Neither bad luck nor chance –

the health crisis in Zimbabwe in the context of human rights

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Summary

The right to health is a human right guaranteed by numerous international treaties and agreements. The present paper reports on the health situation in Zimbabwe over the last decade. Approximately 11 Million people live in Zimbabwe, of which there are about 1 Million orphans. Draw-backs and progress regarding major infections such as HIV and AIDS, tuberculosis, malaria, but also malnutrition and the situation for especially vulnerable groups (pregnant women, children, and prisoners) are presented. Major problems of the health sector are lack of resources and lack of health personnel such as doctors, nurses, pharmacists. The current dire situation of the health system can only be understood against the backdrop of the political situation. Therefore, in particular the obligations and failures of the government to fulfil, protect and respect the right to health is considered. While some progress has been registered in stabilization of the economy since the creation of the unity government in 2009, the continued violation of civil and political rights is undermining the country's ability to secure those gains, and may continue impacting seriously the right to health as well.

Keywords

Zimbabwe, human rights, right to health, health crisis, Zimbabwe Association of Doctors for Human Rights (ZADHR)

Zusammenfassung

Das Recht auf Gesundheit ist ein Menschenrecht, das in vielen internationalen Verträgen garantiert wird. Der vorliegende Artikel beschreibt die Situation im Gesundheitswesen im Simbabwe der letzten Jahre. Simbabwe hat etwa 11 Millionen Einwohner, darunter über 1 Million Waisen. Rückschritte und Fortschritte in Bezug auf die Hauptinfektionskrankheiten AIDS, Malaria und Tuberkulose einerseits, aber auch von Mangelernährung und der besonders schwierigen Lage für werdende Mütter, Kinder oder Gefangene werden vorgestellt. Die

Hauptprobleme im Gesundheitssektor sind Mangel an Ressourcen und die Auswirkungen der Emigration von unter anderem Ärztinnen und Ärzten, Krankenpflegepersonal oder Apothekern und Apothekerinnen. Die sehr schlechte Situation des Gesundheitswesens in Simbabwe lässt sich nur vor dem Hintergrund der politischen Situation verstehen. Daher werden in diesem Artikel insbesondere die Verpflichtung und das Versagen der Regierung angesprochen, das Recht auf Gesundheit zu respektieren, zu schützen und zu erfüllen. Während Fortschritte bezüglich der wirtschaftlichen Stabilisierung seit 2009 beobachtet werden können, bedroht die Missachtung und Verletzung politischer und bürgerlicher Rechte die Möglichkeiten, solche Fortschritte zu sichern, und es ist möglich, dass dies auch weiterhin ernsthaft das Recht auf Gesundheit gefährdet.

Schlüsselbegriffe

Simbabwe, Menschenrechte, Recht auf Gesundheit, Krise des Gesundheitssystems, Zimbabwe Association of Doctors for Human Rights (ZADHR)

"Health is not just a blessing to be wished for, but a right to be fought for."
Kofi Anan, Secretary General of the United Nations

Preliminary remarks

The right to health is enshrined in the 1948 Universal Declaration of Human Rights and has been incorporated into many subsequent international and regional covenants and treaties. Among the most important of these are Articles 11 and 12 of the International Covenant of Economical, Social and Cultural Rights (ICESCR), which guarantee these rights and oblige states to fulfil them[1, 2]. As early as 1946 the constitution of the World Health Organization emphasized the right to health which it defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[3].

[1] UN *Covenant on Economic, Social and Cultural Rights*, ICESCR, December 16, 1966. ratified by Zimbabwe May 13, 1991; full text can be found here: http://www2.ohchr.org/english/law/cescr.htm
Many of these and other important characteristics of the right to health are clarified in general comment N° 14 (2000) on the right to health, adopted by the Committee on Economic, Social and Cultural Rights.

[2] For a facts sheet about the right to health, see this document by the WHO and the UN High Commissioner for Human Rights http://www.ohchr.org/Documents/Publications/Factsheet31.pdf, ISSN 1014-5567.

