the parallel sessions**

The delegates identified a number of recommendations and areas of follow up action flowing from the discussions on the Equity Watch report and the presentations in the plenary and parallel sessions. These are summarised below from the reports to plenary from each group.

Given both the challenges and the potentials within Zimbabwe's socio-economic conditions and international evidence on advancing country-led UHC, stakeholders endorsed equity as a guiding principle for UHC, as well as health in all policies, as necessary to promote health, prevent avoidable, costly ill health burdens for households, health services and the economy, as well as to promote the widest benefit from health and the health sector as economic assets. They called for strengthened consistent co-ordination of the institutions and agencies that influence the determinants of health and delivery on UHC.

#### **Access to safe water, sanitation and food security**

The key recommendations were **on water and sanitation, to**

1. Ringfence funds collected for water by local authorities and use this for improving water supplies including investments in infrastructure;
2. Involve rural communities in user groups to build and maintain water supplies;

3. Every new home to have a toilet- this should be a legal requirement;
4. More rigorously enforce by laws on waste management and waste collection;
5. Strengthen education and awareness raising for individuals and communities on safe use of water and sanitation and safe waste management, with coordination between MOHCW, Education and other stakeholders
6. Sustain the intersectoral co-ordination on water and sanitation and explore how to involve public private partnerships for financing the operation, maintenance and infrastructure investments while protecting access for poor communities;

#### **On food security, to**

1. Mainstream and increase the visibility of food and nutrition across all sector programmes in different programs
2. Promote urban agriculture and community gardens to encourage healthy eating
3. Promote awareness of food safety and ensure stronger powers at ports to prevent unsafe food imports
4. Use tariff and education measures to promote traditional and locally available foods and balanced diets
5. Examine options for taxing high sugar, high fat and other unhealthy foods to make them more expensive than healthy foods
6. Promote use of post-harvest technologies and management to increase the availability of food

#### **On Health promoting trade, it was recommended that**

1. Local production of pharmaceuticals be strongly promoted, through among other things; a deliberate policy on local procurement; lowering of tariffs on related raw materials; targeted incentives by government e.g cheap loans and exploring PPPs. It was suggested that a task force under Ministry of Trade could bring together all the relevant stakeholders to advance this.
2. Full use be made of the flexibilities in the WTO TRIPS Agreement for compulsory licensing, parallel imports and regular exceptions.
3. Regulation and policing at border posts be strengthened to prevent hazardous foods, substances, products and medicines getting into the country.
4. Coordination across the agencies involved in health be strengthened so that the inputs and interests of all sectors that have an impact on health can be balanced;
5. There be active and early consultation and involvement of health officials in regional and multilateral trade negotiations.
6. The economic and trade value of health related industries and services be recognized and developed - without compromising the core role of the domestic health sector to equitably address health needs- to support the expansion of local services, such as through local medicines production and through catering for the region.

#### **Universal access to essential health services**

The national stakeholder meeting supported the National Health Strategy proposal to make clear the essential health service benefit/ entitlement – public health and personal care- that will be made universally available to the whole population. This should include the basic services and inputs/ roles from communities and from other sectors that are key for health (eg water, waste management, sanitation, food safety). Key gaps in the current in areas of maternal and child health services, non communicable diseases, environmental health including water, sanitation and waste management, transport and energy need to be addressed. This service benefit at the relevant level should be provided by all health providers (central and local government, private for profit and private not for profit). It should be costed, and, in the public sector, funded through tax funding.

The recommended actions to take this forward were thus to

1. Update the current core district health package in line with the population health profile, policy and law to produce an essential health benefit, starting at community, primary care and district level



2. Consult communities on their views on the revised essential health benefit
3. Consult other sectors, providers on inputs to the revised essential health benefit
4. Cost the final updated essential health benefit at the different levels and across provinces and providers and review the implications for budget bids, agreements between MoHCW and local government and not for profit providers and benefits packages in the private sector

### **Adequate equitable health financing**

Delegates agreed on the need to adequately resource essential health services through predictable, progressive and adequate domestic financing. The principles were agreed, that financing should be progressive, should not burden the poor, and should take account of stakeholder perceptions. Delegates endorsed that while those who can contribute to services should do so, this should not be through user fees at point of care but through pre-payment mechanisms.

