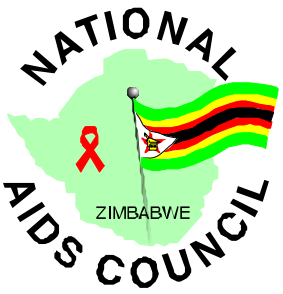
National Health Financing in Zimbabwe 2005: Contribution of the National AIDS Levy to National Health Care Support

Amon Mpofu and Phillip Nyahoda
National AIDS Council of Zimbabwe



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Executive Summary

How much does the AIDS levy contribute to Zimbabwe's health budget? Is it helping the country to achieve its Abuja Declaration targets, which require it to spend 15% of its annual budget on health? To answer these questions, we conducted research on the National AIDS Trust Fund (NATF), which receives the levy, and the National AIDS Council, which administers the fund. This work was implemented under the Regional network for equity in health for east and southern Africa (EQUINET) theme work on fair financing for health, co-ordinated by Health Economics Unit, University of Cape Town.

The study consisted of a review of existing literature, which formed the basis of our budget analysis, and additional information that was collected from focus group discussions and interviews with key informants. Interviews were held with various stakeholders involved in the provision of finance, including the Ministry of Health and Child Welfare, the Ministry of Economic Development, the Ministry of Finance, the Department of Social Welfare, the Zimbabwe Revenue Authority, the Central Statistics Office and the National AIDS Council. Data on the beneficiaries of the AIDS levy was also gathered by interviewing people living with HIV (PLWH), community members, schools, and heads of non-governmental organisations (NGOs) and households. Current data on financing was reviewed, including the inventory of donor assistance to Zimbabwe for 2005. Two provinces were randomly sampled for the in-depth assessment of spending on AIDS levy.

The study revealed that the contribution of the AIDS levy has so far been insignificant. Furthermore, it is not a stable source of funding due to high levels of inflation in Zimbabwe. Inequities exist in the allocation of funds from the AIDS levy according to province, the most extreme case being Matabeleland South province, which had the highest HIV prevalence but received the second-lowest allocation. Unfortunately, many households already have to pay for health services themselves, so the AIDS levy has simply become an additional tax burden.

Fixed costs, such as vehicles, and variable costs, such as care activities, accounted for most of the expenditure at the NAC Head Office in 2005, with anti-retroviral drugs (ARVs) making up the bulk of the care expenditure. For the theme areas, the overall cost per beneficiary per year was US$6 for the NAC Head Office, US$1.63 for a Provincial AIDS Action Committee (PAAC) and US$1.41 for a District AIDS Action Committee (DAAC). The figures show that PAACs and DAACs, where most patient care takes place, are severely under-funded, and that Head Office is over-spending. Overall, the results revealed that the NAC Head Office was more of an implementer than a co-ordinator of the multisectoral response to the HIV/AIDS epidemic in Zimbabwe. The low figures confirm reports that Zimbabweans who are infected and affected by HIV/AIDS have yet to benefit from the AIDS levy.

If inflation is controlled for, the AIDS levy is a noble idea, which can be sustainable if it involves the community in funding AIDS interventions and reduces donor dependence. It is a best practice that can be replicated in other African countries that are resource constrained. At present, donors or partners need to offer more financial support to the NAC. The NAC could also mobilise more resources by reducing fixed and variable costs in those areas that are not the 'core business' of the NAC.

1. Introduction

Zimbabwe's high HIV prevalence rate makes it one of the countries in the world that are worst affected by this disease. This has led to marked worsening of the quality of life, with increased morbidity, mortality and orphan-headed households. An important contributing factor in the worsening poverty situation and economic deterioration has been the devastating impact of the HIV/AIDS epidemic. The economic decline in Zimbabwe is also creating conditions that encourage the spread of the epidemic and make it more difficult for those infected and affected by AIDS to cope. The structural adjustment programme, followed by a period of poor economic performance, has also led to decreased spending on the social sectors, while HIV/AIDS has significantly increased costs and demands on the health sector, which is already operating under tremendous strain. For households, reduced public spending on health services and increased demands due to AIDS care add additional burdens to household spending on health.

The National AIDS Council (NAC) Zimbabwe was established in 1999 by the National AIDS Council Act, No. 14 of 2000 to co-ordinate, facilitate, mobilise, support and monitor a decentralised, national, multisectoral response to HIV/AIDS in accordance with the Zimbabwe Strategic Framework for HIV/AIDS interventions (2000-2004). The NAC is tasked with the statutory responsibility of administering the National AIDS Trust Fund (NATF), which collects a levy of 3% of taxable income from every individual and corporate tax payer (pay-as-you-earn tax, or PAYE). This levy is referred to as the AIDS levy. The NAC has, however, limited institutional and operational capacity to respond to increasing demand for care, support, prevention and mitigation services to those infected with and affected by HIV/AIDS. The NAC and all implementing agencies deal with high attrition rates (partly due to deaths by AIDS and migration), with the NAC facing a constant battle to replace technical capacity. Zimbabwe has accepted the concepts of a single national AIDS strategy, a single national AIDS co-ordinating mechanism, and a single monitoring and evaluation system, and is putting much energy into making these concepts a reality.

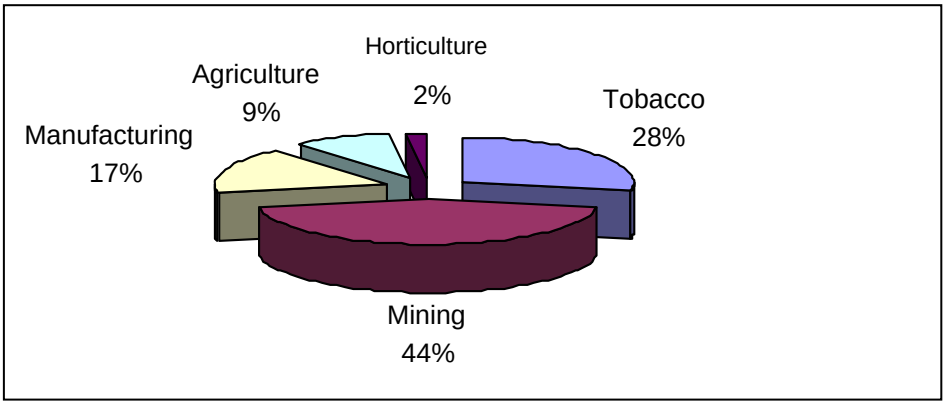
Zimbabwe currently faces two major crises that need to be understood before any analysis of the impact of the AIDS levy can be made: the HIV/AIDS pandemic, which creates a huge demand for health services, and macro-economic instability, which compromises the government's ability to fund these health services. We have provided a brief overview of these issues below. It's essential for one to understand Zimbabwe's macro-economic situation, as it affects HIV expenditure. As we will argue below, a country's health issues cannot be separated from its broader macro-economic context (North, 1990; OECD, 2003; Richardson and Craig, 2005; Robertson, 2006). This report will investigate how the AIDS levy has contributed to additional funding for the health sector and how it has supported Zimbabwe in reaching its commitments at Abuja to allocate 15% of total government spending to the health sector.

