Afrobarometer Briefing Paper No. 99

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Trends in Public Opinion on Health Care in Zimbabwe: 1999-2010

Introduction

Zimbabwe has experienced many economic and political problems in recent years. The unemployment rate is estimated to be close to 90% and the country officially abandoned its currency in 2009. Under such conditions all services including health care have deteriorated. Average life expectancy dropped from 65 in 1990 to 43 in 2005 while under five mortality has increased from 76 per 1000 in 1990 to 82 per 1000 in 2005.[1] Immunisation, antenatal care and chronic disease treatment declined while HIV/AIDS and cholera plague the country. Post election violence in 2008 and restrictions on humanitarian aid compounded the health problems in the country.

The forced evictions under Operation Murambatsvina in 2005 contributed to the decline in the living standards and health of the population. It was estimated that 700 000[2] people lost their homes. Some returned to rural areas while others moved to low income settlements in the cities. Inadequate attempts were made to re-house those who were displaced and who now reside in informal settlements under unsanitary conditions with poor access to basic services such as clean water and sanitation. Pregnant women and new born babies are especially vulnerable to illness and death under these conditions. Poverty constrains most women from utilising clinics as they do not have money for transport to clinics or to pay for services. The 2005-6 Zimbabwe Health and Demographic Survey estimated that 58%[3] of women do not have access to medical treatment because they are unable to afford it. In addition dwellers from informal settlements sometimes face discrimination[4] when trying to access public clinics and they may be turned away.

Using data from Afrobarometer this paper will examine public opinion trends pertaining to health care in Zimbabwe from 1999 to 2010. The data permit assessments of access to health care, problems experienced at health care facilities, satisfaction with public health care services as well as indicators of the perceived prevalence of HIV/AIDS and cholera.

The Afrobarometer is a comparative series of public attitude surveys on democracy, governance, markets and living conditions. The surveys are based on a randomly selected national probability

[1] Health Action in Crisis: Zimbabwe. World Health Organisation. 2008.
[2] No Chance to Live: New born Deaths at Hopley Settlement, Zimbabwe. Amnesty International. 2010.
[3] Ibid.
[4] They Swallow the Wind and they Die: Newborn Deaths in Hopley Settlement, Zimbabwe. Amnesty International. 2010

sample of 1200 respondents representing a cross-section of adult Zimbabweans aged 18 years or older. A sample of this size yields a margin of error of ±3.0 at a 95 percent confidence level. All interviews are conducted face-to-face by trained fieldworkers in the language of the respondent's choice. Previous Afrobarometer surveys were conducted in 1999, 2004, 2005, and 2009, selected results of which are presented here for purposes of comparison. The most recent survey was conducted in October 2010.

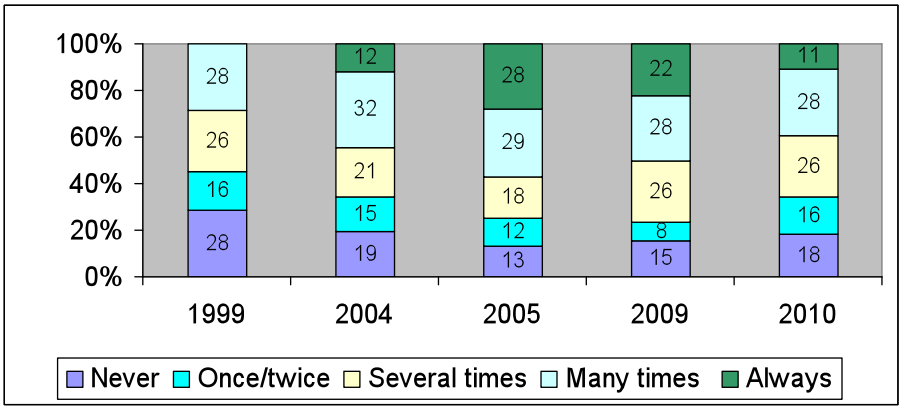
The key findings of the paper include the following:

- Access to modern medical care and medicine improved in 2009 and 2010, although one in three (39%) went without modern medical care and medicine always or many times in 2010.
- One in five had access to traditional medicines.
- More than half (55%) experienced difficulty when seeking treatment at a clinic.
- One in three and one in four respectively went without food and water always or many times in 2010. Thus potential for malnutrition and cholera prevail.
- Seven out of ten (71%) regularly had no cash curtailing their ability to pay for treatment or even transport to a health facility.
- One in five Zimbabweans (20%) made illegal payments to public health facilities.
- High cost of medical care is the most important health problem in the country.
- Other critical problems are shortages of supplies, poor infrastructure and insufficient staff.
- The majority of Zimbabweans (59%) prefer quality health care even if they have to pay for it
- In 2009 there was optimism that government had improved health and other basic services but by end of 2010 people were disillusioned and government performance ratings fell.
- One in three was not satisfied with maternal and child health care services.
- One in three was not satisfied with nurses and midwives while one in four was dissatisfied with the village health workers network.
- One in four waited for long times for service and reports of dirty facilities and illegal payments increased since 2005.
- There was some improvement with the availability of medical supplies and doctors in public clinics since 2005.
- HIV/AIDS is believed to be the primary killer of women and children.
- There was widespread satisfaction with government performance on HIV/AIDS.
- The majority (58%) did not want government to prioritise HIV/AIDS above other problems.
- Over 80% were content with the information provided on HIV/AIDS prevention and treatment as well as their own ability to apply it.

Access to Health Care

The respondents were asked how often they or anyone in their families went without modern medicine and medical care in the past 12 months. Reported shortages of modern medical care and medicine provide an indication of the access to health care among Zimbabweans.

Figure 1: Access to Medicine/medical care, 1999[5]-2010 (percent)



Over the past year, how often, if ever, have you or anyone in your family gone without: Medicines or medical treatment?

Figure 1 presents data on access to medical care from 1999 to 2010. In 1999 just over one in four (28%) Zimbabweans stated that they or their family members went without modern medical care many times in the past year. The percentage of people reporting frequent shortages (always or many times) of medicine and medical care increased to 44% in 2004 and then to 57% in 2005[6]. In 2009 there was some improvement in access to medical treatment as only 50% noted frequent shortages while in 2010 39% said that they went without medicine or medical treatment in the past year. Thus access to modern medical care appears to have significantly improved since 2009.

A closer examination of the 2010 data reveals that there are no significant differences among urban and rural Zimbabweans with regard to accessing medicines and medical care. There is a slight gender difference, 42% of men compared to 38% of women go without modern medicine and medical care always or many times. Lack of access to modern medicine and care were more pronounced in Bulawayo, Mashonaland West, Mashonaland Central and Matabeleland North where just over 40% experienced frequent deficits.

Table 1: Health clinic within Walking Distance, 1999-2010 (percent)

	1999	2005	2009	2010
Health Clinic	40	23	77	61

Are any of the following facilities available within the primary sampling unit/enumeration area? Health Clinic.

