2008

EQUITY WATCH

Assessing progress towards equity in health

Zimbabwe

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

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About the equity watch

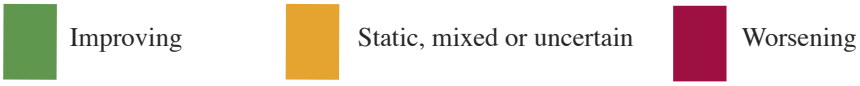
To advance equity in health we need to monitor our progress and actions on the key dimensions of health equity. This equity watch, implemented by EQUINET at both country and regional level, aims to strengthen strategic reviews, dialogue and networking on health equity, assessing the current status and trends on a range of priority areas, as identified in our regional equity analysis. The country 'equity watch' tracks the priority health equity indicators and progress on measures that promote equity, particularly within health systems, in the following key areas:

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

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

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

Following the introduction, the indicators are shown within four major areas. Under these areas, each progress marker reports on past levels (1980-2006) and current levels (most current data publicly available) and includes a commentary on progress towards health equity. A coloured bar on the left side of the page shows whether the indicator is:



The relationship to the average in east and southern Africa is also shown in this bar; ⊕ indicates above regional average and ⊖ indicates below regional average according to data from official sources presented in the regional equity analysis (EQUINET SC, 2007). This presentation approach aims to provide an accessible overview of country and regional trends in relation to the key health equity progress markers.

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Key areas

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- Formal recognition and social expression of equity and universal rights to health
- Achieving UN goals of universal access to prevention of mother to child transmission, condoms and antiretroviral treatment by 2010
- Eliminating income, area differentials in immunisation, antenatal care and deliveries by skilled personnel
- Eliminating income and urban/ rural differentials in maternal mortality, child mortality and stunting
- Achieving the Millennium Development Goal of reducing by half the number of people living on $1 per day by 2015

Household access to the national resources for health 15

- Achieving universal primary and secondary education for women
- Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
- Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in the region)
- Increasing the ratio of wages to profits
- Abolishing user fees from health systems
- Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems
- Overcoming the barriers disadvantaged communities face in accessing and using services

Resourcing redistributive health systems 25

- Achieving the Abuja commitment of 15 per cent government spending on health
- Achieving the WHO target of $60 per capita spending on health systems in the public sector
- Increasing progressive tax funding to health; reducing share of out-of-pocket financing in health
- Harmonising the various health financing schemes into one framework for universal coverage
- Establishing a clear set of comprehensive health care entitlements for the population
- Allocating at least 50 per cent of government spending on health to district health systems (including level 1 hospitals) and 25 per cent of government spending on primary health care
- Formally recognising in law and earmarking budgets for training, communication and mechanisms for direct public participation in all levels of the health system
- Implementing a mix of non-financial incentives agreed with health workers organisations

A more just return for countries from the global economy 37

- Debt cancellation negotiated
- Allocating at least 10 per cent of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers
- No new health service commitments in GATS and inclusion of TRIPS flexibilities in national laws
- Health officials involved in trade negotiations and clauses for protection of health in agreements
- Bilateral /multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration

Summary

EQUITY WATCH

Economic inequality in Zimbabwe is high. The poorest tenth of the population shared less than 2 per cent of national income in the last decade, while the richest tenth shared nearly half the national income. To improve human development and meet commitments to the Millennium Development Goals, Zimbabwe needs to address inequality, including in health. This report tracks a selection of progress markers relevant to household, national and global levels to assess progress in addressing inequality and achieving equity in health in Zimbabwe.

Potential for progress

Zimbabwe's progress in health has been undermined in recent years by AIDS, economic decline, hyperinflation and political discord. A nationwide cholera epidemic in late 2008 is a sign of the significant decline in health and health care. Yet there are also signs of a potential for recovery. Adult HIV prevalence has recently declined, there is a reasonable physical infrastructure of facilities in the public sector, the population is educated and primary health care (PHC) initiatives have been successful in the past. These positive elements suggest that gains in health equity are possible, if reinforced by investments and an improving economic and socio-political context.

Zimbabwe's stated policy commitment to health equity needs to be underpinned by constitutional provisions for the right to health and access to health care, and supported by plans and budgets with clear targets that can be monitored and reviewed over time.

Identifying the gaps

There is limited up to date household evidence and future planning needs to be informed by updated facility and household survey figures, disaggregated by income, area and gender, as well as by updated poverty assessments. Available evidence suggests we need to address a number of gaps. Most profound of these are the gaps between:

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

Closing the gaps

Rising costs and direct charges in the private sector signal that building the universal, comprehensive systems to address these gaps can only be public sector led. Zimbabwe needs to do the following:

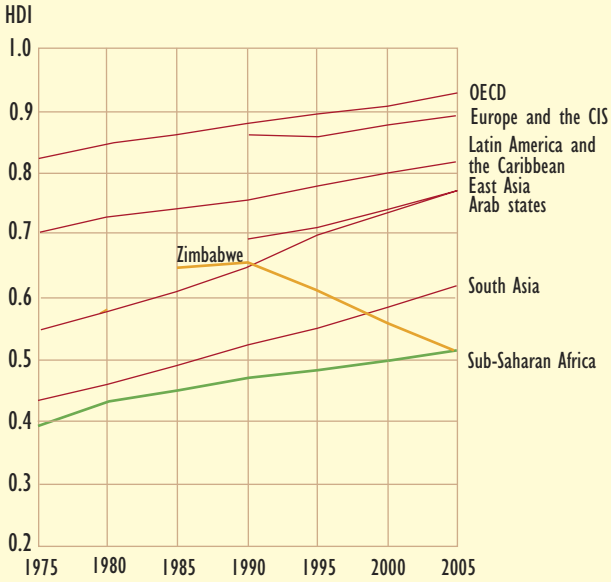
- revitalise various health inputs, including primary education;
- clarify and cost the package of benefits that every person is entitled to;
- reinforce efforts by the Zimbabwe Health Services Board to negotiate sector-wide incentives for health workers, including career path support and housing;
- revisit financing measures that pool risks, like social health insurance, as soon as economic conditions permit;
- create market incentives and encourage investments to boost local production of drugs and health inputs, while monitoring pricing, financing and pharmaceutical practices in the private for profit health sector;
- ensure that people with greatest health need benefit by allocating public resources to:
  - rebuild the environments and infrastructures for health (functioning water, sanitation and waste disposal systems; local food production schemes);
  - fund districts with greater health needs, integrating needs in the allocation formula and using equalisation grants to improve capacities to absorb funds;
  - strengthen drug, staff, transport and outreach resources at primary care and district levels of the health system, with additional measures to support uptake.

Where is the starting point?

The turnaround in child immunisation in the past two years shows that we can make gains by blending relevant resources with community action. We could achieve immediate health gains for low income communities by making new investments in: incentives and skills for local health workers; district services and primary health care outreach, including for vehicles and fuel; and in the recognition, resourcing and capacity support for community and community health worker roles.

These measures address the deeper, structural, national and global inequalities that challenge health equity in Zimbabwe.

Human Development Index (HDI) Zimbabwe and the rest of the world 1975–2005



Introduction

HIV and AIDS, economic decline and hyperinflation, and political discord have detracted from Zimbabwe's progress towards equity in health in the past decade. AIDS-related mortality has had a sharp and significant negative impact on health for all groups, leaving Zimbabwe with one of the lowest life expectancies in the world (UNDP, 2008).

Zimbabwe ranks 151 of 177 countries in the 2007/8 Human Development Index. After its Human Development Index (HDI) peaked in 1975–1990 at .654, it fell to .513 in 2007/08, its lowest mark in 25 years. Zimbabwe's Human Poverty Index in 2004 was 40.3, putting the country at 91 out of 108 countries (UNDP, 2008)(See figure on page 5). Economic inequality is high with the poorest 10 per cent of people sharing only 1.8 per cent of the national income in 1999–2005, while the richest 10 per cent shared 40.3 per cent of the income. The ratio of richest 10 per cent to poorest 10 per cent in the period was 22 (UNDP, 2008). Inequality remains a determining feature of socio-economic wellbeing and addressing equity is central to reducing poverty and achieving targets for the Millennium Development Goals.

Yet opportunities for improving health and closing gaps between groups exist: HIV prevalence in adults declined from 25.7 per cent in 2002 to 15.6 per cent in 2007, presenting new opportunities to improve health in all social groups (UNICEF, 2007). Land redistribution offers the potential for low-income rural households to improve their incomes for health, if we invest in living environments and make production resources accessible.

The challenges

Tapping these opportunities faces a range of challenges, including:

- A 35 per cent decline in GDP between 1999 and 2007 (World Bank, 2007);
- An official year-on-year inflation rate in January 2008 of 100,580 per cent, the highest in the world (CSO in Chikwanda, 2008);
- Significant declines in tobacco, cotton, maize and winter wheat production since 2000 (FAO, 2008);
- Fertiliser and fuel shortages;
- Shortfalls in a range of basic needs, including food;
- An orphan population of nearly one million (MoHCW, 2008) largely dependent on fostering from poor households;
- Declining real levels of public spending on health and social welfare;
- Rising costs and declining availability of production inputs;
- High out-migration of skilled and experienced health workers from the health sector (GoZ, 2004);
- Political violence, homelessness and displacement disrupting households, increasing vulnerability and undermining social cohesion (ZADHR, 2008; UNOCHA, 2008).

These challenges set a testing context for the policies and trends needed to address the different dimensions of inequality in health that are explored in this analysis.

The indicators

We assess progress towards achieving equity in health in Zimbabwe using the EQUINET definition of equity (see box on page 2).

We use available indicators and peer reviews from key stakeholders to explore progress in how far:

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

EQUITY WATCH

Advancing equity in health

Progress markers

- Formal recognition and social expression of equity and universal rights to health
- Achieving UN goals of universal access to prevention of mother to child transmission, condoms and antiretroviral treatment by 2010
- Eliminating income, area differentials in immunisation, antenatal care and deliveries by skilled personnel
- Eliminating income and urban/ rural differentials in maternal mortality, child mortality and stunting
- Achieving the Millennium Development Goal of reducing by half the number of people living on $1 per day by 2015

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

PAST LEVELS (1980-2006)

- Despite various constitutional processes and amendments since 1990, the right to health or health care has not been addressed and is not explicitly provided for in the Zimbabwe constitution.
- There is no single overall National Health Act. The Public Health Act (1924) is the major enabling law and has had numerous amendments. The Medical Services Act (1998) and regulations were introduced to regulate health service standards, particularly of private sector services and voluntary medical aid societies.
- In 1980, 'Planning for equity in health' made equity a central policy principle. Health systems were organised around primary health care (PHC) and measures were taken to strengthen access and availability of public services and personnel, and to redistribute resources to district services and among underserved areas. Access among disadvantaged groups was also improved by promoting health, deploying village health workers and 'free' services for those earning below Z$150 (US$22) (MoHCW, 1999).
- While equity remained a core policy principle, subsequent health plans and strategies gave more emphasis to quality and efficiency, and cost recovery measures undermined access.
- National policy promoting gender equity led to review of laws such as the Equal Pay Regulations, Sexual Discrimination Removal Act, Administration of the Deceased Estates Act and Sexual Offences Act.