In Zimbabwe, an estimated 1.6 million people out of a population of 12 million are living with HIV/AIDS (UNAIDS, 2005). Despite these alarming statistics, Zimbabwe was the first country in Southern Africa to record a drop in the prevalence rate, from 24.6% in 2003 to 20.1% in 2005. The Demographic Health Survey (DHS) preliminary results (2006) confirmed this decline, showing a prevalence rate of 18.1 %, while more recent studies estimate HIV prevalence at 15.6% (MoHCW, 2007).

In March 2007, the Behaviour Change Strategy partly attributed the decrease to changes in sexual behaviour among Zimbabweans, such as using condoms and having fewer sexual partners (UNAIDS, 2005). Despite the promising news, new infection rates remain unacceptably high, and women and girls continue to be particularly vulnerable. According to the preliminary results of the Demographic and Health Survey (ZDHS 2007), 21% of women are HIV positive, while 15% of men are HIV positive. Women are being infected with HIV at an earlier age than men, so differences in levels of infection between women and men are most pronounced among young people aged between 15 and 24 years. According to the Behaviour Change Strategy, married women are particularly vulnerable to infection and this needs to be highlighted in future intervention programmes. Other vulnerable groups include those living at growth points, in mining areas, on commercial farms and in areas with army camps. The high risk in these groups is due in part to the fact that they provide a concentrated population in rural areas, where people converge for groceries, entertainment and transport. A higher concentration of people means that they are more often exposed to HIV and other transmissible diseases.

Zimbabwe is a landlocked country with a land area of 390,752 km^2, of which 85% is used for agricultural purposes, with the rest consisting of national parks, state forests and urban land (United Nations Development Programme, 2004). The economy is diversified, but biased towards agriculture and mining, which make up most of the country's exports. *Figure 1* illustrates total exports based on budget estimates for the year ending 31 December 2006 (Ministry of Finance, 2007).

Figure 1: Zimbabwe's total exports



Source: Ministry of Finance 2007

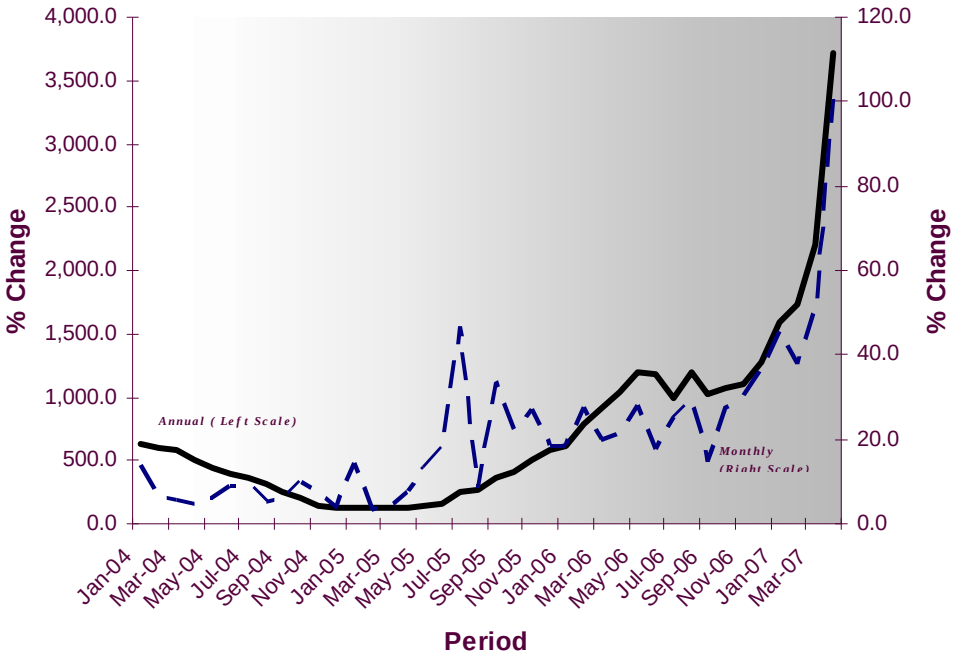
As can be seen from the figure, Zimbabwe relies heavily on agro-mining activities, which are highly susceptible to international market prices due to varying levels of demand. The global movement towards restricting tobacco, for example, will reduce the income earned on this crop and perhaps reduce the country's foreign currency earnings further unless the price for base metals, its other main export, remains firm due to demand. The government will have a reduced fiscal budget to finance recurrent expenditure on sectors such as the health sector, in particular HIV- and AIDS-related activities, as a result of lower income flows. Mining and agriculture are also subject to natural disasters such as flooding, which affect productive capacity and reduce significantly the yield from these key sectors. Fewer financial resources are then available to the fiscus to earn enough foreign currency to import commodities such as ARVs, test kits, reagents and

other resources, thereby prohibiting full ART roll-out to those who need treatment and care. Natural disasters also place a burden on food security, as grain output drops dramatically and the state is forced to import grain to meet its national requirements.

In 1980, Zimbabwe inherited a dual economy consisting of a small, relatively well-developed modern sector and a much larger, poor rural sector that employed 80% of the population (United Nations, 2005). The new government sought to address this gap with three plans: the Growth with Equity Strategy (1981), the National Transitional Development Plan (1982-1985) and the Zimbabwe First Five-year Development Plan (1986-1990). These plans prioritised poverty reduction, socio-economic development and equity, and caused the social sector to expand in the 1980s, for example in education and health. However, the 1990s witnessed a steady decline of the socio-economic gains of the 1980s. In 1991-1995 real GDP growth averaged 1.5%. High levels of inflation have further eroded people's real disposable incomes and increased poverty in the country (see *Figure 2*).

Savings have been severely affected, and pensioners are struggling to survive as their incomes are eroded by inflation. Inflation has also undermined the competitiveness of Zimbabwe's exports.

Figure 2: Zimbabwe's inflation figures, January 2004-April 2007



Source: Central Statistical Consumer Price Index Reports, 2004-2007

According to the Reserve Bank Governor (2006:24-6), high inflation in Zimbabwe is caused by:

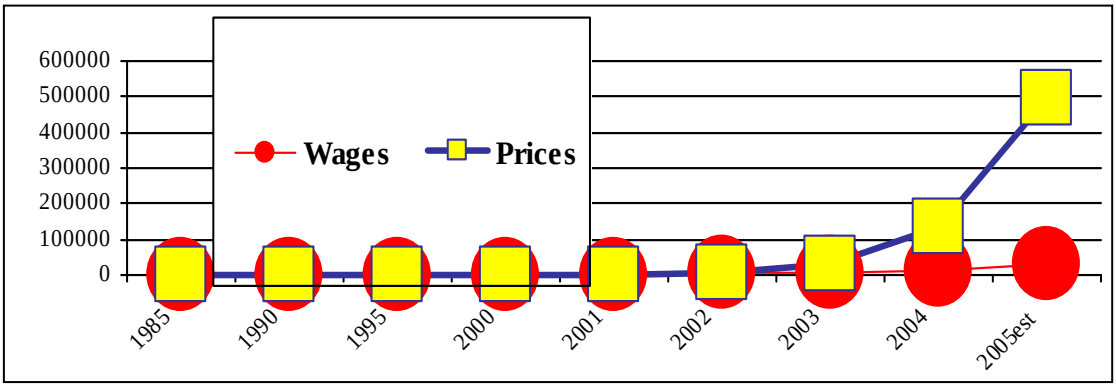
- Money supply has recorded high growth to 43 trillion Zimbabwe dollars in circulation due to the propensity to print money and the need to obtain high volumes of cash to meet rapidly inflating prices. This is because most of the population would rather use money immediately to purchase commodities,

including pharmaceuticals, before the value is eroded by inflation. The supply increased by 528% in February 2006, compared to an increase in 670% in May 2006. Fischer , Sahay and Végh (2002) found that a high association exists between money growth and inflation.

