MINISTRY OF HEALTH AND CHILD CARE
NATIONAL INSTITUTE OF HEALTH RESEARCH
TRAINING AND RESEARCH SUPPORT CENTRE

in collaboration with the
Technical Working Group on Universal Health Coverage

NATIONAL RESEARCH FORUM:
Evidence for advancing Universal Health Coverage in Zimbabwe

CONFERENCE REPORT

Harare, Zimbabwe, 19th & 20th March 2015

Contents

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1. Background

On 19th and 20th March 2015, the Ministry of Health and Child Care (MoHCC), the National Institute of Health Research (NIHR) and the Training and Research Support Centre (TARSC) in collaboration with the Technical Working Group on Universal Health Coverage with support from the 'Rebuild programme' held a one and a half day National Research Forum under the theme ***"Evidence for advancing Universal Health Coverage (UHC) in Zimbabwe"***. The Technical Working Group (TWG) on Universal Health Coverage proposed to hold the Forum given the research implemented on UHC since 2012. The forum brought together 100 people from a wide range of constituencies and sectors including researchers, policy makers, state officials, health workers, civil society, the private sector and international agency personnel. The forum aimed to gather people from all constituencies and sectors doing or using research on any aspect of UHC in Zimbabwe, to present and share their research findings, discuss the policy implications and identify priorities for future work.

The conference had four theme areas related to UHC:

1. *Health Equity:* Reducing the gap in access to and coverage of health care and of social determinants of improved health.
2. *Health financing:* Mobilising financial, health worker, medicines and other resources for health, pooling of funds, reducing out of pocket spending and fair allocation and effective use of health resources.
3. *Widening services to meet new challenges,* such as non communicable diseases, Ebola and multiple/co- morbidity.
4. *People centred approaches:* partnerships in health between communities, health workers, institutions and private sector.

Presentations in plenary and parallel sessions for each of the theme areas were followed by discussion and recommendations, with further time for debate and reflection during the poster sessions.

The programme is shown in *Appendix 1* and the delegate list in *Appendix 2.*

The many contributions to the conference are gratefully acknowledged.

- The conference organising committee comprised R Loewenson, M Makandwa, J Chakupwaza, Z Mlambo, F Chakupwaza at TARSC, N Masuka, G Mhlanga at MoHCC and S Mutambu, M Geza NIHR.
- An announcement and open call for abstracts was disseminated in December 2014 and again in January 2015, including in national media, and through members of the TWG on UHC. The conference scientific committee reviewed the call and abstracts for the programme. This committee included Dr R Loewenson TARSC, Dr N Masuka MoHCC, Dr S Mutambu NIHR, Dr S Laver Consultant, Mr H Mphwanthe Cordaid, Dr J Chirenda UZ Dept Community Medicine, Dr G Chigumira ZEPARU and Mr S Buzuzi BRTI.
- Many delegates contributed as presenters, chairpersons, poster judges, as acknowledged in the report.
- The conference received financial support from Liverpool School of Tropical Medicine (Rebuild consortium), Biomedical Research and Training Institute, and from delegate registration fees. About two thirds of delegates were sponsored for their participation.
- The report of the conference has been prepared by TARSC (B Kaim, R Loewenson) with rapporteur input from A Kadungure TARSC and M Geza NIHR and photos from TARSC.

2. Opening Plenary

Dr N Masuka, Acting Director Preventive Services, on behalf of Brigadier General Dr G Gwinji, Permanent Secretary of the Ministry of Health and Child Care (MoHCC), welcomed delegates to the conference, noting the importance of this conference in building a body of knowledge on universal health coverage as Zimbabwe moves toward realising the right to health as embodied

in the new constitution. He gave some background to the conference (as above) and welcomed the participation of the Health Advisor to the President of Zimbabwe, Dr T Stamps; the chairperson of the Parliamentary Portifolio Committee on Health, Honourable Dr R Labode, the chairperson of the Health Services Board, Dr L Mbengeranwa, the Executive Director of the Health Services Board, Mrs R Kaseke, the past Minister of Health, Dr H Madzorera, the representatives from World Health Organisation (WHO) Drs Nganda and Midzi, and representatives of research Institutions, service provider institutions, professional associations, civil society, international agencies and other sectors and delegates attending. He wished all delegates a productive two days.

2.1 Official Opening by the Minister of Health and Child Care

Hon Dr P.D Parirenyatwa, the Minister of Health and Child Care, Government of Zimbabwe, officially opened the conference. He recognised the senior personnel at the conference, as above, and complemented the convenors for organising the Forum, dealing with the important subject of how to make quality health care affordable and accessible to all. Dr Parirenyatwa noted with concern that only 10% of the population is covered by medical aid; with the other, often poorer 90% having to meet their health care needs through out-of-pocket expenditures which often leave them more impoverished than before. This conference, he emphasized, is about supporting the health needs of the 90%. This implies extending quality services to cover everyone, especially those with greatest health need. The government has already implemented policies that exempt the most vulnerable groups from paying health service fees, but this is not sufficient. He urged for the work on the national health insurance scheme to be advanced. Dr Parirenyatwa invited the medical aid industry, private practitioners and church-related health institutions to join with government to make this a reality. He especially referred to the family and nurse practitioners who in other parts of the world have been able to provide comprehensive health care that expands to support the whole community.

All of this requires resources. While noting the fiscal constraints in Zimbabwe he observed:

> *"I am convinced that UHC supports health equity and should be encouraged and supported. We need to mobilise resources and claim from the Ministry of Finance 15% of the national budget. The national budget should allocate 15% of what they have to the health sector and I know that the Parliamentary Health Portfolio Committee is strongly helping us to achieve this."*

Hon Minister of Health and Child Care Dr P.D.Parirenyatwa officially opening the Forum

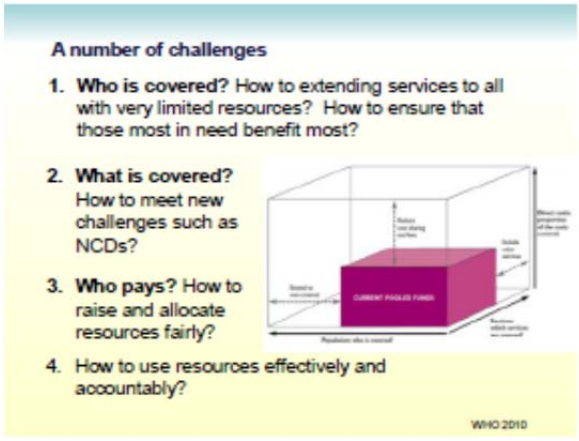
Finally, the Minister observed that the World Health Assembly has set a target for all countries to achieve UHC by 2025. He urged this conference to review where Zimbabwe is on this and to see what can be done to push for the attainment of UHC by 2025 in Zimbabwe and the African region as a whole.

2.2 Advancing towards UHC: Building a coalition of evidence and action

Dr G Mhlanga, Chair of the Technical Working Group on Universal Health Coverage gave a keynote address in the opening plenary. He defined UHC as:

> *'ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardships.'*

It aimed for all to access effective, quality health interventions and services that they need (system wide coverage); to close avoidable inequalities in health and allocating resources in relation to health need; to provide financial protection and ensure transparency and participation in entitlements and obligations, and accountability in financing. UHC is not a new concept; rather, it is a new name for a longstanding policy, having its roots in the 1978 Alma Ata Declaration that called for the development of Primary Health Care, the Health for All campaigns of the 1980s, through to the Zimbabwe National Health Strategy 2009 -2015 'Equity and Quality in Health – A People's Right'. In 2013 the concept of UHC gained further momentum in Zimbabwe with the new constitution including a clause on the right to health.



Dr Mhlanga noted that these commitments give policy direction on equity, quality and relevance of care, but do not say how UHC can be achieved. There is still a need for informed evidence on progress and gaps. This is especially true when looking at the challenges UHC faces, shown adjacent. With this in mind, in 2012 the MoHCC, with support from TARSC, set up a Technical Working Group on UHC in order to organise and review evidence and advise on research and technical input to policy dialogue on UHC. Since its formation, members of the Technical Working Group have worked on updating the 1995 essential health benefit; undertaken research on domestic health financing, on accountable fund management; on monitoring progress in equity and UHC amongst other areas. Dr Mhlanga noted areas of progress in service availability, but also pointed to the social factors that can lead to inequalities in uptake noting that addressing these is also key for access and coverage.

Dr G Mhlanga, MoHCC, chair of the TWG on UHC

He pointed to a number of new challenges, with a rising level of chronic conditions such as hypertension, diabetes and cervical cancer. What evidence, Dr Mhlanga asked, will lever other sectors to prevent these NCDs? There is continued concern over the shortfalls in funding, which leaves communities still contributing 39% to overall health expenditure through out-of-pocket payments. This has to shift, but the question is how and with what arrangements to pool different funds for UHC? He noted that research has a role to play in answering these, and other, questions. He asked delegates how far their research is problem-raising or problem-solving, observing that researchers need to have evidence available when the policy makers need it in a form that is accessible for key targets.

In conclusion, Dr Mhlanga commented from successful experience in advancing UHC on the 'triangle that moves the mountain', that is the involvement of political and policy leadership; technical options and institutional capacity; and social, civil and society roles. He thus welcomed that the conference involved a coalition of actors bringing together evidence, policy and action.

2.3 Universal Health Coverage in the WHO Africa Region

Dr Benjamin Nganda, Health economist at the WHO Inter Country Support Team expressed his hope that this conference will serve to inform the future of UHC in Zimbabwe. He pointed to the WHO position that universal coverage is the best way to attain the right to health, with UHC

embodying three interrelated objectives: equity in access to health services, quality of health services, and financial-risk protection for individuals and families. He recognised that ideally every country would want to provide health coverage to the entire population but, realistically, limited finances mean that hard choices need to be made between the proportion of the population to cover, the range of services to be made available and the proportion of total costs to be covered from pooled funds. Nevertheless, a number of African countries have developed policies in support of UHC, and some have made progress toward achieving this goal.

Dr. Nganda gave examples of strategies that have been used within the region. In Botswana, for example, the health system ensures coverage of the population for a wide range of services financed through taxes by meeting the Abuja target of 15% of the budget to health. Gabon introduced new taxes in 2009 to raise additional funds to subsidise health care for low income groups, while Ghana introduced a National Health Insurance Scheme which covers 60-75% of the population. Rwanda, a resource constrained country, has moved towards UHC by developing a decentralised health financing strategy using community based insurance schemes tailored to focus on increasing coverage to those outside formal employment. Dr Nganda noted that many other examples exist beyond the region, including in Thailand, Kerala State in India and Brazil.

These experiences indicate that there is no single path or magic bullet to achieve UHC: each country needs to devise its own route to achieve this goal. In all the countries Dr Nganda mentioned, the health sector prioritised population coverage, relying heavily on compulsory public (especially tax) financing with some elements of social health insurance. WHO recognises that private voluntary mechanisms including community based insurance have a limited role in UHC, and user fees are identified as unjust and unnecessary. WHO recommends public financing as the key to achieving UHC, covering both formal and informal sectors.

Dr N Masuka, MoHCC, Dr B Nganda WHO Plenary 1

3. Plenary 1: Health equity and health financing

This session was chaired by *Dr N Masuka, MoHCC.* It focused on two of the four themes of the conference, with four presentations exploring equity in health and financing of UHC.

3.1 Universal Health Care – A debate at the crossroad

Dr S Laver, Consultant provided evidence from a study undertaken in Zimbabwe in 2013 which aimed to determine how stakeholders perceive UHC, what requirements are needed to achieve UHC in more challenged environments, the relations between UHC and peace and state-building and the contribution of civil society in UHC. The study was part of a larger study undertaken in four countries by Cordaid. In Zimbabwe, a series of semi-structured interviews was conducted with 22 respondents from a wide spectrum of local health, policy, technical and civil society stakeholders. Respondents drew comparisons with "Health for All" and PHC ambitions but UHC was interpreted as an opportunity to improve an (integrated) national health system under the country's own stewardship, enhancing a rights-based, equity oriented, quality integrated financial strategy with broader coverage. The voices from the field recognised that

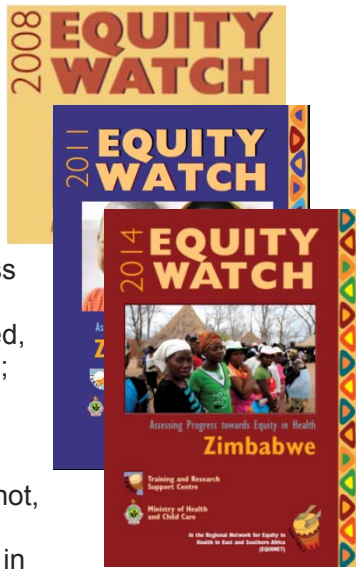
> "a *large degree of dependency on private funding (external partners and out-of-pocket contributions) still exists in the health care system…. And these dependencies are problematic."*

Desire for 'domestic design' was keenly felt, with learning but no copy-paste from other countries. Community involvement was considered essential for sustainability with recognition of enhanced

roles for local civil society in agenda-setting. From the study, a picture emerges of UHC being 'a debate at a global crossroads'. UHC has this potential not only because it ties in with the UN policy debates, but more importantly because it calls for a deeper transformation in which the battle for gaining domestic control and working towards sustainability is particularly fierce.

