

# PHM ASSESSMENT-ZIMBABWE

## Step 1

**What are your government's commitments? What international covenants, treaties, and consensus documents has your government ratified/ signed-on to?**

Every person has the right to the highest attainable standard of health, the right to life, the right to seek, receive and impart information of all kinds, the right to nondiscrimination and equal protection of the law, and the right to be protected from violence. International human rights law also requires states to address persistent violations of human rights and take measures to prevent their occurrence. These rights are guaranteed by important international and regional treaties to which Zimbabwe is a party. Zimbabwe's human rights obligations under international and national law Zimbabwe's human rights obligations include both the commitments contained in the Constitutional Bill of Rights and the international treaties to which it is a State Party. Zimbabwe is State Party to, amongst others, the following:

### **RATIFICATIONS AND CONSENSUS DOCUMENTS**

1. [The African Charter on Human and Peoples Rights](#), adopted June 27, 1981 (ratified by Zimbabwe in 1986)

2. [The Millennium Development Goals](#)

3. [International Covenant on Economic, Social and Cultural Rights \(no Reservations\)](#)  
New York, 16 December 1966. (Acceded to by Zimbabwe in May 1991). Article 12 of the ICESCR states that state parties to the covenant should take steps to the present Covenant to achieve the full realization of these rights which shall include those necessary for, "the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which could assure to all medical service and medical attention in the event of sickness.

4. [International Covenant on Civil and Political Rights](#)

New York, 16 December 1966, (acceded by Zimbabwe, May 13, 1991)

5. [Convention on the Elimination of All Forms of Discrimination against Women](#)

New York, 18 December 1979, (acceded to by Zimbabwe on May 13, 1991)

6. [Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment](#)

New York, 10 December 1984.

7. [Convention on the Rights of the Child](#)

New York, 20 November 1989.

8. [Convention on the Rights of Persons with Disabilities](#)

New York, 13 December 2006

9. [The International Conference on Population and Development Program of Action.](#)

10. [The Beijing Platform for Action](#)

## 11. The Alma Ata Declaration, 1978

### **Are there any specific constitutional or legal provisions applicable against which one can assess the RTHHC?**

Although the Zimbabwean constitution does not have explicit provisions on the right to health and health care, Section 11 provides that every person in Zimbabwe should be protected and entitled to the fundamental rights and freedoms of the individual whatever his race, tribe, place of origin, political opinions, color, creed or sex. Chapter 111 of the constitution guarantees specific rights such as the right to life, to personal liberty, to privacy, to personal security, freedom of expression, assembly and association and protection of law.

Under Zimbabwe's legal system, international treaties which have been acceded to or otherwise ratified are not automatically incorporated into national legislation. According to Section 111b of the Zimbabwean Constitution,<sup>(3)</sup> international conventions, treaties and agreements which have been acceded to, concluded or executed only form part of Zimbabwean law once an Act of Parliament has been passed. Most of the above conventions and documents have therefore not been incorporated into Zimbabwe's domestic laws.

However, under international law, international treaties must be observed in good faith by those States which have ratified or acceded to them. Furthermore, a State Party may not invoke the provisions of its national law as justification for its failure to implement a treaty. In this sense, States Parties are obliged to repeal or amend domestic laws to ensure that they are consistent with international treaties as well as to adopt measures to ensure the implementation of the obligations contained in the treaties to which they are party.

### **The law used as a tool to repress human rights**

Since 2002 the Government of Zimbabwe has introduced or revived several pieces of legislation which restrict freedom of expression, association and assembly, rights which are also fundamental to the realization of the right to health. The authorities have used provisions in such legislation in a discriminatory manner, applying the restrictive provisions to critics of the government, but rarely to government supporters.

Laws which have most severely constrained the work of human rights defenders in Zimbabwe include the Public Order and Security Act, the Access to Information and Protection of Privacy Act, the Private Voluntary Organizations Act and the Miscellaneous Offences Act. Many provisions of these Acts directly contravene international human rights law and standards.