- An increase in parallel market activities and in corruption, as exemplified by the multiple pricing of commodities in various sectors of the economy. For example, there are two prices for fuel – one for newly resettled farmers and one for the general public – farmers and public transporters pay Z$23/litre, while others pay Z$520/litre. (From July 2006 the currency was revised by removing the extra three zeros. For example Z$1,000 is now Z$1.) This price difference encouraged rent seeking, as it became more lucrative to sell fuel at parallel market rates at Z$520/litre having procured it at Z$23/litre, thereby making a massive profit of Z$507/litre, which they could not have earned from agricultural activities. In addition, speculative or rent seeking behaviour is also closely linked to the above activities, as profits are used to buy and sell foreign currency by well-connected ruling party officials, who can buy foreign currency from the central bank at preferential exchange rates and then sell it on the black market at nearly 400 times the price. This speculative behaviour diverts scarce financial resources from the health sector, which is unable to buy the commodities it needs for the national HIV/AIDS response.
- The benchmarking of prices on the parallel market exchange rate for products such as fuel has had a multiplier effect on the other sectors of the economy, creating price distortions. For example, in the health sector, some commodities and services have become unaffordable.
- Public sector borrowing requirements for the budgetary financing of quasi-fiscal activities funded through the Reserve Bank has resulted in high internal debt accumulating. To pay off this debt, cuts will have to be made to health budgets, and the deficit will have to be met by both internal and external financial obligations, which will pose a serious challenge.

Due to the high levels of inflation, wages have not been able to keep up with the prices of commodities, as shown in *Figure 3* below.

Figure 3: Increases in wages and prices of commodities, 1985-2005



Source: Robertson, 2006.

In 2006, hyperinflation, poverty and food insecurity continued to increase the vulnerability of many citizens and limited the nutritional choices of people living with HIV and AIDS (PLWHAs). At a macro level, health resources had to compete with other national priorities, such as subsidies to parastatals like Air Zimbabwe and fuel imports,

electricity, food and key raw materials for agriculture, mining and manufacturing. These problems also effectively reduce the purchasing power parity of the AIDS levy (what it would have been able to buy in US dollar terms) because fewer goods and services can now be imported for PLWHAs and HIV/AIDS activities in the country.

Hyperinflation has become so pronounced that about 85% or more of the country's population is surviving on incomes far below the Poverty Datum Line (PDL), and more than half of these people are living at levels below the Food Datum Line (FDL), being the minimum resources needed to avoid malnutrition (*The Zimbabwe Independent*, 2007). Macro-economics have severely impacted on health delivery system in general, and more specifically on the resources available for the procurement of commodities such as antiretroviral drugs, opportunistic infection drugs, other regimes of antibiotics, test equipment and reagents, all of which have to be paid for in foreign currency.

As we can see from the above discussion, issues of access and equity to health services are proscribed by the prevailing macro-economic conditions. Households are now faced with the burden of financing their own health care and end up paying for out-of-pocket expenses from their meagre savings, for example for transport and services from private health service providers such as private clinics, hospitals and pharmacies. The cost of these services is normally pegged by using the purchasing power parity of the US dollar prevailing on the parallel market.

In *Table 1*, Zimbabwe's key development indicators are provided to underline the country's diminishing capacity to pay for HIV interventions, in particular treatment-related needs. The table shows slow and, in some cases, declining levels of growth, which reduces the country's development potential, as well as its ability to finance the HIV/AIDS epidemic and build up a productive health work force. There are gaps because some figures are missing and others are combined figures for several years. Lack of data was a serious limitation in the literature review.

Table 1: Zimbabwe's key development indicators, 1990-2005

Key development indicators	1990	1995	2000	2001	2002	2003	2004	2005
Population (millions)	10.4	11.8	–	–	11.65	11.87		12.9
% population growth rate	3.1	–	–	–	1.1	–	–	–
% HIV/AIDS prevalence (population aged 15-49 years)	–	–	25	–	34	34	24.6	18.1
Life expectancy at birth (in years)	61	55	43	43	43	42	37	–
Structural unemployment	–	–	>50	–	–	>63	–	_
% rural population with access to safe water	65	75	75	–	68	68		_
Real GDP growth (%)	7.0	0.2	-8.2	-2.8	-14.5	-13.9	-2.5	1.5
Per capita real GDP growth (%)	5.5	-1.3	-7.7	–	-14.7	-14.1	–	–
% inflation	15.5	22.6	55.2	112.1	198.9	598.7	132.7	585.8
ODA flows (US$ millions)	295.9	347.7	192.6	–	–	–	–	–
Net foreign direct investment (US$ millions)	-12	98	16	-0.3	22.6	3.5	8.7	–

Sources: UNDP, 2004 and 2005; Government of Zimbabwe, 2006.

2. Methodology

We have already discussed the macro-economic challenges that affect issues of equity and access to effective HIV support through a national financing mechanism. In using this political/ economic approach to the analysis of health financing, it can be argued that health is dialectically linked to economic processes. It is therefore important to have a fair understanding of the economic issues that form the core determinants of HIV financing, so these issues will be further addressed in this paper. This work was implemented under the Regional network for equity in health for east and southern Africa (EQUINET) theme work on fair financing for health, co-ordinated by Health Economics Unit, University of Cape Town. The paper's epistemological framework takes a positivist and post-positivist approach, which is based on the extensive use of standardised measures and existing records, such as financial records, to validate our claims.

The first step in our research was to conduct a review of existing literature on the AIDS levy in Zimbabwe, including current data on public health financing, such as the inventory of donor assistance to Zimbabwe for 2005. We looked at relevant studies on Zimbabwe, which included the national health accounts, and studies on development indicators, inflation, poverty and the national response to HIV/AIDS, mostly from printed sources and internal reports. We obtained additional information through interviews with key stakeholders in Zimbabwe: the Ministry of Health and Child Welfare, the Ministry of Economic Development, the Ministry of Finance, the Department of Social Welfare, the Zimbabwe Revenue Authority, the Central Statistics Office and the National AIDS Council (NAC). We also conducted focus group discussions with those who stand to benefit from the AIDS levy, namely PLWHAs and other affected parties, such as community members, schools, health NGOs and the heads of ordinary households.

Two provinces were randomly sampled for an in-depth assessment of their spending of allocations from the current AIDS levy, using information derived from a review of existing literature on budget analysis and the focus group discussions mentioned above. The sources of budget data for sub-accounts (beyond the national health accounts) included: budget books, budget reviews, expenditure reports, auditor general reports, ministry budgets, annual reports, costing reports, strategic plans, NAC databases, lower NAC structures, reports of implementing agencies, household data from the Central Statistics Office, and census and research reports. *Table 1* provides details of the sources that were used for this paper.