It was thus recommended that

1. Both the 15% Abuja target and WHO and essential health benefits per capita funding benchmarks continue to be used to ensure health is prioritised.
2. The primary mechanism should be through progressive taxes, linked to areas of consumption and high growth areas of the economy and to activities that generate health burdens. The options, projected revenue flows, financing incidence of VAT, sin taxes (on spirits, beer, cigarettes, high sugar and high fat foods, fuel and road tolls) and earmarked taxes on areas of high economic growth ((mining; tourism, finance; and agriculture) should be identified and reviewed with stakeholders, together with the institutional options and procedures for managing additional earmarked revenues. Tax incentives may also be used to encourage contributions to essential health benefits.
3. Prepayments by communities should replace user fees and should not be used for the basic entitlements and essential health services, which should be covered from tax or other funding but for quality improvements defined locally, with funds managed locally.
4. Public facilities should track and cost the referrals (lower to higher levels) to assess and manage costs of inappropriate referrals in the health system.
5. At each level governance mechanisms should be in place to ensure participation, monitoring, effective management, accountability in and public reporting of use of funds. This includes health centre committees, hospital boards, and the establishment of a credible stakeholder board and financial systems for a public health trust fund for earmarked tax revenues.



Discussions on the follow up

## 6.2 Institutionalising equity monitoring

Dr Portia Managazira, MoHCW presented an outline of opportunities for institutionalising equity monitoring. She outlined the existing systems in the MoHCW, including surveillance of the 17 major public health conditions, the routine health information system, the data on basic services trends and on the public health infrastructure, medicines available and financial and budget analysis in the health sector.

She agreed that there was need for more regular tracking of equity in health and saw the indicators in the equity watch as a good start. She suggested that it would be important to review the indicators periodically, to identify those for routine annual monitoring and to involve other sectors relating to health, including the economic sectors and indicators.

She raised areas that also need to be developed for equity monitoring, including budget tracking, operations research to better understand the findings from routine data and periodic household surveys and population based surveys to better track some indicators. It would be important to strengthen ICT in rural areas for better management and use of evidence. She noted that the Equity Watch was timely and welcomed input of evidence on equity in the forthcoming strategic review.

Finally Dr Managazira commented on the need to include private health providers and the private sector in the information system, to include their evidence in the national picture.

In the various parallel sessions other points raised on future equity analysis included recommendations that

1. the MoHCW continue to use the Equity Watch to track equity in universal access to services, working with Zimstat and others, as well as to link equity tracking to national health information system.
2. the National Health Accounts specifically include a focus on equity, and
3. allocations and spending be reported by service level – community, primary, district etc- and area, to facilitate tracking of who benefits from the distribution of health spending.

Dr Rene Loewenson, TARSC / EQUINET noted in the concluding comments on the session that the evidence for tracking evidence is available- it is a matter of analyzing and using it. There are some gaps, such as in tracking the distribution of maternal mortality, analysing expenditures by level, and having disaggregations to district level that need to be addressed. Data is also not always stratified in the same way across all sectors. Delegates endorsed that the next equity watch include other sectors at the onset, to agree on and contribute to the monitoring.

Dr Loewenson commended the commitment and ideas coming from across all sectors towards realizing shared values on health. The meeting had helped to bring together principles and key areas of work for building universal health coverage with equity, inclusive of action on the social determinants of health.

She thanked the leadership of MoHCW, EQUINET colleagues, TARSc and the inputs of civil society, parliament, Advisory Board of Public Health and WHO in the planning of the meeting, and the speakers and delegates and IDRC Canada financial support for the contributions.

Dr Loewenson committed to continued EQUINET support to the process, noting that the work and initiative in Zimbabwe would be shared with other countries implementing equity watch work through regional processes planned in April and at the ECSA Health Community.