CURRENT LEVEL (most recent data)

- The constitution provides for protection of the right to life but not specifically for the right to health or health care. The Zimbabwe 'National health strategy 1999-2007' advocates for health rights to be included in the constitution.
- Zimbabwe is signatory to the main African and United Nations declarations, including the International Convention on Economic, Social and Cultural rights (article 12 on the right to health), the African Charter on Human and People's Rights (1990) and the Convention for the Elimination of all forms of Discrimination Against Women (CEDAW). The development of a Patient's Charter in 1996 provides information on rights and responsibilities of patients and health providers but is not actively used.
- The 'National health strategy 1999–2007' made quality and equity central principles of health policy (MoHCW, 1999). The policy underpinned health sector reforms that opened up greater private sector participation but also aimed to:
  - ensure core health services for all Zimbabweans;
  - promote equity through services based on health needs;
  - redirect resources to prevention and primary health care;
  - empower local health service managers and communities;
  - establish national social health insurance; and
  - improve the resource allocation formula.
- The Ministry of Health and Child Welfare (MoHCW) is currently drafting a new national health strategy for 2008–2012 and has circulated a working consultative document, 'Developing a national health strategy, 2008–2012'.

Progress

- Zimbabwe has had a consistent policy commitment to equity in health since 1980.
- This commitment has not yet been adequately translated into constitutional provisions. This calls for advocacy to include rights to health and health care in the constitution (with obligations for reasonable measures within available resources to realise these rights) and to update public health law.
- We need an incremental plan to operationalise long-standing policy commitments to equity (prevention, primary health care, equitable resource allocation, social health insurance, local empowerment) through specific targets and timeframes that can be monitored, without being overshadowed by disease-specific targets. This would mean we could assess the impact of health sector reforms on equity commitments.
- The drafting of a new strategy presents an opportunity for awareness and engagement on these issues.

Achieving the UN goals of universal access to condoms, antiretrovirals and treatment to prevent mother to child transmission by 2010

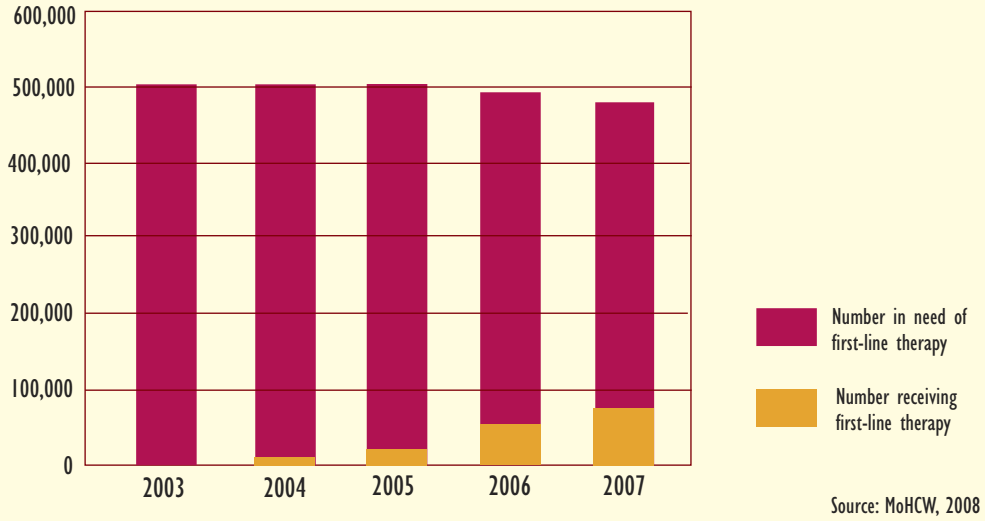
PAST LEVELS (1980-2006)

- The AIDS levy and National AIDS Trust Fund were established in 1999 as a unique tax-based contribution to public spending on AIDS, although implying additional individual tax burdens. In 2002, government declared AIDS a national emergency.
- Condom consumption in 2005 was about 80 million, 50 per cent of target levels.
- Voluntary counselling and testing (VCT) expanded in 2003–2005, with mobile outreach to hard-to-reach populations.
- Only 1.5 per cent of people needing antiretroviral treatment (ART) received it in 2004 (MoHCW, 2007) but this had risen to 7 per cent by 2005 (NAC *et al.*, 2006).
- A national Prevention of Mother to Child Transmission programme (PMTCT) was set up in 2002 aiming to reach at least 80 per cent of pregnant women and improve child survival in HIV infected/affected children by at least 50 per cent (MoHCW, 2006b).
- In 2005, 80 per cent of new antenatal care bookings were counselled. 67 per cent of those counselled were tested and 20 per cent were HIV positive. 54 per cent of positive mothers received nevaripine and 51 per cent of HIV exposed babies received nevaripine (MoHCW, 2006b).

CURRENT LEVEL (most recent data)

- Adult HIV prevalence fell from 25 to 20 per cent between 2003 and 2005 and was estimated at 15.6 per cent by 2007. This was partly due to changing sexual behaviour among young people (MoHCW, 2008).
- Young people, sex workers, prisoners, married women, men who have sex with men, sexually abused people and orphans are susceptible (NAC *et al.*, 2006). Risk rises with poverty, food insecurity, gender inequality, mobility and spousal separation.
- A national HIV/AIDS strategic plan for 2006–2010 includes targets and guidelines in key areas of prevention, treatment and care. But minimal external funding has meant significant resource constraints in implementation, despite the innovative AIDS levy (see discussion in a later section on health financing).
- The aim is for 85 per cent of people to know their HIV status by 2010 but VCT access is currently about 15–16 per cent of adults (NAC *et al.*, 2006; MoHCW, 2007). In 2006: 92 per cent of pregnant women were pretest counselled for HIV; 72 per cent of those counselled were tested, of whom 18 per cent were HIV positive; 60 per cent of these mothers were treated with nevaripine while 60 per cent of exposed children were treated (MoHCW, 2006). Zimbabwe follows the WHO recommended guidelines for prevention of mother to child transmission.
- In 2007 provider initiated testing and counselling (PITC) for all patients visiting health institutions was introduced (MoHCW, 2007).
- First line antiretrovirals were given to 16 per cent of those in need in 2007, leaving an estimated 394,000 people untreated (MoHCW, 2008b). Only 9 per cent of children in need received ART in 2006 (MoHCW, 2008). The need for treatment will continue to rise, according to estimates.
- Drug shortages and stockouts, shortages of HIV test kits, staff attrition and low male participation are reported to threaten programmes, including for meningitis and TB, and patients cannot afford drug prices in private pharmacies (MoHCW, 2007).

Access to antiretroviral treatment 2003-2007



Source: MoHCW, 2008

Progress

- Zimbabwe has amongst the highest HIV sero prevalence in the region but levels have fallen since 2002. There are still groups in the population with higher risk of HIV infection and the figure of half a million people needing treatment is likely to increase.
- While the policies, institutions and programmes are in place to respond to these prevention, treatment and care needs, resources are lacking for the scale up required. Further investment is needed in effective additional measures to promote uptake among vulnerable or marginalised groups. For example, while access to paediatric drugs has improved, low coverage rates persist due to supply, cost and specific access barrier issues.
- Innovative measures such as the AIDS levy provide potential sources of progressive national funding for AIDS, particularly if formal employment levels improve and funds are equitably allocated to households in need. We still need to integrate equity into the allocation of AIDS resources.
- The barriers to treatment and to PMTCT identified are likely to particularly affect rural, low income populations for whom service access is weaker and cost barriers higher. This calls for specific measures to enhance and monitor uptake in these groups.

Eliminating income and urban: rural differentials in attendance by a skilled person at birth and access to immunisation and antenatal care

PAST LEVELS (1980-2006)

- In 1994, 80 per cent of 12-23 month olds received all basic vaccinations. Differentials in immunisation percentage rates were: rural: urban – 78:84 ; and mothers educated: not educated – 87:72 (CSO, Macro Int., 1995)
- In 1999, vaccination coverage among 12-23 month-olds declined to 75 per cent with rural: urban percentage rates of 72: 81. (CSO, Macro Int., 2000). Some groups, such as the apostolic sect, raise religious barriers to immunisation but the decline has mainly been due to outreach and access to services issues.
- While antenatal care (ANC) visits increased by 64 per cent between 1990 and 1999, antenatal care bookings and numbers of women delivering at health facilities decreased by 30–50 per cent in 2005, attributed to shrinking disposable incomes and increases in service fees (MoHCW, 2006, 2007).

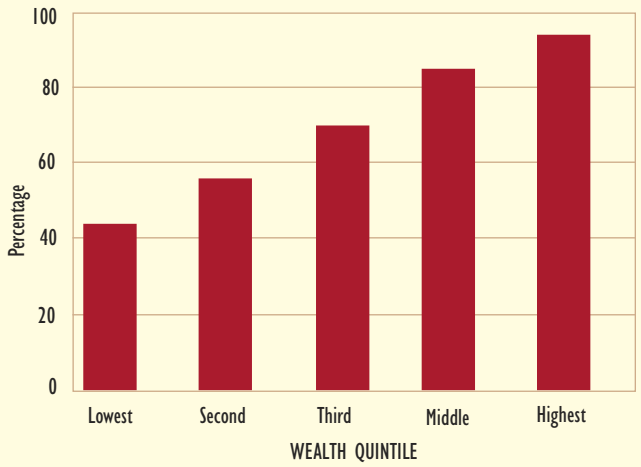
CURRENT LEVEL (most recent data)

- Infants of 12-23 months immunised fell to 53 per cent by 2005/6, with rural: urban and lowest: highest income quintile percentage differentials of 50:58 and 43:64 respectively (CSO, Macro Int., 2007).
- Since mid-2005, Child Health Day campaigns have reached two million children biannually through a one-week national vaccination outreach. Consequently, overall immunisation coverage increased to over 80 per cent in 2007 (Singizi 2007; see case study).
- In 2005/6, 94 per cent of women who had had a live birth in the preceding five years made at least one antenatal care visit (CSO; Macro Int., 2007).
- Attendance by a skilled person at birth fell to 69 per cent in 2005/6, with significant rural: urban percentage differential rates of 58:94 and lowest: highest income quintile rates of 46:95 (CSO; Macro Int., 2007).
- Village health workers help improve uptake of health services but lack resources (GoZ/UNICEF, 2007).

Progress

- From one of the highest performances in immunisation in the east and southern African region, Zimbabwe fell to amongst the lowest by 2005, with rising rich: poor ratios and rural: urban differences. Zimbabwe had overtaken those in some neighbouring countries but thereafter a concerted immunisation campaign restored coverage to above 80 per cent by 2007.
- This indicates the potential to reverse declines if resources are organised and directed to primary health care, including for fuel, vehicles, supplies and personnel in services and in the community to support outreach, such as village health workers and those in civil society.

Percentage of deliveries in health facility by wealth quintile 2005/6



Source: CSO Macro Int., 2007

Eliminating income and urban/ rural differentials in maternal mortality, child (under 5) mortality and children (under 5) stunting rates

PAST LEVELS (1980-2006)

- Maternal mortality rate doubled from 283 to 578 per 100,000 between 1994 and 1999 (CSO; Macro Int., 2000). Rural: urban or wealth quintile differentials in maternal mortality and coverage or uptake of sexual and reproductive health services rates are not available. Most maternal mortality is due to: limited availability of skilled birth attendants at first referral level; limited access to health facilities and transport; and unwanted teenage pregnancies and abortion complications. Social attitudes that condone violence against women and inadequate services to address gender violence undermine sexual and reproductive health services (Parl of Zimbabwe, 2008).
- The child (<5) mortality rate in 1999 was 102 per 1,000. Rural rates were 1.6 times urban rates (CSO; Macro Int., 2000).
- Child under nutrition (<5 years; weight for age) was 13 per cent in 1999. Child stunting increased from 21 to 27 per cent between 1994 and 1999 (CSO; Macro Int 2000).