Table 1: Sources of data used in the research process for this paper

Organisations and other stakeholders	Types of data collected	Methods and data sources
Ministry of Health and Child Welfare	• Actual expenditures • Utilisation figures • In-patients' length of stay • Bed occupancy rates	• Expenditure review of budget books • Health Information Management Systems (HIMS) review to identify utilisation data on opportunistic infections • Survey of selected providers according to type of facility and ownership
Other government ministries and departments, including the National AIDS Council (NAC)	• Actual expenditures	• Expenditure review of budget books • HIMS review to identify utilisation data on opportunistic Infections • Survey of selected providers by level of care and region • Key informant interviews
Donor organisations	• Budgets • Disbursements	• National survey of all donors involved in funding HIV/AIDS services • Key informant interviews
NGOs	• Budgets • Disbursements	• National survey of all donors involved in funding HIV/AIDS services • Key informant interviews
Firms and corporations	• Actual expenditures	• National survey of all firms and corporations involved HIV/AIDS financing and delivery
Providers	• Actual expenditures • Utilisation figures	• National sample survey of selected facilities according to type of ownership (Ministry of Health and Child Welfare, private not-for-profit facilities and private for-profit facilities) and the level of care provided (health centres, district hospitals, provincial hospitals and central hospitals)
People living with HIV/AIDS (PLWHA)	• Actual expenditures • Utilisation figures	• Special survey targeting PLWHA who have been confirmed HIV positive and are 15 years old or older
United Nations	• External expenditures on HIV	• UNAIDS report based on questionnaires sent to bilateral UN agencies and International NGOs

The main objective of this study is to determine the role the National AIDS Trust Fund (NATF) has played in mobilising additional domestic resources to help the government meet the Abuja target, which requires governments to spend 15% of their annual budget on health. The NATF is a fund that has been administered by the National AIDS Council (NAC) since its inception in 1999, and it contributes to the government's fight against HIV/AIDS.

More specifically, we set out to achieve the following objectives:

- Assess the level of funding in the AIDS levy fund from 2000 to 2005 in terms of its contribution to overall government spending on health and more specifically to the share of spending on health relative to the Abuja commitment of 15%;
- Assess the various national sources of funding for HIV/AIDS programmes and activities and how the AIDS levy will contribute to overall national HIV/AIDS funding;

- Establish the contribution of households to HIV/AIDS funding (by paying out-of-pocket expenses each time they use facilities); and
- Determine, by province and district, the geographical distribution of allocations from the HIV/AIDS levy, and compare it with the geographical distribution of HIV.

3. Results

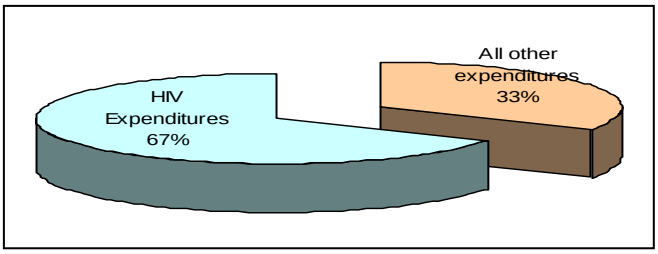
The Zimbabwe government is a signatory to the Abuja Declaration of 2000, where countries agreed to allocate 15% of their budgets to the health sector. The declaration was reiterated in Maseru and Maputo in 2003 and 2004 respectively (African Union, 2006). The National AIDS Council (NAC) was established in 1999 by the Parliament to co-ordinate, facilitate, mobilise, support and monitor a decentralised national multisectoral response to HIV/AIDS in accordance with the Zimbabwe Strategic Framework for HIV/AIDS Interventions (2000-2004). The NAC was tasked with the statutory responsibility of administering the National AIDS Trust Fund (NATF), collecting 3% of taxable income from every individual and corporate taxpayer, which is known as the AIDS levy. This form of tax was implemented in 2000 to contribute the funding of national HIV/AIDS interventions.

In this section, we will begin with general results of our research by discussing sources of HIV/AIDS financing in Zimbabwe and we shall explain how the AIDS levy contributes to the country's achievement of its Abuja goals. Thereafter, we will analyse more specific results, using 2005 data, namely, the programme costs for the National Aids Council (NAC), the distribution of programme costs by level, the distribution of fixed and variable costs by level and the theme areas funded by the National AIDS Levy. At all times, we will be considering the question of whether the levy is making a significant contribution to helping Zimbabwe meet its Abuja goals or not, and if it isn't, why not.

3.1 Sources of HIV/AIDS funding in Zimbabwe

Figure 4 shows how spending on HIV/AIDS fits into the government's total expenditure on health, taking up more than two-thirds of the total expenditure.

Figure 4: Government HIV/AIDS spending as a proportion of total health expenditure

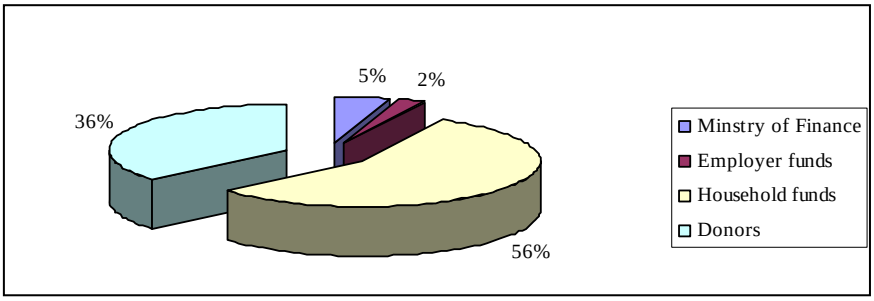


Source: National Health Accounts: HIV & AIDS Sub-analysis for Zimbabwe, 2005.

Figure 5 shows how HIV/AIDS health care is financed – it provides all major sources of funding, ranging from the government itself to out-of-pocket expenses paid by households. Households were the major source of finances, contributing about 56% of the total HIV/AIDS health expenditure, which means that PLWHAs bear the greatest

financial burden. In addition, the prohibitive cost of direct household out-of-pocket spending makes it almost impossible for the poor to access health care services (WHO, 2000).

Figure 5: Sources of funding for HIV/AIDS health care, 2005



Source: National Health Accounts: HIV & AIDS Sub-analysis for Zimbabwe, 2005.

3.2 The National AIDS Council and the National AIDS Trust Fund

Zimbabwe's national response to HIV/AIDS is co-ordinated by the National AIDS Council (NAC), which was created in 1999. Its work is overseen by a multisectoral NAC Board, the members of which are nominated by the Minister of Health and Child Welfare, and appointed by the President of the Republic. The NAC has administered the National AIDS Trust Fund (NATF) since its inception, and the AIDS levy is a major contributor to the Fund. The AIDS levy consists of a 3% tax on income, which is collected from all workers and major corporations. To support this initiative The Zimbabwe National Aids Strategic Plan 2006-2010 clearly articulates the need for treating HIV/AIDS as an emergency and to move from planning to action. HIV/AIDS must continue to be a top national priority. Guiding Principle 1 of the National HIV /AIDS Policy for the Republic of Zimbabwe states that "HIV/AIDS should be addressed through a multisectoral approach, which will be co-ordinated by the National AIDS Council (NAC)."

In this regard, it was proposed that NAC would ensure delivery of a well-co-ordinated and effective national effort for HIV/AIDS prevention, control and care, and the implementation of an acceptable policy framework. Initial funding of NAC was to come from the government, private sector and donor organisations, and, after establishment, NAC was also going to add resource mobilisation to its functions and mandate. In other words, the NAC would be able to harness technical and financial resources in the form of pooled funding from bilaterals to complement the funds from the AIDS levy.