3.2 How well are we doing on equity in UHC? Tracking progress through the Zimbawe Equity Watch 2014

Dr R Loewenson, Training and Research Support Centre (TARSC) presented evidence on progress in advancing equity in health in Zimbabwe, drawing on the 2014 Zimbabwe Equity Watch, undertaken by TARSC/ EQUINET and MoHCC. The 2014 Equity Watch updated evidence from 2008 and 2011 Equity Watch (EW) reports. Dialogue on the 2008 EW called for renewal of PHC; while dialogue on the 2011 EW called for 'refinancing' of health and social determinants for UHC. She indicated that she hoped that the 2014 EW would provoke similar social dialogue on the challenges to address in overcoming inequalities in health. She noted that since 2011 there has been progress: The human development index (HDI) has improved, mainly due to better health and HIV outcomes, urban levels are stable; the new constitution includes the right to health; and the GDP grew in 2011-13. Inequalities narrowed between rural and urban areas and gender parity in education was sustained. Howe ver, there have also been challenges: while rural wealth has increased, rural poverty has not, meaning that there is rising *within* rural inequality. There are gaps on Millennium Development goal targets in child survival and inequalities in many areas of child health. There is rising urban poverty, household food insecurity and access to improved water and sanitation has fallen since 2008/9. Health services are treating people's illnesses and then sending them back to the conditions that made them sick. The evidence indicates that there is a strong need to address environmental and chronic ill health, including through interventions by trade, water, infrastructure and other sectors.



It also calls for new domestic resources: for health promotion, to detect and manage non-communicable diseases (NCDs), to ensure supplies and personnel at primary care and district services, and to support outreach for continuity of care, including through schools, communities and workplaces. She noted that proposals have been made for mandatory pre-payment financing in ZimAsset to improve progressive tax funding, including from earmarking VAT and excise taxes, and she noted the need for measures to ensure equity, efficiency, transparency and accountability in their management. Needs based resource allocation would need to apply to new resources, so that no district receives reduced funds, calling for monitoring of service gaps and capacities to absorb and use funds effectively. However she indicated that UHC is not only a matter of resources. Health improvements in Zimbabwe depend on engaging the strong social assets for health, supporting social roles in comprehensive PHC, addressing the social, cultural barriers to wellbeing and uptake, such as though health literacy and information. She noted that health centre committees are now playing a role in results based financing, but that their roles including and beyond this need to be formalised in law.

The evidence from the 2014 EW suggests that measures to improve equity are key to achieving UHC, and that this calls for

- Closing coverage gaps across provinces and for poorer groups within areas
- Strengthening comprehensive PHC to engage other sectors and communities to
- promote, prevent and treat
- Strengthening the MoHCC public health role to predict and prevent ill health
- Sustaining the gains in maternal and child health services, and widening services to address environmental health and NCDs
- Increasing domestic financing for health and
- Supporting social literacy, roles and mechanisms in health.

In the *plenary discussions* following the plenary and health equity presentations, delegates debated on the role of government in implementing UHC policies. The speakers reiterated that, while it is clear that UHC cross cuts all sectors - including the private sector and civil society - government needs to play a role in leading and coordinating the programme and in implementing key measures such as pooling resources. This calls for strong public health authority, and Dr Laver emphasized that a priority area of concern is the need to bring the revised Public Health Act 'that we all worked on' to Parliament for ratification as soon as possible. There was some discussion on the data used in UHC research. Dr Loewenson pointed to the importance of moving away from measuring individual disease outcomes to measuring system and population health gains as a way of ensuring the universal aspects of UHC.

3.3 Integrating equity in the allocation of scarce resources for UHC

Mr T Chituku from Atchison Actuaries began his presentation by pointing out that a key component to achieving equity in healthcare is in allocating resources towards those who have highest health need and the workloads of health services. He outlined the work done in a study by Atchison, TARSC and MOHCC to identify a tool for resource allocation to achieve this, by including measures of population, health need and capabilities (poverty) and health workloads using appropriate indicators. He noted that steps were implemented to identify the key indicators that reflected policy priorities and stakeholder views. These indicators were then subjected to Principal Component Analysis using data from Zimstat household surveys (such as the demographic and health survey) and the MoHCC Health Information System, categorised in four main areas: population; health need-related indicators; health capability–related indicators, including poverty; and health system workload-related indicators. From this the indicators that explain most of the variability across districts were identified as shown adjacent. These indicators were applied to the 2013 MOHCC recurrent budget at district and primary care level, excluding that for health workers, to compare the allocation integrating equity against that implemented in 2013. He noted that the application of this formula is not complex, so that training of officers should not be difficult.

Final selected indicators suggested for the resource allocation formula

Area	Indicator	Weighting	Source
Population	Total population	3	ZIMSTAT Census
Health needs	Under five year mortality rate	2	ZIMSTAT DHS , census
Household capabilities	Poverty severity index	1	ZIMSTAT PICES
Health service workloads	Percent pregnant women attending ANC 4th visit / women attending ANC 1st visit	1	MoHCC HIS

He noted that this would lead to improvements in some districts and reductions in others and that it would not be correct to reduce any district's budget. Hence he indicated that integrating equity into resource allocation should be done when budgets are improving. This could be done, for example, using new resources from earmarked taxes. In prior work, for example, earmarking 1% of VAT, as has been done in other countries, would raise an additional $5,74 per capita in 2013 to $15.21 in 2032, or US$77milion in 2013 rising to $276 million by 2032. He showed how a more equitable allocation of resources could be achieved by applying these new resources using the formula integrating the above indicators of health need. He concluded that a more equitable and efficient formula is both possible and necessary for attainment of UHC, as long as the household surveys continue to generate good quality data, and recommended that a formula integrating equity be applied to the recurrent budget in any area when budgets are increasing. However he also noted that a formula can only guide allocation, and that other factors and local conditions need to be taken into account, such as the capacity to absorb the resources. He also urged that a monitoring framework and clear outcomes be developed to monitor the allocation and use of public funding.

3.4 Field assessment of funding flows from central to operational level

Dr G Chigumira, Executive Director, Zimbabwe Economic Policy Analysis and Research Unit (ZEPARU) reported on a study by ZEPARU and the Royal Tropical Institute (KIT) aimed at identifying and describing organizational, institutional and governance arrangements and procedures for pooling and channelling of funds for health. His presentation covered the field survey and interviews with key informants at district and national level on major sources of health financing in Zimbabwe and how they reach operational level. He presented the flow of health financing. The evidence with high out of pocket funding (39% in 2010) and low government share (18%) points to a limited pooling of private resources, a population exposed to catastrophic healthcare expenditures and a high dependence on external funders. He noted that funds are fragmented, with different sources ring-fenced, handled separately, with divergent rules and time consuming unsynchronised reporting requirements. He observed that facilities are often unaware of their allocations and unsure of getting full amount and that disbursements to facilities were reported to have an average lag of 6 to 12 months, with funds sometimes released during the last quarter of the year. MoHCC functions as healthcare purchaser, provider, payer and verifier. The performance agreements in the public sector between councils and central government and between ZACH and central government are based on ex ante budgets, not performance. Respondents in the survey felt that Health Transition Fund financing should be allocated in line with needs rather than the current flat rate and that medical aid societies should be compelled by law to honour claims within a specified time frame and, if not paid, the claim should accumulate interest, at a rate specified in law. The health facilities surveyed were complying with legal provisions, but lacked accounting software and capacities and had high work-loads to account, plan and manage funds. The results of audit reports took time to be shared at operational levels and for follow up of implementation of recommendations.

Dr Chigumira concluded that presently the mechanisms used are not cost- efficient and are highly fragmented. He recommended an increase in overall public funding for health to avoid high OOP expenditures. He suggested that there was need for high level decisions on whether to create new structures or whether to use a current institution to create one single pool (noting that stakeholders preferred to use NAC if existing mechanisms are used). He recommended further that equity be integrated into all fund allocations and to review and clarify tasks and responsibilities of all stakeholders in health financing.

Debates in the plenary in health financing

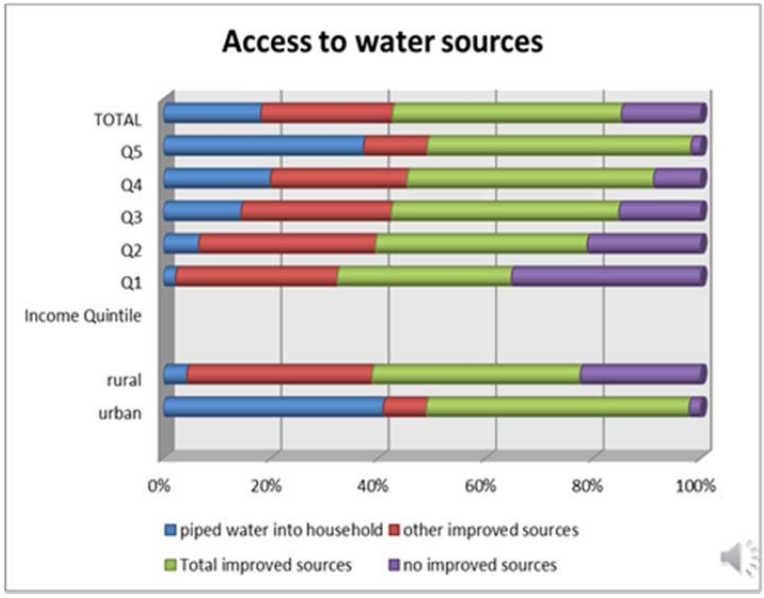
In the *plenary discussion* that followed, delegates raised their concerns that data used should represent all sections of the population. In particular, it was noted that the Health Information System (HIS) does not have a way of directly measuring those people who are in need of health care but do not make it to the clinic for a range of reasons (distance, cost, etc). Mr Chituku eased delegates concerns by noting that his work was based on household surveys (ie the population surveys of health , poverty and income that Zimstat does) and not facility data. He agreed that it was important to use these community level surveys in assessing health need. It was also noted that the HIS needs to be used by researchers, such as by comparing community and facility data, to improve its quality, as it is a key tool for planning and financing performance. At the same time, any measures to improve equity need to include information directly from the community concerned.

After the plenary, two parallel sessions were held on health equity and health financing, viz; the two plenary themes. This report provides a summary of the presentations and discussions in each session.

4. Parallel Session: Health Equity

There were two parallel sessions dedicated to this theme. The first parallel session was chaired by *Ms A Rietsma, Cordaid* and the second by *Dr M Chemhuru, Midlands Provincial Medical Director, MOHCC*.

Dr. J Chideme-Maradzika Department of Community Medicine, University of Zimbabwe reported on research undertaken to assess income disparity as a predictor of access to health determinants. Using a community-based household survey, the study interviewed over 4000 households from all 10 provinces in Zimbabwe in an attempt to identify the relationship between income disparities, geographical location and socio-economic risk factors (environmental safe water, sanitation and use of energy). The study concluded that there was a significant effect of residence and income quintiles for access to improved water and sanitation, and the type of energy sources used, concluding that differences in income do affect the ability to access health protective measures. Public health policy formulation should, therefore, take into account equity principles to address the differences that are apparent between places of residence (urban vs rural) and income disparities since these factors affect people's ability to achieve optimum health.



Mr G Machacha, National AIDS Council addressed the issue of poor uptake of Voluntary Medical Male Circumcision (VMMC) in Mashonaland West province. He noted that the percentage uptake of 7.2% in Mashonaland West was way off the 80% target. The study sought to identify determinates of this poor uptake through an analytical cross sectional study design using client and key informant interviews in four of the seven districts, including both urban and rural males. The study found that men in rural areas were less likely to be circumcised. Men who gained information about VMMC from churches were 15.5 times more likely to be circumcised, while those referred for MC by counsellors were 7.17 times more likely to be circumcised. Men that indicated it reduces chances of penile cancer as a benefit were 3.35 times more likely to be circumcised. This research study provides valuable evidence on how messaging of VMMC is not equitably covering all sub-population groups of Zimbabwe in terms of religion, tradition and educational level. It recommended decentralising procedures to facilities in the periphery areas for easy access. This implies accelerating task shifting to allow nurses to conduct the procedure. Message design should target traditional/religious circumcising communities and specific messages for non-circumcising communities. There is also a need to strengthen the integration of VMMC with HIV testing and counselling referral systems.

Ms Ethel Dauya, Biomedical Research and Training Institute presented on the missed opportunities for HIV testing of children in high prevalence areas. She noted that HIV testing is the gateway to accessing HIV treatment, and yet coverage of HIV treatment for children disproportionately lags behind that in adults. Opportunities to identify HIV-infected children are currently missed as family members of HIV-infected individuals are not offered testing. HIV-infected children frequently experience changes in guardianship and loss of their parents, which

may increase their vulnerability and further contribute to delayed diagnosis. The study under review investigated the effectiveness of routine opt-out HIV testing (ROOT) compared to conventional opt in testing (PITC) for children aged 6-16 years attending six primary care clinics in Harare. The results confirmed that children attending the ROOT programme were five times more likely to be offered an HIV test, concluding that the use of ROOT was a feasible and effective way to increase child diagnosis. This approach must be combined with adequate training and support for Health Workers, logistical support and include the involvement of local health providers and government bodies. Ms Dauya concluded that policy makers urgently need to develop child-focused HIV testing services and track family members of identified HIV positive individuals to address the treatment gap for children living with HIV.