Over the past three years Zimbabwe's independent media has come under sustained attack. The government has attempted to legalize this repression - introducing the Access to Information and Protection of Privacy Act (AIPPA) in March 2002. Amnesty International believes AIPPA is inconsistent with international law and standards on freedom of expression. The African Commission has described AIPPA as likely to have a "*chilling effect* on freedom of expression and introduce a cloud of fear in media circles" and has recommended that the law should be amended to meet international standards for freedom of expression.

For the RTHHC to be realized fully, the government of Zimbabwe needs to incorporate international human rights law and standards into national law and ensure all provisions are fully implemented.

As Zimbabwe has ratified, *inter alia*, the International Covenant on Civil and Political Rights and the African Charter on Human and Peoples' Rights, national legislation that does not contribute to the violation of the RTHHC, but rather laws which drive its fulfillment, must be brought into line with the fundamental rights and freedoms contained in these legal standards, recognizing and impartially enforcing them.

## **Step II**

**Are your Government's policies appropriate to fulfill these obligations?  
Which are the Main Policies and program that guide the health system in Zimbabwe?**

Among others, Zimbabwe has the following health related policies:

1. The National Health Strategy (10 year plan)
2. Reproductive Health Policy
3. Family Planning Policy
4. Gender policy
5. HIV/ AIDS Policy
6. The Zimbabwe National Water Resource Policy
7. The Extended Program on Immunization (EPI)
8. Zimbabwe Patients' Charter (Consumer Council)

### **(The National Health Strategy 1997-2007)**

In this strategy the role of Ministry of Health and Child Welfare is to “support, promote and advocate for the provision of quality health services and care to all citizens” (National Health Strategy: 1997-2007). To achieve this, some of the main areas of reform that have been targeted include:

- Decentralisation – The cornerstone of this process is the progressive creation of an enabling administrative, managerial and operational environment, in which all stakeholders in the health sector as a whole, can play their rightful roles. Ultimately, the goal is to ensure that investment in health, public or private, is linked to the achievement of national health objectives.

- Regulation of the Health Sector – The enactment of the Medical Services Act (1998), heralded a shift from “control” towards regulation. The act creates a legal environment which regulates the operations of stakeholders in the health sector as a whole.

Within the context of implementing the National Health Strategy (1997 – 2007), it has been recognized that it is no longer prudent to look exclusively at the government health care system, without examining the role other sectors, both public and private, can play. Similarly, the role of the Ministry of Health and Child Welfare must be articulated in relation to what other government agencies can contribute

towards improving the health and quality of life of the population.

**Are your government's policies appropriate to fulfill these obligations? What kind of health staff is available? Is it sufficient?**

The economic turmoil in the country which has pushed many poor and middle-class Zimbabweans to the brink of starvation has caused healthcare professionals to leave in droves for neighboring countries and positions abroad. According to statistics from the ministry of health, government hospitals require at least 1,530 doctors to function smoothly – they currently have less than half that number and a little more than half of the required 11,640 nurses.

As if these staff shortages are not enough in a country ravaged by HIV/AIDS, the public health sector has been hit by perennial strikes and has been turning away patients, advising them to seek treatment at private health institutions – a luxury few Zimbabweans can afford. Private hospitals are demanding a deposit for a three-day stay of the equivalent of more than 300 US dollars before they will even admit patients. Maternity sections are charging 1,700 US dollars, and a major operation may cost as much as 6,000 US dollars (Mushonga, 2008).

### **Step III**

**Is the health system of Zimbabwe adequately implementing interventions to realize the right to health and health care for all?**

**Has privatization affected the availability and access of health services to the poor and marginalized groups?**

For the first decade after independence, not much attention was given to the private (for profit) sector as Government concentrated on policies which emphasized universal provision of health services by the state. However, since the early 1990s, there has been a steady growth in the provision of private health services, ranging from relatively small, industry owned, clinics to large institutions. This was accompanied by a sudden mushrooming of smaller facilities such as General Practice surgeries and nursing homes. This growth has however been almost restricted to urban areas. Reasons for this expansion include:

- Increased demand from a population which is growing in urban areas and some of which perceives the quality of public services as being poor.
- Expansion has also been aided by de-regulation, which allows state employed doctors and nurses to engage in private practice.