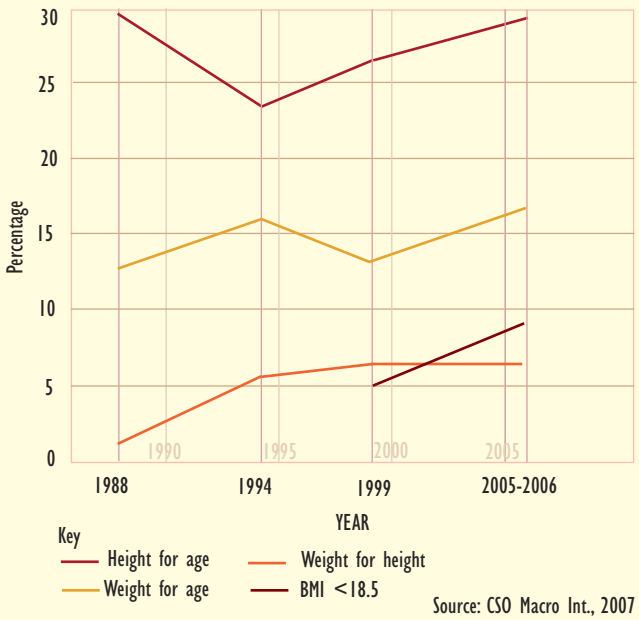
CURRENT LEVEL (most recent data)

- By 2005/06 the maternal mortality rate had stabilised at 555 per 100,000 (CSO; Macro Int., 2007). Improving coverage of adolescent sexual and reproductive health services, post-abortion care and skilled birth attendants at primary care level and ensuring security of generic reproductive health commodities are priorities. The Domestic Violence Act chapter 14 (2006) challenges gender violence. Government aims to reduce maternal mortality to 70 per 100,000 by 2015 (MoHCW 2008b).
- Child (<5) mortality fell to 82 per 1,000 in 2005/6 with rural rates falling to 1.1 times urban rates. Lowest to highest income quintiles were 72: 57 per 1,000 (CSO; Macro Int., 2007).
- Child (<5) undernutrition increased to 17 per cent in 2005/6, with urban: rural and lowest: highest income quintile differentials of 11: 18 and 21:9 per cent respectively. Child (<5 years) stunting increased to 29 per cent, with rural: urban and lowest: highest wealth quintile differentials of 31: 24 and 34:23 per cent respectively (CSO; Macro Int., 2007).
- Poverty and national food insecurity have affected nutrition. Severe declines in child nutrition have partly been buffered by child supplementary feeding. Rates of exclusive breastfeeding in the first 6 months are still low (GoZ/UNICEF, 2007).

Progress

- Zimbabwe has a relatively high level of maternal mortality for its income level, with poorer performance than 9 of the 16 east and southern African countries. Disaggregated information on geographical and socio-economic differentials in maternal mortality would help identify those with highest risk. Programme targeting and general improvements in access to sexual and reproductive health services already underway could then be complemented by more focused measures to address supply and uptake barriers to use of services in these groups.
- The child mortality rates and differentials are, however, not among the highest in the region, with improvements in both overall levels and in closing differentials across area and income groups.
- Food insecurity has been acute nationally and there is also chronic insecurity in poor households. Under-nutrition and stunting rates are relatively high for the national income level. There has been some mitigation through relief and supplementary feeding programmes.

Trends in child and maternal nutrition 1998-2006



Source: CSO Macro Int., 2007

Achieving the Millennium Development Goal of reducing by half the number of people living on US$1 per day by 2015

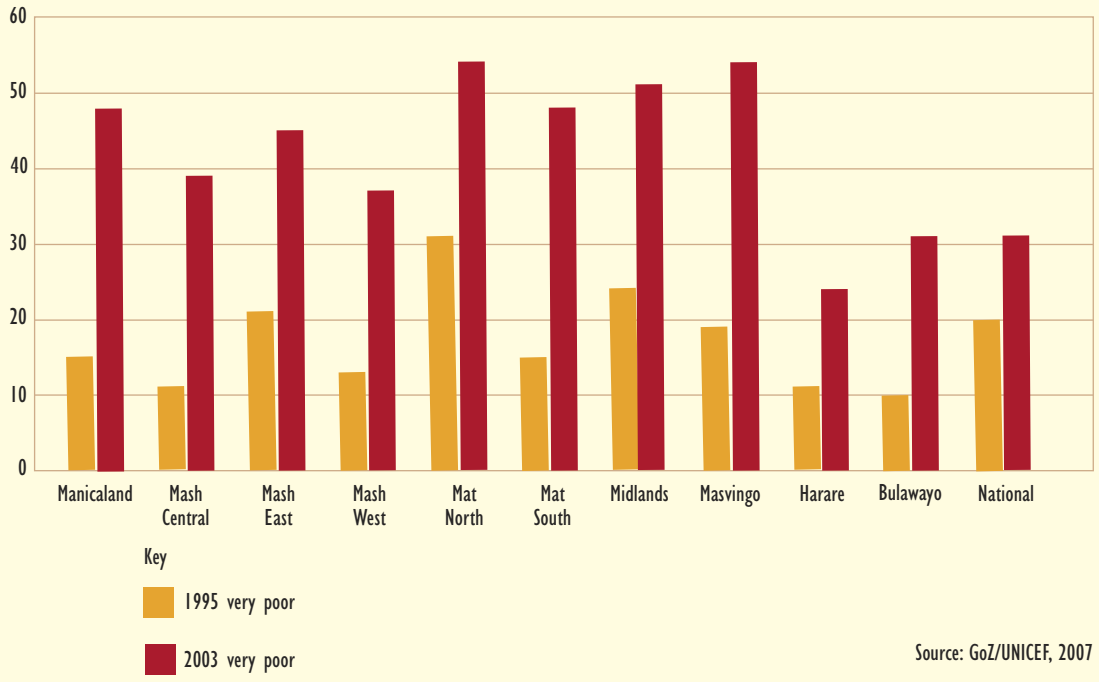
PAST LEVELS (1980-2006)

- Poverty increased between 1995 and 2003. The percentage of population below the food poverty line (FPL) rose From 29 per cent in 1995 to 58 per cent in 2003; and those below the total consumption poverty line (TCPL) increased from 55 per cent to 72 per cent (MoPSLSW, 2006; GoZ/UNICEF, 2007).
- The increase in those below the total consumption poverty line between 1995 and 2003 was 21 per cent higher in urban than in rural households although rural households are still poorer than urban. Female-headed-households are poorer than male-headed-households by 8 per centage points (MPSLSW, 2006).

CURRENT LEVEL (most recent data)

- Between 1990 and 2005, 56 per cent of people were living on under US$1 a day and 83 per cent earned below US$2 a day (UNDP, 2008). Poverty tripled between 1995 and 2003 in some provinces (GoZ/UNICEF, 2007).
- Poverty levels have not been measured since 2005. Zimbabwe is experiencing significant economic problems: the economy has shrunk cumulatively 40 per cent since 1999; hyperinflation has eroded purchasing power; declining investment and aid and periodic drought are reported to have deepened poverty. Remittances from family members outside the country have become an important source of household income (Bracking and Sachikonye, 2006).

Percentage of households below the food poverty line by province: 1995 and 2003



Source: GoZ/UNICEF, 2007

Progress

- Zimbabwe's share of people in poverty was higher than that of eight other countries in the region in 2003 and there is evidence that poverty has increased since 1995.
- Given the significant changes after 2003, it would be important to carry out a new poverty survey disaggregated by area, income group and by other social factors to identify groups now most at risk. This is particularly important as the informal nature of many cash transfers and the decline of formal employment and markets has made it difficult to make inferences from formal data sources. This is essential data to plan resource allocation and service outreach, given the key role of public sector health services in mitigating poverty.

EQUITY WATCH

Household access to the national resources for health

Progress markers

- Achieving universal primary and secondary education for women
- Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
- Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in the region)
- Increasing the ratio of wages to profits
- Abolishing user fees from health systems
- Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems
- Overcoming the barriers disadvantaged communities face in accessing and using services

Achieving universal primary and secondary education for women

PAST LEVELS (1980-2006)

- The primary school completion rate fell from 73 per cent in 2000 to 68 per cent in 2004 while the secondary school completion rate fell from 78 per cent to 73 per cent in the same period. The gender ratio (girls: boys) in primary education increased from 97:100 in 2000 to 98:100 in 2004 and in secondary education from 88:100 in 2000 to 91:100 in 2004 (GoZ/ UNICEF, 2007). Some districts had significantly wider female to male gender gaps (for example, Umguza, Bubi, Bullilima and Mangwe).
- Dropout rates from primary school in 2003 were slightly higher in males (51:49 per cent), while at secondary school the rate was higher among females (53 per cent females: 47 per cent males). Financial constraints accounted for 20 per cent of non-enrolments in primary school and 70 per cent of non-enrolments in secondary school in 2003. Girl children leave school to care for sick parents or other young children (MPSLSW, 2006).
- Adult literacy for men and women in 2003 was 89 per cent (MPSLSW, 2006).

CURRENT LEVEL (most recent data)

- Updated information on enrolment and completion rates is not available.
- Education is the biggest beneficiary of the national budget, mainly for salaries. Households pay 85 per cent of the cost of primary education and 80 per cent of the cost of secondary education, so cost is a barrier for poor households. The government BEAM programme has increased in nominal terms from Z$300, 000 in 2001 to Z$190 billion in 2005 for nearly a million children. It does not, however, meet the level of demand (GoZ/UNICEF, 2007). The National Girls' Education Strategic Plan launched in 2006 mobilises resources to keep girls, orphans and vulnerable children in school in spite of economic hardship, with over US$2 million spent on girls' education in one year: 'Educating girls yields a higher rate of return than almost any other investment available in the developing world' (UNICEF, 2006).
- Despite salaries being the major budget line, real wages for teachers have fallen, conditions are poor and teachers have experienced political violence, leading to demotivation or absence from work (MPSLSW, 2006; Dugger, 2008).

Progress

- The 2003 PASS records Zimbabwe's net enrolment ratio as one of highest among developing countries. This combined with a positive gain in gender ratios makes a positive contribution to health equity.
- There are however challenges: the shortfall in public sector resources, with constraints on teachers' wages, service quality and household support. The cost burden on households has increased, with increased stress for the lowest income households. Marginal groups, such as orphans, who do not access safety nets are particularly disadvantaged. The present BEAM safety net is inadequate and stronger state support is needed for affordable education, including for disadvantaged children.

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

PAST LEVELS (1980-2006)

- Access to clean water and sanitation did not increase between 1990 and 2000. In the 1999 labour force survey, 75 per cent of rural households and 99 per cent of urban households had access to safe drinking water. By 2004 this remained constant in urban areas but had fallen to 66 per cent in rural households (CSO, 2006).
- While only 1 per cent of urban households in the period had no access to sanitation, 55 per cent of rural households did not have safe toilets.
- While access in urban areas is high, overcrowding of services and interruption of supplies has been a problem.
- As an indicator of environmental risk, diarrhoea rates increased from 32 per 1,000 people in 2004 to 47 per 1000 in 2005, with highest increases in Mashonaland West, Midlands, Harare and Chitungwiza (MoHCW *et al.*, 2004, 2005b).