Dr RA Ferrand, Biomedical Research and Training Institute continued with the HIV theme by reporting on a study that reviewed the barriers to provider-initiated testing and counselling (PITC) for older children and adolescents. This study investigated the provision and uptake of provider-initiated HIV testing and counselling among children 6-15 years in primary health care facilities in Harare, and explored health care worker (HCW) perspectives on providing HIV testing to children. PITC relies on HCWs offering testing, as well as on guardians consenting to have their children tested. The study showed that the main reasons given by HCWs for not offering PITC were the perceived unsuitability of the accompanying guardian to provide consent for HIV testing on behalf of the child, and lack of availability of staff or HIV testing kits. Children who were asymptomatic, older, or attending with a male or a younger guardian had significantly lower odds of being offered HIV testing. Male guardians were less likely to consent to their child being tested. The HIV prevalence among children tested was high, highlighting the need to focus on HIV testing in children. For PITC to be successfully implemented, clear legislation about consent and guardianship needs to be developed, addressing issues of expanding proxy consent, ethical guidance to address inadvertent disclosure of parental status and strategies to address guardian refusal. Health workers need training on counselling and confidentiality and on laws and policies. She also noted the need to address supply side challenges, such as availability of testing kits and onsite care and linkages with other support services.

Mr A Kadungure, Training and Research Support Centre reported on how far Zimbabwe's public health laws are being enforced with a focus on compliance of food regulations. He noted that the enforcement of the public health law is one instrument for ensuring equity in UHC. The country has food labelling (including for breast milk substitutes and infant nutrition) regulations. However, monitoring and enforcing these regulations in Zimbabwe is affected by the country being a net importer of food items, with a large and growing informal sector involved in food marketing, and staff shortfalls in the public sector inspectorate. In the increasingly liberalized market in Zimbabwe, and with rising levels of non-communicable diseases, protection of nutrition and food safety demands enforcement of legal measures to protect the public against risks. TARSC carried out an observational survey of 714 food labels from formal and informal (total 357) shops from high, medium and low income areas of 5 urban and 6 rural sites in Zimbabwe. The sample included a mix of locally produced and imported products. The assessment pointed to areas where the law is being implemented in the surveyed sites. Food labels correctly described food content, did not create a false impression, showed the usual/common names of foods and were mostly in English, clear, prominent and legible. However the font size on labels, expiry dates, information on artificial flavouring or chemical preservatives were not in line with legal requirements, and some breast milk substitute labels were not in English or Shona. The assessment suggested that there needs to be stronger enforcement of the law by the ministry responsible for trade and commerce, as well as by public health

A NAN package in Portuguese only

inspectors. However, Mr Kadungure argued that it is not possible to sustain approaches that chase breaches in compliance. He thus recommended

- Proactive measures rather than chasing breaches eg when issuing import permits.
- Pre shipment inspection of consignments of food imports
- Awareness on the provisions of the regulations be raised within communities and stakeholders responsible for implementation (through their associations)
- A clear and shared procedure across the authorities responsible for enforcing the regulations for notification of or enforcement orders on breaches, a specified time for correction and common enforcement approach
- Mobile technologies to be used as tools for public monitoring of breaches and
- The Trade, Industry and Commerce ministry to promote voluntary compliance and effective tracking of violations for administrative action, legislative measures and judicial sanctions to deal decisively with repeated breaches.

Dr Grace McHugh, Biomedical Research and Training Institute deepened the discussion on routine opt-out HIV testing (ROOT) already reported on earlier in the conference by reviewing the effectiveness of routine opt-out HIV testing (ROOT) compared to conventional opt-in provider initiated testing and counselling (PITC) for children attending primary care clinics in Harare, Zimbabwe. Following an evaluation of opt-in PITC services for children aged 6 to 15 years in six primary health care facilities in Harare, Zimbabwe from January to May 2013, ROOT was introduced. The change in the proportion of eligible children offered and receiving tests, reasons for not testing, and yield of HIV positive diagnoses were compared between the two HIV testing strategies from July 2013 to March 2014. There were 3943 primary care attendances by children eligible for HIV testing in the period when ROOT was implemented. The proportion of children offered HIV testing and the uptake of testing rose from 75.9% to 91.1% and 75.6% to 94.1% respectively. The yield of positive HIV tests increased from 2.8% to 4.5%. Guardian refusal of testing fell from 6.0% to 0.5% while child refusal remained unchanged. ROOT increased the proportion of children undergoing HIV-testing, resulting in an overall increased yield of positive diagnoses, compared to opt-in PITC. ROOT provides a feasible and effective approach to reduce missed HIV diagnosis. She said there is an urgent need to identify child focused HIV testing services, as recent changes in law have given children older than 12 years the ability to seek HIV testing without guardian consent. She noted that while there is ready access to Paediatric ARVs, testing services have lagged behind, so that healthcare providers need to educate communities on HIV infection and the possibility of HIV+ children surviving beyond infancy without treatment.

During discussions on HIV testing of children, delegates noted that the old model of pre-test counselling needed rethinking to include training nurses in task shifting, legal and ethical issues, how to work with children and their guardians, and trauma counselling. Delegates reiterated the importance of setting clear guidelines on who can give consent to HIV testing in ROOT and how to include siblings of HIV+ youth. Discussion also centred on how to manage adolescent adherence, with delegates recommending that the schools become more actively involved. The discussion led to delegates advocating for health services to also become more welcoming of males at the clinics.

The evidence on the link between income disparity and the social determinants of health was seen as important and necessary to act on, especially in light of the deteriorating situation with regard to access to clean water and sanitation. Delegates suggested that there may be need to look beyond health authorities to include other players in monitoring food regulations, such as the Standards Association and Ministry of Agriculture. The meeting acknowledged that, in the present economic climate, it is difficult to police food safety.

Following discussions on the presentations, delegates discussed overall recommendations with regard to the link between UHC and health equity. These recommendations are listed in Section 10.

5. Parallel Session: Health Financing

There were two parallel sessions dedicated to this theme. The first parallel session was convened by *Dr J Chirenda, University of Zimbabwe Department of Community Medicine*; the second session by *Mr K Kalweit, Private Hospitals Association of Zimbabwe*.

Mr Lazarus Muchabaiwa, Bindura University of Science Education focused his presentation on assessing the feasibility and sustainability of community based health insurance (CBHI) in one rural area in Zimbabwe. He noted that as of 2010/11 (ZDHS) only 6.6% of the population was covered by health insurance in Zimbabwe, with out of pocket payments leading to medical impoverishment and inequity. He suggested CBHI as an alternative for pooling financial risk amongst informal income earners, citing its use in India, Ghana, Senegal and Rwanda. He outlined plans for a survey of 270 families in Musana for 3 years to establish whether CBHI is viable and its impact on healthcare utilization and health status. A pilot willingness to pay (WTP) study on potential study participants yielded a median WTP for CBHI $5, a mean health expenditure of $11.61, a mean medication per visit of $4.20 and 2.4 visits per month. The agreed contribution is $2 per family of 5, with additional members paying $0.50 each. Medical expenditures average $94.50 per month against average contributions of $58.50 leaving a financial gap of $36. The 6 months initial phase revealed low uptake with 29 members joining out of 150 members who attended awareness workshops, linked to issues of trust and low incomes. The study identified enablers as penalties for non-payment and income-generating projects for those community members who want to join but do not have the financial capital.

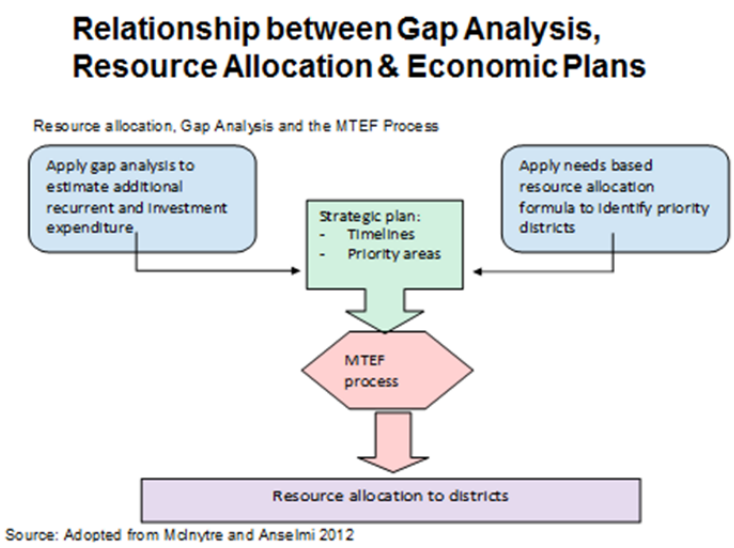
Mr Stephen Buzuzi, Biomedical Research and Training Institute presentation looked at the impact of user fees on patients with chronic diseases. The research explored how health care seeking behaviour has changed over time especially since the economic crisis of 1997 and subsequent economic developments, noting that budget allocations to the health sector has declined over the years. The study aimed to find ways in which current health financing policies can be improved to ensure access to healthcare services by the poorest households.

Researchers undertook 'life history' interviews targeting patients with chronic diseases and key informant interviews with selected health workers and Social Services Officers. The study found a mix of financing mechanisms; GoZ, medical aid, pensioners & war veterans schemes, AMTOs and HSF. There were no changes in fees policy, but implementation was shaped by the economic environment, including by structural adjustment, hyperinflation and dollarization. This led to an emphasis on cost recovery. Patients with chronic conditions without healthcare insurance bear the burden of out-of-pocket payments for medical consultations, drugs, transport and specialised services. Patients are not obtaining the full package of services in public facilities; and even those eligible for exemptions buy more expensive private sector healthcare products/drugs. Patients are adopting various coping strategies: by-passing diagnostic tests at health facilities, delaying treatment, reducing prescription drug doses, and making ad hoc payment arrangements. Not all priority groups listed as benefitting from government-funded exemption schemes have sufficient protection to guarantee their access to healthcare services and medicines. Out-of-pocket expenditures are larger due to a mix in use of both public and

Example of mapping the life course of a woman 55 years old in Mashonaland West, S Buzuzi BRTI

private sector services. Some barriers can be averted by ensuring adequate resourcing of public health facilities. He recommended an assessment of the unmet or partly met healthcare needs of priority disadvantaged groups and that priority be given to assessing systemic inefficiencies in procurement and service delivery that lead to the utilization of a mix of public and private sector health care services. He noted that equity cannot be achieved without adequate government funding of the exemption schemes and proposed that the answer lies in adequate resourcing of public health facilities.

Mr Shepherd Shamu, Training and Research Support Centre presented evidence on a gap analysis study undertaken in Mashonaland Central and Matabeleland North provinces to examine the extent of gaps in capital resources (facilities, equipment and staffing) to guide in allocation of capital expenditure, to address resource allocation for equity, as shown in the adjacent figure. The study gathered evidence from secondary data sources from two provinces and in all their districts, using maternal and child health services as a proxy. It included all government and mission district hospitals and two health centres per province. The study assessed facility density, equipment and personnel against norms. The gaps were costed to estimate the additional financial resources needed for the districts to cover them. The study found that investments in maternal and child care equipment and the refurbishment of key buildings by external partners reduced gaps, but without a guarantee of sustained financial support for their costs and potential gaps in other areas such as diagnostics for certain non-communicable diseases. He suggested that a full gap analysis be done using asset registers and physical verification of use and functionality of key equipment, especially for district that should be absorbing more recurrent resources. He also noted the need to revisit the current norms for the district and rural health facilities, some of which have not been updated for many years.



*Dr Jurrien Toonen, Royal Tropical Institute (KIT)*noted that pooling funds for UHC requires strong organisational, institutional, governance and accountability arrangements and procedures. To investigate this further, a study was undertaken by KIT and ZEPARU in the Rebuild Consortium to explore the present situation of governance in Zimbabwe's health financing and to raise issues for discussion at policy level. The research included desk reviews, a qualitative field survey at district level and interviews at national level. He noted some of the field study findings reported earlier by Dr Chigumira ZEPARU, in relation to the highly fragmented, not cost- efficient, unpredictable, delayed nature of health financing. He noted that the semi-autonomous funds such as the National Aids Council (NAC) and external donor funding through the Health Transition Fund (HTF) are more timely, but usually earmarked for specific programs. Health financing is highly dependent on donor funding, though the

Parallel session on health financing

most important funds (HTF, NAC) follow national regulations. Planning of funding is bottom-up, though arbitration takes place at central level. At the operational level, health centre committees (HCC) are consulted, but the DMO and the PMO of the MoHCC make the final decision. He presented experience from other African countries on these issues, in raising increasing funding for health through a levy on mobile phone companies, on currency/ financial transactions and 2,5% of VAT. He noted that some countries have identified a (semi-) autonomous fund holder to manage tax funds in Ghana, Gabon and Kenya. He suggested that there is need in the design of the UHC model to decide whether to use an existing institution (like NAC) or establish a new framework. From other African countries he also noted, amongst other issues, the need for measures to align different sources of funding, to align priorities of policies with budgets, to reduce transaction costs and to avoid frivolous use and fraud in providers.