There has also been an exponential increase in registered pharmacies. Until about 1994, the number was static at between 75 and 80. By the end of 1999, the Medicines Control Authority, had over 300 pharmacies registered, again almost exclusively restricted to urban areas, within reach of private facilities. Poor drug availability in the public sector has partly fueled this expansion, as doctors resorted to giving patients prescriptions to be taken to private pharmacies.

The privatization of health has led to health care being treated as a commodity. It is offered at a price on the market and it is purchased like food. When health is viewed as a commodity with a price, it tends to be differentially distributed among members of the society which in turn is also stratified in terms of power, wealth, education, etc.

A man who is unemployed, or on minimum wage, for example, is unable to buy drugs from the drug store, when a prescription is given by a doctor. In some cases drugs that are not available in the hospital are found in the drug store where they are purchased by anybody with a prescription. A man who cannot afford the price of drugs has to do without that medicine.

Even if he is on medical aid he is unable to obtain treatment. To this extent medical treatment is determined by the purchasing power of the individual. If purchasing power is the determining factor, then health or medical care is not accessible to many people, particularly not to those that are unemployed or underemployed or those in the most remote parts of the country. Medical care is, therefore, differentially distributed in favour of those with purchasing power.

If society is socially stratified in very general form into those with income and those without, health care can be regarded as reflecting the classes in our society. To this extent health is not treated as a right. Health care is not affordable, accessible nor available in the same manner to all social groups in our society.

## **Step IV**

### **Zimbabwe's General health indicators**

- Life expectancy at birth has fallen below 34 years for women (WHO, 2006)
- 1 in 5 Zimbabwean adults is living with HIV and AIDS (Zimbabwe DHS, 2005-2006)
- There are 1.8 million orphans and vulnerable children largely as a result of the AIDS pandemic (UNICEF).
- 1 in 12 children dies before the age of five: 82 per 1,000 births. Almost 40% of these will die in the first month of life. (Zimbabwe DHS 2005-2006)
- The lifetime risk of a woman dying of pregnancy or childbirth related causes is 1 in 16 or 6250 per 100,000
- 56% of the population lives on less than US \$1 a day whilst 80% live on less than US \$2 a day (Poverty Assessment Study Survey 2006).
- Since 2002 the World Food Programme has been distributing food. Numbers have varied; in 2003 more than 7 million people received food aid whereas in 2007 it was approximately 4.1 million.
- Primary school enrolment rates remain comparatively high for the region at over 90%. However completion rates have steadily declined since the late 1990s and were at 68% in 2004.
- 58% of married women use a form of modern contraception. (Zimbabwe DHS, 2005-2006)
- The nutritional status of under-fives has deteriorated due to food security. Underweight has increased to 17% as compared to 13% in 1999. (Zimbabwe DHS, 2005-2006)
- In 2001 almost 70% of the rural population had access to clean water in 2006 more than 30% of the water (DFID, 2008)

- Zimbabwe is the first country in Southern Africa to have reduced HIV prevalence. Prevalence fell from 20.1% to 15.6% over the past two years. (MoHCW 2007)
- Zimbabwean women use more female condoms than any other country.
- Over 500,000 Zimbabweans know their HIV status.
- The steady decline in child immunisation rates has been reversed and since 2003, increasing numbers of children are being vaccinated.
- Zimbabwe is expected to be declared polio free by the WHO within a short time.
- Contraceptive use is high at 60% and continues to increase helping parents to plan their families.