[3] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

This paper looks at the right to health in Zimbabwe, a country stricken by political violence and the concomitant economic down-spiralling. The political and economic situation of the last decade has resulted in an unprecedented emigration of health workers and the breakdown of the health infrastructure of a country that was previously seen as a "shining example" among the African post-colonial states. I will give a brief overview of the current situation regarding communicable and non-communicable diseases, and look at man-made factors which threaten the right to health, exacerbating the often difficult situation regarding health care in a developing country with limited resources. In this article I would also like to acknowledge the heroic efforts of Zimbabwean doctors, nurses, and other health workers who have been insisting through their work and activities that the recognition of all human rights is the prerequisite and pivotal point in the implementation of the right to health.

1 Introduction

The current dire situation of the health system in Zimbabwe can only be understood if it is viewed against the backdrop of the political situation. Rhodesia, as Zimbabwe was called formerly, unilaterally declared independence from the United Kingdom of Britain in 1965 and eventually became independent in 1980 after 15 years of civil war. Robert Mugabe was elected prime minister soon after independence, and after a further period of internal fighting during which he orchestrated massacres ("gukuruhundi", at least 20.000 died) against his opponents he also became president in 1987 [4]. In the years immediately after independence Zimbabwe´s economy grew, substantially supported by the international community, and the government invested in the health care system (1). Zimbabwe became a prosperous country. However, the economy plummeted in the mid ´90s. The downturn was fuelled by the country's involvement in the war in the Democratic Republic of Congo and payments to 'war veterans'. In the early 2000s the government started a ‚land reform' by confiscating large commercial farms mostly, but not exclusively, from the ethnic minority of white Zimbabweans. Most of the land was turned into small, subsistence farming units for black citizens. In addition to the new owners' frequent lack of experience and investment power, the agriculture also suffered from a series of droughts in those years. This eventually precipitated a collapse in agricultural exports, traditionally the country's leading export-producing sector. Soon, the country had lost its main source of hard-currency and a hyper-inflation had set in. A chronic shortage of imported fuel and consumer goods followed, the poorer segments of the population being particularly hard hit. Opposition to the ZANU-PF party of Mugabe grew in civil organizations, unions and churches, and the so-called Movement of Democratic Changes (MDC) formed in 1999. A decade of unrest followed, with rigged elections, the use of severe oppression and violence against the opposi-

[4] For a detailed description of the history of Zimbabwe in this period please refer to literature such as Wikipedia, or Martin Meredith "Mugabe: Power, Plunder, and the Struggle for Zimbabwe's Future", ISBN-10: 158648558X.

tion forces and local human rights organisations, the brutally forced eviction of 700.000 people from the high-density suburban areas in Harare (operation "Murambatsvina" – "get rid of the trash" in 2005)[5], a mass exodus of Zimbabweans (about 25% of the population left the country), and a cholera epidemic in 2008, which killed several thousand people. Robert Mugabe finally consented to share power with the opposition and its leader Morgan Tsvangirai, and an agreement was reached. In February 2009 a government was formed and a new constitution is currently in preparation. This improved political framework has also led to some economic improvements. The Zim-Dollar was suspended in 2009 and the US Dollar is in use, preventing hyperinflation.

The health sector, like all other sectors in the country, has been severely affected by the economic melt-down and the political oppression of the last 15 years. Resources for the health system have become scarce; hyperinflation and sheer lack of bank notes have wreaked havoc with the salaries, including those of health personnel. By 2009, public hospitals were extremely short of or even lacked water, electricity, paper, drugs, gloves, bed sheets, syringes, needles, disinfectants, or operation equipment. In fact, hospitals were no longer functioning and had to turn away many patients, even those with life-threatening conditions. Moreover, the government took steps to prevent people who wanted to secure the right to health for all in this political turmoil from providing active and practical help. Lawyers and health personnel who wanted to assist and treat victims of political violence and torture were abused and persecuted. Humanitarian aid organizations were restricted in their activities or forced to observe discriminatory regulations. Foreign journalists who might have alerted the international community were thrown out of the country, the local press gagged by restrictive laws.[6] It is evident that under the leadership of Robert Mugabe the Zimbabwean government has actively refused to respect, protect and fulfil not only the right to health, but also the rights to freedom of discrimination, to freedom of expression, protection under the law and many others. Taken together, this has culminated in the extremely difficult health situation faced by the country today. The situation after 2009, i.e. the formation of the Government of National Unity (GNU) is described in chapter 4 below.