Mr Yotamu Chirwa, Biomedical Research and Training Institute began his presentation by pointing out that health worker performance is arguably the most critical factor affecting access to and quality of care. In post-crisis settings where health systems and health worker livelihoods have been disrupted, retention of skilled health workers is essential. This is especially true when primary care vacancy rates are high, particularly in rural areas, as for example shown below:

December 2007	Establishment	In Post	Vacancy Rate
Nurses/ Midwives	17338	11822	38%
Environment HWs	2395	1245	52%
Doctors	1761	660	63%
Clinical officers	48	27	56%

Incentive policies remain an important strategy for this. His study examined the evolution of incentives and their intended and unintended effects with regards to access, quality of care and ultimately the attainment of UHC. The research used mixed methods including a document review; key informant interviews; career histories of health workers and a health worker survey. In the three sectors studied (government, mission and municipal), remuneration emerged as the key attribute impacting on health worker attraction, retention, distribution and performance. Municipal providers offer a robust incentive package which translates into a stable and highly skilled workforce. The public and mission sectors offer lower salaries and a targeted retention allowance which in the short term has seen improvements in health worker attraction and retention. He noted that the MoHCC still needs to secure support of key line ministries responsible, (finance, public service), for ensuring that funds are made available for the review of health worker remuneration and that retention schemes in the health sector are not harmonised for all workers, causing problems and affecting service delivery and creating tensions in the internal labour market. He recommended that salaries in government, mission and rural council sectors need to compare favourably with municipality salaries to stem internal migration of health workers and that retention strategies target all staff categories.

Mr Kurudzirayi Musikavanhu,Independent researcher, reviewed experience from twelve countries on their health financing models to inform policy in Zimbabwe. He noted that UHC as a goal is deeply embedded in politics, ethics and international law. Despite efforts to improve the provision of health services, many low and middle-income countries are still far from achieving UHC. Developing countries bear 93% of the world's disease burden, yet merely account for 18% of world income and 11% of global health spending. Low income countries rarely have the financial means and institutional capacity to provide state-based health insurance. A large amount of health costs is, thus, directly borne out by patients. These "out-of pocket-payments" account for a third of the total health expenditure in about two thirds of all low income countries. This situation became even more prevalent after the introduction of cost sharing mechanisms in many developing countries (e.g. user fees, co-payments, or deductibles). Examined the experience of other countries he urged for a health-financing model that will lead to a decrease in out of pocket spending, while recognising that how this is done depends strongly on economic and social conditions. He concluded by quoting Jim Yong Kim, President of the World Bank, who said *"All of us together must prevent universal coverage from ending up as a toothless slogan that doesn't challenge us, force us to change, force us to get better every day."*

In the discussion there was debate on CBHI. The evidence presented suggested that programmes cannot work if the insured are all sick and poor. Health Insurance programmes need a mix of healthy and sick people, rich and poor to pool the risks. The general feedback was that CBHIs are not sustainable, as has been found in other research.

Some queries were raised on what people were paying user fees for. Stephen Buzuzi clarified that services are mandated to be free at primary care level, but noted that when patients are sent to referral hospitals they have to pay. And they pay even more if they go straight to the district hospital, bypassing the primary health facility. On the gap analysis the challenges were raised in collecting valid information on all providers in an area, especially with the proliferation of private health institutions.

There was much discussion on the issue of health worker incentives. A representative from the MOHCC noted that staff vacancies are no longer as great an issue today, compared to 2007. More relevant now is the high health worker workload and a lack of responsiveness from the central body. Delegates also noted the need to review the workforce mix and roles and the team approaches. Remuneration is still inadequate and there is need to provide managerial skills training at all levels. It was recommended that we move away from piecemeal solutions to the problem of recruitment, retention and attrition of health workers. Delegates recommended that closer links be established between researchers and the Health Services Board and their processes, such as to link research to development of the human resources strategy, so that the research community can provide evidence around challenges faced in implementing the strategy.

6. Plenary 2: Meeting new challenges and building people-centred and partnership approaches

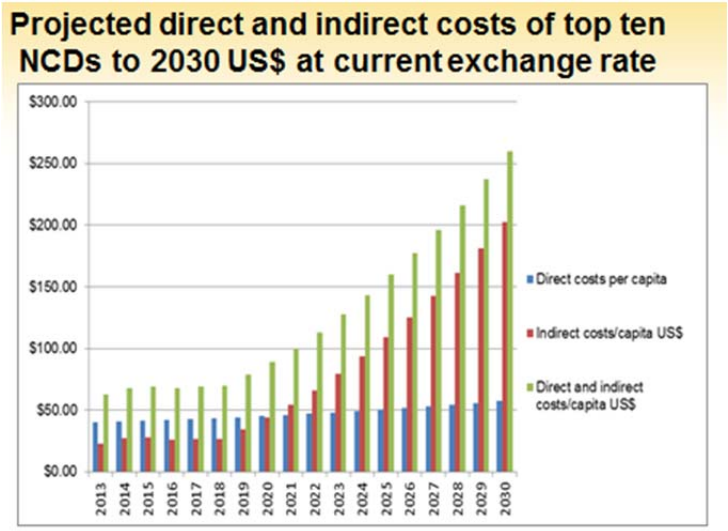
The second plenary session introduced the third and fourth themes of the conference to explore the widening of services to meet new challenges, and the organisation of partnerships in health between communities, health workers, institutions and the private sector. The session was chaired by *Dr Lovemore Mbengeranwa, Executive Chairperson of the Health Services Board.*

Plenary session 2, Dr Mbengeranwa and Dr Nyamukapa

6.1 The costs of not responding to chronic diseases

Dr N Masuka, PMD Matabeleland North, Acting Director Preventive Services, MOHCC presented a paper prepared jointly with TARSC and Atchison Actuaries that provided a persuasive argument for investing now to prevent unsustainable costs in the future in relation to the rising rate of non-communicable diseases (NCDs) in Zimbabwe. Dr Masuka noted that many countries are facing increased disease and economic burdens due to NCDs, calling for investment in interventions that prevent future morbidity. Finance ministries facing competing concerns need persuasive information on these costs and their distribution, to allocate new resources for such interventions. The study explored the current and projected direct and indirect costs to health services, economy and households, should resources not be mobilized for improved intervention. Zimbabwe's ten most common NCDs, including hypertension, stroke, heart disease, diabetes, cervical cancer, were identified by triangulating survey and health information system data, and the costings done using available service cost data for 2012. Actuarial projections were made for these top 10 NCDs, in terms of their prevalence and utilisation rates, and their direct and indirect costs projected to 2030, taking economic and demographic changes into account, using cost of illness and economic growth approaches. Assuming no major intervention to control them, the research showed that for these top 10 NCDs alone, their direct annual costs to the health sector

calculated at $39.86 / capita in 2012 (compared to $93/ capita total health spending) will rise by 44% to 2030. However, the projected rise in indirect costs to the economy and households will be sharper and more significant, estimated in the analysis to rise from $308mn to $3.6bn by 2030. These finds of higher indirect costs, shown in the adjacent figure, are similar to findings in a 2011 World Bank study. Avoiding such future costs calls for cost effective measures in the health sector and cross-sectoral policies that prevent NCDs. The study recommends that the costs of preventing and managing NCDs need to be factored into any discussion on UHC, and that new domestic financing be mobilised to fund the interventions to prevent them.



6.2 The contribution of schools to supporting the wellbeing of children affected by HIV in Eastern Zimbabwe

Dr Constance Nyamukapa, Biomedical Research and Training Institute observed that schools are often cited as sources of support for orphaned and vulnerable children. They can provide a buffer against the effects of poverty, trauma, social isolation and discrimination. Even in conditions of poverty, schools have assets that they can use to support children. 'HIV-competent schools' are places where people work collectively to reduce stigma, promote positive behaviour change, and support children affected by HIV. This study, conducted in 2009-2011, used the concept of 'HIV-competence' to investigate the success of schools at including and supporting the wellbeing of orphaned and vulnerable children in rural Zimbabwe. Data from a cross-sectional household survey of 4,577 children, aged 6-17 was linked to data on the characteristics of 28 primary and 18 secondary schools from a parallel facility survey. School HIV-competence included measures of physical infrastructure, HIV policies, fee structure and support, community links, teaching, and extracurricular activities. Multivariable regression was used to test if greater HIV-competence was associated with improved educational outcomes and wellbeing for children overall and for specifically for orphaned and vulnerable children. HIV-competence was not associated with school attendance, but was associated with children being in the correct grade-for-age. Females were 2.2 times more likely to be in the correct grade than males; gender had no effect on any other outcomes. For primary school-age children, schools with the greatest HIV-competence were associated with better wellbeing for children overall, but the association did not differ between vulnerable and non-vulnerable children. For secondary school-age children, HIV-competence was not associated with wellbeing. Contextual factors were associated with greater wellbeing, including higher levels of community group participation and lower HIV prevalence. Community group participation was associated with increased secondary school attendance. HIV-competence is associated with greater wellbeing in primary school children in eastern Zimbabwe, and the community context affects schools' ability to include and support children.

Dr Mbengeranwa summarised the main points arising from the presentations, expressing concern at the high costs of not treating NCDs and the implications especially for the economy, if action is not taken immediately to avert this impending crisis. He also expressed interest in the term 'HIV competent' schools and made specific reference to Dr Nyamukapa's definition of school quality and the significant association between school quality and education outcome.

The presentations were discussed by delegates. Responding to a query on costs, Dr Masuka acknowledged that projected costs for treatment of NCDs may be high, but it is also important to understand that, as long as medicine is not available in the public sector, costs of obtaining medicine through private health institutions will raise the overall costs of treatment both for the individual and the health system as a whole.

Delegates questioned how far there is interest to control risks of tobacco when Zimbabwe is one of the largest producers of tobacco in the world. Dr Masuka noted that it is one of the cheapest countries for buying cigarettes. There is solid argument to tax tobacco at point of sale to raise prices and this budget revenue can be used for control measures.

Delegates agreed with Dr Nyamukapa's point that wider support is needed both for in-school and out-of-reach children who have already dropped out of the education system.

Delegates making a point in the discussions

7. Parallel Session: Meeting new challenges

Mrs V Chitimbire, Zimbabwe Association of Church Hospitals (ZACH) chaired this session on the new challenges facing the health sector, to inform the widening of services for these challenges.

Mr Oscar Tapera, Department of Research, Metrics and Information Systems, PSI-Zimbabwe focused his presentation on the beliefs and attitudes toward cervical cancer screening among women 25 years and older. In Southern Africa, cervical cancer is one of the leading causes of premature death and ill-health among women and it contributes significantly to disability adjusted life years. Early screening and treatment of pre-cancerous lesions has been proven to be an effective strategy to curb cervical cancer. PSI-Zimbabwe and its partners are working with MOHCC to provide affordable cervical cancer screening (CCS) services. This study was aimed at gaining in-depth understanding of barriers and facilitators to provide evidence for better communication strategies that may also inform policy in Zimbabwe. The study undertook in-depth interviews of 21 females aged 25 years and above from Harare, Bulawayo, Chiredzi and Mazowe. Ten participants had been screened at least once using visual inspection with acetic acid cervicography (VIAC). Four of these were HIV positive. Eleven had never been screened before. Thematic codes were iteratively generated to identify barriers and facilitators to cervical cancer screening. Barriers were identified in perceptions that: woman should go for CCS when they experience a serious health problem, CCS is for women with money, CCS is for promiscuous women, too busy to have CCS, CCS is painful and embarrassing. There were also facilitators identified, in: services being available, knowledge about the disease and the role of CCS in early treatment, women's view on taking responsibility for their health, that CCS is for all women regardless of their background and on social support for CCS. He proposed that effective communication strategies need to be developed to address barriers to CCS among target audiences to improve service coverage and that the findings of this study be used to inform the national cancer policy, which is still in its development stages in Zimbabwe.

Ms Knowledge Mudungwe, Masvingo School of Midwifery talked to the factors that affect provision of personal protective clothing and equipment for staff in Masvingo Provincial Hospital. She clarified that under Zimbabwean law employers are obliged to provide personal protective clothing/equipment(PPC/E) and workers have a right to safe work environments. This is important for health worker safety, given the emergence of new epidemics such as Ebola. A study was undertaken in Masvingo Provincial Hospital to investigate the provision of PPC/E to staff in all departments, the factors affecting this and the knowledge and perception of Masvingo staff on occupational health and safety. Masvingo Provincial Hospital is a referral centre for the six districts in the Southern Region of Zimbabwe, and refers complicated cases to the central hospitals. It has 22 departments with an establishment of 271 workers. Simple random sampling was used to select two members from each department, and 4 from male medical and 4 from female medical to a total sample size of 50 participants. The research revealed that 84% of the workers did not have adequate PPC/E and 10% of workers had partial PPC/E. Two thirds of

workers (68%) shared PPC/E, but all were not comfortable doing so. The research indicated that 57% of workers pointed out the possibility of risk for spread of infections while 29% noted the possibility of acquiring new infections and 14% noted that it was unhygienic. Nearly all workers (94%) had not had occupational health and safety training. The study concluded that there is inadequate PPC/E for staff at the hospital and a knowledge gap on occupational safety and health in the staff, raising possible exposure to risks of infection and other hazards. It recommends procurement of adequate PPC/E for staff in all hospital departments, that the hospital mobilise adequate funds for this, and that workers be trained in environmental occupational health and safety.