**Does the health status of different social groups and the population as a whole reflect a progression in their right to health and healthcare?**

In the Journal of Social Development in Africa (Agere, 1990, 5, 1, 31-38), a report on Issues of Equity in Access to health care in Zimbabwe, stated that uneven development which, as a result of colonial history and capitalist economy, differentiates society into urban and rural areas. The urban area has more and better health facilities than the rural area. This differentiation in the provision of services by geographical regions is not only found in health services but also in housing, transportation, education systems and other social services. Communication patterns and facilities make health or medical care inaccessible.

Although in many parts of Zimbabwe, there is still no transportation, nor roads leading to the nearest clinic or hospital, in some cases roads are available, but are impassable with the result that transport operators do not find it profitable to operate on such roads. In these remote parts of the country there are neither private doctors nor pharmacies, because they are always placed in areas where there is a huge capital from which they can make a profit. These private facilities have become very expensive for urban dwellers and there have been reports on National television news that recently people are moving from urban areas are now going to private mission hospitals in the rural areas to seek treatment.

Health in Zimbabwe is not adequately and equitably distributed to and consumed by all geographical areas and social groups. The problem is not only unequal access to health care, but also that the poor and the unemployed cannot afford good health care and are therefore worse off than any other group in society. **Look at the current stats of how many Zimbabweans are living below the poverty datum line.** This is despite the attempts that have been made in the last years to make health care accessible to all the people in the country. The quality of health, whenever and wherever it is offered, still differs by geographical region (urban and rural), by social class (those that have cash to pay for services), and to some extent by sex.

High quality medical care is that which utilises all the relevant knowledge and techniques available to the health sciences. The components of quality medical care are, therefore, the individual competence of medical care providers, the availability of the equipment and drugs, and the ancillary personnel required to perform the most effective preventive,

diagnostic, therapeutic and rehabilitative procedures, and the ability to gain the confidence of the patients and their cooperation with the demands of medical treatment. In examining the general measures of health, such as life expectancy, disease patterns, infant mortality rates, etc it is observed that the poor and the rural population are the most disadvantaged. Malnutrition, for example, is higher in the most remote part of the country, as well as in the poorer communities within the urban areas. These social groups are also vulnerable to periods of economic crisis such as drought, unemployment, inflation, poor housing conditions, etc. Check this and use Statistics. You can use the Operation Murambatsvina Stats too.

### **What is the Government doing to remove barriers to the enjoyment of health rights of the poor, minorities, and marginalized groups?**

The health situation in Zimbabwe is getting worse by the day. The political situation has resulted in no ministries running at the moment. There are no budgetary allocations for any government health programs for the coming year. No health recovery programs have been introduced to remove the barriers to the enjoyment of health rights by the poor or other marginalized societies. Health rights have not been enjoyed fully because of the food crisis in the country. The country has had its worst crop in 15 years and has failed to produce sufficient grain to meet the needs of its people. The World Food Programme (WFP) estimates that 5.1 million people will be food insecure between January and March 2009. The situation will be made more difficult by recent rises in world food prices. In addition, the impact of HIV and AIDS means that families who are already poor and vulnerable will be less able to deal with such difficult times.

The government has not done enough to curb the economic crisis which has shrunk the people's health purchasing power. Monthly inflation is over a million per cent, reported to be the highest in the world. Annual inflation is over 200 million %. Prices are doubling every two to four days. Gross Domestic Product (GDP) has fallen from US\$8 billion in 1998 to US\$4 billion today. External debt is US\$5 billion. Agricultural production has shrunk by over 50% since 1996. Gold production is at lowest levels for 90 years. Electricity is severely restricted, blackouts are common and water shortages last for days at a time in some areas. Basic food and fuel are difficult to obtain, and people are turning to the black market as a result of high prices. As a result of a combination of the above challenges, there has been gross violations of economic, social and cultural rights which include the every individual's right to enjoy the best attainable state of physical and mental health. The Zimbabwean government has failed to take the necessary measures to protect the health of its people and to ensure that they receive medical attention when they are sick.