## 7. Closing

Dr Stanely Midzi, World Health Organisation and Hon Blessing Chebundo Parliament Portfolio Committee on Health chaired the closing session.

Mr Serge Heijnen, Royal Tropical Institute, Netherlands, thanked the hosts for the hospitality and productive meeting. He noted a number of positive features and lessons from the meeting. The meeting had defined UHC as a long term, organic and domestic process, led by national strategy and policy. He realised from the meeting that there is a window of opportunity in Zimbabwe in that there is positive commitment to move forward and a situation of injustices to address. There is a delivery capacity in health and other sectors and potential economic expansion in the coming years could support and resource the growth of this delivery capacity. He noted that the public are behind the demand for solidarity and improved health.

*“There is a spark in the meeting! People have identified the things that need to be done. This is a unique process in defining the policy principles across stakeholders and sectors for how to address equity, universal health coverage and the social determinants of health within one framework, rather than in parallel tracks. Linking evidence to policy dialogue as you are doing will help to deepen learning for all of us, and support effective policy”.*

He wished delegates well in the future work.

Ms Sakhile Dube Mwedzi, Pharmaceutical Society of Zimbabwe, on behalf of the Advisory Board of Public Health (PHAB), thanks delegates for the commitment they showed right to the end of the meeting. She noted that the meeting had set important principles that would be discussed further by the PHAB to give advice to the Minister. The meeting reminded her of the first meeting for the review of the Public Health Act, that had also started by setting principles, and had completed the proposals for the review of the Act in 2011, with stakeholder consultation. She hoped that all would bring the same constructive inputs and ideas to this process. Finally she welcomed delegates to training that would be held on the Public Health Act in April.

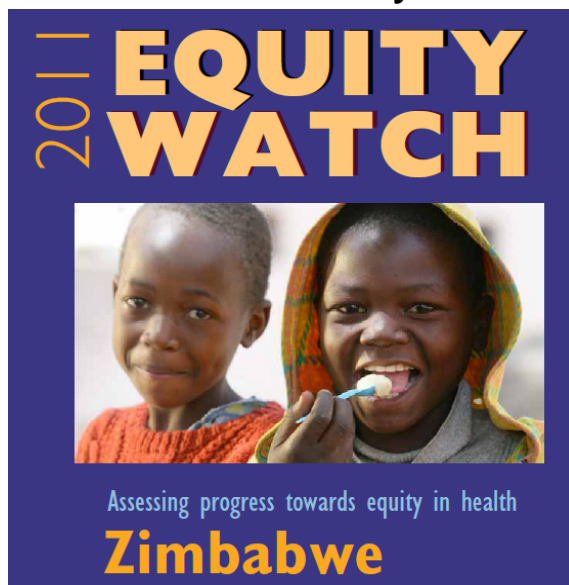
Dr Gibson Mhlanga closed the meeting for Ministry of Health and Child Welfare. He noted that the objectives intended had been achieved, and that the meeting had been fruitful. He thanked delegates for their commitment, recognising that Hon MPs and others had remained involved throughout. He thanked the chair, speakers, rapporteurs and all those who had been involved in the organisation.

*“We take this commitment to equity, universal health coverage and collaborative action on social determinants of health seriously, and will not let this be a talkshop”.*

Dr Mhlanga informed delegates that the report would be sent to them and the deliberations would be taken forward within the appropriate follow up platforms within the Ministry and with the Minister, and within the relevant inter-ministerial forums. The work in Zimbabwe would be shared with others in the regional forums.

He wished delegates safe journeys home and closed the meeting.

## APPENDIX 1: Summary brief on the Zimbabwe Equity Watch



This brief summarises key issues from the Zimbabwe Equity Watch to support stakeholder dialogue.

The full Equity Watch report provides details on the points raised.

The summary table on the full watch is shown on the last two pages.