In what follows I will provide some facts on communicable and non-communicable diseases which illustrate the scope and complexities of the situation in the health sector in Zimbabwe. As has been done before, I will also emphasize that the poor health situation in Zimbabwe has not developed as a result of chance factors or ill fortune, but is to a large extent due to the government's failure to respect, protect and fulfil human rights. Indeed, the organisation *Physicians for Human Rights,* which shared the Nobel Prize for Peace in 1997, considers the situation in Zimbabwe to be a crime against humanity and recommended in

[5] www.amnesty.org/en/library/asset/AFR46/005/2006/en/61b5b38c-d3fc-11dd-8743-d305bea2b2c7/afr460052006en.pdf

[6] For instance, the "Access to Information and Protection of Privacy Act", which prevents media organisations from hiring unaccredited journalists; the "Public Order and Security Act", was widely used to prosecute critics of the government, president, his government and policies; or the "Broadcasting Services Act".

2009 that it should be referred to the International Criminal Court.[7] However, thus far this call has not been taken up by other NGOs.

Not all diseases are in the focus of the health research community to the same extent. Table 1 shows the numbers of scientific publications on various diseases in Zimbabwe. Most research has been concerned with HIV, which is certainly a major health concern. However, research on other issues of great importance for health policy development, such as malnutrition, water-borne diseases, or maternal mortality, have received comparatively little attention. Unfortunately, it is beyond the scope of this short paper to deal with all health issues. I have therefore chosen to focus on the "major killers" and on concerns related to the millennium development goals. I have had to leave out other aspects such as the health toll resulting from diabetes and the situation of the mentally ill. However, I have included information about health in prisons, because this is hardly ever mentioned or dealt with at all, despite the desperate situation in Zimbabwean prisons and the associated violations of human rights.

2 Health concerns abound

2.1 The "big three"

2.1.1 HIV and AIDS

Acquired immune deficiency syndrome (AIDS) is a condition due to the destruction of T cells by the human immunodeficiency virus (HIV). HIV is transmitted via blood and other body fluids. Homosexual and heterosexual intercourse are the main routes of transmission. Major routes of transmission can vary between countries. Mother-to-child transmission is possible during birth and is a major concern in Zimbabwe, in addition to heterosexual transmission. HIV infections can be managed with antiretroviral therapy; however, a chemical or immunological-based cure is not available. Untreated HIV infection leads to AIDS, with symptoms such as the development of certain cancers, opportunistic infections, wasting and ultimately death. Measures must be implemented to prevent the transmission of HIV and to ensure treatment of infected persons. In Zimbabwe necessary measures were delayed for many years by denying the tremendous scope of the issue. As a result of this policy of denial, Zimbabwe had one of the highest HIV and AIDS rates of the world, the prevalence in 1997 being estimated at about 29% HIV (2, 3). However, it must be noted that this may be an over-estimation, due to errors in data collection. Between 1999 and 2006 life expectancy at birth plummeted from 63 to 43 years, which was mainly attributable to an increase in mortality from AIDS in young adults. This high rate eventually led to efforts to prevent the spread of HIV. Both the government and the civil society, including the churches, promoted the generic "ABC message" (Abstinence, Be faithful, Condoms) and drew attention to the link between AIDS and risky sexual behaviour. In 2003 I talked