The data in figure 1 on access to medical care are supported by the observational data collected as part of the survey. Table 1 depicts the presence of a health clinic in or within walking distance from the enumeration areas which were sampled for the survey. In congruence with the data in figure 1, the presence of health clinics decreased in 2005, improved dramatically in 2009 but declined somewhat in 2010.

[5] In the 2000 data set a four point scale which differs slightly from that used in subsequent years was used, thus the data for 2000 may not be perfectly comparable to later years.
[6] The World Health Organisation notes that there was a rapid decline in immunisation in 2005/6.

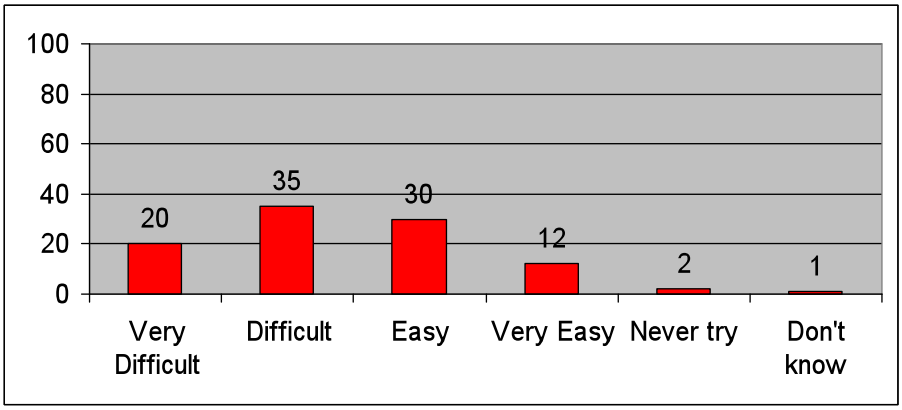
Table 2: Access to Traditional Medicine, 2010

	Percent
Never	51
Once/twice	11
Several times	6
Many times	3
Always	20

Over the past year, how often, if ever, have you or anyone in your family gone without: Traditional medicine or medical treatment?

In 2010, 23% reported that they went without traditional medicines or treatment always or many times. This figure is lower than the 39% who faced equivalent shortfalls of modern medicines and medical care, suggesting that Zimbabweans have better access to traditional medicines. This is possibly due to factors such as the lower costs of traditional medicine, tendency of traditional healers to accept payment in kind and self healing practices among some older Zimbabweans. Urban residents, particularly in Harare and Bulawayo provinces, are more likely to go without traditional medicines than those in rural areas. A number of Zimbabweans eschew traditional medicine for religious or other reasons thus some may voluntarily go without traditional medicines.

Figure 2: Difficulty Obtaining Medical Treatment at a Clinic, 2010 (percent)



Based on your experience, how easy or difficult is it to obtain the following services? Or do you never try and get these services from government? Medical treatment at a clinic.

A question was asked about the level of difficulty encountered when trying to obtain medical treatment. More than half (55%) believed that it was very difficult or difficult to obtain medical treatment at a clinic. In contrast 42% stated that it was easy or very easy to obtain such treatment. Rural respondents were more likely to say that it was easy or very easy. Respondents who lived in greater poverty (as indicated by frequent shortages of food, water, cash and medical treatment) were more disposed to find it difficult or very difficult. More residents of Harare, Manicaland and Mashonaland East tended to face difficulty when seeking treatment.

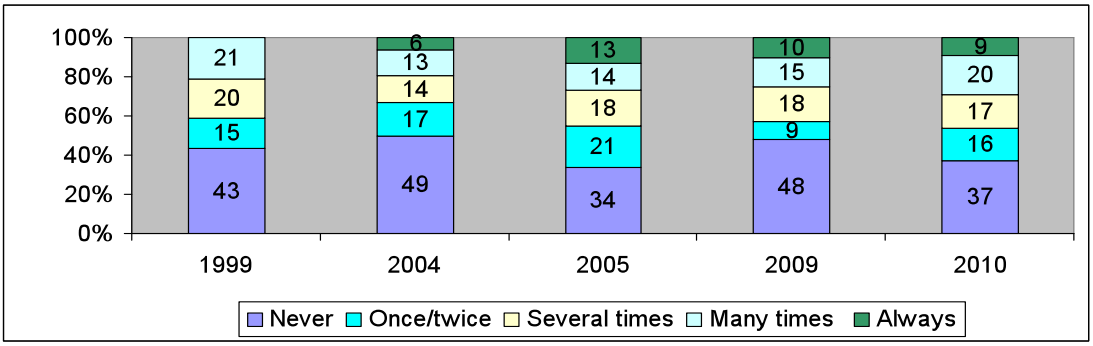
There has been little change over the past five years; in 2005 57% noted that it was very difficult or difficult to obtain medical treatment at a clinic.

Access to other Basic Necessities

It is of interest to examine reported deficiencies of food, water and cash incomes as these are basic necessities which affect health and the survival of new-born babies. In addition, the availability of a cash income influences a household's ability to pay for health services. Research undertaken by Amnesty International[7] proposes critical links between service delivery and health problems.

Access to clean potable water is vital for good health and safety from waterborne diseases such as cholera and dysentery. In 2009 100 000[8] cases of cholera were reported to date, although there was a marked decrease in cholera infections the risk prevails due to unsafe drinking water and poor sanitation.

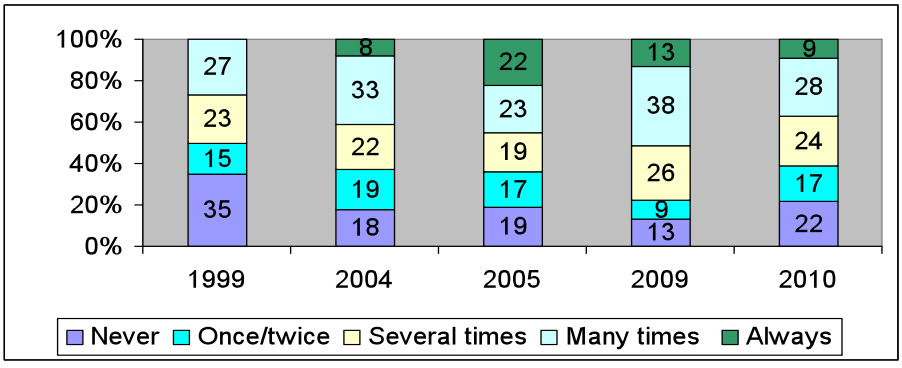
Figure 3: Access to Water, 1999-2010 *(percent)*



Over the past year, how often, if ever, have you or anyone in your family gone without: Water?

In 1999 one in five Zimbabweans (21%) reported that they many times went without "enough clean water for home use." There was no significant change in 2004 (19%) but in 2005 one in four (27%) experienced frequent water shortages and this figure remained fairly stable in 2009 (25%) and 2010 (29%). Although the majority of Zimbabweans have access to water, the quality of the water is not always safe for human consumption.

Figure 4: Access to Food, 1999-2010 (percent)



Over the past year, how often, if ever, have you or anyone in your family gone without: Food?

[7] They Swallow the Wind and they Die: Newborn Deaths in Hopley Settlement, Zimbabwe. Amnesty International. 2010.