November 2011

### The context for health equity

1. 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 economic and social challenges in the past decade that threaten health. However, there are signs of recovery in a fall in inflation, improved industrial capacity, availability of goods and services, and a rise in gross domestic product per capita. 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.
2. The level of debt makes debt relief important, to ensure that debt servicing does not withdraw resources from investing in this social recovery.
3. The 2011 Equity Watch report assesses progress made in advancing equity in health in terms of health, the social determinants of health, redistributive health systems and returns to health from the global economy.

### Equity in health outcomes

1. There is evidence of recent progress in health outcomes, particularly in 2010, with significant reductions in HIV prevalence; improved child mortality and under-nutrition; better immunisation coverage; and some improvement in assisted deliveries. The progress needs to be sustained.
2. 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.
3. Child stunting shows wide differences across mothers with different social and economic conditions.
4. Maternal mortality levels are high and rising, with wide wealth, education and provincial differentials in antenatal care coverage and assisted deliveries.
5. There are social differentials in access to interventions for prevention and treatment of AIDS.
6. Social differentials are lower at near universal coverage levels, and rise when coverage falls.

## Household contexts and social determinants

1. The benefits of the recovery are not reaching all, as inequalities in wealth remain persistently high. Although rural wealth has improved, urban food poverty has increased. While the share of national income to profits has grown, it has not translated into investment for new jobs, leaving many in vulnerable employment.
2. 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.
3. Zimbabwe has a high net enrolment ratio and gender parity in education, that are key contributors to health equity. However costs of education are an increasing barrier for households, leading to falling primary school completion rates for low income households and marginal groups.
4. A decline in local industry and wide trade liberalisation have led to imports of some products that are harmful to health, eg some foods, cosmetics, and alcohol.
5. These issues call for action by a range of sectors outside health and support for primary health care. The health sector role in intersectoral action faces constraints such as limited regulatory capacities, high vacancy rates for environmental health officers and limited resources for preventive services.

## Enhancing equity through the health system

1. The new national health strategy promotes equity, primary health care and the right to health. Constitutional debate, consultation on the Public Health Act, an active parliament and civil society advocacy have raised the profile of the right to health. There is policy commitment to public participation in health.
2. Zimbabwe's physical infrastructure could support universal access and staffing and supplies to clinics and districts have improved.
3. With wide use of public services by poor households, improved staffing and medicines in public services, especially at primary care level have contributed to improved coverage and reduced barriers to services. Service bottlenecks, such as tutor capacities for midwifery training, gaps in deployment of pharmacy and environmental health cadres and supply chain management for medicines need to be addressed.
4. 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.
5. 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.
6. Acceptability of services has been raised by 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 social barriers and need to cover all districts, backed by legal recognition, guidelines and resources.
7. While making progress, Zimbabwe has not yet met the Abuja commitment on 15% government budget to health 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, despite the critical importance of improved public services for coverage in vulnerable groups.
8. Government resource allocations by level do not publicly report on spending to primary care level, despite the higher benefit of primary care for poor people.
9. Raising revenue for public services means continuing the recent trends to increase public financing from taxes, identify further equitable tax and other revenue sources, define the basic health service entitlement and what it costs, address concerns about financial accountability and allocate and track resources to primary care levels.



PROGRESS MARKERS	STATUS AND TRENDS	PRIORITY AREAS FOR ACTION
<b>EQUITY IN HEALTH</b>		
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.
<b>HOUSEHOLD ACCESS TO RESOURCES FOR HEALTH</b>		
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
<b>REDISTRIBUTIVE HEALTH SYSTEMS</b>		
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.
<b>A JUST RETURN FROM THE GLOBAL ECONOMY</b>		
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.