CURRENT LEVEL (most recent data)

- In 2006, rural to urban access to clean water was 72: 98 per cent and rural to urban access to sanitation was 37: 63 per cent (WHO, 2008). So access had fallen further in both urban and rural areas. Authorities report that daily urban supply, limited by shortages of chemicals, is about 30 per cent of demand (ZINWA, 2008).
- Government, parliament and civil society report a worse situation, however, with a range of urban problems, including: aging and unrepaired sewer systems; waste put in sewers due to poor waste collection; illegal waste dumps; overflowing septic tanks; and frequent water and power cuts. While high density areas are particularly affected, these problems have spilled into all areas with some long-term interruptions in supplies (USAID, 2008; CWGH, 2008; CHRA, 2007; Parl of Zimbabwe, 2008b).
- Increasing costs of water and basic hygiene items, such as soap, have also reduced consumption in poor households. Reported rates of diarrhoea fell slightly from 47 per 1,000 in 2005 to 43 per 1,000 in 2006 but reports of epidemic outbreaks of water-related diseases, including in urban areas, have increased (MoHCW *et al.*, 2006). A massive cholera epidemic from August 2008 into 2009 had by December 18 2008 led to a reported 20896 cases and 1123 deaths with more possibly unreported (UN OCHA 2008). Poor households are least able to meet the costs of these environmental diseases. One resident of a high density area (Highfield, Harare) related the story of her 5 year old daughter's death due to fever and diarrhoea: 'I took her back to the clinic three times,' she said, 'but every time they said that she would get better soon if I give her food and lots of water – that it was just the fever and there was nothing they could do because they had no drugs. I thought about taking her to the Harare central hospital but it costs so much money and people said things are no better there. I just hoped.' (McGreal, 2008).

Progress

- Closing rural to urban differentials in access to safe water and sanitation is a priority in meeting Millennium Development Goal targets.
- The situation on the ground indicates that while infrastructures exist, they are old and malfunctioning. Lack of safe water leads people to source unprotected water informally. Even when safe water is available, tariff structures are needed to protect poor households' access to it. ZINWA currently provides 20 cubic litres at the lowest rate but this is till too high for some households. Residents and parliament are calling for safe water to be given higher priority (not included in load shedding and prioritised for chemical procurement). Infrastructure investment and better communication between residents and authorities are also priorities.
- In rural areas, disaggregating data by area would help direct the allocation of funds to expand infrastructure.

Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in east and southern Africa)

PAST LEVELS (1980–2006)

- In 1995-96 the Gini coefficient was 0.59 (MPSLSW, 2006).
- UNDP reported the Gini coefficient had fallen marginally to 0.57 by 2003 (UNDP, 2005) while government data reported it had increased marginally to 0.61. Medium poverty provinces saw a reduction in inequality, particularly in Mashonaland Central and Mashonaland East for unclear reasons (MPSLSW, 2006).

CURRENT LEVEL (most recent data)

- By 2005, UNDP report that the Gini coefficient had fallen to 0.50 (UNDP, 2008).
- The poorest 10 per cent of people in 1999-2005 had 2 per cent of national income The richest 10 per cent shared 40 per cent of national income, 22 times the wealth of the poorest 10 per cent.

Progress

- While the Gini co-efficient has fallen since 2003, it remains one of the highest in the region. Extremely high levels of inequality in wealth call for significant investment in redistributive systems.

Increasing the ratio of wages to profits

PAST LEVELS (1980–2006)

- Public data on this indicator could not be found.
- Growth in formal employment was relatively low at 1.8 per cent in 1980-1990, declining slightly to 1.6 per cent in 1990-1994 (Chitiga, 2004). While there was some growth in formal employment in the public sector in the early 1980s, the structural adjustment reforms in the 1990s were associated with a planned reduction in public sector employment and a fall in real wages.

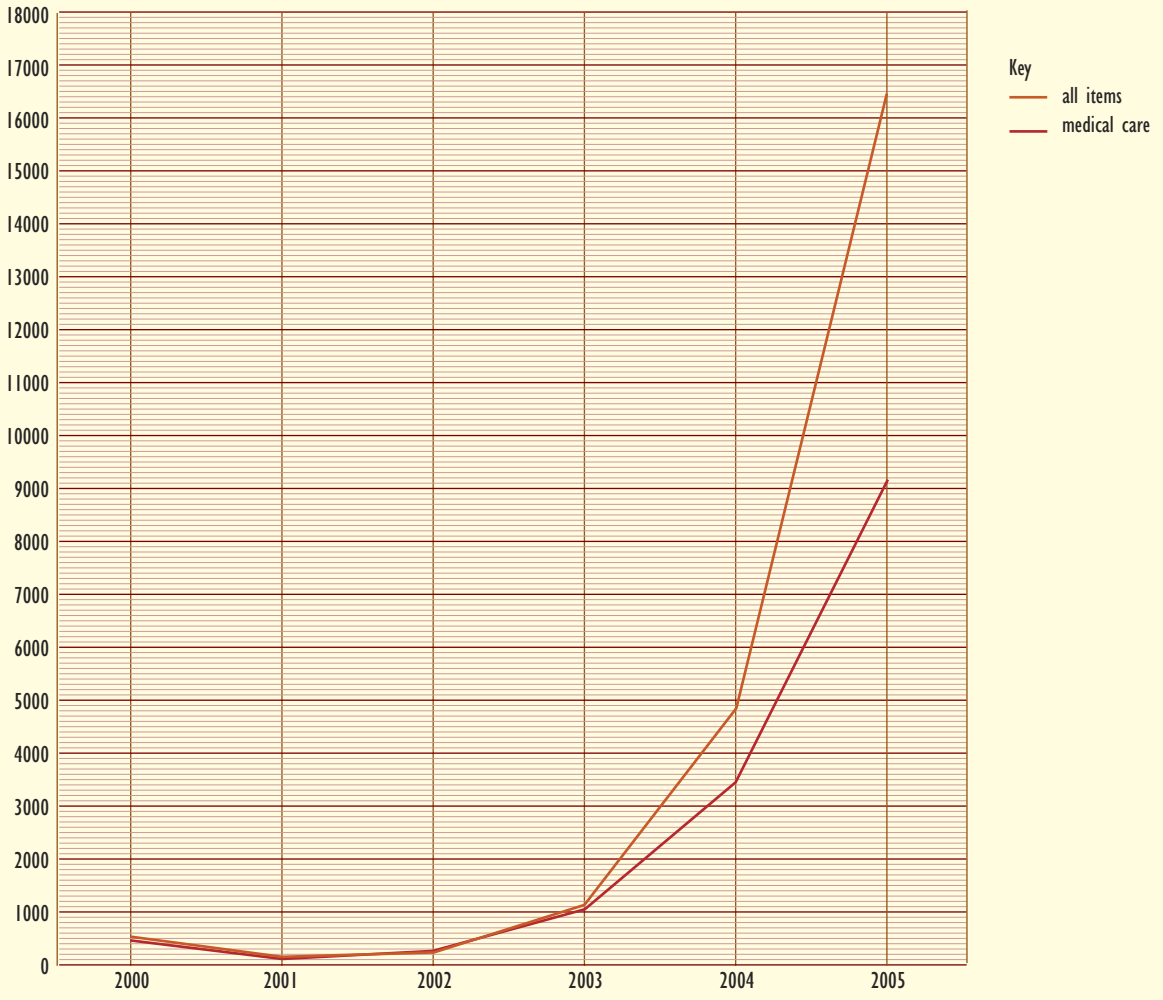
CURRENT LEVEL (most recent data)

- Public data on this indicator could not be found.
- Falling real wages in the public sector have been a push factor for out-migration and industrial action, and efforts to provide incentives have not matched the pull of competitive wages in other countries (HSB, 2007).
- Because there has been a substantial shift towards earnings and profits within informal markets and through remittances it is difficult to track real changes in this indicator through formal data sets.

Progress

- Assessing overall and disaggregated levels and trends in this indicator calls for household and company survey data not yet available.
- The shift towards informal markets and earnings has implications for the design and implementation of health financing and social protection schemes.

Consumer price index (CPI): medical care and all items 2000–2005*



*Between 1990 and 2000, there was generally a correlation between the CPI for all items and for medical care.

Source: CSO, 2008

Abolishing user fees from health systems

PAST LEVELS (1980–2006)

- In 1980 a policy of free health care for those on low incomes (below Z150; US$220) was introduced, and user fees were reduced as a financing source.
- The policy position on user fees has been that those who can afford to pay for services should do so but implementation of the principle has been mixed. Managing exemption from fees has been difficult and costly, with some consequent injustices in who was exempted. In 1990, more emphasis was placed on fee collection although, after evidence of high dropout from services, user fees in rural primary care services were suspended in 1995. The Medical Service Act (1998) gave the minister the authority to fix fee or no fee levels at government and state-aided hospitals. The 'National health strategy for Zimbabwe 1997–2007' aimed at free treatment for the majority but also stated that the policy of free health 'creates a disincentive for people to join medical insurance schemes'. While consultation was free at rural health clinics, this was implemented inconsistently, with different fee levels charged for drugs and consultations by the same types of facilities in different provinces (Euro Health Group, 2005).
- Poor people thus faced a variety of de facto cost barriers: the falling real value of the threshold for free care; transport costs; private purchases of medicines due to drug stockouts; and poorly functioning exemption schemes (MoHCW, 1999).
- At the same time higher income earners obtained a number of tax-funded public subsidies, including: tax relief for medical insurance subscriptions and free services due to difficulties with determining earnings and a 'treat first, pay later' practice.

CURRENT LEVEL (most recent data)

- The policy of free public sector care at rural clinics is still in force. Pregnant mothers, children under 5 and adults over 65 are also exempt from fees up to district level.
- In 2008, the 'Access to health services' study found that 59 per cent of respondents were charged for health care services, especially in urban, large-scale farming and mining areas. Of these, 36 per cent reported inability to pay. The study recommended removing user fees, especially at rural health centres and clinics, because they are barriers to access and do little in terms of income generation due to the hyperinflationary environment. This view was also held by the majority of the survey respondents and by the parliamentary committee on health (Makuto and James, 2007; Parliament of Zimbabwe 2007).
- The greatest inflation has been in the private for profit sector, although the medical consumer price index has been lower than the 'all items' consumer price index (See figure on page 20). Cost increases in the private sector are likely to have been a push factor in the urban shift from private to public services noted from surveys.
- Private sector fee increases require ministerial approval. In March 2006, government invoked this authority to impose a short-lived freeze on fees in the private sector but the hyperinflationary environment limits the effectiveness of this policy and varied charges being levied on clients in both public and the private sector services are reported.

Progress

- There has been some shift in the region towards abolition of user fees, with evidence that this is more successful when accompanied by increased investment in primary and district level services.
- Zimbabwe has both geographical and income level fee exemption policies but application has been mixed, with informal charges and consequent cost barriers for poor households.
- There would be equity gains from blanket abolition of user fees at primary care and district level services, including in urban areas. This needs to be accompanied by targeted investment in supply side issues and community awareness to prevent informal charges as well as increased funding to services in the lowest income areas and in community outreach to promote uptake in the lowest income groups.
- While the Ministry of Health and Child Welfare has a policy of free care at clinic level this has not been applied uniformly by local government and mission clinics. This needs following up with relevant ministries and increased funding, including grant funding, to replace fee income.