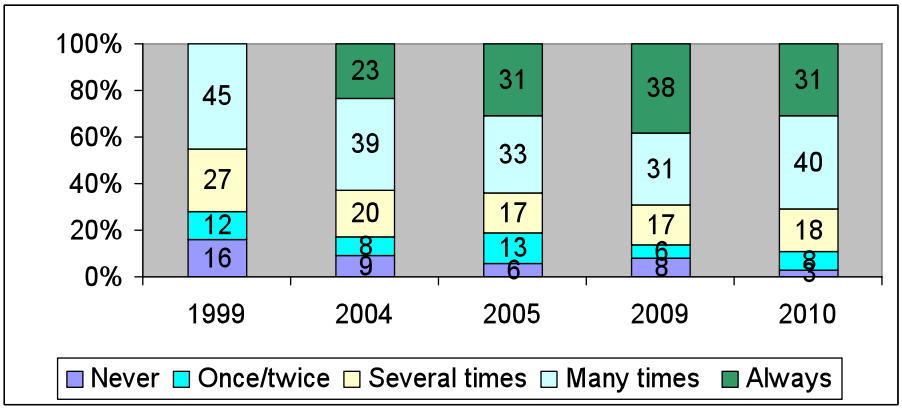
[8] Zimbabwe: Beyond Cholera – Beyond the Crisis. Doctors without Borders. August 17 2009.

Around one in four people (27%) claimed that they did not have "enough food to eat" always or many times in 1999. Regular food deprivation increased to 42% in 2004, 45% in 2005 and peaked at 51% in 2009. The 2009 survey questions reflected on the 2008-2009 period when Zimbabwe experienced acute food shortages due to the collapse of the currency. It is positive that the percentage stating that they go without food always or many times was 37% in 2010, a decline of 14% from the 2009 level.

Prevalent food deprivation affecting one in two in 2009 and one in three in 2010 indicates that the health of the population may be undermined as poor nutrition leads to health problems as well compromising the ability of individuals to cope with exposure to diseases such as HIV/AIDS and tuberculosis. The health of children is particularly vulnerable. The 2008 Zimbabwe Combined Micronutrient and Nutrition Survey[9] found that 27% of children under five suffered from stunted growth due to inadequate nutrition. Furthermore, lack of food is an indicator of hard core poverty. Those who contend with regular food shortages are unlikely to be able to afford medicines and medical care, even if severely ill.

Access to Cash Income

Figure 5: Access to Cash income, 1999-2010 *(percent)*



Over the past year, how often, if ever, have you or anyone in your family gone without: A cash income?

Since 1999 there have been notable increases in the number of Zimbabweans who go without a cash income always or many times. In 1999 45% attested to going without a cash income always or many times, in 2004 this figure had risen to close to two thirds of adult Zimbabweans (62%). Thereafter there were steady increases and in 2010, 71% reported going without cash very frequently. Access to cash is critical for Zimbabweans as a number of clinics charge fees.[10]

Interviews conducted by Amnesty International[11] found that many pregnant women go without medical care because they cannot afford health care. The cost of registration for antenatal and postnatal care is US$50, which is beyond the means of the many Zimbabweans who do not have cash on a regular basis. The cost of an ambulance is US$30 and private doctors may be charging as much as US$300 for a consultation. Amnesty International also found that women do not

[9] ZADHR Newsletter. Vol 7. Issue 3. 3 August 2009.
[10] Zimbabwe: Beyond Cholera – Beyond the Crisis. Doctors without Borders. August 17 2009.
[11] No Chance to Live: New born Deaths at Hopley Settlement, Zimbabwe. Amnesty International. 2010.

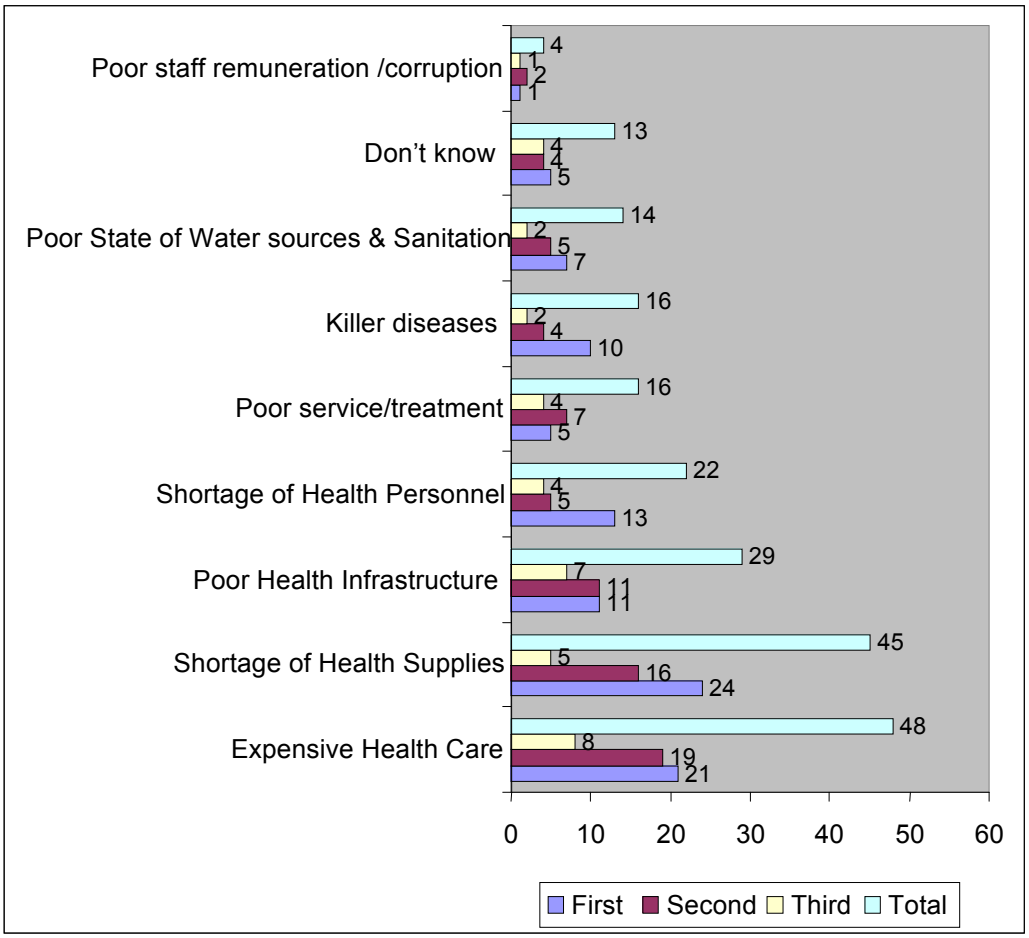
have money for transport to the clinic and that pregnant women may walk long distances to clinics when they have complications. Dwindling confidence in clinics[12] due to staffing constraints and lack of medical supplies may discourage some from spending money to go the clinic.