[7] http://physiciansforhumanrights.org/library/documents/reports/2009-health-in-ruins-zim-full.pdf

to primary school teachers who described how they had only recently started teaching their pupils the value of self-confidence and friendship, i.e. promoting an age-adapted concept of autonomy over one´s body. In 2007, the rate of infection with HIV was down to about 16%, with was partly due to the natural course of the epidemic (death of patients and increased emigration, especially among the young infected men), and also to a significant decrease in risky sexual behaviour, in particular a reduction in the number of sexual partners. Indeed, Zimbabwe fared better than neighbouring countries, and a recent analysis published in the *International Journal of Epidemiology* comes to surprising conclusions as to the underlying reasons (3, 4). Thus, implementation of programmes aimed at awareness-raising and changing risky sexual behaviour have contributed to the fall in prevalence. The success of the programmes was presumably also facilitated by the high levels of secondary education and a high marriage rate among urban men in Zimbabwe. According to the authors of the study, another factor appeared to be *shock,* as almost everyone was witness to the deaths of relatives or friends, making the threat of the disease tangible. Lessons learnt from Zimbabwe could also help to reduce the prevalence of HIV in other African countries. Despite this encouraging scenario, the fact that 15% of the population are infected means that an estimated 1.2 million children and adults (half of them women of child-bearing age) are in need of antiretroviral treatment (ART). Physicians for Human Rights reported in 2009 that only about 10% of these individuals had access to ART. This is the lowest percentage for any country in southern Africa (5) and no major programme has enrolled new patients. Indeed, in 2008 the government even illegally took huge sums of money donated by the Global Fund, although they were later forced by public outrage to return it.[8] Between 2003 and 2011, the Global Fund has donated about 200 Million dollars to HIV programmes in Zimbabwe.[9] The supply of drugs has become erratic, however, due not only to lack of funds, but also because dispensaries have been closed and medical personnel have left the country (see below). A recent study reported that health personnel can draw "strength and motivation from the dramatic physical and emotional recovery made possible by ART" (6). On the other hand, a huge deficit in resources, communication with the health ministry and training persists, especially in rural clinics (6, 7). Exacerbating the situation for most patients is the generally poor health situation of the population resulting from wide-spread malnutrition, uncertain food supplies, displacement, exposure to other diseases, and last but not least poverty. A ray of hope in this context is the fact that the maternal-to-child-transmission programme is achieving good results (Rutendo Bonde, ZADHR, personal communication), mainly due to foreign donors. Roughly fifty million dollars have been given by various international donors for the prevention of mother-to-child transmission and paediatric AIDS programmes, according to the Minister of Health and Welfare in a recent interview.[10]

[8] www.nytimes.com/2008/11/03/world/africa/03zimbabwe.html?ref=africa, http://www.medicalnewstoday.com/articles/128076.php, both articles last accessed May 13, 2011

[9] According to the website of The Global Fund, http://portfolio.theglobalfund.org/?lang=en, (accessed on April 4, 2011)

[10] www.swradioafrica.com/pages/qt100211.htm, transcript of an interview conducted by the journalist Lance Guma with Minister of Health Dr Henry Madzorera on Question Time on SW Radio

2.1.2 Tuberculosis

Tuberculosis (TB) is an infectious disease caused by Mycobacterium tuberculosis. It is spread via droplet infection, for instance by coughing or even talking. It is still a leading cause of morbidity in many countries, and very often an opportunistic infection in HIV patients (also called "people living with HIV and AIDS (PLWHA)"). A poor general state of health drastically increases susceptibility to TB, as do over-crowding in urban areas and poor sanitation. Malnutrition due to the ongoing food crisis in Zimbabwe, the HIV and AIDS epidemic and overcrowded urban areas are all contributing to a rise in tuberculosis (TB) infections in Zimbabwe, which has reached alarming rates.

Zimbabwe is among the 22 countries with the heaviest TB burden worldwide.[11] According to the World Health Organization's (WHO's) *Global Tuberculosis Control Report 2009*, Zimbabwe had an estimated 71,961 new TB cases in 2007, with an estimated incidence rate of 539 cases per 100,000 population. Treatment is possible once the disease has been detected. The Zimbabwe Association for the Rehabilitation and Prevention of Tuberculosis *(RAPT)* warned that TB was emerging as the major opportunistic killer of people living with AIDS and fast getting out of control. It is therefore very important to identify those who are infected. However, the Zimbabwe Tuberculosis programme National Reference Laboratory ceased operating for two years in 2008. Even before this, the detection rate was much too low, with only 27% of estimated cases being diagnosed. As an expert working with Zimbabwe's tuberculosis programme told a Physicians for Human Rights investigator in 2009: "The TB programme is a joke. The national TB lab has one staff person"[12]. The National TB Control Program (NTCP) has only recently gained new staff, with the support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. A policy is in place, but no figures on the number of treatments are available.