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

PAST LEVELS (1980–2006)

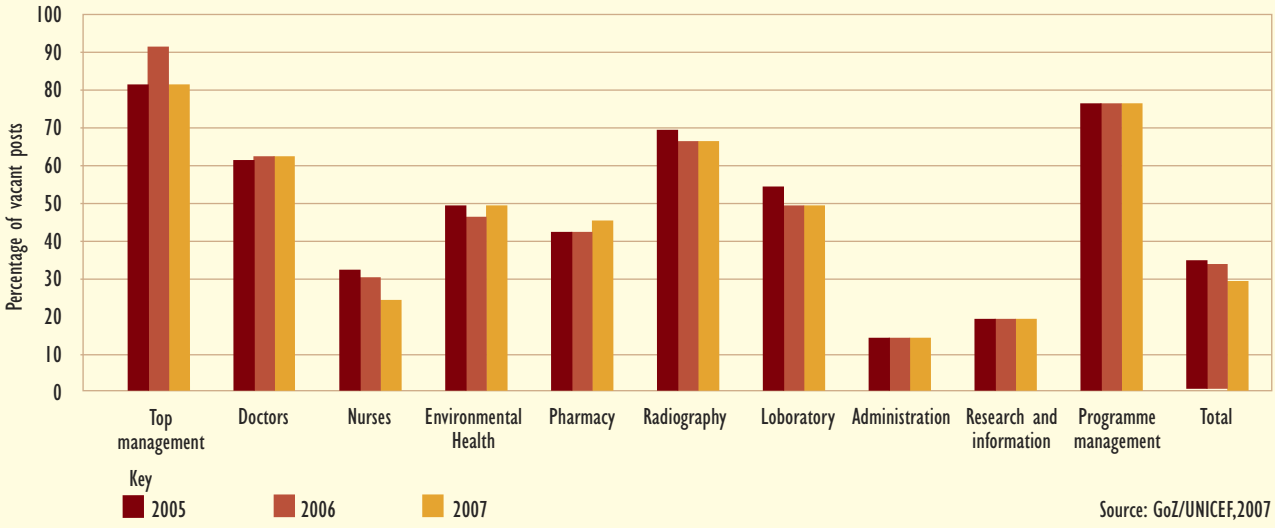
- Adequacy and distribution of health workers has been a persistent issue. In 1980, a range of measures were applied to produce, deploy and redistribute health workers, including training of new para-professional cadres.
- In the 1990s adequacy and internal migration were the main constraints. The density of doctors was 0.15 per 1,000 and of nurses 1.18. In 1992, 46 per cent of registered doctors practised in the public sector, with 64 per cent of these at central hospitals and only 21 per cent at district level. Almost all private sector doctors worked in urban areas. For nurses the respective figures were 45 per cent at central level and 33 per cent at district level. (MoHCW, 1999; Normand *et al.*, 2006).
- In the 2000s, there was a marked shift towards external migration of health workers. Staff vacancies rose sharply between 2001 and 2003: from 40 to 80 per cent for pharmacists; from 10 to 60 per cent for doctors and from 10 to 20 per cent for nurses (UNICEF, 2007b). In 2000, 20 per cent of health professionals migrated annually from Zimbabwe. By 2004, 68 per cent of health workers surveyed indicated their intention to migrate (Chikanda, 2005).
- Health workers' push factors were: poor pay, low savings, poor living conditions, under-resourced health services, job stress and lack of confidence in their future (Awases *et al.*, 2004).
- By 2004, the density of doctors remained at 0.16 per 1,000 but density of nurses fell to 0.72 (WHO, 2007).
- The Ministry of Health and Child Welfare implemented an essential drug programme in 1980 and significantly improved drug management, monitoring and evaluation. The public sector adopted prescription of generic drugs (MoHCW, 1999). Drug availability was reasonable but did not fully match demand, with 72 per cent availability of vital drugs and 56 per cent availability of essential drugs (GoZ/UNICEF, 2007). The shortfalls were more pronounced at primary care services most used by poorest communities.
- In 2004, drug availability fell from 82 per cent at central hospitals to 80 per cent at district hospitals and 60 per cent at rural health centres (MoHCW, *et al.*, 2004).

CURRENT LEVEL (most recent data)

- Policy targets are for 80 per cent coverage of essential medical personnel and for vacancy rates to be reduced to 10 per cent (HSB, 2007). In December 2007, vacancy rates rose to 62 per cent of posts for doctors, 24 per cent of posts for nurses posts and 45 per cent of posts for pharmacists, with 61 per cent of total health worker posts filled (MoHCW, 2008b). These figures are higher than December 2006 levels.
- External migration is high and deployment to rural, peripheral areas continues to be a problem, although there was some improvement in deployment of doctors to rural services in 2008.
- Push factors are financial (pay, cost of living) and welfare (lack of accommodation, inadequate supervision) (HSB, 2007; MoHCW 2008b). Many facilities have less qualified staff standing in for more highly skilled counterparts, for example, primary care nurses in place of state registered nurses (Makuto, 2007).
- Incentives have been used to address internal distribution: bonding agreements in district hospitals are for one year instead of two years in central hospitals; the primary care nursing programme and scaling up of nursing training has helped to limit vacancy levels of trained nurses at rural facilities (HSB, 2006). Recent training of primary care nurses in midwifery also improves assisted facilitated deliveries.
- In 2005 drug availability had fallen to 41 per cent, with vital drugs dropping to 63 per cent and essential drugs to 21 per cent (GoZ/UNICEF, 2007). Drug availability at central, district and clinic levels in 2006 was reported as constant but with lower availability at rural health centres (MoHCW *et al.*, 2006b).
- Drug availability is constrained by lack of foreign currency, with limited or no buffer stocks of many drugs. A 2004 consumer survey reported that access was limited by overall availability (89 per cent), followed by cost (7 per cent). Scarcity may be driving cost increases in the private sector, with drug prices in Zimbabwe higher than in neighbouring countries (Euro Health Group, 2005). Rural communities report greater difficulty than urban communities in affording the additional costs of drugs (Makuto, 2007).

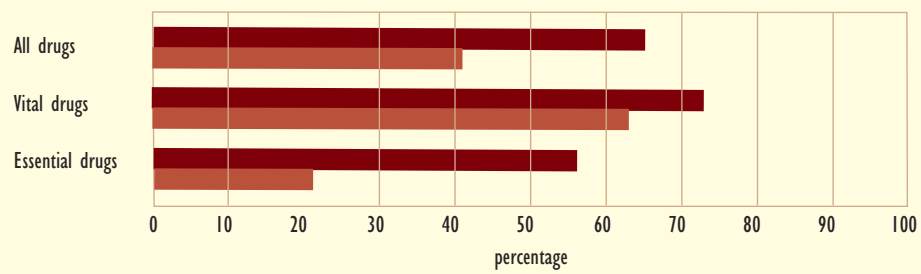
- Limited drug availability in public sector primary care institutions and high private sector prices present a higher cost burden for lowest income, peripheral communities, who also have highest health needs. However, these issues cut across a wide range of communities: 'Zimbabweans have been pelted left, right and centre by shortages of drugs, inaccessible hospitals (especially in remote areas) and by a general increase in medical care expenses' (ZCTU, 2007).

Trends in staff vacancies in Ministry of Health and Child Welfare 2005, 2006 and 2007



Source: GoZ/UNICEF,2007

Drug availability at NatPharm 2004, 2005



Source: GoZ/UNICEF, 2007

Progress

- In 2004 Zimbabwe had lower densities of nurses than nine of the sixteen east and southern African countries, and lower densities of doctors than seven of these countries. The position has worsened since then and external migration (vs internal migration) has become a dominant problem. Measures are in place to improve communications and incentives but factors beyond the health sector drive migration and limit their impact. Recent reports suggest some improvement in deployment of doctors to rural facilities.
- Failing availability (drug and staff) to some extent masks the role of cost escalation as a barrier to access. The observation that private sector drug prices in Zimbabwe are higher than in other countries in the region is worrying. Furthermore, recent provisions allowing pharmacies to charge for medicines in foreign currency may escalate prices unless closely monitored.
- This calls for public authorities and communities to monitor markups and pricing of key health service inputs, including drugs, to prevent unfair mark-ups due to scarcities; and pressure to improve supplies in the public sector.
- The fall off in drug availability from secondary to primary care level undermines equity, pointing to the need to address the determinants of this drop.
- Having an industry for local production of key pharmaceuticals reported to be able to satisfy an estimated 30 per cent of essential drug needs represents a strategic asset. Investments (foreign currency and raw materials) are needed to tap this on the basis of predictable demand through public sector procurement.

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

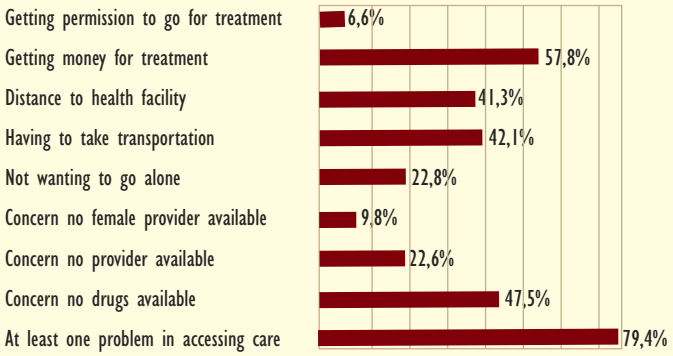
PAST LEVELS (1980–2006)

- While the 'National health strategy 1997-2007' aimed at all households being less than 10kms from a health centre, by 2003, 25 per cent of all households and 30 per cent of the poorest households were still too far from facilities (MPSLSW, 2006).
- Between 1994 and 2004, labour force surveys reflected more visits to a facility by those ill in the preceding month (62 per cent to 71 per cent in both urban and rural areas). While use of facilities was higher in the urban private sector than in rural areas in 1994 (25:3 per cent) and 1999 (18:3 per cent), this fell significantly by 2004 (8:5 per cent). Cost was cited as a barrier in 23 per cent of cases of people not visiting services after falling ill in 2004 (CSO, 2006).
- Poverty was a general barrier to access but orphans and other vulnerable children were specifically identified as facing cost and social barriers in accessing health services in 2004 (UNICEF, 2005). By 2005/6, 24 per cent of children were orphans (GoZ, UNICEF, 2007).

CURRENT LEVEL (most recent data)

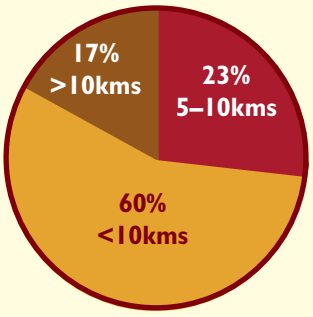
- The share of households more than 10kms from a facility had reduced to 17 per cent by 2007, although 40 per cent were still more than 5kms away.
- While policies aim for universal access to health care, numerous factors prevent this; shortages of drugs, ambulances, water, electricity and sanitation services at health institutions and long, costly referral processes hinder health service uptake in poor households. While patients favour care close to home, these constraints result in referrals to distant facilities (Makuto, James, 2007). This undermines primary health care and significantly increases households' transport, drugs and fee costs.
- Women face numerous barriers, including treatment fees, drug availability, transport and distance to facilities. Financial barriers were cited by 75 per cent of women in the lowest income quintile compared to 35 per cent in the highest income quintile (CSO; Macro Int., 2007).
- Recent reported efforts to improve access to services include: converting farm houses into health centres; immunisation outreach (see case study); staff incentives to accept district posts and institutionalising traditional medicine. Civil society activities help promote health service uptake in vulnerable communities.

Percentage of women citing problems in accessing health care



Source: CSO, Macro Int., 2007

Percentage of households at varying distances from health facilities: 2007



Source: Makuto, James 2007

Progress

- Zimbabwe's reasonable physical infrastructure could support universal access, particularly if we pursue measures underway to establish clinics in large-scale farming areas and adequately resource services.
- People wouldn't have to leave services close to them or spend significant amounts on transport, drugs and fees for higher level services if we adequately resource services in the lowest income areas.
- Further, those facing cost and social barriers need additional inputs to support uptake and coverage, including through cooperation with civil society organisations. The shift to use of public sector services is an opportunity to reinvest and revive its role, which is important for equity.
- Disaggregated service coverage monitoring and reporting are essential in planning equitable resource deployment.

EQUITY WATCH

Resourcing redistributive health systems

Progress markers

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

Achieving the Abuja commitment of 15 per cent government spending on health – excluding external funding

PAST LEVELS (1980–2006)

- Government expenditure on health was at its peak of 17 per cent in 1997, falling to 7.4 per cent in 2000 and rising to 9.2 per cent in 2003 (Govender *et al.*, 2008).
- Expenditure on health peaked in 1998 at 10.8 per cent of GDP. It fell thereafter to 6.5 and 8.1 per cent of GDP in 2005 (WHO, 2008c), according to the Ministry of Health and Child Welfare's nominal and inflation adjusted budget 1996-2005 (GoZ/UNICEF, 2007).