The nature of cash has changed over the years. Prior to 2009 a weak Zimbabwean dollar with low purchasing power was widely available. The US dollar has much higher purchasing power but may be less available especially in rural areas.

Perceived Problems with Health Care

Those taking part in the survey were asked to list the three most important health problems facing Zimbabwe.

Figure 6: Most Important Health Problem, 2010 *(percent)*



For the moment, let us only consider issues of health and health care. In your opinion, what are the most important health-related problems facing this country?

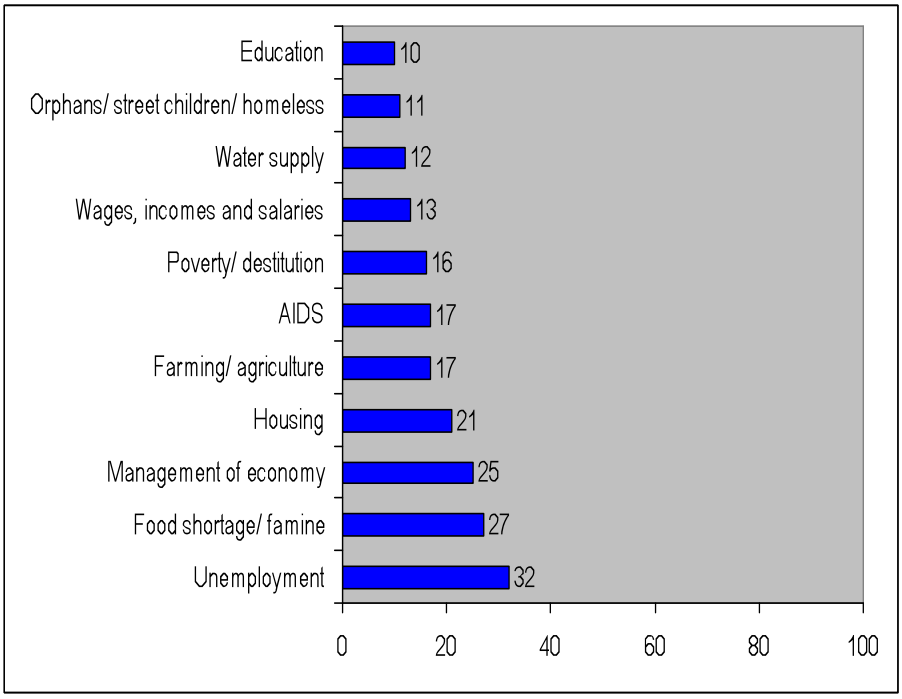
Just less than half (48% and 45% respectively) mentioned expensive health care and shortage of health supplies as the two most serious problems. One in five listed the aforementioned problems as the first most important problem. Nearly one in four (29%) said that poor health

[12] ZADHR Newsletter. Vol 7. Issue 3. 3 August 2009.

infrastructure was the most serious problem while one in five (22%) maintained that it was the shortage of health personnel. Only 16% felt that killer diseases were among the top three most severe health problems.

Public opinion on the health care problems is in line with assessments by the World Health Organisation[13] which found that there were shortages of health supplies, poor health infrastructure and that around half of the posts for doctors and a third of those for nurses were vacant. In 2009 it was estimated that 69%[14] of doctors' posts and 80% of posts for midwives were vacant.

Figure 7: Most Important Problem, 2010 *(percent)*[15]

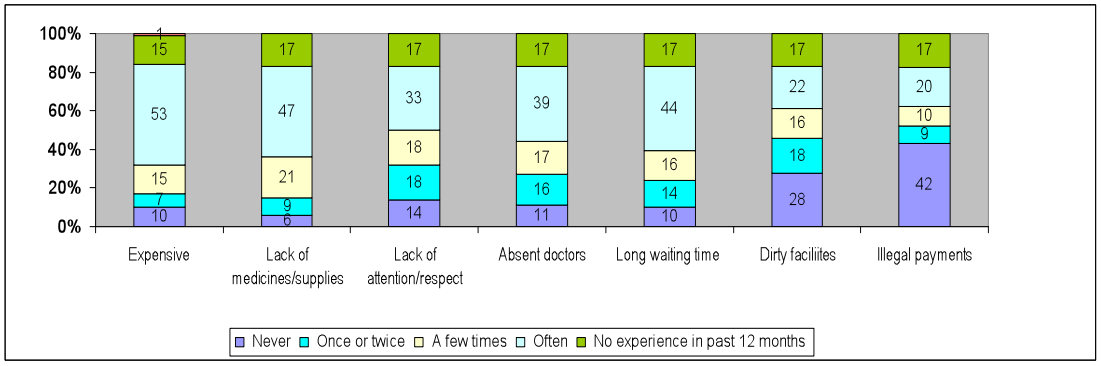


In your opinion, what are the most important problems facing this country that the inclusive government should address?

When the respondents were asked to name the three most important problems facing Zimbabwe a range of problems emerged but economic problems were dominant. Nearly one in three (32%) stated that unemployment was of the most concern. One in four listed food shortages and famine as the most serious problem. Less than one in five (16%) felt that the most important problem was AIDS and a mere 3% rated health as the most severe problem in Zimbabwe. It is not surprising that health is dwarfed by economic problems given the high levels of poverty and unemployment in the country. Furthermore, improved economic conditions would enable citizens to afford more medicine and medical care.

[13] Health Action in Crisis: Zimbabwe. World Health Organisation. 2008.
[14] ZADHR Newsletter. Vol 7. Issue 3. 3 August 2009
[15] Only figures for the top ten problems are shown in the graph.

Figure 8: Problems with Public Clinics or Hospital in the Past 12 months, 2010 *(percent)*

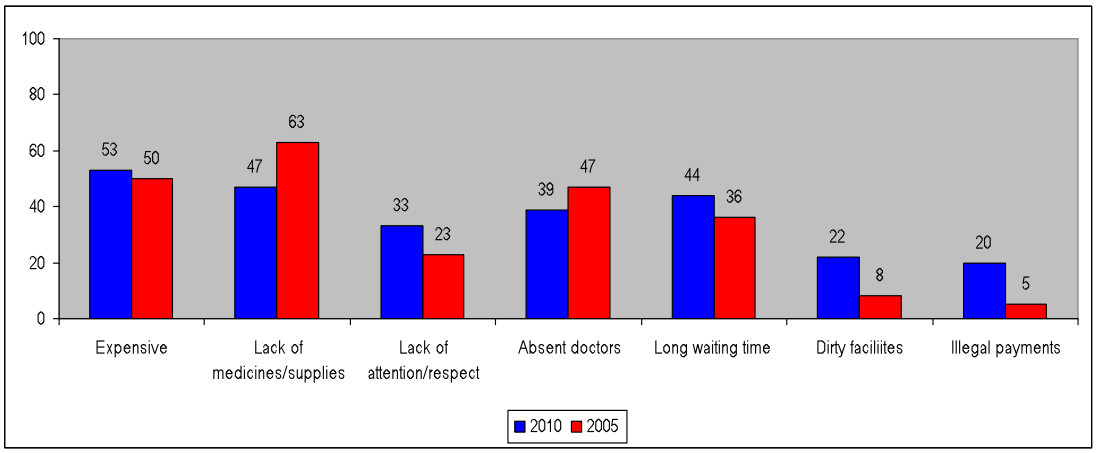


Have you encountered any of these problems with your local public clinic or hospital during the past 12 months?