Dr Vengesai Jaravaza, College of Primary Care Physicians of Zimbabwe, drawing on the history of health services development in Zimbabwe and a literature review of experiences from other countries, reflected on the value of a family physician-led and coordinated comprehensive PHC team as an important link in Zimbabwe's health delivery system. He noted that 30 years after Alma Ata, UHC as a goal requires a long term commitment of funding from government, private and external sources to ensure a minimum comprehensive package of service delivery. We need to build on our success with maternal and perinatal; reproductive health, HIV /STI/TB/Malaria to develop robust services for chronic conditions which not only require improved access, but also improved quality. He observed that the family physician provides a gate-keeper role for quality and access throughout the referral chain from the community to the clinical specialist and sub-specialist levels. He proposed introducing family medicine through a district based post-graduate vocational training in family medicine; initiating a grand-fathering process for doctors currently on the general practice register based on an agreed cut-off point; introducing a well-supported vocational up-skilling programme to be rolled out throughout Zimbabwe; and through vocational training of allied health team members of the comprehensive PHC team, including diabetic educators, health promotors, mental health nurses, social workers, clinical psychologists, optometrists and others.

In the discussions, delegates suggested that a sample size of 21 in the study on beliefs and attitudes on cervical cancer screening was too small to make policy recommendations and urged a larger study be done. However, other delegates felt that this was a detailed qualitative study, and that the qualitative in depth methods can be done with smaller sample sizes given the time involved. They felt that insights from the study could indeed be used for debate that informs policy, as it is the depth of the interview that is important.

Delegate input at the discussions

In the study on factors affecting personal protective clothing it was clarified in response to a query that the pre-test of the questionnaire was done in a different ward to that used in the research to control bias from this.

Participants urged that people be aware that health services screen people for NCDs and not wait until they get sick. Opportunities for health services to make this connect were identified. It was for example noted that Community Working Group on Health has a health literacy programme that can be used to widen awareness on early screening of NCDs, media can play this role and information on screening can be sent by cellphone if clinics keep a register of people in their catchment area. These links would ensure that there are multiple channels of communication on health issues to people in the community. Delegates proposed that all families be registered at their primary care facility so that a family focus and not a disease focus to health is achieved. It was also noted that the positive outcomes experienced in health at independence

and afterwards were a result of prior years' planning. The changes in the health system being proposed need to be well planned.

The major reason given by the hospital for not providing personal protective clothing was lack of finance. While the researcher argued that the hospital can start some income generating projects to alleviate this, a number of delegates felt that it should come from the core budgets of hospitals and that it was important for hospitals to prioritize their expenditure to include this legal duty.

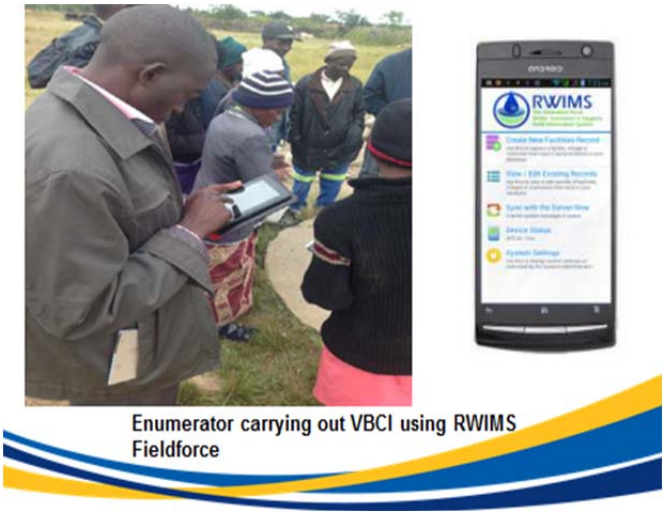
8. Parallel Session: People-centred and partnership approaches

This session was chaired by *Dr S Mutambu, National Institute of Health Research*.

Ms Judith Feremba –Takavarasha. Social Science Researcher explored the effectiveness of the support group model for young people living with HIV (YPLHIV). She noted that the HIV support group model has been portrayed as a panacea to stigma reduction, a support system for psycho-social support, a forum for sharing experiences and information dissemination among People Living with HIV (PLHIV). The general assumption is that the challenges faced by all PLHIV are cross cutting leading to a one size fits all approach to policy, strategy and programme design and implementation. Formation of youth specific support groups in a Zimbabwe National Network of People Living with HIV (ZNNP+) programme has met with scepticism and resistance, with many young people preferring to be members of mixed - age support groups of PLHIV from diverse social backgrounds away from their community. It is against this background that this research was carried out. The research analysed the effectiveness of the HIV support group model for young people (18 – 24 years) living with HIV who are members of the ZNNP+. 35 participants were included in the study. 25 were YPLHIV and 10 were key informants. Focus group discussions, questionnaires, in depth interviews and key informant interviews were used to collect data. The study found the support group model to be a suitable intervention for YPLHIV, but they are not keen to have such groups for youth *only* because of stigma and discrimination. A comparative perspective from Africaid showed that YPLHIV support groups are a safe and free space for YPLHIV to socialise, network, share information, talk openly without judgement and provide peer to peer counselling. However, these support groups should be led by youths with adults giving guidance, material support and making referrals to other service providers.

Dr Endris Mohammed Seid, Cordaid Zimbabwe reported on Cordaid's experience in involving Community Based Organisations (CBOs) in administering client satisfaction surveys as part of Zimbabwe's Results Based Financing (RBF) programme. Results from these surveys are used to calculate 20% of each health facility's overall quality score, based on client satisfaction and through verifying the authenticity of patients listed in the facilities' registers. This, in turn, is linked to health facility payments based on a set of criteria developed within the RBF programme. In the programme, CBO members are trained on how to administer the survey questionnaires and analyse the survey results. CBOs are paid $5 for each completed questionnaire. A list of 19 clients with their contact address and questionnaires with names of clients on each questionnaire are given to CBOs. CBOs trace clients as per their contact address and administer the questionnaire. CBOs submit the completed questionnaires and the summary of findings to CORDAID field staff members and Health Centre Committees. Counter verification exercises are conducted by the university to maintain the quality of the client satisfaction survey. To date, over 82 500 questionnaires have been completed with a response rate of over 90%.The strength of this approach is that the client satisfaction survey is being conducted by an independent body.

This has given clients the chance to express their level of satisfaction without reservations. In addition, it has created an opportunity for CBOs to provide feedback to Health Centre Committees, monitor the trend in level of service satisfaction over time and inform Health Centres so that they can take corrective actions. Involvement of CBOs is an innovative approach to empower communities and improve partnership between communities, health facilities and partners and should be further strengthened.



Mr Carl C Mateta, National Institute of Health Research reported on use of the Rural Wash Information Management System (RWIMS). Mr Mateta explained that government through the National Action Committee of Water, Sanitation and Hygiene Cluster aims to provide communities and stakeholders with up to date data on water supply services, sanitation and hygiene enabling facilities. This information is necessary to assist in planning for appropriate resource allocation and service delivery. Efforts in this direction led to the development of the Rural WASH Information Management System (RWIMS). This is an integrated information management system comprising of 3 main components: RWIMSFieldforce, an android based application; RWIMSGeodatabase, the geographic database containing all the rural WASH data at national level; and RWIMSOnline: a web-based software system that authorized users can use to query, analyse and visualize data as well as generate reports with ease. This is now being used as the data and information management platform to be scaled up to all rural WASH sectors in the country. This use of ICT illustrates how the government departments/ministries, communities, non-governmental organisations and private enterprises can work together to improve service delivery in the rural areas. It provides a monitoring tool to collect and provide accurate, reliable and timely information on rural WASH services in terms of functionality, coverage and location. The data is continually updated through direct reporting from the community of users, potentially channelled through traditional structures to ward-based government extension workers. This means that the initiative provides a direct channel between the community of users and government or service providers.

In the discussion there was much debate on the issue of paying CBOs to complete client satisfaction surveys. Delegates expressed concern that the high cost of maintaining this approach (a total of over $400 thousand since Cordaid began this study) was not sustainable and that it was more likely to create divisions within the community based on financial gain, than to unite them in organising for better health services for all. Dr Seid responded that CBOs are part of the community and that their link with the Health Centre Committees resulted in positive changes for the community as a whole and in improved services at health facility level.

Delegates expressed an interest in the Rural Wash Information Management System noted that it would be important for such software to be open source.

The recommendations then made for policy attention and research are outlined Section 10.

9. Poster Presentations

The posters dealt with one of the four themes of the conference and were available for review in the foyer of the conference throughout the two days, with dedicated times for discussing posters with the presenters. The discussions were lively and interesting! The abstracts for each of the poster presentations are briefly summarised below, with their lead presenter below the title. Further detail is provided in the Forum abstract book.

Reducing the gap in access to and coverage of health care and social determinants of health

Wilson Chamunorwa, Independent researcher

There is no consensus about the meaning of the concepts healthy equity and health disparities, despite their being goals in UHC and the practical consequences for measurements of progress in UHC. Health disparities by sex, race, wealth and other factors are unjust and their causes need to be addressed. From a pilot study carried out by this researcher in farms and villages in Mashonaland Central, it was found that disparities in health care and well-being of parents living in isolated resettled farms and remote villages are not adequately addressed in public health policy. In December 2014 convenience sampling was applied to include 70 people interviewed in Guruve district and six clinics and one hospital. Interviewees reported long distances to reach clinics and hospitals so that they use health care services only when they have serious problems. They cited geographical and financial barriers as the main reasons. The findings also indicated vertical inequities in the use of interventions for treatment of diarrhoea and acute respiratory infection among under-five year old children. The publicly-provided services for some of the selected interventions (such as child delivery) benefited the non-poor more than the poor. There is need to adequately integrate health equity in reaching isolated villagers and settled farmers in the remotest part of the country. It is recommended that government expand further its programmes, initiatives and services to address disparities in access to child health services for these communities.

Comparing the sensitivity and specificity of *Plasmodium falciparum* polymerase chain reaction based methods in malaria screening programmes

Mrs Zvifadzo Matsena-Zingoni, National Institute for Health Research

Prompt and accurate diagnosis of malaria is important for good implementation of appropriate treatment to reduce associated morbidity and mortality. Accurate detection of malaria is of value in surveillance to inform malaria control strategies and for research on anti-malarial drug efficacy. Understanding the performance of *Pf*chloroquine-resistant (PCR)-based tests will help in malaria control programmes to reduce the risk of getting high values of false negatives hence compromising the implementation of malaria control

Discussions during the poster sessions

programmes. This study aimed to determine the specificity, sensitivity and positive predictive values of *Pf*CRT PCR assay with reference to cytochrome b gene PCR assay in malaria screening research projects. Malaria asymptomatic study participants (473) were randomly selected in Mutasa District, Manicaland in February to August 2013. Of the 473 samples assayed, 2.3% were positive for cytochrome b gene, whilst 21.6% were positive for *Pf*CRT assay. Comparing the performance of *Pf*CRT PCR assay with reference to cytochrome b gene assay, *Pf*CRT showed a sensitivity of 8.82% and a specificity of 99.5% . A positive predictive value of 81.8% was obtained for the assay. The results in this study showed that *Pf*CRT PCR assay gave a higher number of malaria parasite positives compared to the reference assay. *Pf*CRT PCR assay was shown to be much more specific and had a higher positive predictive value as compared to cytochrome b gene PCR assay though its sensitivity was low. These results suggest that *Pf*CRT PCR assay can be used as an alternative gold standard in *Plasmodium falciparum* malaria confirmatory diagnosis test.

People centred approaches in results-based financing to promote universal health access in Zimbabwe

Dr. Paul S. S. Shumba, HTF-RBF Programme Team Leader, Zimbabwe

Crown Agents Zimbabwe in collaboration with Hera is implementing the Health Transition Fund (HTF)-Results Based Financing (RBF) Programme in partnership with the MoHCC in 42 rural districts in Zimbabwe. The partners monitor and assess the performance of rural health facilities on sixteen maternal, neonatal and child health (MNCH) indicators based on counter verified DHIS 2 data, quarterly Client Satisfaction Survey scores compiled by CBOs, and District Health Executive quality of care scores. The performance results are used to process invoices and pay performance subsidies to facilities to encourage and motivate facilities. RBF provides equity bonuses for vulnerable regions/ facilities based on poverty of the population, distance to the referral centre, or unfavourable location. Such inequity is compensated with additional bonuses on top of the basic indicator subsidies and an additional equity subsidy may be provided for each health facility to assist individual vulnerable patients. Health Centre Committees (HCCs) and Community Based Organizations (CBOs) provide a mechanism of participation. HCCs identify priority health problems with communities, plan how to raise resources, organize and manage community contributions. HCCs are also involved in developing clinic operational plans. HCCs implement plans and make authorities accountable for their health actions. They advocate for more resources for clinics, discuss issues with clinic health workers and report on community grievances regarding quality of health services. CBOs conduct client satisfaction surveys in the community with the results are used to improve the quality of services. CBOs also cross check the authenticity of hospital records to verify if patients received services, verify client satisfaction with the health services and verify whether subsidized activities are indeed taking place, with the results taken into account in the performance payments to the facilities.