CURRENT LEVEL (most recent data)

- Revised budget estimates for 2007 put health spending at 8.7 per cent of the total budget (MoFin, 2008).
- Budget estimates for 2008 allocated 12.2 per cent of the annual government budget to health. Actual expenditure will need to be assessed given the practice of supplementary budgets and direct disbursements from the central bank (Shamu and Loewenson, 2006).
- While the share of spending has increased, the real value of this spending has fallen due to high inflation; the overall public spending is low relative to need.

Progress

- Zimbabwe has not met the Abuja commitment although it has made some efforts to reverse significant declines in the health share of the budget.
- An additional per capita spending of US$30 was needed in 2003 to meet the Abuja commitment. Given the extent to which the lowest income communities with greatest health need are reliant on public sector services, increased funding should largely be spent within the public health sector.

Budget allocations to selected ministries

	2000	2001	2003	2004	2005	2006	2007	2008
Public Service, Labour and Social Welfare	2%	6%	6%	4%	4%	3%	4%	8%
Defence	15%	16%	13%	13%	10%	9%	8%	5%
Lands, Agriculture and Rural Development	3%	5%	11%	7%	3%	2%	8%	5%
Local Government, Public Works and National Housing	2%	3%	2%	3%	4%	2%	3%	3%
Health and Child Welfare	9%	14%	11%	11%	11%	7%	9%	14%
Education Sports and Culture	26%	36%	24%	21%	20%	16%	17%	11%

Source: Ministry of Finance, National Budget Blue Books 2000-2008

Achieving the WHO target of US$60 per capita spending on health systems in the public sector.

PAST LEVELS (1980–2006)

- Total per capita health expenditure (average US dollar) fell from $48 in 2000 to $21 in 2005. Per capita government expenditure on health was about half of this, falling from $21 in 2000 to $9 in 2005 (WHO, 2008).

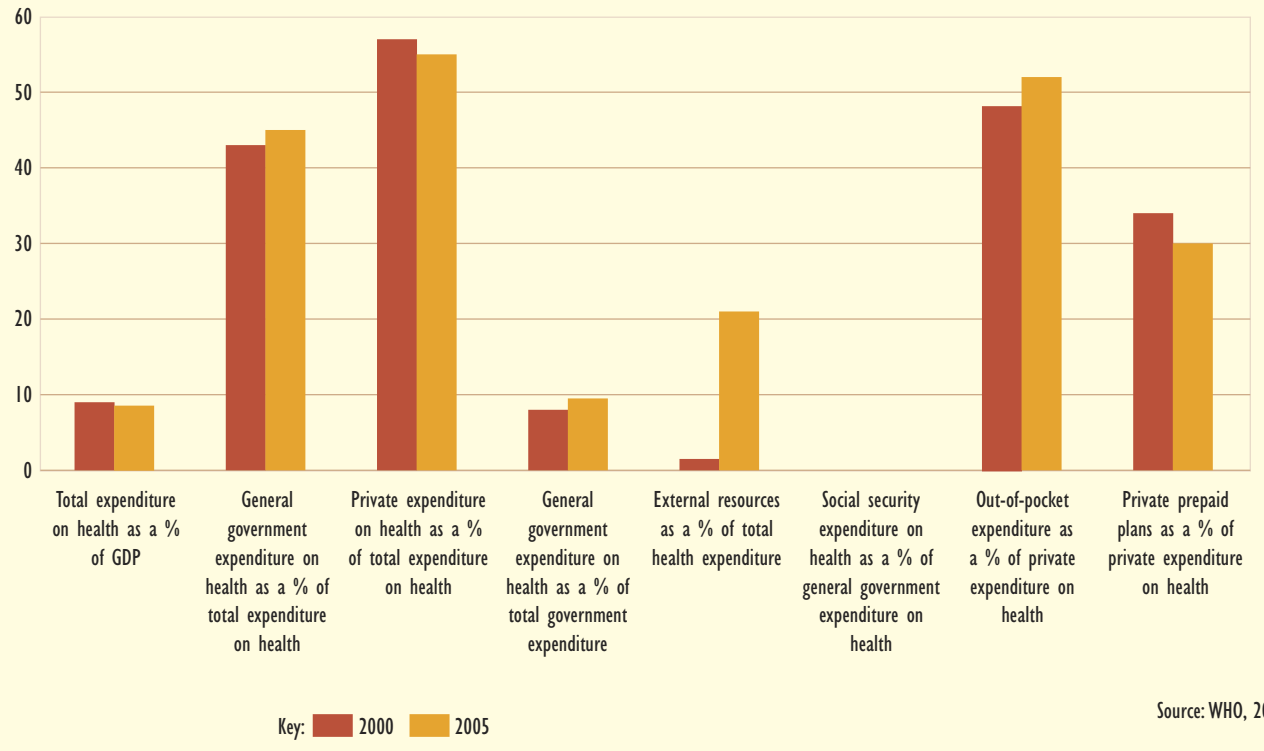
CURRENT LEVEL (most recent data)

- Per capita expenditure on health fell marginally further to US$19 in 2006 (WHO, 2008c).
- Figures for 2007 were not available. and assessment of spending in 2008 is complicated by extra-budgetary spending by the Reserve Bank of Zimbabwe.

Progress

- Per capita expenditure on health was estimated at US$19 in 2006 (WHO 2008) This is half of the level estimated by the Macroeconomic Commission on Health needed for interventions for HIV, TB and malaria only, and a third of the US$60 per capita estimated to be needed for a functional health system in the public sector. The health sector is thus significantly under-funded in Zimbabwe, as it is in other countries in the region (EQUINET SC 2007).
- Per capita spending on health is relatively high but a large and increasing share of this is in the private sector. With high poverty levels and wide use of public services by poor households this trend has a negative impact on equity.

Shares of health expenditure 2000, 2005



Source: WHO, 2008

Increasing progressive tax funding to health to a significantly larger share than a reducing share of out-of-pocket financing in health

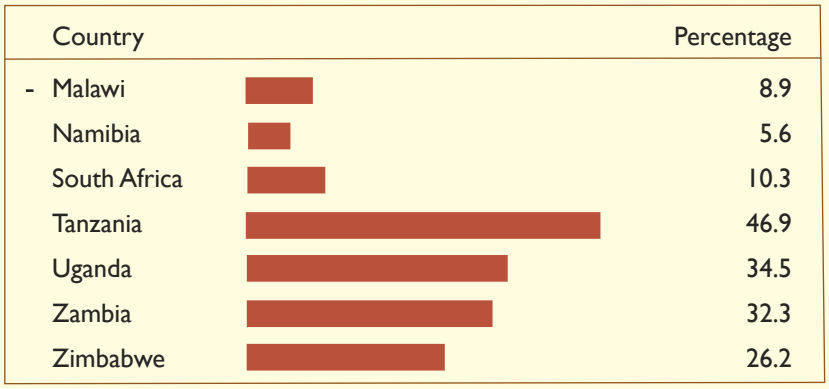
PAST LEVELS (1980–2006)

- In 1994 public expenditure was 51 per cent of total health expenditure and private expenditure was 49 per cent of total spending (Normand *et al*., 2006).
- By 2000 these shares had reversed, with public expenditure at 42 per cent of total health expenditure, and private expenditure 58 per cent of total spending. The out of pocket share (for example, on user charges or direct purchases) was at 48 per cent and external funding at 1.6 per cent (WHO, 2008; Shamu and Loewenson, 2006).
- The AIDS levy added a new source of tax revenue in 2001, with increased revenue in real terms from $59mn in 2001 to $75mn in 2005 (GoZ, UNICEF, 2007).
- This does not meet the gap left by relatively low levels of international funding after 2000. Although this share rose to 14 per cent by 2003, it remained relatively low. Average annual donor spending per HIV-infected person in Zimbabwe is US$4, compared to US$74 in southern Africa (GoZ/UNICEF, 2007).

CURRENT LEVEL (most recent data)

- By 2005, the share of public expenditure was marginally higher at 45 per cent of total health expenditure and private expenditure 55 per cent of total spending.
- Although the share of external funding has risen (21 per cent), so too had the share of out of pocket spending at 52 per cent (WHO 2008a) Later data is not publicly available.
- Social health insurance is a policy goal that could reduce rising out of pocket spending but is as yet unimplemented. Voluntary insurance covers mainly higher income groups and most women (91 per cent) do not have health insurance (CSO; Macro Int., 2007). Upfront cash charges and high inflation rates undermine the value of medical aid reimbursements.
- Other tax revenue proposals for health have been raised, such as the Parliamentary Portfolio Committee on Health's proposal in 2007 to introduce a 'sin tax' on luxury items that negatively affect health such as liquor or tobacco. They have however not been implemented.

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



Source: WHO, 2007 in Govender et al. 2008

Progress

- High shares of out of pocket spending are associated with inequity in health financing.
- High levels of out of pocket spending pose fee barriers that, together with informal charges, undermine the redistributive nature of health systems.
- This points to the need to strengthen the economic conditions for and the level of tax based financing to improve services as a primary measure.
- It would also be important thereafter to revive the social health insurance debate as soon as the economic environment permits.
- The diminished pool of voluntary insurance and private sector use provides a limited opportunity for this (and it is possible that the private sector will expand rapidly under improved economic circumstances).
- There is a need for annual reviews and reporting on the relative shares of different funding sources to underpin strategic public health leadership in and social support for fair financing.

Establishing a plan and strategy for harmonising the various health financing schemes into one framework for universal coverage

PAST LEVELS (1980–2006)

- 'Planning for equity in health' (1980) sought to provide universal health coverage and strengthen the public sector. By harmonising different providers within one policy framework, it aimed to redistribute health resources towards health needs. Not-for-profit mission services were, for example, coordinated with government services through public grants.
- In the 1990s, falling public sector revenues limited the state's leverage to achieve this. Health strategy in the 1990s emphasised partnership between public and private sectors to widen the base for providing and financing health care (MoHCW, 1999).
- A 1991 study commissioned by government concluded that a case existed for establishing a National Health Insurance Scheme (NHIS). The 1997-2007 National Health Strategy confirmed the policy intention to introduce national social health insurance as a means of complementing tax revenue. It was to cover all citizens for basic health services and to improve equity in financing and provision of care (MoHCW, 1999).

CURRENT LEVEL (most recent data)

- While public and not-for profit mission services continue to coordinate provision, financing the health services remains largely segmented between different providers with private funding shares higher than public and limited cross subsidies across funding pools. In 2007 government announced modalities for the proposed NHIS including a minimum benefits package defined by Ministry of Health financed from a 5 per cent levy on gross formal sector salaries and administered by the National Social Security Authority (NSSA). Members were encouraged to supplement their benefits through private medical aid societies, while unemployed and informal sector earners would be funded through the public sector from tax revenue.
- The scheme was reviewed through public and parliamentary consultation. Concerns were raised over: the adequacy and transparency of the management of funds; the scope of the benefits package (which excluded ART); the tax burden on formal employees in an unfavourable economic climate; and the adequacy of measures to promote service quality for poor households (Parliamentary Committee on Health, 2007b).
- The introduction of the scheme was postponed although relevant regulations have been drafted.

Progress

- While there is a stated policy intention to provide universal health coverage through a harmonised health system, financing remains largely segmented between different providers with limited subsidies across funding pools. Potentials for strengthening the harmonised framework for health financing exist in the formal agreements between the public and the large, not-for profit mission sector and in the dialogue on social health insurance. While cost barriers have meant reduced use of private services, this may change rapidly and any demands for cross subsidy of low income groups made on private voluntary insurers are modest.
- There is scope for a more active review of the policy and financing measures needed to strengthen the framework for universal coverage.