Survey participants were asked if they had experienced a range of specific problems with public clinics or hospitals that they had visited in the past twelve months. The most commonly cited problem (mentioned by 53%) was that public clinics and hospitals were too expensive. Just less than half (47%) often found that there was a lack of medicines and supplies while 44% complained that they had frequently had to wait for a long time before being attended to. One in three (33%) were often treated poorly by staff and 39% regularly found doctors to be absent. One in five, 22% and 20% respectively often encountered dirty facilities or had to make illegal payments for services.

In 2010 those who reported that they often experience the problems in figure 10 were more likely to live in Harare and Mashonaland West, in particular reports of frequent illegal payments were prominent in these areas. Those hailing from Masvingo were moderately less disposed to note problems. Rural respondents were significantly much more likely to state that doctors were absent and waiting times long on a regular basis. Unsurprisingly those who stated that public health facilities were often expensive or who often made illegal payments tended to go without modern medical care or medicine often.

Figure 9: Problems with Public Clinics or Hospital in the Past 12 months, 2005-2010
(Percent answering often)



Have you encountered any of these problems with your local public clinic or hospital during the past 12 months?

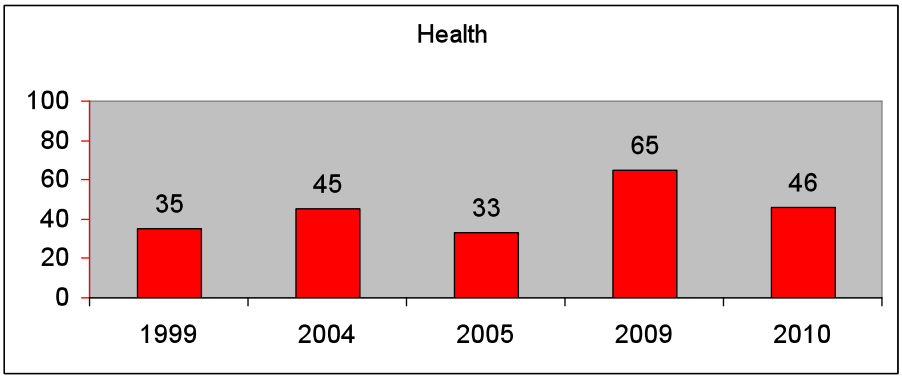
A comparison of problems with public clinics over time, from 2005 to 2010, reveals some improvement as well as deterioration of service quality. Significantly fewer respondents in 2010 reported that there were often shortages of medicines and supplies as well as absent doctors, implying that there has been improvement. In contrast, significantly more respondents in the 2010 survey often experienced a lack of care from staff and long waiting times, indicating service decline. The fourfold increase, from 5% in 2005 to 20% in 2010, of people who often have to make illegal payments to access public health facilities is of grave concern. Similarly, there was a sharp increase in mention of dirty facilities in 2010. There was little change in perception of the high cost of public health facilities.

Satisfaction with Government Performance on Health Care and Related Services

The survey contains a battery of questions which evaluate government performance on a broad range of functions. In 2009 and 2010 reference was made to the performance of the inclusive government.

Figure 10: Performance of Government with regard to Health, 2010

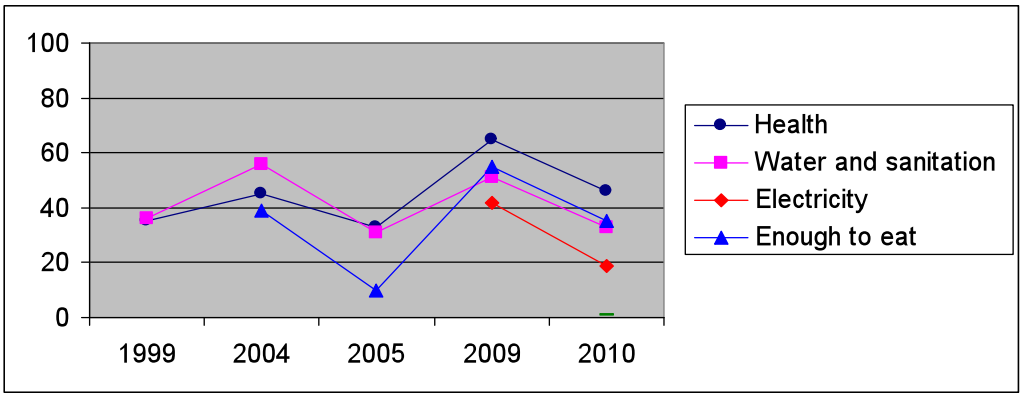
(Percent answering fairly well or very well)



How well or badly would you say the inclusive government is handling the following matters, or haven't you heard enough to say: Improving basic health services?

Between 1999 and 2005 roughly one in three Zimbabweans stated that government was doing fairly or very well in terms of improving basic health services. In 2009 the percentage of people stating that government was doing fairly or very well almost doubled to 65%. The positive rating in 2009 may reflect the public's optimism with regard to the newly formed inclusive government. However, the decline to 45% stating government was doing fairly or very well in 2010 implies that a number of citizens have been disappointed by the inclusive government's efforts to improve basic health care.

Figure 11: Performance of Government with regard to Services, 1999-2010
(Percent answering fairly well or very well)



How well or badly would you say the inclusive government is handling the following matters, or haven't you heard enough to say: Providing water and sanitation services? Ensuring everyone has enough to eat?Providing a reliable supply of electricity?

A comparison of the government performance ratings with regard to improving basic health care with other services which affect health reveals a similar trend of dissatisfaction after 2004 and optimism in 2009 which dissipated somewhat by 2010. Satisfaction with the provision of water and sanitation as well as food provision declined sharply between 2004 and 2005. In 2005 only 10% said that government was performing fairly or very well in terms of providing enough to eat while only 31% were content with the provision of water and sanitation. In 2009 just over half believed government was doing fairly or very well with regard to the provision of these services but in 2010 only one in three shared this conviction. Likewise there was a decline in performance ratings of the supply of electricity from 2009 to 2010. Overall, ratings for basic health care tended to be better than those for other services.