Displays of research reports and materials

Assessment of hospital debt in Masvingo Provincial Hospital in 2014

Justice Mudavanhu, Ministry of Health and Child Welfare

Masvingo Provincial Hospital has been facing challenges mobilizing finances for healthcare. Treasury

disbursements last came in 2013 and Health Service Fund is now the backbone of healthcare funding. As of June 2014 the hospital was owed USD2.2 million by 28 800 patients and institutions. Even though there is a debt collection company working with the hospital, the debt is increasing monthly. An assessment was carried out of hospital debt, using Masvingo Hospital as a case study. Interviewer administered questionnaires were used to obtain demographic characteristics and factors associated with patients falling into medical debt. Record reviews were done from 2009 to 2013 to identify trends in debt accumulation and stratify the debt by hospital department. Medicines contributed 23% of the debt, followed by consultations (22%) and theatre (5%). Fifty-four percent of the household income of debtors was below US$250 per month and only 8% was above US$500. Out-of-pocket payment for health expenditure was 59%, followed by 28% social welfare and medical aid only paid for 5% of the patients. Patients are the biggest debt owners followed by medical aid and social welfare, with medicine payments contributing to the majority of the debt, followed by consultations at outpatients department. The combined household income of debtors does not support repayment of debt and most of those with hospital debt also have other debts. The estimated debt that can be recovered at the hospital is 50% of total debt and the debt gap at the hospital is growing yearly as the difference between the hospital debt and debt repayment is widening.

Heterogeneity in impact of conditional and unconditional cash transfers on education for different wealth groups: Results from a randomised controlled trial in Manicaland
Rory Fenton, Biomedical Research and Training Institute, Harare, and Imperial College London
Conditional (CCT) and unconditional (UCT) cash transfers can increase school attendance but the effect may vary by household wealth. The study investigated the impact of CCTs and UCTs on the relationship between household wealth and school attendance, on quality of education, and on household spending on education. Data from the baseline and follow-up surveys of a cluster-randomized controlled trial of CCT and UCT in 30 clusters (15,000 households) in Manicaland province from 2009 to 2010 were analysed using logistic and linear regression. The odds of repeating a year of school was used as a measure of quality of education. At baseline, wealthier participants were more likely to have higher school attendance. After receiving the transfer, this effect was removed in the UCT arm while not changing in the CCT arm. In the poorest quintile, there was an increase in the odds of 80% attendance at baseline vs. follow-up of 2.98 for UCT vs. control and 3.17 for CCT vs. control. UCT recipients reported spending more (46.1%) of the transfer on school expenses than did CCT recipients (44.8%). UCT participants were no less likely than those in the control group to repeat a grade of school, whereas CCT participants had 0.69 lower odds vs. control of repeating the previous school grade. The benefits of UCT were greatest among poorer recipients and eliminated income inequality in school attendance amongst recipients, while CCT increased the quality of education received. Conditions reduced school-related spending among those already meeting the conditions – perhaps due to conditions discouraging spending on school expenses among those who had already met attendance conditions – but did not increase it amongst those who are not.

Widening services to meet new challenges of emerging new diseases, including ebolaandmultiple/co morbidity
Vuyelwa T. Sidile-Chitimbire, Zimbabwe Association of Church Related Hospitals.
The spectrum of tasks for health promotion in third world countries has widened, with challenges from infectious diseases such as HIV/AIDS/TB. However with the changes in lifestyles and climate change, new and old diseases combine to pose a major threat to the development and health. Most emerging diseases have remained unrecognized or ignored due to lack of knowledge or finance. The emerging diseases are the non-communicable diseases and new

Discussions during the poster sessions

threatening diseases like Ebola whose infections are multiple and cause co morbidity creating chaos in health. Although population health has improved, these new infectious diseases have emerged due to factors such as poverty, urban over-crowding, environmental changes, unguided health behaviours, collapsed infrastructure and systems including health and medical inequalities. They demand new policy responses to support social cohesion, sustainable environments and to address the ecological and geophysical issues impacting on health, to address population health and avoid risks. Health promotion needs to strengthen links between the health sector and civil society, including those struggling to promote development, human rights, human security and environmental protection and should address those emerging population health influences that transcend national boundaries and generations.

Health equity through innovation: The need for a health delivery system model to advance UHC in Zimbabwe.

Kurudzirayi Musikavanhu, Independent researcher

Zimbabwe faces challenges in increased demands for health services and rising costs of healthcare associated with rapid changes in way of life, technology and demographics. There are three global health system challenges posing significant strain on the health care systems globally: (i) shifts in population demographics and social characteristics, (ii) balance between containing costs while maintaining access and quality and (iii) fragmented health care delivery models and bias towards acute versus chronic illness service delivery. Zimbabwe's health care system was created as a hospital-centered model focused on acute care. This has continued into the present despite a shift to population health needs towards chronic disease management. Systems are under increased pressure to deliver effective early-stage interventions that either prevent or effectively treat chronic disease conditions and their risk factors. Systems that fail to do so face increased costs resulting from delayed detection and treatment of individuals in advancing stages of pathology, placing heavy burdens on acute care resources.

Pilot phase of targeted spontaneous reporting of anti-retrovirals and anti-tuberculosis

Priscilla Nyambayo, Medicines Control Authority of Zimbabwe (MCAZ)

Adverse drug reaction monitoring is essential in achieving the goals of anti-retroviral (ARV) and anti-tuberculosis (anti-TB) treatment, and is an important element in promoting rational medicine use principles and promoting patient safety. The pilot phase of the Targeted Spontaneous Reporting (TSR) system for monitoring adverse drug reactions pilot phase research was carried out to strengthen pharmacovigilance activities in the National ART and TB programmes in Zimbabwe; and to understand and characterize adverse drug reactions (ADR's) or individual case safety reports due to ARV and anti-TB medicines. TSR refers to the reporting of adverse events by spontaneous reporting from a known cohort of patients on a particular medicine or group of medicines. The Medicines Control Authority of Zimbabwe (MCAZ,) in collaboration with the MoHCC piloted TSR of ARVs and Anti-TBs in public and selected private health institutions in 2012 -2013 with participants aged 0.9-76 years and a median of 38 years. Most of the reports described at least one ADR (83%) and a few reported more than one (2 ADR's=11% and 3 ADR's=6%). The majority of ADR's reported were mainly cutaneous in nature (44%), followed by central nervous system (27%), and metabolic (11%). Gender as a demographic variable showed an association with development of cutaneous reactions and metabolic reactions. Rash seems to have an association with gender in this population; females had lower odds of peripheral neuropathy compared to males. Pharmacovigilance activities need to be strengthened and included as part of clinical care especially for patients on ART and anti-TB treatment including essential medicines. The TSR is considered a relatively feasible cost effective method and has been scaled up. Further in depth analysis is required of individual case safety reports of other medicines, such as of tenofovir in combination with other anti-retrovirals.

Bridging the gap between access to and coverage of health care through teacher education in Zimbabwe

Mr Gilbert Nyabadza, Marymount Teachers College

A major health concern in Zimbabwe is increasing access to and coverage of health care particularly among disadvantaged sections of society, especially urban and rural poor people. This paper places teacher education at the centre of the process of providing relevant education

on health care that will improve access to and coverage of health care from a very early age. It is argued that empowering student teachers with health education will enable them to reach poorer communities and pupils. The poster focused on traditional foods as an example, given the 'onslaught' of western foods and the role of food in addressing health challenges, such as of HIV/AIDS. The study was implemented in a teachers' college with student teachers and staff as main sources of information. It used document analysis to collect data on policies and focus group discussions and observations to obtain evidence on people's perceptions and attitudes towards traditional foods. Observations of meals provided to students as well as the nutrition garden at the College were also done. The study established that teachers' colleges had the capacity in terms of resources and were strategically positioned to enable the increase of access to low and disadvantaged sections of society through teacher education.

The transmission and acquisition of indigenous medicinal knowledge through informal education in rural communities in Chipinge district

Mr Savania Magaya: Marymount Teachers College

The health of any community can be viewed as a product of its interaction with its physical environment in the sense that the outbreak, transmission and containment of any disease are dependent on the nature of the physical environment. On the other hand the physical environment can also be a source of medicinal plants, fruits, liquids and tubers which can remedy a number of ailments affecting communities. This has been the case for most communities in Zimbabwe which continue to depend on the use of some of these traditional medicines despite the negative perceptions created by white colonialists during the colonial era. With a sizeable section of the Zimbabwean community still relying on the indigenous medicinal knowledge there is therefore a need to preserve and transmit the knowledge of traditional medicine to the next generation. However while the transmission of knowledge of modern medicine is catered for and guaranteed through nursing schools and universities very little is known on how traditional knowledge of medicine is transferred, adapted and preserved. It is acknowledged that this knowledge is transferred informally but limited knowledge exists on the teaching learning processes involved in the acquisition of this knowledge. The study will use a case study design, where data will be collected from some traditional healers, herbalists, villagers and community leaders in Chipinge district. Interviews and focus group discussions will be used to collect data. The study highlights how far the traditional medicine on which some communities are dependent will continue to play a role in promoting the health of some communities in Zimbabwe in the new millennium.

During the poster sessions, *Ms Arianne Rietsema, Cordaid* and *Dr Patron Mafuane PMD Manicaland MoHCC* separately judged the posters on their originality and relevance of content, visual presentation and oral presentation and response to questions asked. They asked presenters to summarise the key features of their posters in 3-4 minutes and asked questions about them. Their ratings were compiled and a certificate presented to the 'best poster' at the Forum. The award for best poster was presented by the *Hon Minister of Health and Child Care Dr P.D.Parirenyatwa* to *Mr P Shumba Crown Agents* and HTF-RBF Programme Team Leader, Zimbabwe for the poster on *People centred approaches in results-based financing to promote universal health access in Zimbabwe.* The full poster is shown overleaf.

Best poster award presented by the Hon Minister of Health and Child Care Dr P.D.Parirenyatwa to P Shumba Crown Agents (with Dr R Loewenson TARSC)

People Centred Approaches in Results-Based Financing to Promote Universal Health Access in Zimbabwe

Presenter: Dr P.S.S. Shumba, HTF-RBF Programme Team Leader

BACKGROUND

Supported by the Health Transition Fund, Crown Agents Zimbabwe in collaboration with Hera is implementing the HTF-RBF Programme in partnership with the MoHCC in Zimbabwe in 42 rural districts, covering 800 rural health facilities with an estimated total catchment area population of 6,6million.

The HTF-RBF Programme embraces Universal Health Coverage (UHC) including Health Equity, Widening Services to meet New Challenges and People Centred Approaches.

HTF-RBF monitors & assesses the performance of RHFs on selected sixteen (16) maternal, neonatal and child health (MNCH) indicators based on counter verified DHIS 2 data, quarterly Client Satisfaction Surveys (CSS) scores conducted by CBOs, and District Health Executive (DHE) quality of care scores.

The performance results are used to process invoices and pay performance subsidies to RHFs.

CORE AREAS OF CROWN AGENTS IN HEALTH

1 Maternal Newborn Child Health (Health Transition Fund - Results-based Financing)	2 Medical products Vaccines Technologies (Delivery Team Topping up, Vital Medicines Availability and Health Services	3 Human Resources for Health (Human Resources Retention Scheme)

HTF-RBF PROGRAMME GOAL AND OBJECTIVES

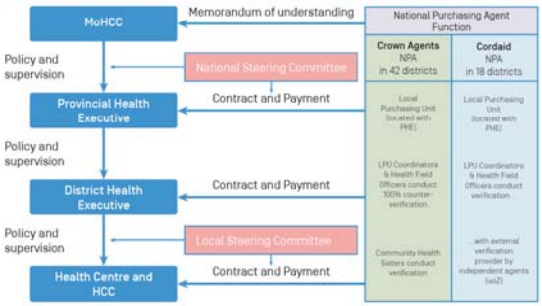
HTF-RBF PRIMARY CARE INDICATORS

- Curative care consultations OPD (new consultations)
- First ANC before 16 weeks
- Antenatal care visits (4)+
- Pregnant woman tested for HIV
- ARV pregnant woman Option B+ (PMTCT)
- Pregnant woman received TT2+
- Pregnant woman screened for syphilis
- Pregnant woman received Malaria prevention (2x IPT)
- Delivery attended by skilled health worker in health institution
- High Risk Maternal cases referral out
- Postnatal care visit x 2 visits
- First and repeat visits for FP modern methods. Repeat for short-term only
- Child < 1 year fully immunized (Primary Course Complete)
- Vitamin A given to a child 6 to 59 months
- Growth Monitoring child < 5 years

THREE STRUCTURAL RBF COMPONENTS

Result-based Contracting	• Relational contracts linked to operational planning and budgeting • Explicit roles: provider, purchaser, regultor, verifier • Use of free market principles to correct market failures • HF autonomy with key support of HCCs
Management & Capacity Building	• Strengthening planning and management capacity (management of HTF RBF cycle: Facility, District, Provincial and National levels) • Purchasing, verification, strategic management
Monitoring & documentation	• M&E and reporting framework with baseline setting • Capture of effects on health outcomes and various aspects of the health system • Emphasis on Process Monitoring and Evaluation mixed methods approach, contextual factors, ongoing, knowledge management

INSTITUTIONAL IMPLEMENTATION ARRANGEMENTS



EQUITY CRITERIA

PEOPLE CENTRED APPROACHES

- HCCs and CBOs provide a mechanism of participation.
- Strengthen the accountability and ownership of the RBF programme.
- HCCs identify priority health problems with communities, plan how to raise resources, organize and manage community contributions.
- HCCs are also involved in developing Clinic Operational Plans.
- HCCs implement plans and make authorities accountable for their health actions.
- HCC advocate for more resources for clinics.
- HCCs discuss issues with health workers at the clinics, HCCs report on community grievances regarding quality of health services, and discuss health issues with health workers.
- To date 3,745 HCC members have been trained
- CBOs conduct client satisfaction surveys (CSS) in the community and the results analysed, used to improve the quality of services.
- CBOs cross check the authenticity of clinic records to verify if patients indeed received the services.
- CBOs verify client satisfaction with the health services received and verify whether services were free of charge, with the results taken into account in the quantity performance payments for the facilities.
- Community involvement has a positive impact on the attitudes of health workers, making them more service-oriented and client-friendly.