3.3 The AIDS levy

The AIDS levy is seen as a best practice in mobilising funding for HIV/AIDS interventions, especially in resource-constrained countries. It is a tax collected by the Zimbabwe Revenue Authority (ZIMRA) and deposited in the NAC's bank account. The government does not interfere in the use of the AIDS levy. The disbursements are made according to district plans that are developed by the multisectoral committees. Some money is also given for proposals submitted by strategic institutions and approved by the Disbursement and Operations Committee of the NAC Board. An example of a strategic insitution is the Harare Polytechnic, which has a committee for implementing the Behaviour Change Strategy. The committee ensures that prevention-related IEC

materials are ready available to students and helps form student support groups that will support the national Behaviour Change Strategy.

The levy is an inovative way to mobilise resources for HIV programmes, and it has some distinct advantages:

- It is a home-grown (local and African) solution to the self-reliant financing of HIV and AIDS initiatives. It gives ownership to the government and its people in deciding how the accumulated funds should be spent, and also reduces donor dependency.
- It can be a fairly stable resource base because it depends on the government's revenue collection system, not on external funding, which is subject to changes in the exchange rate.
- The funds can be accessed fairly easily by communities to support their HIV prevention and mitigation programmes and AIDS care programmes.

Disadvantages do exist, however:

- Because the tax is deducted from an employee's income, it's an additional burden to the employee, who is already paying an excessive amount of income tax.
- As we saw in *Figure 5*, households contribute the most to health services, so the levy becomes an extra financial burden to them too.
- The levy depends entirely on the government's ability to collect taxes, so if the revenue collection system is inefficient, the amount of money collected for the levy collected will be insufficient.
- Any tax adjustments made by the government directy affect inflows to Fund, creating high level of uncertainty.
- In a hyper-inflationary environment like Zimbabwe's, the levy may no longer be a viable alternative.

The most worrying concern though, is that the amount of money collected through the levy is not enough to meet Zimbabwe's needs to fight HIV/AIDS, a clear case of demand outstripping supply. *Table 2* shows how much in Zimbabwe dollars (Z$) has been collected through the AIDS levy. Even though the amounts increase dramatically, very high inflation levels in Zimbabwe have shrunk the buying power of the Z$ tremendously, so the increase is effectively an illusion.

Table 2: Amounts collected through the AIDS levy, 2000-2006

Year	Amount (Z$)
2000	793,904
2001	1,525,923
2002	2,835,887
2003	11,247,338
2004	86,197,430
2005	227,865,076
2006	2,234,114,867

`*Source:* National AIDS Council Financial Report, 2007.

A further complication exists in interpreting this table. The amounts are in Z$, and conversion to US$ is complicated because the rate of exchange between the two

currencies changes very frequently. The collection and disbursement of the AIDS levy from the Zimbabwe Revenue Authority (ZIMRA) to the Ministry of Finance and then to the NAC is done periodically, so exchange rates may differ at those times. This needs to be kept in mind when reading financial statistics from other tables in this paper.

3.4 How does the AIDS levy contribute to achieving the Abuja goals?

As mentioned earlier, the AIDS levy was designed as a tool to fight the HIV/AIDS pandemic in Zimbabwe by allowing the government to gather income in the form of a tax and hand it over to the National AIDS Council (NAC), which in turn would allocate it to various provinces to fund their HIV/AIDS programmes. *Table 3* shows where the NAC receives the funds that are used for this purpose.

Table 3: Sources of NAC funds, 2005

Source of funds	Total income (Z$)	Total contribution (%)	Total income (US$)	Total contribution (%)
Payee	227,865,075	74	14,437,552	76
Donors	16,064,255	5	441,619	2
Bank interests	64,003,908	21	4,193,401	22
TOTAL	307,933,238	[100]	19,072,572	[100]

Source: National AIDS Council Annual Financial Report, 2005 and 2006.
Note: small differences in percentages in the two columns relate to variances in exchange rates in Z$ to US$ conversions at the time of conversion.

The total income for National AIDS Council (NAC) for 2005 was Z$307,933,238, with the bulk coming from the AIDS levy (74%) and bank interests on investments (21%). In *Table 4*, one can see how these funds are allocated to the 10 provinces into which Zimbabwe is divided, taking into account HIV prevalence in each province as a basic indicator of the province's HIV/AIDS health needs.

Table 4: HIV prevalence and the allocation of the AIDS levy by province, 2005

Province	HIV prevalence (15-49)	Estimated numbers of PLWHAs (15-49)	Total amount allocated from AIDS levy (Z$)	Amount allocated per individual PLWHA (Z$)
Mashonaland East	18	288,000	10,882,501,850	33,787
Mashonaland West	19.1	305,000	8,270,550,000	27,117
Midlands	16.1	257,600	16,717,981,200	64,898
Manicaland	19.7	315,200	11,965,064,000	37,960
Mashonaland Central	18.5	296,000	7,778,283,500	26,278
Matabeleland South	20.8	332,000	7,414,748,850	22,334
Bulawayo	16.8	268,800	5,225,524,915	19,440
Harare	19.3	308,800	13,416,550,000	43,447
Masvingo	15.1	241,600	11,280,507,500	46,691
Matabeleland North	19	304,000	8,559,401,550	28,156

Source: National AIDS Council Annual Financial Report, 2005 and 2006.

The level of funding that each province gets from the AIDS levy is based on the number of wards it has, which explains why Midlands province received the most funding in 2005 even though it has the second-lowest HIV prevalence in the country. Similarly, Matabeleland South Province, which has the highest HIV prevalence, received the second-lowest disbursement. The inequity in the allocation of the AIDS levy to provinces according to how many wards they have instead of their levels of HIV prevalence is a serious problem. Above all, the amounts that are allocated to PLWHAs are very small and clearly insufficient in a hyper-inflationary economy, once again highlighting the problem of under-funding – the AIDS levy cannot meet the huge demand for HIV/AIDS health care.

In section 3.1, we discussed the sources of HIV/AIDS funding for Zimbabwe but did not explain exactly how the AIDS levy fitted into the funding scenario. In *Table 5* below, details are provided to show the relationship between the national budget, the health budget and the AIDS levy.

Table 5: How are the national budget, health budget and AIDS levy related?

Year	Total health budget (Z$)	Health budget as % of total national budget	AIDS levy allocation (Z$)	Health budget and AIDS levy as % of total national budget
2000	9,272,051,000	9.2	793,903.65	10
2001	10,933,711,000	11.5	1,525,922.59	11.9
2002	22,459,863,000	9.5	2,835,887	10.6
2003	73,427,927,000	12.7	11,247,338	14.6
2004	701,209,680,000	9.5	86,197,430	15.1
2005	2,754,736,749,000	11	227,865,076	11.9
2006	8,110,431,506,000	9.33	2,234,114,867	11.73

Source: Zimbabwe Budget Estimates, 2001-2007.

As can be seen from the above table, Zimbabwe has only once achieved the Abuja target of contributing 15% of its total national budget to health care; this was in 2004, with shortfalls in other years. The contribution of the AIDS levy to the health budget has also been minimal, except for 2004, when Zimbabwe managed to meet its target of 15%.