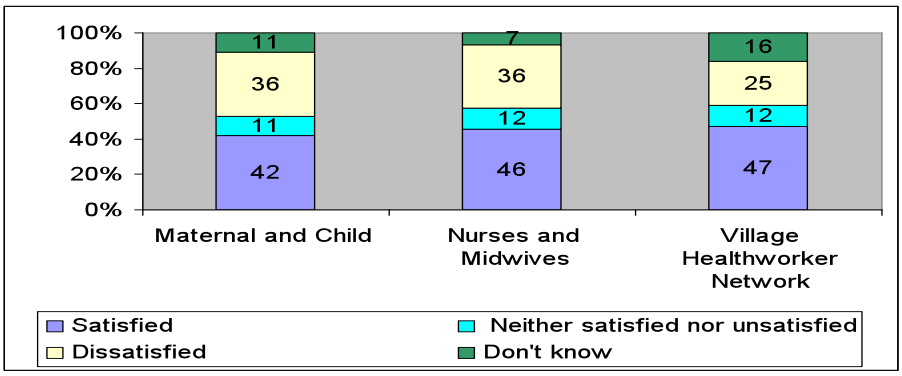
Maternal and Child Health

Maternal health has deteriorated rapidly and estimated deaths are 725 per 100 000[16], reflecting a more than fivefold increase since 1990. There has also been a threefold increase in the number of infants with brain damage and other birth complications. The neonatal death rate is 29 per 1000 births. Almost half of women do not have access to postnatal care. There has been a steady rise in the number of births at home since 1999. A survey released in 2009 found that 39%[17] of women of who had given birth in the preceding two years delivered at home. Research undertaken by Amnesty International found that women in some informal areas gave birth alone with no help or with help from a neighbour. Maternity clinics in some areas run by the Harare City Council charge a US$50[18] registration fee which poor women cannot afford. A government official maintained that free care is available at council run clinics and that the head of the clinic has discretion to decide who will not be charged. There appears to be a lack of clarity regarding charges at council run clinics and some women in low income areas do not seem to know that

[16] ZADHR Newsletter. Vol 7. Issue 3. 3 August 2009
[17]Central Statistical Office. Zimbabwe Multiple Indicator Monitoring Survey: Preliminary Report. November 2009.
[18] They Swallow the Wind and they Die: Newborn Deaths in Hopley Settlement, Zimbabwe. Amnesty International. 2010

free care may be available. Transport costs also deter pregnant women from attending clinics and in some areas transport is not available at night.

Figure 12: Satisfaction with Maternal Health Services, 2010 (percent)



Overall, how satisfied or unsatisfied are you with the following health programs and providers? Or haven't you heard enough about them to have an opinion?

Respondents were asked to rate their satisfaction with three categories of maternal health care services. The results suggest that the quality and performance of these services were not consistent. A plurality of above 40% were satisfied with maternal and child health care, nurses and midwives and the village health worker network. One in three respondents was not satisfied with maternal and child health care (36%) as well as nurses and midwives (36%) while one in four (25%) was dissatisfied with the village health worker network. Rural respondents were slightly more satisfied with these services than their urban counterparts.

Satisfaction with maternal and child services as well and nurses and midwives is notably lower in Harare while satisfaction with both was more evident in Masvingo, Midlands, Mashonaland Central and Matabeleland North. Satisfaction with the village health worker network was greater in Midlands, Mashonaland Central and Matabeleland North.

The respondents were asked to give their view on the leading cause of death among women and children in Zimbabwe.

Table 3: Main Cause of Death among Women, 2010

	Frequency	Percent
HIV/AIDS	782	66
Pregnancy complications	147	12
Other diseases (excluding HIV/AIDS)	56	5
High cost of medical care/poverty	28	2
Violence (domestic/murder)	19	2
Poor health service delivery	18	2
Stress/over-work	28	2
Sexually transmitted diseases	6	1
Hunger/starvation	6	1
Other	6	1
Don't know	96	8
Total	1192	100

In your opinion, what is the main cause of death among women in Zimbabwe?

Two out of three (66%) stated that HIV/AIDS is the leading cause of death among women. One in ten (12%) raised pregnancy complications and 5% said that other diseases were the primary cause of death for women. Examples of the other diseases referred to include tuberculosis, malaria, cholera, breast cancer and cervical cancer.

Table 4: Main Cause of Death among Children, 2010

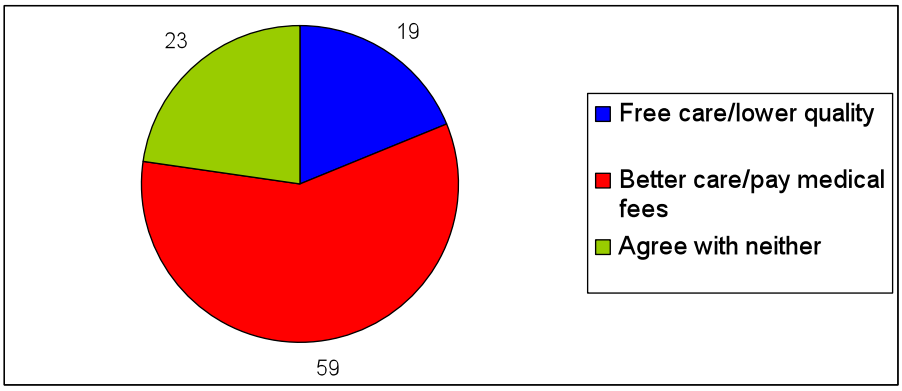
	Frequency	Percent
HIV/AIDS	515	43
Other diseases (excluding HIV/AIDS)	224	19
Hunger/starvation	126	11
Diseases - dehydration/diarrhoea	32	3
High cost of medical care/poverty	21	2
Disease - Fontanelle (NHOVA)	19	2
Poor health service delivery	13	1
Poor water & sanitation services	7	1
Negligence from parents	11	1
Pregnancy complications	3	0
Violence (domestic/murder)	1	0
Drug/substance abuse	3	0
Sexually Transmitted Diseases	3	0
Lack immunization	2	0
Other	12	1
Don't know	191	16
Total	1191	100

In your opinion, what is the main cause of death among children in Zimbabwe?

A majority of 43% listed HIV/AIDS as the main cause of death among children in Zimbabwe. Nearly one in five (19%) were of the view that diseases other than AIDS were primarily responsible for child deaths. Rural respondents were more likely to say that other diseases were the key cause. Some of the other diseases included malaria, cholera measles and the six killer diseases (poliomyelitis, tuberculosis, whooping cough (pertusis), measles, diphtheria and neo-natal tetanus.

Free Care versus Payment

Figure 13: Perceptions of Free Care versus Paid Care, 2010 (percent)



Which of the following statements is closest to your view? Choose Statement 1 or Statement 2.
Statement 1: It is better to be able to visit clinics and get medicines for free, even if the quality of health care is low.
Statement 2: It is better to raise health care standards, even if we have to pay medical fees.