The breakdown of the rule of law and the widespread disregard for economic and social rights by the government of Zimbabwe were thrown into stark relief in 2005 during Operation Murambatsvina. Evictions carried out under Operation Murambatsvina were marked by violence and violations of a range of economic, social and cultural rights including the right to adequate housing, the right to education, the right to work and the right to health and health care. Throughout Operation Murambatsvina, educational and health facilities were destroyed, school children were

displaced and denied access to educational facilities and people living with HIV had their treatment disrupted and discontinued.

During the operation, the government made few attempts to provide or facilitate priority humanitarian assistance to displaced vulnerable groups including children, female headed households, chronically ill and elderly people. Operation Murambatsvina disrupted access to medical treatment for a significant number of people living with HIV/AIDS. Scores of people living with HIV/AIDS lost their access to anti-retroviral treatment and home-based care. Six months after the evictions, many displaced persons living with HIV/AIDS were still unable to access anti-retroviral, tuberculosis or opportunistic infection treatment. Local NGOs working with those living with HIV/AIDS reported that they were unable to trace or reach many of their clients. (Amnesty International, 2006) Over two years after Operation Murambatsvina, thousands of people remain without adequate shelter and access to health care is a huge challenge. At a very minimum, the government of Zimbabwe has an obligation to ensure that those it rendered homeless during Operation Murambatsvina are re-housed and develop a comprehensive human rights-based health program to address the healthcare needs of all victims of Operation

## **Step V**

**What does the denial or fulfillment of the right to health in your country mean in practice?**

**Which of the core obligations are not being fulfilled?**

### **The right to health**

The right to enjoy the highest attainable standard of health is guaranteed by the ICESCR, CEDAW and the ACHPR.

General Comment 14 of the Committee on Economic, Social and Cultural Rights states that State parties must 'ensure the right to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups' The WHO country cooperation strategy document (2004-2007) reports that new indigenous farmers who were resettled on what used to be white commercial farms under the Agrarian land reform program have no access to basic health services because no new health facilities have been erected due to economic constraints and because of the political turmoil, it has been difficult for NGOs to run other services such as outreach services.

### **To ensure equitable distribution of health facilities, goods and services.**

Access to health cannot be limited on the basis of discrimination or cost. All people must be able to access health care, regardless of gender, ethnicity, sexual identity, poverty or other status. Zimbabwe's constitution does not guarantee the right to health but reference is made to health care. The government of Zimbabwe has failed to ensure that the most vulnerable members of society such as poor PLWHA are adequately protected through its user health fee exemption policies. Nor has it created more affordable health programs to increase effective access to health care for the increasing number of poor people living with HIV/AIDS. Restrictions that are not necessary such as those placed on CD4 tests and user fee exemptions that are often randomly applied and subject to review, violate the Zimbabwe's government's obligations to recognize and fully realize the right to health.

### **The right to information**

Access to information about HIV/AIDS has been reaffirmed as a human right. Article 21 of the ICCPR recognizes that everyone has the right to “seek, receive and impart information of all kinds.” Access to information is also essential to secure the right to the highest attainable standard of health and accurate information is necessary to allow persons to make decisions about their personal and private lives. Accurate information should be available, accessible, and in a format that is relevant to the target audience in order to ensure its maximum impact.

Taking these requirements into account, the government of Zimbabwe in order to meet its obligations, should be ensuring that people are informed that a CD4 count is not required to access ART, and ensuring that government hospital staffs are aware that the requirement of a CD4 count is not necessary to provide treatment. PLWHA cannot exercise their right to treatment if the government fails to inform them that a CD4 test is not necessary before commencing ART, and are barred by third parties from accessing ART without the test. The government must provide information to the public on the criteria for user fee exemption and on criteria for applying for informal trading licenses.

### **The right to work**

Article 23 of the Universal Declaration on Human Rights sets out that “Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.” This is articulated as a binding obligation in article 6 of the ICESCR which calls on state parties to “recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts...”

The government of Zimbabwe has an obligation to provide its citizens with opportunities to earn a livelihood in whatever field they choose including the informal sector because this empowers the people economically hence ensures access to healthcare. The right to work in the informal sector is especially important in the current environment of high unemployment in the country. The informal sector in Zimbabwe has grown dramatically since unemployment has been reported to have reached over 80%, however the government has not introduced any programs to guide its growth and success.