Nonetheless, efforts to fight the disease have to rely on donors, as the Ministry of Health and Children Welfare is not stepping in on the scale required and, if questioned, lament its own lack of funds. In 2008 USAID provided 1.6 Million $ for such programmes.[13] However, critical voices point to the government expenditure on the health of a single individual, namely Robert Mugabe, each of whose trips to Singapore for health checkups in 2010 and 2011 cost the state 3 million dollars (The Zimbabwean, online issue 23.03.11)[14]. In the light of this, the failure of the state to fund extremely urgent health measures appears more like a choice than a necessity.

Africa, published Feb 9, 2011

[11] www.irinnews.org/report.aspx?reportid=49466, accessed March 31, 2011

[12] http://physiciansforhumanrights.org/library/documents/reports/2009-health-in-ruins-zim-full.pdf

[13] www.usaid.gov/our_work/global_health/id/tuberculosis/countries/africa/zimbabwe_profile.html (accessed April 4, 2011)

[14] www.thezimbabwean.co.uk/index.php?option=com_content&view=article&id=38348:mugabes-health-costs-us-12m-in-4-months&catid=31:weekday-top-stories&Itemid=30 (accessed April 4, 2011)

2.1.3 Malaria

Malaria is an insect borne disease caused by the parasitic Plasmodium species. Its main symptoms are high fever, pain and general malaise. Currently, no immunization exists, but effective drug-based treatments such as artimesinin and quinine are available. Efforts to eradicate malaria such as the Roll Back Malaria Campaign started in 1998 by the WHO have not achieved satisfactory results so far. A major reason for this is the increasing resistance of Plasmodium falciparum to drugs (in Zimbabwe all malaria is caused by this species). Artemisinin combination therapy is currently the gold standard, however, it is much more expensive than less effective drugs, and the WHO has been accused of failing to fully implement good policies due to economic pressures (8). According to the latest WHO Report,[15] each year there are more than 225 million cases of malaria worldwide and 781,000 people die. The risk of contracting, suffering more severely from, or dying from malaria is higher in children, pregnant women and HIV infected persons. Indeed, world-wide the majority of deaths from malaria occur among young children in sub-Saharan Africa. As both exposure prophylaxis (such as mosquito nets) and treatment cost money, malaria is commonly associated with poverty. In 2010, fewer than 50% of households owned an insecticide-treated mosquito net, and fewer than 5% of young children sleep under them. Malaria is the leading cause of absence from work due to illness and thus constitutes a severe brake on economic development. According to the WHO, "In Zimbabwe, the number of confirmed malaria cases fluctuated between 16 000 and 117 000 between 2004 and 2009, partly because of changes in the number of cases examined by microscopy. It is therefore not possible to identify any trends in malaria incidence in Zimbabwe. There was a large decrease in the number of recorded malaria deaths in Zimbabwe between 2002 and 2009, while the total number of deaths reported from all causes appears to have increased over this time." (Malaria Report 2010, WHO)[13]. Again, as with TB and HIV, the correct identification of patients is hindered by poor access to laboratory-based diagnosis.[16] The underlying reason is the melt-down of the health infrastructure, which has only slowly been recovering since 2009.

2.2 The silent killer: Malnutrion

Nutrition is not often reported in the scientific literature as a health concern. In sub-Saharan Africa, 38% of children under five years of age suffer from chronic malnutrition or stunting (height-for-age z-score below -2 of an international growth reference[17]), and acute malnutrition or wasting (weight-for-height z-score below -2) affects 9% of preschool children (9). About one third of all children under three years are stunted and malnourished. The "under 5" mortality rate in Zimbabwe is 119 per 1000 live births, which

[15] www.who.int/malaria/world_malaria_report_2010/worldmalariareport2010.pdf

[16] It is important to realize that quality of statistics and numbers are likewise impaired by poor resources and patient identification.