KEY PEOPLE-CENTRED TRAINING

Health Transition Fund — Supporting the National Health Strategy to improve access to quality health care in Zimbabwe

hera

CROWN AGENTS

10. Closing Plenary

The closing session was chaired by *Dr Nyasha Masuka, MoHCC*. The rapporteurs *Barbara Kaim and Artwell Kadungure, TARSC* read the recommendations from the discussions held in the conference plenary and parallel sessions within each theme area, in terms of:

- issues for policy attention,
- areas for research, and
- areas for further debate and social dialogue.

These recommendations were reviewed in the plenary and delegates then confirmed that they reflected the views of the Forum. They are shown below.

10.1 Recommendations arising from the conference

ISSUES FOR POLICY ATTENTION

Health equity

i. Equity is central to government policy and to UHC. There should be serious efforts to track, monitor and address inequalities in health and in access to social determinants of health and health care, with explicit measures for 'closing the gap'.
ii. All sectors that affect health should be engaged on this. UHC calls for the co-ordinated efforts of all actors, public and private and communities, with leadership from government and space for co-ordinated initiative by all. Those in leadership roles, such as parliament, councils, community leaders need to be informed to take forward debates and actions on equity and UHC. Particularly the education sector and teachers should be engaged and supported to play a role in health promotion, prevention and uptake of health care.
iii. Public health and comprehensive primary health care are a cornerstone of UHC. The public health authority of the health sector needs to be reclaimed. The Public Health Act should be known and implemented and the Public Health Bill developed under MoHCC with wide social and institutional dialogue brought to parliament.
iv. Explicit attention must be given to the gender norms and practices that affect uptake of services, such as low male involvement in HIV testing, and measures put in place to address these by all sectors. Quality of care should be given greater attention in UHC.
v. There is need for a more bottom up approach to social and community participation in health. While this exists in policy it needs to be implemented in approaches that inform, consult, involve and enable communities to play their role, including through legal recognition of mechanisms like health centre committees.

Health financing

i. With the fiscal limitations there is need to think outside the box, on all three dimensions of UHC, (extending services to all, widening services and reducing OOP) and to use the available resources more effectively.
ii. Domestic health financing needs to be strengthened. Research and policy evidence on options for this should now be taken to wider dialogue to get feedback so that what is proposed takes the current context and people's situation and views into account.
iii. Resources should be equitably distributed in line with health need, health workloads, disease and social profiles of specific areas and the reality of local contexts, with measures to support areas that have weaker capacity to absorb resources and for resources to be effectively used. Resource allocation measures should not reduce funding to any district, but progressively increase resources to those with higher health need.
iv. The segmentation of resources and funds (in both public and private sectors) is generating high reporting workloads at operational level. Reporting requirements of different funds need to be harmonised and options identified for pooling different funds for UHC, including in terms of what institution manages pooled funding.
v. Retention incentives are a 'stop-gap' measure that can be eroded over time. Addressing the basic pay of health workers across *all* categories provides a more sustainable solution.

Meeting new challenges

i. Services need to organise to address the changing pattern of population health to chronic and acute conditions and new health risks, including from climate change and disasters.

Every family should be registered at the primary care level, to move from a disease approach to a family oriented approach to care, to widen coverage of promotive, preventive and care services, encourage early uptake and medical checks, including to prevent or detect early the rising chronic conditions.

ii. A more proactive model of prevention, earlier detection and uptake and reach to all groups calls for improved enforcement of public health law and practice, and strengthened outreach into communities to support health promotion and uptake of services, including of screening for NCDs, with messaging and communication that takes community perceptions and social organisation into account

iii. Health personnel need to be trained and supported to meet new challenges, including through post graduate training in family medicine for primary care level, training in occupational health and safety and MoHCC guidelines for budget allocations for ensuring infection control measures and disposable and other personal protective equipment.

People-centred and partnership approaches

i. Partnership approaches with other sectors, private sector and civil society are noted above as is the priority for strengthening the relationship between health services and the community.

ii. Communities should have a voice in policy, in prioritizing health needs, health service promotion, resource mobilization and monitoring quality of care. Health Centre Committees provide a vehicle and should be recognized in law. Community-based organisations and peer to peer support groups provide innovative approaches in empowering communities and strengthening partnership.

iii. Schools should be given a central role in UHC, given their key role in meeting the health needs of vulnerable children, such as HIV competent schools for youth infected and affected by HIV. Wider support is needed for school programmes for in-school and out-of-school children.

iv. The use of ICT should be invested in to strengthen partnerships and links, to provide information on services and for planning, to support uptake of screening and treatment services, to manage health information data, to monitor service quality and to strengthen direct channels between the community of users and service providers and regulators.

ISSUES FOR FURTHER RESEARCH

Generally, delegates noted that a lot of research has already been done- we should be using and acting on the evidence we have already gathered. Researchers need to make greater use of routine data, government and researchers to draw more on evidence from communities and government needs to engage local researchers to support strategy development. Delegates further identified evidence gaps in:

Health equity

i. What are the causes / drivers of 'within area' inequalities in health and uptake of health care in urban and rural areas and what measures can address these? What factors are leading to positive performance in districts that have good health outcomes?

ii. What is leading to children on ART dropping out of school and how can this be addressed?

iii. In the response to inequalities in health
   a. How do we assess, value and reward social factors such as health worker commitment, social participation, leadership, trust and communication in the health system?
   b. How is UHC supported in the way emergency and humanitarian responses are implemented- eg for food or flood relief?
   c. What role are the provincial level services / hospitals playing?
   d. What are the institutional and other constraints to more effective co-ordination of all actors? How can these be overcome?

Health financing

i. What is the relationship between levels of external funding across districts and health outcomes? What tools can be used for monitoring this?

ii. What resources would be raised from a tax on airtime? How progressive is this tax?

iii. What effect are user fees having on access to services for children?

iv. What areas of cost reduction can be made in the health sector and the wider economy?

v. What factors and conditions are limiting health workers from optimal levels of performance

and how can these be addressed? What skills mix and career path development is optimal for addressing current and future population health challenges?

Meeting new challenges

i. Delegates called for a survey to update population level evidence on NCDs, noting the last survey was done in 2005. This should also assess risk factors and practices that are promoting NCDs, and those that are curbing them, and the level of co-morbidity between NCDs, HIV and other conditions. It was noted that the dialogue between WHO and MoHCC on this should be concluded.
ii. What is the readiness and performance of private sector health services on quality of care, especially for new challenges?
iii. What are the level of occupational risks and occupational morbidity in health workers and what barriers are facilities facing to improved risk prevention?

People-centred and partnership approaches

i. How can we ensure that marginalized groups and gender disparities are taken into account in programming and partnerships for UHC?
ii. How are partnerships perceived by community groups, private sector, civil society or other partners? Is there a shared understanding? Are the processes enabling? Who is included and excluded, with what implications? What gains or costs are they seen to bring?
iii. What role has ICT played in other countries in strengthening people-centered and partnership approaches? How are these options perceived in Zimbabwe?

ISSUES THAT NEED FURTHER DEBATE AND SOCIAL DIALOGUE

Generally what UHC means and the vision for how it is to be achieved in Zimbabwe needs more social information and dialogue to build a shared national vision and goals. A number of other areas of debate in the conference needed further dialogue.

Health equity

i. What prevention measures need to be put in place now to avoid the rising levels of chronic conditions/non communicable diseases?
ii. What should be the distribution of authority between central and local level and between state and non-state actors and communities in UHC? How can more powers be given to local level and communities? What has been the positive and negative experience of other countries on devolution?
iii. How and by whom should equity, quality and effectiveness of financing, service and health outcomes in UHC be monitored? Should this be done by state, non-state actors or both?

Health financing

i. What institution should manage pooled funds for UHC?
ii. How should domestic and external resources be distributed between primary, secondary, tertiary and central level services? What role should external funders play in UHC?
iii. How sustainable and viable is community based health insurance?
iv. What services should be free at point of care and what should not?
v. What are the trade-offs between efficiency and equity? When do we need to accept reduced economic efficiency in the interests of reaching underserved groups?

Meeting new challenges

i. How should local authorities work with the private health sector? With what distribution of roles?
ii. What 'works' for prevention of priority health problems to inform programming eg:
    a. For improved waste management in public and private sector health services
    b. For implementing measures on the Framework Convention for Tobacco Control given Zimbabwe's role as a major producer of tobacco.
    c. For addressing community and lifestyle issues in NCDs?

People-centred and partnership approaches

i. Should community researchers / monitors be paid fees or should their time be voluntary?
ii. Do young people living with HIV want to participate in support groups which only include youth, or do they want to be in mixed-age groups?
iii. How do different people understand community empowerment?

10.2 Panel on evidence and knowledge gaps in moving to UHC

Dr Rene Loewenson, Training and Research Support Centre and *Dr Susan Mutambu, National Institute of Health Research* moderated this panel discussion, asking questions of the following panellists:

- *Dr Timothy Stamps, Health advisor, Office of the President and Cabinet*
- *Hon Dr Ruth Labode, Chair, Parliamentary Portfolio Committee on Health, Parliament of Zimbabwe*
- *Mr Tafadzwanashe Nkrumah, Programme Officer, Community Working Group on Health*
- *Dr Shungu Munyati, Assistant Director General, Biomedical Research and Training Institute*
- *Mr M Muzite, Programme Director, National Economic Consultative Forum*

Delegates in the panel discussion

Dr Stamps initiated the panel discussion by encouraging researchers to focus on current realities and not to look back to the 1980s. Our responsibility is to face the problems and challenges of today, and to plan for the future. He called for meaningful research on health funding and how resources are used. Dr Labode asked why it is that the government needs so much convincing to allocate sufficient resources to the health sector. She bemoaned the fact that "our (economic) pot is leaking" and encouraged researchers to include audits of cash flows in their research work to make explicit where and how funds are being used. Using the example of 0% pass rates in 15 schools in Matabeleland South, she linked these failures to teenage pregnancies, asking why this problem had taken so long to reach the attention of the Parliamentary Health Portfolio Committee for action through parliament. "The data is available" she declared "so why are we not acting on this?" This brought her to request for regular information from researchers – "your research is essential in supporting our battles in Parliament."

Mr Nkrumah, CWGH called for priority to be given to resourcing the health system at primary care level. CWGH work shows that communities know what is best for them and are willing to use their time and resources to improve their health system. They are also the most appropriate group to monitor their own services. CWGH will continue to advocate for the elimination of out-of-pocket expenditure and for realisation of the Abuja Declaration of 15% for health.

Dr Munyati, BRTI representing the research community, supported Dr Labode's contention that there needs to be better uptake from research to action. She proposed a closer, more formalised link between the MoHCC/ Portfolio Committee and the research community to ensure researchers respond to the specific information needs of policy makers, and package information in a way that is useful and accessible to them. She highlighted that the Community Advisory Committees have specifically been developed in recent years to support research work at community level. Dr Loewenson pointed out that this conference has confirmed that researchers are not only those people who hold a university degree. In both plenary and parallel sessions, we have heard from health workers, teachers and community-based researchers, proving that anyone can undertake research and document evidence.

Mr Muzite, NECF recognised that many health problems emanate from outside the health sector-for example trade, water, road traffic – and yet, if these sectors do not support healthy actions, the health sector has to deal with the consequences. This has economic implications, especially when the health sector does not get the finances it needs to implement its policies and

programmes. He pointed to the need for evidence-based policy making as a way of ensuring a larger budgetary allocation for health, indicating that resources would be allocated where health improvements can be achieved. He thought it important to use local skills and manpower more in developing local products, particularly pointing out that local medicine development would ensure cheaper medicine for all. Dr Loewenson responding to his point suggested that this would imply a review of tariffs as at present, local producers pay high tariffs to bring in raw materials for local production of medicines, despite policies supporting local production.

The conference raised many areas where policy coherence and synergies and links between different actors are important for UHC. Dr Labode put in a plea that all sectors continue to play a role in supporting the Health Portfolio Committee in reviewing and passing the proposed Public Health Bill in parliament. Following up on a comment made by Dr Stamps about ensuring bottom-up planning, Mr Nkrumah pointed to the importance of Health Centre Committees as a successful mechanism for bridging the gap between the health sector and the community. Other existing statuary bodies, such as the Thematic Working Group on UHC could also be used to bring together different sectors. A question was asked of the panel for their view on public-private partnerships (PPPs). Dr Labode argued that in the present economic situation, the public sector needs private sector support. ECONET, for example, is storing MOHCC vaccines because they have a 24 hour generator and can deal with electricity cuts. They are also helping with health outreach. Chitungwiza Hospital is another example where wards have been adopted by private sector donors. Dr Stamps cautioned delegates about getting into these type of partnerships, giving an example from the United Kingdom where the private sector came in to support the building of hospitals and then left the government heavily in debt to them. He called for greater focus on where we are doing things right and where we are doing things wrong, and on focusing our resources and time on those who need it the most.