## APPENDIX 1: Programme

Time	Session	
08:00-08:30	Registration and administration	
<b>Session 1: Trends and priorities for advancing equity in universal health coverage and in the social determinants of health</b> Chairs: Dr D Parirenyatwa, Parliament Portfolio Committee on Health; Dr D Dhlakama Director Policy and Planning Ministry of Health and Child Welfare		
08:30 – 09:00	Opening speech	Hon Minister H Madzorera MoHCW
09:00 - 09:30	Meeting aims and overview of the findings of the Zimbabwe Equity Watch	Dr G Mhlanga, MoHCW Dr R Loewenson, EQUINET
09.30- -10:10	Panel comment on the findings: Economic trends and health equity  Health Sector contribution to health equity	Mr A Mushaniga , Executive Secretary National Economic Consultative Forum Dr D Dhlakama Director of Policy MoHCW
10.10-10.45	Discussion on priorities raised	
10:45-11:15	Tea/ coffee	
<b>Session 2: Parallel Sessions on advancing equity</b>		
11.15	<b>Enhancing universal health coverage and equitable health financing</b> Chairs: Mr S Shamu,UZ; Mr I Rusike CWGH	<b>Health in all policies on the social determinants of health</b> Chairs: Dr S Midzi, WHO, Mr R Machemedze SEATINI
11:15-11:45	Improving universal access to essential health services Dr L Mbengeranwa, Zimbabwe Health Services Board Discussant: Mr. Alexious Zindoga NCDPZ	Access to safe water and sanitation- Mr T Mutazu Chair NAC, MoWD Household food production and nutrition – Ms J Nyatsanza, Chair Food and nutrition council

Time	Session	
<b>Session 2: Parallel Sessions on advancing universal coverage and equity</b>		
11.45-12.45	Universal health coverage discussion: Strengthening access to essential health services iv. <i>What do we consider to be essential health services that should be universally available?</i> v. <i>How should we regularly track, report and act on delivery of and equity in access to these services?</i> vi. <i>What are the key gaps in access that we need to address, for whom and how?</i>	Health in all policies discussion: Safe water, sanitation and food security i. <i>What are the key gaps in access to safe water and sanitation that we need to address, for whom and how?</i> ii. <i>What are the priority areas for action in which communities to close gaps in nutrition, healthy diets and household food security?</i>
12.45-14.00	Lunch	

Time	Session	
<b>Session 3: Parallel Sessions on advancing universal coverage and equity</b>		
1400-1420	Chairs: Dr G Mhlanga MoHCW, Dr R Loewenson TARSC/EQUINET Priorities, principles and options for equitable health financing –Mr S Shamu, UZ	Chairs: Mr R Machededze, SEATINI, Dr P Manangazira MoHCW Ensuring healthy production and trade- Mr T Chifamba Ministry of Regional Integration
1420-1500	Discussion on financing for equity and universal coverage i. <i>What options to ensure that financing is adequate and sustainable for essential health services?</i> ii. <i>What measures to ensure that there is financial protection and that resources are distributed according to need?</i> iii. <i>How should we regularly track and report on equity in health financing?</i>	Discussion on barriers and options for strengthening health promoting production and trade i. <i>What are the priority areas and measures to promote health through production and trade?</i> ii. <i>What are the priority areas for attention and measures to avoid trade and production that may be harmful to health?</i>
15.00-15.15	Tea / coffee	

<b>Session 4: Plenary review and next steps</b>		
Chairs: Dr S Mizdi, WHO, Hon B Chebundo Parliament Portfolio Committee on Health		
1515-1615	Plenary feedback from the 2 parallel sessions Discussion	Session rapporteurs
1615-1645	Institutionalising equity monitoring Discussion and next steps	Dr P Manangazira MoHCW Dr R Loewenson EQUINET
1645-1700	Closing remarks	Mr S Heijnen, KIT; S Dube Mwedzi, Advisory Board of Public Health. Dr Mhlanga MoHCW