[17] A *z-score* of 1 .0 equates to one standard deviation above the mean.

is very high. Malnutrition is a major cause of child mortality in developing countries (10). The situation is very serious, with more than 12,000 children under the age of five dying from malnutrition every year, according to the 2010 Zimbabwe National Nutrition Survey.[18] This high level of malnutrition will make it impossible to achieve the Millenium Goals for mortality among children. This was also recognized last year by Prime Minister Morgan Tsvangirai and government officials. Reasons for malnutrition in children are complex, including failure to breast-feed for long enough and lack of safe water and sanitation facilities (which are directly associated with water-borne diseases such as diarrhoea) and, of course, poor quality food. First and foremost, many children do not have enough food! It must, however, be realized that some food aid programmes were suspended abruptly two years ago due to political insecurity or discrimination. This has left children far more vulnerable in times of food shortages such as those looming in several Zimbabwean provinces due to drought and the rising cost of living. Indeed, basic foodstuffs have been out of reach for many households. A new situation analysis acknowledges these issues openly, which can be seen as an important step towards rectifying the situation (A Situational Analysis on the Status of Women's and Children's Rights in Zimbabwe, 2005 – 2010; authored by UNICEF and the Zimbabwean Government)[19]. Nonetheless, the government is not taking action on the basis of its own report. On the contrary, civil organisations such as Women of Zimbabwe Arise (WOZA) and human rights defenders who are trying to hold the government accountable and demand social justice and improvements in the health framework continue to be oppressed and face shrinking freedom of expression/media space. In fact, they often find themselves in prison. Amnesty International continues to raise these concerns and is being forced constantly to campaign on behalf of these human rights defenders.

2.3 Especially vulnerable groups

2.3.1 Maternal Health

Pregnancy is not an illness, yet many women die in labour or thereafter, e.g., due to a loss of blood or infections. Others die because preventable conditions that arise during the pregnancy are not treated. HIV and AIDS infections too often remain untreated and contribute significantly to maternal mortality. While maternal mortality has declined worldwide, the maternal mortality rate in Zimbabwe has quadrupled in the period between 1996 and 2005 and is far below the millennium development goals. This situation has worsened dramatically since November 2008, due to the closure of hospitals and many maternity services, the recently introduced obligatory fee of 50 US$ for antenatal screening and delayed and costly transport to the nearest clinic. Currently, the maternal mortality rate is 725 in 100,000 live births (the global average was 251 (221-289) per 100,000 live births in 2008. The millennium development goal is 174 by the year 2015 (11). Doctors,

[18] http://allafrica.com/stories/201007121062.html from July 10, 2010; (accessed April 4, 2011)
[19] www.reliefweb.int/rw/RWFiles2011.nsf/FilesByRWDocUnidFilename/EGUA-8F3S8H-full_report.pdf/$File/full_report.pdf

nurses and midwives were not paid for almost a year in 2008, and eventually left the country in large numbers; key equipment and supplies for delivery were not available. A total of 18.000 women each year require Caesarean sections. If they cannot have this surgery they may die. A major obstacle is the the fact that they have to pay fee of 50 US$ before receiving antenatal check-ups. This is prohibitively high for many women. Recent newspaper articles suggest that government officials recognize this issue. Deputy Prime Minister, Thokozani Khupe, called for a reduction of the maternity fees at local clinics. "We are working very hard to scrap user fees for ante-natal care, women can simply not afford to pay for national duty, a service to the nation. They should not be punished for being mothers," she said.[20] This may possibly have been mere political rhetoric, but it reiterates a misunderstanding that access to necessary health care is a mere moral obligation, in this case to pay for a service rendered by women, namely child-bearing, rather than a duty and obligation of human rights. Moreover, the government has failed to acknowledge that the economic crisis was and is government-made, and that the current framework of political oppression does little to improve the situation.