### **Women’s rights**

The UN Commission on Human Rights has emphasized “that violence against women and girls...increases their vulnerability to HIV/AIDS, that HIV further increases women’s and girls’ vulnerability to violence and that violence against women and girls contributes to the conditions fostering the spread of HIV/AIDS.”

According to the CESCR Committee, the failure to prosecute perpetrators of domestic violence, to discourage harmful traditional practices both in law and in fact, and to adopt a gender-sensitive approach to health, amount to violations of a state’s obligations under CEDAW.

The CEDAW Committee recommends that States “intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them.” The Committee further recommends that HIV/AIDS programs “give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and

their subordinate position in some societies which make them especially vulnerable to HIV infection.”

While Zimbabwe has made some efforts to incorporate the vulnerable position of women and children into its HIV/AIDS policies, has legislated against some harmful practices, and put in place laws that address domestic violence and sexual offences it has failed to incorporate key provisions of CEDAW to ensure their access to health and social services without discrimination. The government has also failed to adequately address the issue of property-grabbing that continues to take place despite amendments to inheritance laws, in clear violation of the human rights to nondiscrimination and equality under the law.

### **Right to housing**

The Universal Declaration of Human rights Article 25: ‘Everyone has the right to a standard living adequate for..... health and wellbeing of himself and his family, including food, clothing, housing, medical care and the right to security in the event of.....sickness, disability....Motherhood and childhood are entitled to special care....’ The Zimbabwean government has not achieved a practical realization of this right. Mass internal displacement, deteriorating healthcare system and escalating costs of drugs are compelling evidence of disregard for human rights.

### **Millennium Development Goals (MDGs)**

Zimbabwe is on track to achieve the MDG target on HIV and AIDS - to “have halted by 2015, and begun to reverse, the spread of HIV/AIDS.” Declining HIV prevalence from 18.1 % to 15.6% in 2007 is likely to be a result of high mortality rates and changes in sexual behaviour. Most of Zimbabwe’s other MDGs are unlikely to be achieved by 2015 unless the political and social situation improves dramatically. Child and maternal mortality indicators show a steadily worsening situation, exacerbated by HIV and AIDS and by a deteriorating health service.

### **Policy recommendations**

- **People centered health systems-** For health to become fairly distributed and consumed it needs to be democratized, and subjected to control representatives from those who work in the health sector (workers), those affected by the system (patients or consumers), and those chosen by the community and organized groups (for example youth, women and other interest groups). It is important for the government to realize that a fair health system is one which is accountable and transparent and has a greater degree of citizen control. When the people at the grassroots are involved in policy making processes, health resources are most likely to be distributed in line with the needs of the community served. The best people to decide on their priorities are surely the beneficiaries themselves.
- **Decentralisation-** One of the ways of making health care more accessible is to decentralise the decisions, resources down to the regions, rural areas and neighbourhood health care delivery systems which are more responsive to local needs. The professional staff working at a decentralised level is more likely to be perceptive of the norms and needs of the local residents. Decentralisation is not just concerned with the equalisation of resources, but also with responsibilities and facilities controlled at a local level. Within the health field, facilities such as

land, buildings, and manpower to build health centres, can be utilised. In decentralizing health services increased use is made of paramedical personnel, who are produced in greater numbers. A decentralised health system makes preventive work much more effective. If the locally recruited staff is elected by their communities to be trained, they are likely to be more accountable to the masses than to the bureaucracy. In a democratically decentralised system, the consumers are more likely to participate in decision making and in controlling their own health resources.

- **Environmental sanitation-** Many of the diseases that account for a major number of deaths among the people are those that are faecally transmitted. Food and water can be contaminated with human waste leading to such diseases as diarrhea and dysentery. To reduce these water borne and faecally transmitted diseases it is necessary to attack the cause by designing strategies and simple techniques of waste and water treatment.