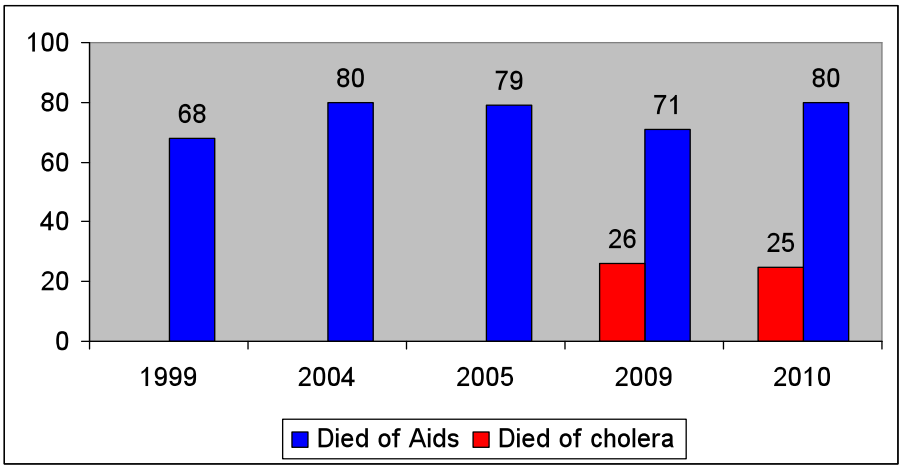
Respondents were asked to choose between two statements which reflected a preference for free care even if quality was lower or better care even if fees had to be paid. The majority 59% preferred better care at a cost. Almost one in five (19%) were willing to sacrifice quality for free health care. There was a greater preference for free health care in Masvingo and Matabeleland South while majorities in Bulawayo and Manicaland would rather pay for better health services. Rural respondents and females were slightly more in favour of free health care even if quality was lower. Those who wanted free health care were more likely to have gone without food always or many times in the past year as well as stated that they always do not have a cash income. In addition they were more inclined to regard public clinics as expensive or to have made illegal payments for service often. In sum, it appears that Zimbabweans who were least able to pay for medical treatment tended to prefer free health services even if the quality of care was reduced.

AIDS and Cholera

HIV/AIDS prevalence is estimated at 15%[19] in Zimbabwe and there are around 400 HIV related fatalities per day. The vast majority of people who are in need of antiretroviral treatment are not likely to receive it.

[19] Zimbabwe: Beyond Cholera – Beyond the Crisis. Doctors without Borders. August 17 2009.

Figure 14: Friend/relative who died of AIDS, 1999-2010 (percent)



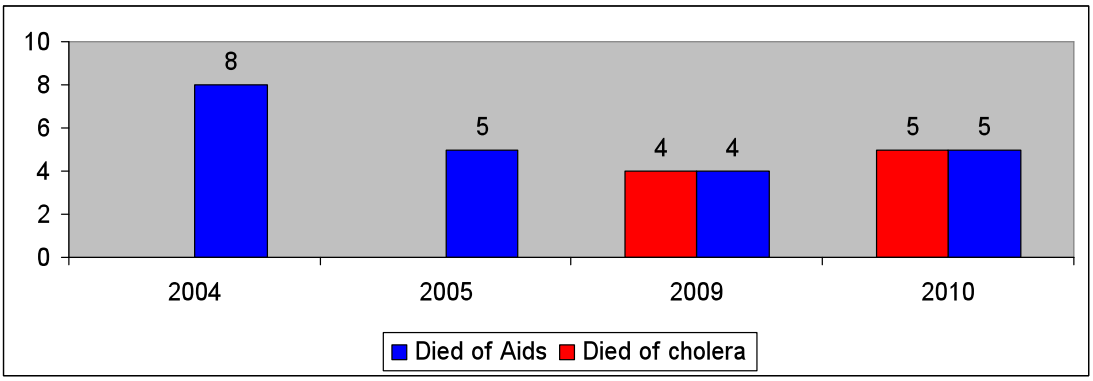
Do you know a close friend or relative who has died of AIDS?/Cholera?

The respondents were asked if they knew of a friend or relative who died of AIDS. The question was repeated for cholera in 2009 and 2010. In 1999, 68% knew of a friend or relative who had died of AIDS. The figure escalated to 80% in 2004 and remained stable at 79% in 2005. There appeared to be some improvement in 2009 as only 71% knew a friend or relative who died of AIDS but in 2010 the figure rose back to 80%.

In 2010 slightly more people in Harare, Masvingo and Manicaland compared to other areas gave an affirmative response to this question on AIDS. Two out of three people who lost a friend or relative to AIDS were in rural areas.

Considerably fewer respondents knew of a friend or relative who had died of cholera. In 2009 and in 2010 one in four people 26% and 25% respectively had lost a friend or relative to cholera. More affirmative responses came from Harare and Mashonaland West as well as from rural areas but the urban/rural difference was not as striking as it was for AIDS.

Figure 15: Average Number who died, 2004-2010



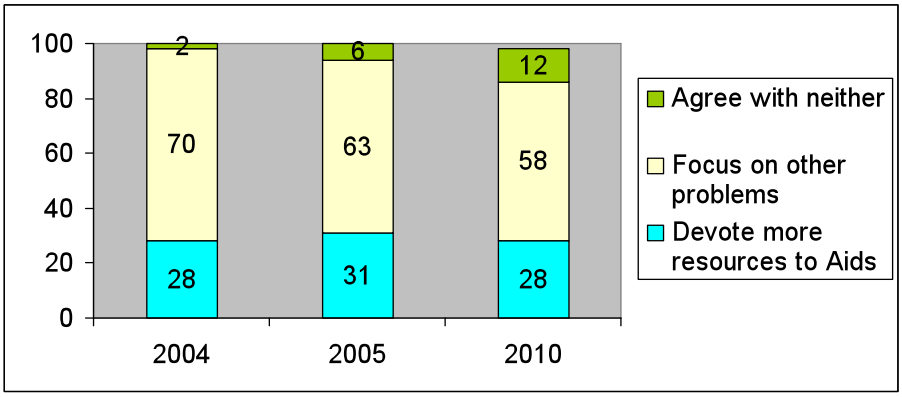
How many friends or relatives is that?

The respondents were asked to estimate the number of friends or relatives who they believed had died of AIDS. Although in 2004 six in ten respondents knew a friend or relative who died of

AIDS (68%), they claimed to know an average of eight people who had died of AIDS. In subsequent years although more people, around eight in ten, knew of friends or relatives who had died of AIDS, the average was lower at five people.

In 2009 respondents had an average of four friends or relatives who died of cholera and in 2010 the average rose to five. Although it appears that respondents have as many friends and relatives who die of AIDS as of cholera it must be remembered that these figures are estimates and that the lingering stigma attached to AIDS may lead to some under-reporting of the number of people who may have died of AIDS.

Figure 16: AIDS versus Other Problems, 2010 (percent)

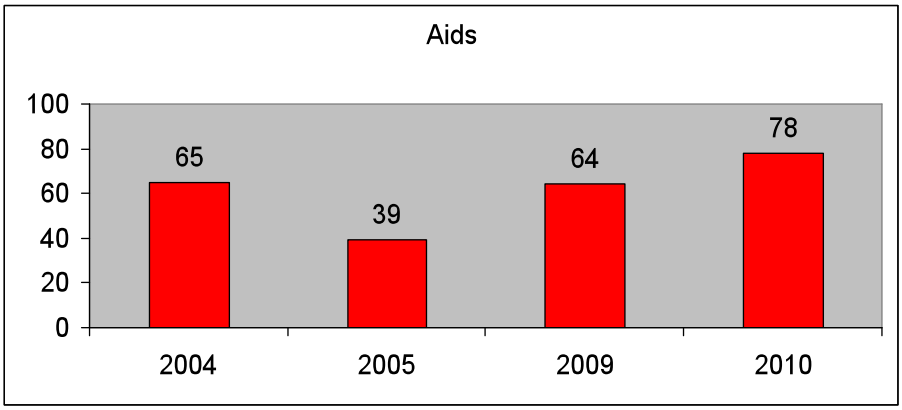


Which of the following statements is closest to your view? Choose Statement 1 or Statement 2.
A. The government should devote many more resources to combating AIDS, even if this means that less money is spent on things like education.
B. There are many other problems facing this country beside AIDS; even if people are dying in large numbers, the government needs to keep its focus on solving other problems.