However, it failed to sustain this performance in subsequent years. Why? Some possible reasons include:

- a decline in the value of the Zimbabwe dollar in relation to major international currencies such as the US dollar, yen and Euro;
- reduced economic activity in most sectors of the economy;
- drought; and
- Zimbabwe's shift from food exporter to food importer.

3.5 Programme costs for the NAC in 2005

According to *Table* 6, the total programme costs for the NAC in 2005 were Z$385,374,219; in other words, this is the amount that it cost the country to set up, or establish, its National Aids Council. This figure gives a fair indication of what it would cost other African countries that may be considering a similar idea.

Table 6: Total programme costs for NAC, 2005

Type of cost	Amount (Z$)	Total costs (%)
Fixed costs	11,807,828	31
Variable costs	266,566,391	69
Total costs	385,374,219	[100]

Source: National AIDS Council Annual Financial Report, 2005 and 2006.

Fixed costs include the costs for buildings, furniture, equipment and vehicles, and accounted for only 31%, while variable costs, such as salaries, utilities, office supplies, transport, prevention, care, mitigation, advocacy, monitoring and evaluation, research, co-ordination and capacity building, accounted for 69%.

Table 7 breaks down the costs from Table 6, listing them by national, provincial and district levels. The table shows most of the fixed and variable costs were incurred at the NAC Head Office, with very little being incurred at provincial and district levels.

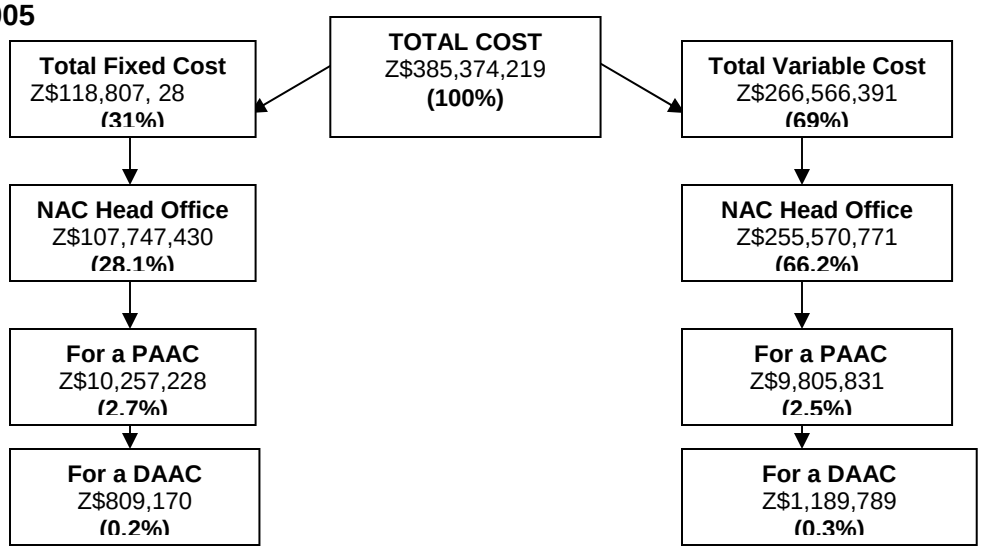
Table 7: Costs by national, provincial and district levels for NAC, 2005

Costs	NAC Head Office		Provincial AIDS Action Committee		District AIDS Action Committee	
	Amount (Z$)	%	Amount (Z$)	%	Amount (Z$)	%
Fixed costs	107,747,430	30	10,251,228	51	809,170	40
Variable costs	255,570,771	70	9,805,831	49	1,189,789	60
Total costs	363,318,201	[100]	20,057,059	[100]	1,998,959	[100]

Source: National AIDS Council Annual Financial Report, 2005 and 2006.

Figure 6 takes the costs listed in Table 7 and arranges them in the form of a flow chart to provide a visual 'map' of how these costs are distributed along the chain of national, regional and district levels, with each level contributing to the total cost.

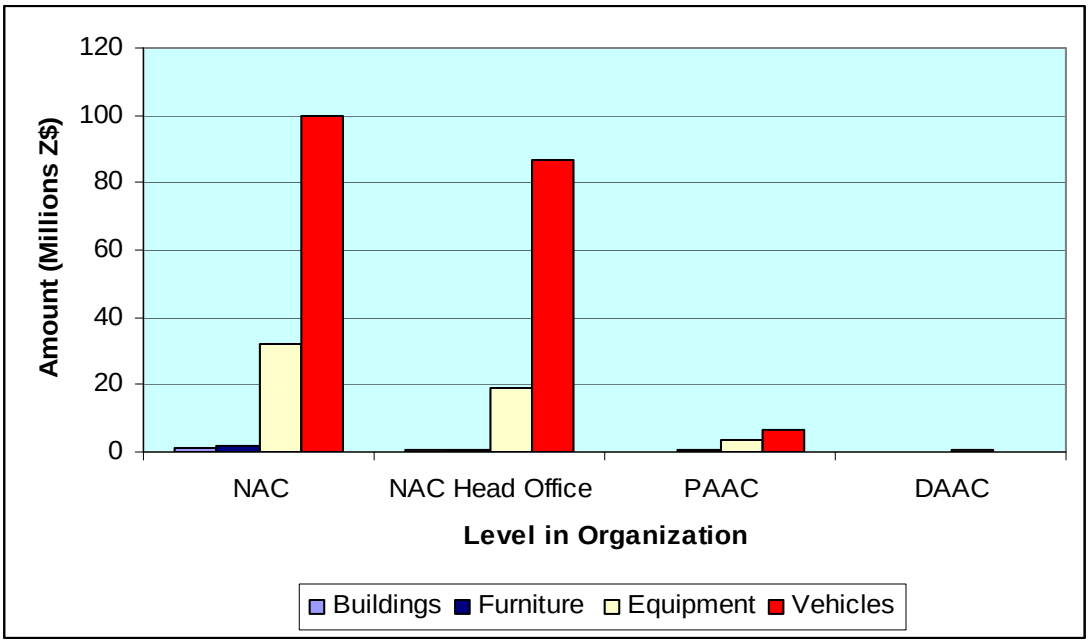
Figure 6: Distribution of costs by national, provincial and district levels for NAC, 2005



Source: National AIDS Council Annual Financial Report, 2005 and 2006.

A major concern is that over 95% of the total fixed costs were for vehicles and office equipment (mainly computers and printers), and this over-spending was more prevalent at the NAC Head Office than at the PAAC and DAAC levels (see *Figure 7*). In contrast, the District AIDS Action Committee (DAAC), which should be the implementing organ of the NAC, did not have a single vehicle.

Figure 7: Fixed costs by national, provincial and district levels for NAC, 2005



Source: National AIDS Council Annual Financial Report, 2005 and 2006.