## APPENDIX 2: Delegate list

	Institution	Name And Position
<b>Government Institutions</b>		
	Ministry of Health and Child Welfare	Hon Dr H Madzorera Minister
		Dr D Dhlakama Principle Director
		Dr G Mhlanga Principal Director: Preventive Services
		Dr P Managazira Director Epidemiology and Disease Control
		Mr G T Mangwadu Director: Environmental Health Services
		Mr S Danda Environmental Health Officer
		Dr Zizhou PMD Mashonaland East, MoHCW
		Mr D Mujiri, PR officer
	Office of the President – health advisor	Ms T Moyo Research Analyst
	Zimbabwe Health Services Board	Dr L Mbengeranwa Executive Chairman
	Ministry of Regional Intergration	Mr T Chifamba Permanent Secretary Mr P Chimanikire Senior Economist
	Ministry of Finance- National Economic Consultative Forum	Mr A Mushaniga , Executive Secretary Ms N Nyahunzvi Programme Officer
	Zimstat	Mrs J Jonasi Statistical Officer
	Ministry of Water Development	Mr T Mutazu Director of Water Resource Planning and Devt Chair National Action Committee on Water
	Ministry of Transport, Communication, Infrastructure Development	Ms P Maringire Director, HR Focal point SDH
	Ministry of National Housing and Social Amenities	Mr O Mhazo Research Officer Focal point SDH
	Ministry of Education, Sports, Arts and Culture	Mrs A Ncube Education Officer Focal point SDH
	Ministry of Lands and Rural Resettlement	Mr L Tagara Director of Human Resources Focal point SDH
	Ministry of Local Government, Rural and Urban Devt	Ms S Thabethe Deputy Director Focal point SDH
	Ministry of Labour and Public Services	Mr L Chinhengo, Director Policy and Programmes Focal point SDH
	Ministry of Industry and Commerce	Mr C Mhurushomana Senior Economist
	Environmental Management Authority	Ms S Yomisi, Focal point SDH
	Food and Nutrition Council	Ms K Mukudoka Programme Officer
<b>Parliament of Zimbabwe</b>		
	Parliament Portfolio	Hon D Parenyatwa
	Committee on Health	Hon B Chebundo
<b>Non state institutions and associations</b>		
	Training and Research Support Centre / EQUINET	Dr R Loewenson Director
	TARSC	Ms M Makandwa Mr A Kadungure
	UZ DCM/HEPRI	Mr S Shamu, Mr T Mabugu
	SEATINI	Mr R Machemedze Director
	Community Working Group on Health	Mr I Rusike Director
	Zimbabwe Association of	Dr C Dhege Medical Superintendent

	<b>Institution</b>	<b>Name And Position</b>
	Church Hospitals (ZACH)	PHAB Member
	Zimbabwe Congress of Trade Unions	Mr J Ngirazi Executive member PHAB Member
	Zimbabwe Council of Churches	Mrs R Munaki Trainer/Programmes Officer
	Zimbabwe Nurses Ass (ZINA)	Mrs R Smith President PHAB Member
	Association of Healthcare Funders of Zimbabwe	Mr N Muza, CIMAS PHAB Member
	Pharmaceutical Society of Zimbabwe/MCAZ	Ms S Dube Mwedzi President PSZ PHAB Member
	Environmental Health Practitioners Association	Mr V Nyamandi Chair
	National Council for Disabled Persons of Zimbabwe	Mr. A Zindoga
	Combined Harare Residents association	Mr M Mlilo Director
<b>Production sectors</b>		
	National Farmers Union	Mrs L Kujeke Goliati Programme Coordinator
	Chamber of Mines	Dr Silence Gavi
	National Health care Trust	Ms Nyasha Pedulu Programmes Officer
<b>International organisations</b>		
	WHO	Dr S Midzi NPO/MPN Dr Lincoln Charimari Diseases Prevention Control Officer
	UNICEF-CCORE	Dr S Laver Director
	KIT Netherlands	Mr S Heijnen Area Leader Health Kelsey Vaughan Health Economist
<b>Apologies</b>		
	MoHCW	Mr T Zigora, Chief Executive Officer Parirenyatwa
	Local authorities	Dr S Mungofa, Director of Health Harare, Chair LAHF
	ZNCC	Mr G Gundani Economist
	CCZ	Mrs R Siyachitema Director
	UNDP	Mr A Zinanga