2.3.2 Orphans and vulnerable children (OVC)

The number of children in Zimbabwe orphaned by the deaths of one or both of their parents from AIDS and other causes is a staggering 1.4 Million children – almost every fourth child is an orphan. This is one of the highest rates in Sub-Saharan Africa. Even if the HIV pandemic is on the decline, the number of orphans will continue to rise for some years to come. Traditionally, orphans are taken in by relatives from the extended family, however, they are more vulnerable than "own" children, risk exploitation, or are the first to be denied education or inheritance rights. Orphaned children are more likely than non-vulnerable children to get diarrhoea and acute respiratory diseases and to be stunted and underweight. Surprisingly, this increased risk is not related to poverty, as shown by a study conducted in 2007. The effects on children whose mothers had died were even worse, reflecting a greater lack of care (12). Tragically, being an orphaned girl is even linked to higher risk of contracting HIV. As shown by study carried out in urban Zimbabwe, girls who have lost their mothers often initiate sex early and are less likely to have used a condom at first sex than children who still have parents (13).

2.3.3 Prisoners

Reviews of public health accord very little attention to and even less compassion for the situation in prisons. Prisons in Zimbabwe are beset by over-crowding, very poor sanitation conditions, shortages of blankets, soap and other articles, shortages of medicines and

[20] www.financialgazette.co.zw/national-report/7773-high-maternal-mortality-rate-robbing-nation.html, accessed April 4, 2011

severe food restrictions. Over-crowded prisons are breeding grounds for TB, a problem which prompted the WHO to issue guidelines for dealing with TB in prisons over a decade ago (14). Hunger is a reality in Zimbabwean prisons. A recent article by Jocelyn Alexander published in The Lancet begins with the sentence: "A bare struggle for survival, with food at its core, has come to define prison life in Zimbabwe". Describing the appalling conditions, the author continues with quoting gruesome statistics of deaths across Zimbabwe´s 40-odd prisons, which reaches well into the thousands (15). In a country where resources are spread to the limit, prisoners are the last in line. Denying food, safe water, toilets and medical care to prisoners constitutes grave violations of their human right to health and their right not be treated in an inhumane and degrading fashion. Officials sometimes justify these violations of the prisoners' right to health and food by stating that they do not deserve better treatment because they are criminals. This is, of course, quite wrong, as human rights cannot be forfeited and every human is a bearer of these rights. International human rights legislation is very clear: everybody has the right to life and health. Moreover, the cynicism of such excuses is evident as many prisoners have not even been tried, let alone convicted, or they may – rightly or wrongly – have been accused of petty crimes such as stealing small amounts of food. In the reality of Zimbabwean prisons a minor prison sentence can be tantamount to a death sentence.

3 The human rights-based approach to health

The right to health, i.e. the right to the highest attainable standard of health, obliges governments as first-line providers and protectors of human rights to take steps to ensure that such a standard of health is attainable. Such steps are to some extent spelled out in the ICESCR, for instance, in Art. 12(d): "The creation of conditions which would assure to all medical service and medical attention in the event of sickness". Public health both needs and profits from a human rights-based approach (16). The international community has developed means of achieving this in practice by determining proper indicators of progress. A human rights-based approach to health includes the establishment of proper legal frameworks, inclusion of stakeholders, the taking of steps to prevent and forbid discrimination and transparency of decisions (17). While resources and funds are certainly pivotal to achieving the right to health, many steps can be taken that solely require political will. Such steps are, for instance, preventing discrimination and facilitating roads of redress for victims of human rights violations, practising equity when handing out available funds and reporting vital statistics. Even for obligations requiring expenditure by the state, the funds can be used more or less efficiently. A human rights-based approach to health is described by the UN as "Health policy making and programming are to be guided by human rights standards" and "Elimination of all forms of discrimination is at the core of a human rights based approach".[21] The government of Robert Mugabe has failed flagrantly in this by wilfully

[21] www.who.int/hhr/news/hrba_to_health2.pdf (published 2010), accessed April 4, 2011
www.ohchr.org/Documents/Publications/FAQen.pdf (published 2006). Accessed April 4, 2011

destroying the economy and persecuting and discriminating against those not on its list of "friends".