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

PAST LEVELS (1980–2006)

- The National Health Strategy 1997-2007 states a policy intention to set health care entitlements: 'To underpin future financing strategies the country will need to guarantee its citizens access to a strategic package of core health services' (MoHCW, 1999). There was no public document in the period that elaborates what these entitlements were.

CURRENT LEVEL (most recent data)

- While the NHIS made provisions for a limited benefits package, no clear set of comprehensive health care entitlements has yet been published or operationalised.
- The Ministry of Health and Child Welfare has conducted studies to identify and cost core health services at the various levels of care to assess the viability of financially guaranteeing these services (MoHCW, 2008b).
- Core health services are currently identified as: those interventions for conditions treatable at the primary care level; environmental health and disease control measures; TB treatment and follow-up; antenatal care and uncomplicated deliveries; and health education within communities (Chihanga, 2008).

Progress

- Technical and policy dialogue (including with parliament and civil society) is needed to establish, cost and raise awareness on a clear set of comprehensive health care entitlements for the population at the various levels of the health services.

Allocating at least 50 per cent of government spending on health to district health systems (including level 1 hospitals) and 25 per cent of government spending on primary health care

PAST LEVELS (1980–2006)

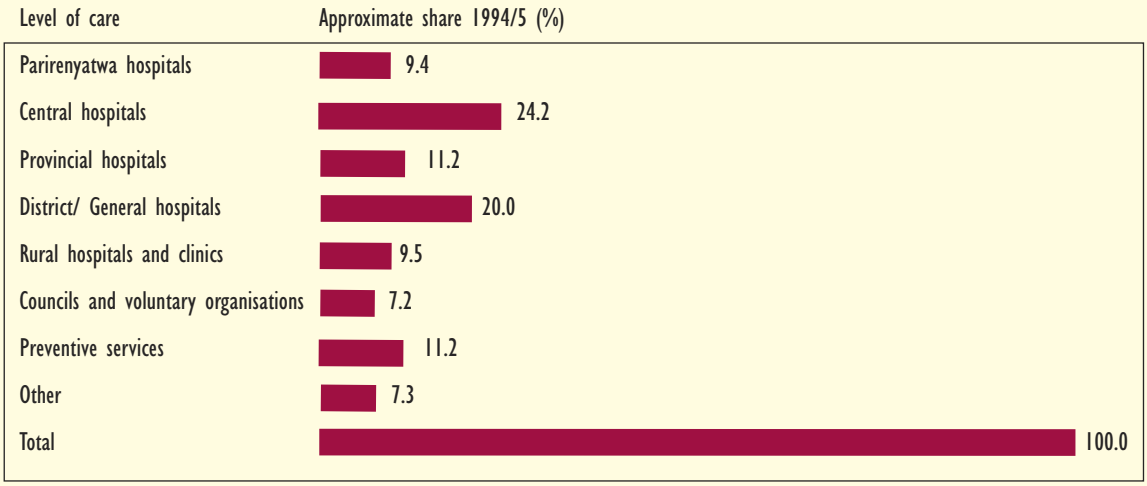
- Policy after the 1980s recognised the weakness of allocating resources on an historical or demand basis and by province and institution. Resources were reallocated from central to district level and towards higher need rural services in the early 1980s. There was some shift in shares back to central level facilities in the later part of the decade (Loewenson and Chisvo, 1994).
- In the 1990s policy intentions were to allocate resources on the basis of health need. District allocations were to be weighted by total district workload and split between the district hospital and peripheral facilities (MoHCW, 1999). No specific cost centre was set up for health centre level, which came under the district vote. This made it difficult to monitor trends in expenditures at that level.
- Review of data in 1994 showed that central hospitals received 34 per cent of total funds, while district hospitals and clinics received 30 per cent, and 11 per cent was allocated to prevention.
- In 1997, the Ministry of Finance authorised fee retention at health facilities for local use. However, user fees accounted for a minimal share of revenue (Makuto, 2007).
- The Health Services Fund set up in 1996 provided resources for district and community level activities in health, drawing resources from retained fees and external funders. A share (40 per cent) was earmarked for community and disease control activities, although expenditure did not follow these guidelines rigorously.

CURRENT LEVEL (most recent data)

- Initiatives were taken in 2000-2001 to introduce needs-based indicators into the resource allocation formula. However with significant levels of real underfunding, demand and historical allocations reverted to being the primary mode of allocation.
- Currently, resource allocation is based on 'budget bids' submitted by medical superintendents of central hospitals and provincial medical directorates. The directorates liaise with facilities in their provinces and then with the Ministry of Health and Child Welfare headquarters for final consolidation and submission to Treasury. Budget allocations are not broken down by primary, district and provincial levels, making it difficult to monitor spending by different levels. The 2005/06 district health survey, however, notes the inadequacy of budget allocations to districts (MoHCW, 2008b)
- Health centres are still not cost centres and so there is no accessible disaggregated data to monitor spending at this level (Euro Health Group, 2005).
- The AIDS levy fund is allocated on the basis of equal shares to all districts and allocations to provincial and district AIDS Action Committees increased from 46 per cent in 2002 to 75 per cent in 2005 (GoZ/UNICEF, 2007). Constraints remain in capacity to absorb and uptake at the district level (Mpofu *et al*., 2008).
- While donor contributions to the Health Service Fund have diminished, the Ministry of Finance continues to make allocations in the form of an 'equalisation grant' for districts with low income generation. However, hyperinflation has rendered the fund insignificant (MoHCW, 2008b).

- Positive trends are evident in the improvement in district shares of the AIDS Levy Fund, the establishment of the equalisation fund and the work done in the past on the resource allocation formula and the Heath Services Fund.
- However, improved allocations to district and primary care levels are undermined by the primary care level not being a cost centre. Also, shortfalls in staffing limit capacity to demand and use resources at lower levels, particularly in the context of demand-based allocations. The negative impact is signalled by indicators such as the reduced availability of vital and essential drugs at lower level services. Budget and costing modalities and capacities are needed for primary care level.
- An incremental plan to allocate resources on the basis of needs would strengthen equity, particularly if aligned to other funding pools (for example, the health basket and AIDS levy funds) and coupled with investments in monitoring, staffing and capacity support needed to absorb funds. A needs based resource allocation formula could also be developed for the AIDS levy fund.
- Equity goals should be raised with civil society and parliament, who have a role in monitoring equity in allocating resources to district and primary health care levels.

Public expenditure by level of care 1994/5 (Normand *et al*., 2006)



Source: Normand et al. (2006)

Budget allocations by allocation head 2002-2008

Allocation head	2002	2003	2005	2006	2008
Administration	4.8%	6.7%6.	8%	8.3%	9.09%
Medical care	78.0%	81.3%	80.5%	81.7%	80.56%
Preventive services	16.0%	10.9%	11.3%	6.7%	9.57%
Research	1.2%	1.1%1.	4%	3.3%	0.78%

Source; Ministry of Finance 2002-2008

Formally recognising in law and earmarking budgets for mechanisms for direct public participation in all levels of the health system

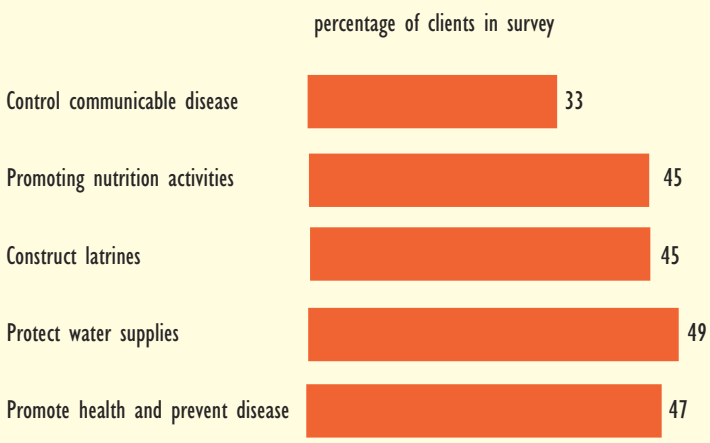
PAST LEVELS (1980–2006)

- Community participation has been central to health policy since 1980. Village and ward health teams were supported by community health workers, with social mobilisation around a range of primary health care services.
- In the 1990s these mechanisms became less active as primary health care services also declined. Evidence suggests strong links between mechanisms for participation and the strength of primary health care services (Loewenson *et al*., 2004). Community health workers, such as village health workers and community-based distributors, played an important role in this link.
- The National Health Strategy 1997-2007 sought to strengthen participation to improve efficiency and accountability in resource use in the health sector through self-managing entities. The Health Services Act (24/2004) established hospital management boards.
- While operations were decentralised, financial authority remained at ministry headquarters: 'Decentralisation of health services, as other programmes, has remained largely a matter of intention within a centralised management system' (MoHCW, 1999).
- Within communities the growth in civil society organisations brought new forms of community involvement in health, including the demand to be involved in policy decisions. For example, the Community Working Group on Health (CWGH), formed in 1998, involves 35 membership-based organisations that support participation in the health sector. Civil society organisations have supported outreach to vulnerable groups and helped re-establish, support and capacitate mechanisms for joint participation in planning and communication in health. While the Public Health Advisory Board and a range of committees and boards at different levels of services provide mechanisms for public input on health issues, participation is often limited among the most vulnerable groups and is often in an advisory capacity rather than in co-decision making.
- Parliamentary involvement in health also increased. Reforms in 1999 led to the establishment of portfolio committees, including the Committee on Health and Child Welfare which has held public hearings, engaged stakeholders and provided forums for community input to budgets and laws.

CURRENT LEVEL (most recent data)

- A 2007 survey found community participation in different health activities in only half or fewer communities.
- Village and Ward Development Committees (VIDCOs and WADCOs) in many districts are reported to meet irregularly or to have been disbanded. Although health centre committees meet at district and centre level, they do not always have the skills or resources for their roles (MoHCW, 2008b).
- The village health worker programme which declined in the 1990s was reintroduced in 2001 and became a ministry priority in 2008. The plan was to increase the coverage of village health workers by 10 per cent, due to their role in driving 'one of the most important preventive measures – health education – that is directly related to increasing health literacy' (MoHCW, 2008b). In 2008, 14 per cent of the preventive services budget was allocated to this programme (GoZ/UNICEF, 2007).
- 'The major cry from communities and health workers is for them to be accountable for policy making and the mechanisms for its implementation. This demand goes beyond the usual perception of community participation as a simple act of assembling stakeholders in a workshop in order to gather their views. Building participation in the development of health services is, by its very nature, a social and political process which will ultimately demand visible results' (MoHCW, 2008b: 120).
- Involving communities in decision making on design and management of health programmes and services is yet to be achieved and there is still no comprehensive legal framework to promote this process.
- Health has continued to receive support from both parliamentarians and portfolio committees, as signalled by its positioning among the top five ministries in funding allocations (MoHCW, 2008b). The Parliament Portfolio Committee on Health and Child Welfare has held a number of public consultations with stakeholders, including on the proposed national health insurance scheme.

Reported level of community activities 2007



Source: Makuto, James 2007

Progress

- A range of positive features provide a good basis for strengthening this vital contributor to equity – adult literacy levels, active civil society and parliament, legal and institutional provisions for joint planning, revival of village health worker programmes and policy recognition of the role of participation in health:

  'Policy accountability, at the national level most likely depends on the extent to which structures such as the Public Health Advisory Board, the Health Services Board and the Parliamentary Portfolio Committee on Health, are able to facilitate wider public participation and consultation' (MoHCW, 2008b: 120).