Survey participants were asked to choose between two statements, one indicating a preference for prioritising the fight against AIDS at the expense of other important issues such as education and the other suggesting that AIDS should not be prioritised over other problems. More than half the respondents (58%) stated that government must focus on other problems rather than AIDS. One in four (28%) felt that AIDS should be given priority over all other problems while 12% were ambivalent. Rural respondents, residents of Masvingo and females were more inclined to prioritise AIDS above other problems.

In 2004 the majority (70%), opted for focusing on other problems, however this conviction fell steadily to 63% in 2009 and to 58% in 2010. Although preference for other problems lessened, the preference for focusing on AIDS did not rise simultaneously. Instead, a growing number of respondents were unable to make this difficult choice, reflected by the "agree with neither" option in 2005 and 2010.

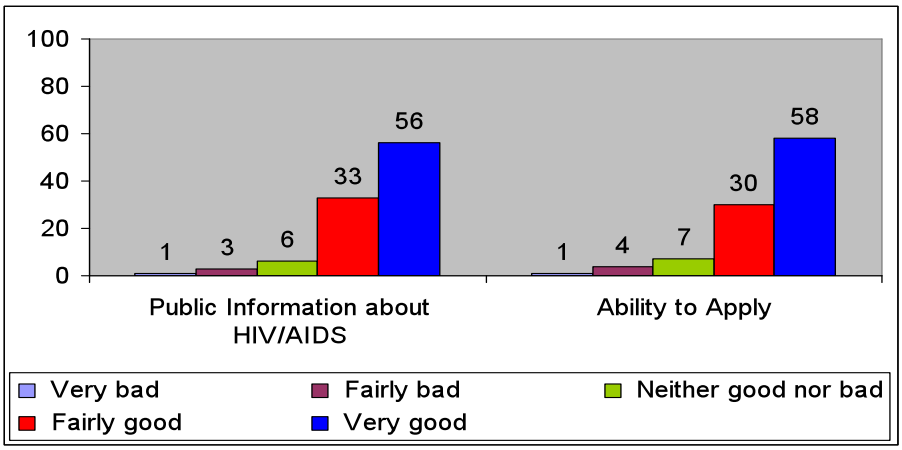
Figure 17: Performance of Government with regard to Combating AIDS, 2004-2010
(percent "well" or "very well")



How well or badly would you say the inclusive government is handling the following matters, or haven't you heard enough to say: Combating HIV/AIDS?

The battery of questions pertaining to government performance included a question on combating AIDS. Since 2005 there were significant increases in the number of people who believed that government was performing well or very well with regard to combating HIV/AIDS. In 2010 the majority, 78% stated that government was doing well or very well in combating HIV/AIDS. In 1999 Zimbabwe introduced a national AIDS levy requiring individuals and organisations to pay 3% of the income to the National Aids Trust. The funds were used to fund HIV/AIDS programmes which coupled with other interventions were widely credited for rapid reductions in the HIV/AIDS prevalence rate. The success of the AIDS levy and trust may have had some influence on public opinion on the inclusive government's efforts fight the pandemic.

Figure 18: Rating of HIV/AIDS Information, 2010 (percent)



And how would you rate the public information provided about HIV/AIDS prevention and treatment? And how would you rate your own ability to apply this knowledge about HIV/AIDS prevention and treatment?

More than half (56%) believed that public information concerning prevention and treatment of HIV/AIDS was very good, while a further 33% thought it was fairly good. Residents of Bulawayo, Midlands and Masvingo had a greater tendency to say very good while those in Manicaland generally opted for fairly good.

Likewise 58% felt that their own ability to apply the knowledge about HIV/AIDS prevention and treatment was very good and 30% chose the "fairly good" option. Again in Bulawayo there were more "very good" responses while people in Matabeleland (North and South) were inclined to offer more modest ratings of their ability to apply the information.

In contrast to the above findings, a survey conducted by the Central Statistical Office [20] found that comprehensive knowledge about HIV transmission was low among women of reproductive age. Only 66% of urban women and 48% of rural women were able to demonstrate comprehensive knowledge by correctly identifying two HIV prevention methods and three misconceptions about HIV transmission. More educated and financially better off women had more knowledge. Only one in three women who gave birth in the previous two years reported being given HIV counselling at an antenatal clinic and slightly more than half (58%) were tested for HIV. Thus in spite of public confidence with regard to their knowledge of HIV prevention there is a need for further HIV prevention information and education to bolster comprehensive knowledge. If antenatal clinics are the conduits for HIV information dissemination then it appears that women who are not able to access these clinics may not get HIV prevention knowledge, HIV tests or antiretroviral drugs to prevent mother to child transmission.

Conclusion

Access to health care in Zimbabwe has improved since the inclusive government has been in power; although in 2010 around one in three Zimbabweans (39%) went without modern medicine or care always or many times in the past year. The cost of medical care (cited as the most important health problem in the country by 48%) as well as associated costs such as transport to medical facilities appear to be the primary deterrents to access to health care. Seven out of ten Zimbabweans faced frequent cash deficits and were thus not in a position to afford health care. Amnesty International found that there was a lack of clarity with regard to the provision of free medical care at public health facilities as some pregnant women were unaware that free care might be available. One in five respondents (20%) claimed that they made illegal payments for medical treatment. Despite the difficulties and shortfalls that they endured with regard to health care access the majority (59%) prefer to pay for quality medical services. Preference for free care which may be of lower quality was evident largely among those who were least able to pay for medical care or medication.

HIV/AIDS is perceived as the main cause of death among women and children. The majority (78%) are satisfied with government's efforts to counter the pandemic and most (58%) did not believe that government should devote more resources to HIV/AIDS. Over 80% were satisfied with information on HIV/AIDS prevention and treatment as well as their ability to apply this information. However other research suggests that comprehensive knowledge on prevention methods is still lacking while misconceptions prevail.

Access to free medical care must be broadened so that there can be improvements in life expectancy, child mortality, immunisation and maternal health. The Zimbabwe Association of Doctors for Human Rights[21] believes that the government is unable to deliver the much needed upgrading of the health care system without donor support. Although Zimbabwe has made

[20] Central Statistical Office. Zimbabwe Multiple Indicator Monitoring Survey: Preliminary Report. November 2009.

[21] ZADHR Newsletter. Vol 7. Issue 3. 3 August 2009.

notable advances in the fight against HIV/AIDS efforts by government and donors must be sustained and improved.

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