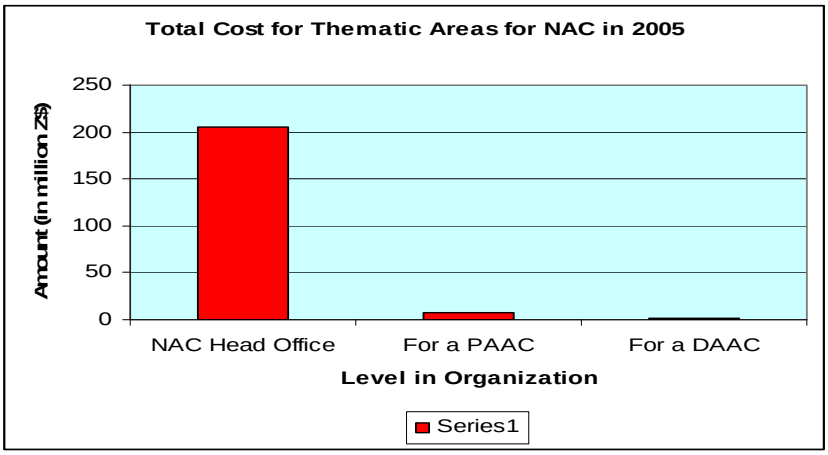
3.6 Theme areas funded by the AIDS levy in 2005

The NAC programme has eight theme areas with regard to HIV/AIDS funding:

1. prevention;
2. care;
3. mitigation;
4. advocacy;
5. monitoring and evaluation;
6. research;
7. co-ordination; and
8. capacity building.

The NAC Head Office spent the highest amount in the above theme areas when compared to the same expenditures at provincial and district levels (see *Figure 8*). A strange situation, no doubt, especially when one considers that the provincial and district levels should be the implementing agents for the NAC programme.

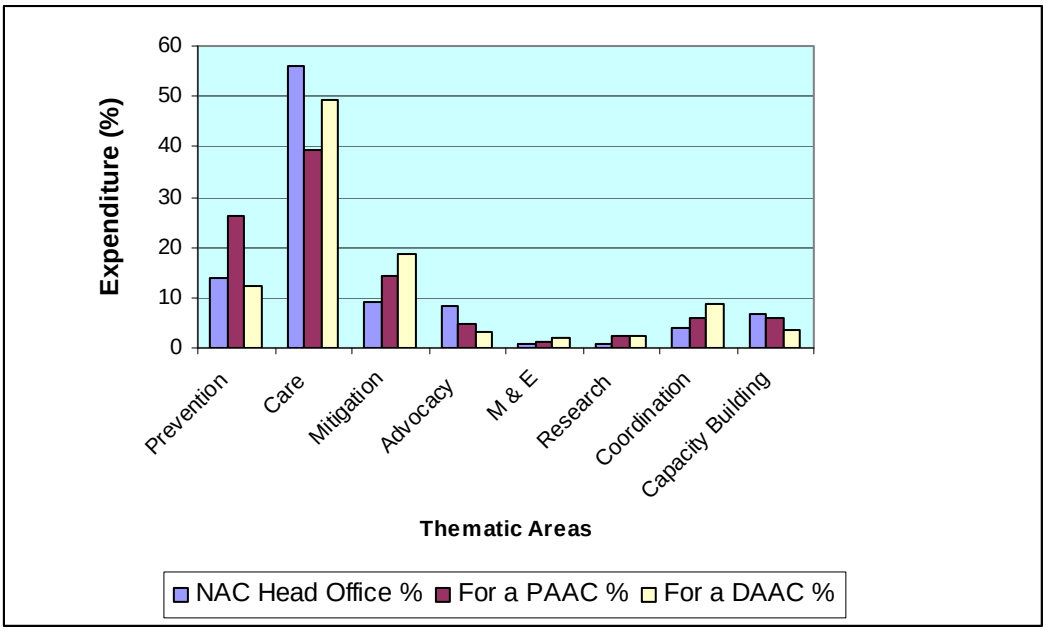
Figure 8: Distribution of total costs by level and by theme area for NAC, 2005



Source: National AIDS Council Annual Financial Report, 2005 and 2006.
Series 1= cost in Z$ million

Unfortunately, Head Office spends the highest amount in terms of assets, whereas the greatest need is at district level, where people living with HIV are supposed to benefit from the interventions. The figures provided in Figure 8 may be further broken down into the eight theme areas, as in *Figure 9* below.

Figure 9: AIDS levy: Funding by theme areas, 2005



Source: National AIDS Council Annual Financial Report, 2005 and 2006.

According to Figure 9, the major costs for the NAC Head Office were prevention and care, whereas, for the PAAC and the DAAC, they were prevention, care *and* mitigation. A further analysis of the NAC Head Office expenditures in the theme areas revealed that the highest expenditure was on care, with the cost of anti-retroviral drugs (ARVs)

contributing about 75% of this expenditure (National AIDS Council Annual Financial Report, 2005 and 2006).

4. Discussion of results

In 2005, the total programme cost for NAC was Z$385,374,219 or US$19,072,572. This is the amount of money that a country intending to establish a similar programme would need to have. The payee system (individual and corporate tax collected through ZIMRA) contributed 74-76% of the AIDS levy, while bank interests on investments contributed 21-22% and the donors or partners contributed 2-5%. The latter contribution was very little and would certainly need to be increased in order for the donors or partners to show that they are supporting the government's multisectoral response to the HIV/AIDS epidemic.

Information gathered from the NAC Head Office revealed that 2-5% of the total National AIDS Levy fund was from donors. Unfortunately, it was not clear how this money was distributed in the fixed and variable costs of this pilot study, as the sample was limited. However, the only partners whose names appeared in some of the documents in relation to those variables were UNAIDS and the Centre for Disease Control (CDC), but their contributions were negligible.

Direct funding to the NAC by the government could not be determined, as the documents provided by the NAC Head Office had financial data only. However, one obvious direct contribution of government to the NAC funds was through the provision of free accommodation and utilities for most DAACs in the districts. Unfortunately, there was insufficient data to calculate government’s contribution to the NAC funds at this level.

The provinces, which are taking care of most people living with HIV/AIDS (PLWHA), only received 41% of the total levy in 2005, while national institutions, such as the Ministry of Health and Child Welfare, (Ministry of Labour) and the National Blood Transfusion Service, received 35%. This left the NAC Head Office with only 24%, presumably to co-ordinate the multisectoral response. There is an urgent need to reduce the 35% spent by national (strategic) institutions, which can rather be disbursed to the PAACs for distribution to PLWHAs. The figure of 24% for the co-ordination of the response was also high. Most institutions tend to spend about 10% of their total income on this kind of activity, so the NAC should try to gradually reduce this percentage at a rate of 3 to 6% per annum.

The fixed and variable costs for the NAC Head Office and the DAAC were almost similar at 30-40% and 60-70% respectively, while those for the PAAC the two had the same percentage (50%). This observation suggested that the NAC Head Office and the DAAC were implementers, rather than co-ordinators, of NAC activities, as they had greater variable costs, including for the eight theme areas, than the PAAC, which appeared to be more of a co-ordinator than an implementer.

A further analysis of the data revealed that the major cost drivers for the expenditure at the NAC Head Office were, for fixed costs, vehicles and equipment, such as computers and printers, and, for variable costs, the theme areas of care and prevention, with the major expenditure under care being for anti-retroviral drugs (ARVs).

While the disbursements to the PAACs were low (41% of total NAC funds), the PAAC and DAAC levels disbursed 90% and 95% of the amounts they received from the NAC Head Office. This is highly commendable, as these levels attempted to increase the amounts expended on the beneficiaries of the National AIDS Levy.

However, for a programme the goal of which is “to empower communities to reduce HIV transmission and minimize the impact of the AIDS epidemic on individuals, families and society," the fixed costs of the NAC need to be reduced to an acceptable 10-20% (National AIDS Council, 2001:1). This would result in an increase in the variable cost component to between 80 to 90%. Such a move would release funds from fixed costs for the theme areas of NAC at provincial and district levels.