- Consolidating this calls for greater recognition of and investment in the capacities, mechanisms and processes for community and public participation.
- This includes adequately supporting cadres such as village and farm health workers, community-based distributors, chloroquin holders, traditional health personnel and school health personnel.
- Community involvement would also be strengthened by investing in mechanisms such as health centre committees, underpinning their role with laws and earmarking resources to support increased capacities and powers for local decision making.

Implementing a mix of non-financial incentives agreed with health workers' organisations, including access to antiretroviral treatment

PAST LEVELS (1980–2006)

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

CURRENT LEVEL (most recent data)

- The public sector offers the following incentives: salary reviews, call allowances, dual practice, part-time work in non-health sector, assistance with school fees and housing allowances. Other retention measures include improving opportunities for housing, bonding, training opportunities, and housing and work environment improvements (EQUINET SC, 2007). While significant effort has been made to improve incentives, this has been eroded by inflation and wider insecurity, while variable application of allowances and current bonding arrangements are reported as a source of frustration (Chimbari *et al.*, 2008).
- In 2007, strikes for better wages in the health sector of up to 10 weeks took place in January, February, June, September and December 2007. The Bipartite Negotiating Panel met thirteen times in 2007 to negotiate salaries and conditions of service. Junior doctors were brought into this framework in 2007 (HSB, 2007). The Health Services Board is constrained by lack of the authority and the funds to implement many of its recommendations (HSB, 2007), while its role and work are poorly understood by the public and even by some health workers (CWGH, 2008; Chimbari *et al.*, 2008).

Progress

- While the health care worker situation is poor (see earlier), a range of steps have been taken to better manage and respond to issues, institutionally, through the Health Services Board and more inclusive negotiating mechanisms and through the incentives offered.
- Blocks to the effectiveness of the board still need to be addressed, including lack of resources and authority.
- Non-financial incentives that are less directly eroded by inflation could be given greater attention, including in partnership with non-government organisations and communities. This includes support for career paths and increased opportunities for housing. With external migration across all categories of staff, sector-wide retention incentives and strategies are needed, including for those in training institutions (see later discussion on negotiations with external partners).

EQUITY WATCH

More just returns from the global economy

Progress markers

- Debt cancellation negotiated
- Allocating at least 10 per cent of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers
- No new health service commitments in GATS and inclusion of TRIPS flexibilities in national laws
- Health officials involved in trade negotiations and clauses for protection of health in agreements
- Bilateral /multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration

Debt cancellation negotiated

PAST LEVELS (1980–2006)

- Total external debt in 1998 was 78 per cent of GDP. By 2000 this had fallen to 68 per cent, with about a quarter of the revenue from the export of goods and services used to service debt (IMF, 2001).
- Zimbabwe was not one of the 14 African nations that received debt cancellation in 2005 and was not listed among countries eligible for debt relief in the near future.

CURRENT LEVEL (most recent data)

- By 2006, Zimbabwe's external debt had risen to 72 per cent of GDP, with 94 per cent of this owed to multilateral and bilateral creditors (SADC Bankers, 2007).
- The economic incentives provided to stimulate domestic manufacturing, particularly for key products like pharmaceuticals and health supplies, will be as important as measures to address aggregate debt.

Progress

- Zimbabwe has not negotiated debt cancellation and, despite high poverty levels, would not be eligible for debt relief under the HIPC scheme due to its classification as middle income.

Allocating at least 10 per cent of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers

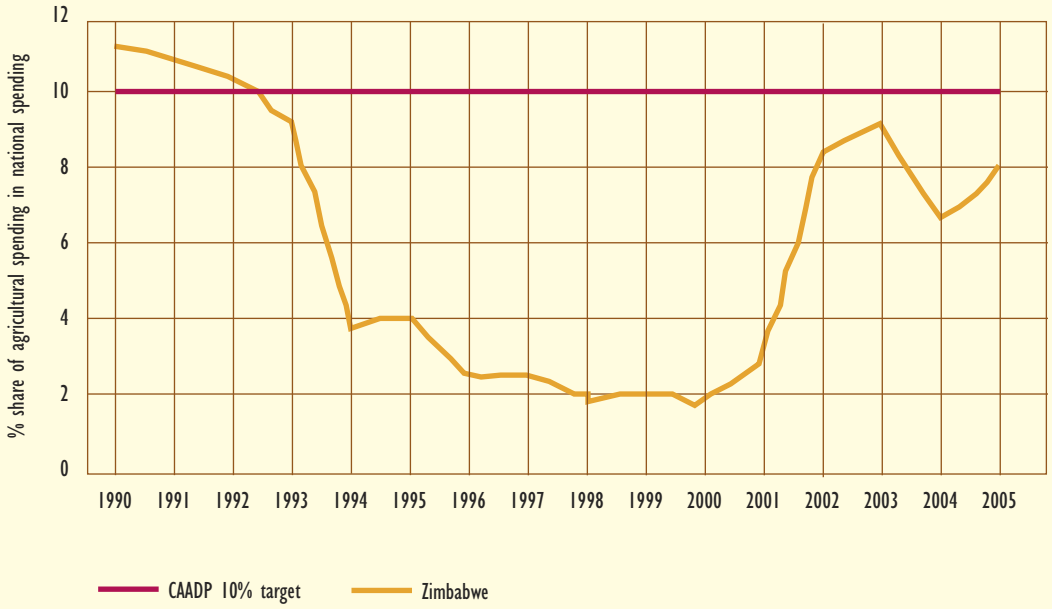
PAST LEVELS (1980–2006)

- Agriculture was allocated 11 per cent of the national budget in 1990 (AU/NEPAD, 2007). It fell thereafter to low levels until 2000.
- The land reform programme from 2000 onwards had stated policy aims of redistributing large-scale land to smallholder farmers. Data on the number of smallholder beneficiaries by gender is not publicly available.
- Government spending on agriculture is not disaggregated by producer level and there is no gender analysis of agricultural spending.

CURRENT LEVEL (most recent data)

- There was a sharp increase in agriculture as a share of the budget in 2001. In 2007, the share allocated to agriculture fell to 8 per cent of the budget (AU/NEPAD, 2007). The real value of this allocation is eroded by hyperinflation.

Share of agriculture in the Zimbabwe budget in relation to the Comprehensive Africa Agricultural Development Programme (CAADP) target of 10 per cent: 1990-2005



Source: AU/NEPAD, 2007

Progress

- While the allocations to agriculture dipped significantly in the 1990s, levels recovered in the 2000s. Current shares are higher than the African Union average of 6.6 per cent. Only one country in the east and southern African region, Malawi, allocated more than 10 per cent in 2005 (AU/NEPAD, 2007). The distribution of this budget and the extent to which it reaches poor households, and particularly women farmers needs to be further assessed.

No new health service commitments in the General Agreement on Trade in Services (GATS) and inclusion of all Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) flexibilities in national laws

PAST LEVELS (1980–2006)

- Zimbabwe has made no commitment to GATS but has ensured that its laws include all TRIPS flexibilities. The country applies an essential drugs list and promotes prescribing generic drugs across public and private sectors.
- In 2002, the Minister of Justice, Legal and Parliamentary Affairs issued a 'Declaration of Period of Emergency (HIV/AIDS)' for six months to allow the government or any person authorised by the minister to manufacture patented medicines or import generic ones to treat people with HIV and AIDS. This was extended to December 2008 through Statutory Instrument 32 in 2003. In 2003 Varichem Pharmaceuticals (Pvt) Ltd was granted authority to produce HIV-related drugs and supply 75 per cent of its product to public health institutions at fixed prices. By October 2003, it had marketed seven generic antiretroviral medicines (Khor, 2007).

CURRENT LEVEL (most recent data)

- Zimbabwe has made no commitment to GATS and its laws include all TRIPS flexibilities.
- The commercialisation of public services and growth of the private for profit sector makes Zimbabwe open to liberalisation of its health service sector. A limiting factor is the poor purchasing power of consumers due to the current economic environment and the falling consumption of private for profit services (referred to earlier).
- The Zimbabwe National HIV and AIDS Strategic Plan 2006-2010 acknowledges the need for affordable AIDS treatment and draws attention to review of trade barriers and tariffs and the further strengthening of local production of pharmaceuticals with the aim of 'facilitating local companies to prequalify according to WHO and other standards' (MoHCW *et al.*, 2006).

Progress

- Zimbabwe has preserved its flexibilities in relation to World Trade Organisation agreements. However, relatively wide commercialisation of services through medical aid purchases of providers, pharmaceutical companies, make it vulnerable to wider liberalisation.

Inclusion of health officials in trade negotiations and explicit inclusion of clauses and measures for protection of health in all relevant trade agreements

PAST LEVELS (1980–2006)

- Civil society has campaigned in the past decade for greater recognition of health in trade and investment policies:
  'We also need to take wider civic action to ensure that public health is given priority over trade, and that people's welfare is not damaged by the rush for profits' (CWGH, 2004:3).

CURRENT LEVEL (most recent data)

- Health sector officials are not directly involved in trade negotiations, which are led by the trade ministry. Health officials are, at most, consulted by the Ministry of Industry and Trade.
- Trade negotiations have increasing impact on health, for example, a proposed economic partnership agreement with the European Union was being finalised at the end of 2008, including negotiations on services.
- While the Parliamentary Committee on Health and civil society have raised trade and health issues, this area is still relatively poorly defined in health advocacy (Mabika, 2008).

Progress

- There is scope for greater audit and protection of health in trade agreements.
- The public health obligations and roles within trade measures are not well defined in public health law. This is not only the case for Zimbabwe but applies across the region.

Bilateral /multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration

PAST LEVELS (1980–2006)

- Zimbabwe is signatory to the 2003 Commonwealth code of practice on the international recruitment of health workers and to agreements with South Africa preventing recruitment of health personnel and blocking applications for permanent residence after completion of training in South Africa. Zimbabwe has been part of the African ministers caucus motivating the discussion of health worker migration at the World Health Assembly.

CURRENT LEVEL (most recent data)

- While agreements in the late 1990s focused on 'ethical recruitment' practices, in the 2000s attention has been given to more direct forms of funding health workers.
- UNICEF and WHO provide foreign currency contributions to retention incentives for government personnel and the Global Fund for AIDS, TB and Malaria provides top-up incentives in 26 districts for district medical officers, district laboratory scientists and pharmacists or pharmacist technicians. UNFPA and the European Union also provide support for salaries or top-up incentives for selected provincial and district personnel (Midzi, 2008).
- A number of bilateral agreements for funding health worker training are in place, including: WHO, the International Association for Educational Assessment (IAEA) and EU scholarships (MoHCW, 2008b).

Progress

- Zimbabwe has been actively involved in the policy dialogue on health worker migration. The negotiation of agreements around retention incentives could be widened to address other dimensions of the incentive regime developed by the Health Services Board.
- A proposal by external partners to pool resources and provide equitable top ups to all key staff in the sector in 2009 would avoid internal tensions caused by selective incentives offered to particular categories of personnel.

From decline to progress in two years

Immunising children on Child Health Days

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

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

Mobilisers like Hedwig Makumbe work to get the message to even the most remote areas:

> '*Often I have to travel for 10 to 15 kilometres in a day conducting door-to-door mobilisation. Sometimes I am lucky with the help of the traditional leadership and I meet the people at central points.*'

According to UNICEF spokesperson, James Elder:

> '*Child Health Days are a critical boost to health services that are under great stress. They have dramatically increased coverage of immunisation for Zimbabwe's children.*'

The initiative has played a role in increasing immunisation in children under five to over 80 per cent after the figure had plummeted to below 60 per cent in 2001. Vitamin A supplementation has increased from less than 10 per cent in 2005 to over 80 per cent in 2007. The country has also seen an 84 per cent drop in suspected measles cases since 2004.

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

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EQUITY WATCH

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

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