The moderators thanked the panellists for their thought provoking inputs, from a diversity of lenses. They noted the wealth of experience, evidence and capacity in the panel and amongst the conference delegates, and hoped that the exchange would continue in shaping the unique path to UHC in Zimbabwe, to protect and advance the positive features of Zimbabwe's health system and address its challenges.

10.3 Closing remarks

Dr Masuka, MoHCC closed the meeting by thanking the panellists for a very informative and lively discussion. He also appreciated all delegates for their participation throughout the duration of the conference and especially thanked the organisers and all those who played a role in making this such a successful meeting. He ended the meeting with a quote from Winston Churchill:

> *'You'll never reach your destination if you stop and throw stones at every dog that barks."*

In explaining this quote, Dr Masuka encouraged all delegates to keep a focus on moving forward in making UHC a reality, despite all obstacles we may face along the way. With that final word, he closed the meeting.

Appendix One: Programme Outline

MINISTRY OF HEALTH AND CHILD CARE
NATIONAL INSTITUTE OF HEALTH RESEARCH
TRAINING AND RESEARCH SUPPORT CENTRE

National Research Forum:
Evidence for advancing Universal Health Coverage in Zimbabwe
Harare, 19th and 20th March 2015

Programme Outline

Thursday 19th March

Timing	Programme	
OPENING PLENARY 0900-1000	Opening by the Minister of Health and Child Care Opening key note presentations	
TEA 1000 1030AM		
PLENARY SESSION 1 1030-1230	**Plenary papers: Health Equity and Health financing**	
	Universal Health care- A debate at the cross Road	
	How well are we doing on equity in UHC? Tracking progress through the 2014 Zimbabwe Equity Watch	
	Integrating equity in the allocation of scarce resources for UHC	
	Field assessment of how the system channels funds from central to operational level	
POSTER SESSION 1230-1300	Poster viewing and discussion with poster presenters (See list below)	
LUNCH 1300-1400		
PARALLEL SESSIONS 1 and 2 1400-1500	**Parallel session 1: Health Equity**	**Parallel session 2: Health financing:**
	Income disparity as a predictor of access to environmental health determinants	Assessing Community Based Health Financing in Rural Areas in Zimbabwe
	Determinants of poor uptake of VMMC by young men in Mashonaland West	Impact of user fees on patients with chronic diseases
	Missed opportunities for HIV testing of children	Mind the Gap: Resource allocation for equity can only be achieved if health system gaps are known
	Barriers to provider initiated testing and counselling for children	Managing health financing in Zimbabwe- learning from other African countries
TEA 1500-1530		
PARALLEL SESSIONS 3 and 4 1530-1615	**Parallel session 3: Health Equity:**	**Parallel session 4: Health Financing:**
	How far are our public health food and infant feeding laws being enforced?	Incentive policies in post crisis Zimbabwe: Challenges and implications for retention of human resources for health
	Effectiveness of routine opt out testing for HIV in Zimbabwe	Advancing Universal Health Coverage in Zimbabwe: seeking health financing models
1615-1700	Discussion on recommendations for policy and research on health equity	Discussion on recommendations for policy and research on health financing
END OF DAY		

Friday 20th March

Timing	Programme	
POSTER SESSION 0800-0845	Poster viewing and discussion with poster presenters (See list below)	
PLENARY SESSION 2 0845-0930	**Plenary papers: Meeting new challenges and building people centred and partnership approaches**	
	The costs of not responding to chronic diseases	
	The contribution of schools to supporting the wellbeing of children affected by HIV in Eastern Zimbabwe	
PARALLEL SESSIONS 4 and 5 0930-1010	**Parallel session 5: Widening services to meet new challenges**	**Parallel session 6: People centred and partnership approaches**
	Beliefs and attitudes around cervical cancer screening amongst women 25 years and above in Zimbabwe	Effectiveness of the Support Group Model for YPLHIV 18 -24 Years: A ZNNP+ case study
	Factors affecting provision of personal protective clothing/equipment for staff in a provincial hospital	Involvement of Community Based Organizations in administering client satisfaction surveys to empower communities?
	Family physician lead and coordinated comprehensive Primary Health Care team as the missing link in the health system	The Rural Wash Information Management System; Bringing Information Communication Technologies to health service delivery
1010-1045	Discussion on recommendations for policy and research on widening services to meet new challenges	Discussion on recommendations for policy and research on people centred and partnership approaches
TEA 1045-11.30		
PLENARY SESSION 3 1130am-1240pm	**Plenary feedback on parallel sessions** and discussion **Panel on evidence and knowledge gaps in moving to UHC**	
CLOSING PLENARY 1240-1300	**Closing remarks**	
LUNCH 1300-1400		

Appendix Two: Delegates List

	Title, Surname Name	Institution and position
1.	Ms Ahmed Yasin	State Registered Nurse
2.	Mr Banda Stephen	Dept Policy, Planning, Monitoring and Evaluation, MoHCC
3.	Mr Buzuzi Stephen	Projects Coordinator, Biomedical Research and Training Institute
4.	Mr Chakupwaza Jacob	Training and Research Support Centre
5.	Mrs Chandiwana Pamela	Research Officer, Biomedical Research and Training Institute
6.	Mr Chamunorwa Wilson	Chifamba Primary School
7.	Dr Chemhuru Milton	PMD MoHCC Midlands Province
8.	Dr Chideme-Maradzika Julita	Lecturer, College of Health Sciences Dept of Community Medicine
9.	Dr Chigumira Gibson	Director , Zimbabwe Economic Policy Research Unit
10.	Dr Chikodzore Rudo	Acting PMD Matabeleland MOHCC
11.	Ms Chifamba Mercy	Actuary (NQ) Atchison Consulting
12.	Dr Chirenda Joconiah	Department of Community Medicine UZ Medical School
13.	Mr Chirwa Yotamu	Research Fellow, Biomedical Research and Training Institute
14.	Mr Chituku Tawanda	Actuary (NQ) Atchison Consulting
15.	Dr Chiware Josephine	Director – Quality Assurance MoHCC
16.	Mr Chiwunze Gamuchirai	Research Fellow, Zimbabwe Economic Policy Analysis and Research Unit
17.	Dr Dauya Ethel	Study Coordinator, Biomedical Research and Training Institute
18.	Dr Dhliwayo Panganai	Secretary General, Zimbabwe College of Public Health
19.	Dr Dhliwayo Patience	Medical Officer, Epidemiology and Diseases Control MoHCC
20.	Ms Fana Shamiso	Researcher, University Of Zimbabwe
21.	Dr Ferrand Rashida	Principal Investigator, Biomedical Research and Training Institute, LSHTM
22.	Mr Geza Milton	National Health Research Institute
23.	Mr Gwati Gwati	Dept Policy, Planning, Monitoring and Evaluation MoHCC
24.	Dr Gwinji Gerald	Permanent Secretary MoHCC
25.	Mr Hooton Nick	ReBUILD Consortium Liverpool School of Tropical Medicine
26.	Ms Hove Caroline	Population Services International Zimbabwe
27.	Mrs Hove Ropafadzai	Director Pharmacy Services, MoHCC
28.	Dr Jaravaza Vengesai	College of Primary Care Physicians of Zimbabwe
29.	Mr Kadungure Artwell	Programme manager, Training and Research Support Centre
30.	Ms Kaim Barbara	Programme manager, Training and Research Support Centre
31.	Mr. Kalweit Keith	Secretary, Private Hospitals Association
32.	Mr Kamusewu Toendepi	Africare
33.	Ms Kaseke Ruth Runyararo	Executive Director, Health Services Board
34.	Ms Kudakwashe Slyvia	Human Resources Officer
35.	Hon Dr Labode Ruth	Chair, Parliament Portfolio Committee on Health
36.	Dr. Laver Susan	Consultant
37.	Dr Loewenson Rene	Director, Training and Research Support Centre
38.	Ms Mabhena Thubelihle	MPH Intern, Cordaid
39.	Mr Machakata Assael	General Manager Finance and Admin, Health Services Board
40.	Ms Machamire Heather	Director Finance and Administration, MoHCC
41.	Dr Mafaune Patron	PMD Midlands MoHCC
42.	Mr Madzima Emmanuel	Medical Research Officer, National Institute of Health Research, MoHCC
43.	Dr Madzorera Henry	General Practitioner Tinamed Medical Services (previous Minister of Health)
44.	Dr Mafuane Patron	PMD Manicaland MoHCC
45.	Mr Magaya Savania	Lecturer, Marymount Teachers College
46.	Ms Makandwa Mevice	Training and Research Support Centre
47.	Dr Manangazira Portia	Director Epidemiology and Disease Control, MoHCC
48.	Mr Mashange Wilson	Researcher, Biomedical Research and Training Institute
49.	Dr Masoja Gift	Acting PMD, Mashonaland West MoHCC
50.	Mr Masuka Josiah	Medicines Control Authority of Zimbabwe
51.	Dr Masuka Nyasha	PMD Matabeleland North, Acting Director Preventive Services MoHCC
52.	Mr Mateta Carl	Research Technologist, National Institute of Health Research, National Coordinating Unit-WASH

53.	Mrs Matsena-Zingoni Zvifadzo	Malaria Section Head, National Institute of Health Research, MoHCC
54.	Dr Mbengeranwa Lovemore	Executive Chairperson, Health Services Board
55.	Dr McHugh Grace	Study Physician, Biomedical Research and Training Institute
56.	Dr Mhlanga Gibson	Principal Director, Dept Preventive Health Services MoHCC, seconded to PSMAS
57.	Dr Midzi Staneley	Health Systems Strengthening & Policies, World Health Organisation
58.	Dr Moyo Obadaiah	CEO, Chitungwiza Hospital
59.	Ms Moyo Thandekile	Office of the President and Cabinet
60.	Mr Mlambo Zvikie	General Manager, Training and Research Support Centre
61.	Mr Muchabaiwa Lazarus	Economics Dept, Bindura University of Science Education
62.	Dr Mudavanhu Justice	Medical Doctor, MOHCC
63.	Ms Mudungwe Knowledge	Senior Tutor , Masvingo School Of Midwifery
64.	Mr Mujiri Donald	Public Relations officer MoHCC
65.	Mr Munatsi Ronald	Programme Manager, Zimbabwe Evidence Informed Policy Network
66.	Dr Munyati Shungu	Ass Director-General, Biomedical Research And Training Institute
67.	Ms Mupanda Ruth	Lecturer, Marymount Teachers' College
68.	Mr Musira Patrick	Freelance journalist
69.	Mr Musikavanhu Kurudzirayi	Independent researcher
70.	Dr Mutambu Susan	Director, National Health Research Institute
71.	Ms Mutsaka Masceline	Senior Research LaboratoryTechnologist, National Institute of Health Research,
72.	Mrs Mutsvangwa	Biomedical Research and Training Institute
73.	Mr Muzite Muzi	Program Director, National Economic Consultative Forum
74.	Mr Mwenda John	National Health Research Institute
75.	Dr Nganda Benjamin	Intercountry Support Team, World Health Organisation
76.	Mr Onias Ndoro	Deputy Director Traditional Medicine
77.	Mr Nkrumah Tafadzwanashe	Programme Officer, Community Working Group on Health
78.	Mr Nyabadza Gilbert	Lecturer, Marymount Teacher's College
79.	Dr Nyamayaro Wenceslas	Acting Principal Director, Policy, Planning, Monitoring and Evaluation, M0HCC
80.	Dr Nyamukapa Constance	Biomedical Research and Training Institute,
81.	Dr Quigley Paula	Health Consultant, Health Partners International
82.	Hon Dr Parirenyatwa P.D	Minister, Ministry of Health and Child Care
83.	Ms Rietsema Arianne	Country Director, Cordaid
84.	Mrs Rufu Annah	Programme Officer, Zimbabwe Association of Church Related Hospitals
85.	Dr Seid Endris Mohammed	Health Improvement Specialist, Cordaid
86.	Mr Shamu Shepherd	Consultant, Training and Research Support Centre
87.	Dr. Shumba Paul	HTF-RBF Programme Team Leader, Crown Agents
88.	Dr Sibanda Tafadzwa	Provincial MCH Officer, Acting Provincial Medical Director MoHCC
89.	Mrs Sidile- Chitimbire Vuyelwa	Executive Director, Zimbabwe Association of Church Related Hospitals
90.	Ms Sobuthana Bernadette	Crown Agents
91.	Dr Stamps Timothy	Health Advisor, Office of the President and Cabinet
92.	Mr Tafirenyika Sherphard	Business Strategies Consultant
93.	Mrs Takavarasha Judith Feremba.	Independent Social Science Researcher
94.	Mr Tapera Oscar	Department of Research, PSI-Zimbabwe, Harare
95.	Dr Toonen Jurrien	Coordinator UHC, Royal Tropical Institute, Amsterdam (KIT)
96.	Dr Van Geldezmalsen Gad	Consultant
97.	Mr Zhou Norman	General Manager, Human Resources, Health Services Board
98.	Ms Zindi Paulina	Deputy Director, Government Analyst Laboratory
99.	Mr Chimedza Andrew	Reporter, Herald Newspaper
100.	Mr Chisipo Jabulani	Journalist, Chaminuka News
101.	Mr Makwiro George	Editor In Chief, Diabetes and Health News
102.	Ms Mbanje Phylis	Reporter, Newsday
103.	Ms Muchemwa Molline	Journalist, Flame News
104.	Mr Munyoro Chivako	Journalist, Nehanda Guardian
105.	Ms MusiwaTaurayi	Journalist, Flame News

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