Most of the variable expenditure for the NAC Head Office was on care and prevention, as highlighted above, which makes the NAC more of an implementer than co-ordinator of activities. Co-ordination is one of the major functions of NAC, and this priority needs to be re-established. The NAC Head Office needs to consider focusing more on its major functions, as stipulated in the NACZ Act of 1999: co-ordination, facilitation, resource mobilisation, monitoring and evaluation, the promotion of research into HIV/AIDS and the development of strategies and policies to combat the HIV/AIDS epidemic. The latter should be left to the DAAC and to the PAAC to some extent.

For the theme areas, the overall cost per beneficiary per year in 2005 was US$6, US$2 and US$1 for the NAC Head Office, a PAAC and a DAAC respectively. This amount is almost negligible when compared to similar programmes taking care of HIV/AIDS clients in other countries. For example, in America, a comprehensive programme for taking care of an HIV/AIDS client would cost between US$1,444 and US$2,437 per month per client, while in Tanzania it would cost about US$80 to US$254 per month per client. This is much more than the projected US$40 per client for the NAC programme.

At a basic level, the concept of a parastatal (the NAC) that funds government activities with a substantial portion of its budget mostly derived from the public by way of taxation needs to be reviewed and a way forward identified. This is a controversial statement because it contradicts one of the roles of government according to social welfare policy, namely that it is required to take care of all its citizens (Donaldson 1994). A possible solution would be to ask the government to take over the funding of activities that are directly under the care of the Ministry of Health and Child Welfare and the Ministry of Labour, and allow the NAC to use the proportion of its budget going to these ministries for PLWHs instead. This direct approach will prevent a common problem – often, not all the funds that are given to public institutions such as ministries go to the targeted areas, but are distributed among the ministries' many competing funding responsibilities.

5. Conclusions and recommendations

5.1 Conclusions

This paper adopts both a positivist and post-positivist approach; the use of both quantitative and qualitative approaches was meant to provide an evaluation of the National AIDS Levy in such a way that this should be a key source of information for politicians, decision-makers, health planners and partners. Politicians will find in this paper some answers to questions of whether the collection of the AIDS levy to support the NAC and its activities is an effective use of scarce resources in Zimbabwe. Resource

scarcity must be considered in the context of other competing national priorities, as well as the reduced purchasing power parity of the Z$, hyperinflation and a deteriorating tax base due to higher levels of unemployment and AIDS morbidity in the existing work force. Politicians, as policy makers in parliament, will need to assess whether or not, given the hyperinflationary environment, the situation currently being experienced by Zimbabwe warrants giving the NAC leverage to convert the AIDS US$ at source as a way of supporting the national response. To achieve this, a special dispensation will have to be legislated and given to the NAC to do this. Similar efforts by the government to hedge against inflation and improve revenue collection in US$ have given ZIMRA a special dispensation to charge duty on all items coming into Zimbabwe in foreign currency (Statutory Instrument, 80A, 2007). This paper provides useful information that forms the basis for monitoring the performance of NAC in terms of whether it is achieving its objectives; for example, if more money is being spent on implementing HIV/AIDS activities instead of co-ordination, this can easily be identified and rectified. The information from the evaluation is also useful in terms of planning for it can highlight the impact, for example, of expanding the programme or shrinking it so that it can become leaner, efficient and be able to reach more beneficiaries. The information contained in the findings and the recommendations are a substantive source of policy related information.

The following are the major findings of this paper:

- The contribution of AIDS levy as additional fund to the health budget towards meeting Abuja targets is insignificant. The AIDS levy is also not a stable source of funding due to inflation.
- Households bear the greatest burden of financing health, and the AIDS levy becomes simply another tax burden for them.
- If inflation is controlled for, the levy is a noble idea that is sustainable, involves the community in funding AIDS interventions and reduces donor dependence. It is a best practice that can be replicated in other African countries that are resource constrained.
- There is inequity in the allocation of the levy from province to province. For example, the province of Matabeleland South had the highest HIV prevalence but received the second-lowest disbursement.
- Fixed costs, such as vehicles, and variable costs, such as care activities, accounted for most of the expenditure at the NAC Head Office in 2005, with anti-retroviral drugs (ARVs) contributing to the bulk of the care expenditure. For the theme areas, the study revealed that the overall cost per beneficiary per year was US$ 6, US$ 1.63 and US$ 1.41 for the NAC Head Office, a PAAC and a DAAC respectively. These amounts were very low, confirming anecdotal reports that most Zimbabwean PLWHAs have not benefited from the AIDS levy.

5.2 Recommendations

The observations made in this study may hopefully help the National AIDS Council of Zimbabwe to re-organise more effectively its co-ordination of the multisectoral response to the HIV/AIDS epidemic in Zimbabwe. The following recommendations are made:

- Because the contribution of the levy is insignificant, we need to look at other ways of mobilising resources for the response to HIV/AIDS, especially advocating for more donor support.

- The NAC needs to mobilise more resources for the multisectoral response and also to use these resources equitably, aside from being dependent on levy, to sustain its activities and retain staff in the prevailing hyperinflationary environment.
- The money saved by reducing NAC Head Office's expenditure can be disbursed to the DAACs so that PLWHAs can receive urgently needed funds. The National AIDS Councils' key priority should be to lobby for HIV/AIDS to be seen as strategic component cutting across priority areas such agricultural mechanisation, food importation and the procurement of materials, in terms of priorities in sourcing and allocating foreign currency at the official rate by the Reserve Bank of Zimbabwe. This would allow them to buy more commodities, such as ARV's, test kits, CD4 analysis equipment, reagents and urea analysis kits, to meet the treatment needs of most of the 300,000 who are in need of treatment.
- Strategic and close working relations with the private sector must be developed, not only because it contributes the bulk of the levy through taxes, but also to assist in the production of ARVs. One of two local pharmaceutical companies is currently waiting for WHO certification and the National AIDS Council could invest in them to produce ARVs to meet national and regional needs, instead of having to import ARVs at a high cost and at the mercy of fluctuating exchange rates. This should supply ARVs to 300,000 PLWHAs and test kits for 600,000 (MoHCW, 2007).

The private sector can also play a mentoring role in installing values, such as quality orientation in the provision of services, as well as introduce efficient inbound and outbound logistics to improve the distributive capacity of commodities by the MoHCW and NAC. It could also assist in providing efficient management systems that have been tried and tested in a globally competitive environment.

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Acronyms

CSO	Central Statistical Office
DALYS	Disability Adjusted Life Years
ESA	Eastern and Southern Africa
GDP	Gross Domestic Product
GOZ	Government of Zimbabwe
HIB	Health Insurance Benefit
HPC	Health Profession Council
HSF	Health Services Fund
ICES	Income Consumption & Expenditure Survey
MoF	Ministry of Finance
MoH&CW	Ministry of Health & Child Welfare
NAMAS	National Association of Medical Aid Societies
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NSSA	National Social Security Authority
PHR	Partners for Health Reform
PSMAS	Public Service Medical Aid Society
PVOs	Private Voluntary Organisations
SPSS	Statistical Package for Social Scientists
STI	Sexually Transmitted Infections
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
VOC	Vote of Credit
WHO	World Health Organisation
PAAC	Provincial AIDS Action Committee
DAAC	District AIDS Action Committee
ZIMRA	Zimbabwe Revenue Authority

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

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

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