3.1 The exodus of health workers

It is well known that there is migration of health workers in a global setting (18). The economic and political situation described in the Introduction has forced an unprecedented fraction – about one third – of the population out of the country in order to earn money, ensure an education for their children or flee from violence. Health workers have not been exempt from this movement; indeed, they can migrate easily because they are well-educated and much sought-after on the global job market (especially in Britain and other English-speaking countries). In 2008/2009 this exodus became critical. A few figures are given in Table 2. They illustrate the devastating impact this drain of skilled workers has had on the provision of health care. However, the economic situation was not the only reason for emigrating. Further contributing circumstances were the political oppression and abuse and torture of health workers who stayed and dared to keep their Hippocratic Oath and treat Mugabe´s political opponents (19, 20). Detailed descriptions of incidents in which doctors and nurses were beaten up and of reports that victims of violence had to be classified as "accidents" in order to be able to treat them at all ((20) and (21)) give a vivid picture of just how unbearable the situation became in these years and how the government wilfully drove away the human core of its health sector.

3.2 A shining example – doctors fighting human rights abuses

In 2002 the Zimbabwe Medical Association (ZiMA), the Ministry of Health, the Health Profession Authority, and the Medical and Dental Professions Council refused to take a stand and affirm the obligation of health professionals to respect and protect human rights. In response to this failure, 26 doctors formed the *Zimbabwe Association of Doctors for Human rights (ZADHR)* (1). ZADHR has now grown substantially and about 30% of all Zimbabwean physicians are currently members of the organisation. ZADHR[22] documents abuses and organizes protests and lobbies for the health sector in national and international forums. The organisation also aims to educate health professionals on human rights, based on the understanding that they are frontline witnesses of abuse and in a unique position to document and competently analyse instances of abuse. The founder of the organization, Dr. Douglas Gwatidzo, has himself been subject to interrogation and harassments (22). He was awarded the prestigious Jonathan-Mann Award for Global Health and Human Rights in 2009 for his work in promoting human rights and fighting for his patients. The work of ZADHR brought the health and human rights crisis to the attention of the world, as members liaised and networked with regional and international organisations in the field of

[22] www.zadhr.org

with health and human rights.[23] This resulted, for instance, in the passing of a resolution by the World Medical Association at its General Assembly in Copenhagen in 2007.[24]

4 Hope and challenges for the future

Most of the facts described above are derived from statistics published until the year 2009. It is now almost two years since a window of opportunity opened when the Government of National Unity (GNU) was formed, headed by Robert Mugabe and with Morgan Tsvangirai as Prime Minister. A constitution is being developed, using input from the civil society. This could include an extended Bill of Rights, including the right to health. Nonetheless, two years after the unity government was set up in Zimbabwe, Amnesty International was concerned about lack of progress in implementing key reforms to address the legacy of human rights abuses.[25] Hopes kindled two years ago that the unity government would put an end to a decade of human rights abuses two years ago, appear to have been ill-placed. In the run-up to new elections realistic fears of instability are widespread.

The Inclusive Government of Zimbabwe – led by the Ministry of Health and Child Welfare with support from UNICEF, the World Health Organization (WHO), and the World Bank – has launched the *Health Sector Investment Case,* a roadmap for reviving the entire health sector over the next three years. Speaking at the launch of this initiative, Minister of Health and Child Welfare Dr. Henry Madzorera said most of the challenges in the sector resulted from limitations of funds. According to the report "Keeping the promise: United to achieve the millennium goals", which was published by Labour and Social Welfare Minister Paurina Mpariwa in Harare in February 2011, the country is still far from achieving the millennium development goals; the user fees for pregnant women still exist and the per capita health expenditure is only 9 US$ annually. There is a tendency to blame sanctions imposed by the EU, which continues to be a major donor for Zimbabwe. These sanctions are a freeze on personal assets of senior members of government and other high-ranking officials, a ban on their travelling to EU Member States and an embargo on the sale of arms. None of this affects the health sector or has led health professionals to emigrate.

While some progress in the stabilization of the economy has been registered since the creation of the unity government, continued violation of civil and political rights is undermining the country's ability to secure those gains and may have a a grave impact on the right to health as well. Writing about the way forward for health in Zimbabwe a year ago Tood et al. (5) wrote: "A new opportunity now exists to rebuild the health-care system; its

[23] In 2009 they visited Amnesty International. A video interview can be found here: www.amnesty.org/en/news-and-updates/video-and-audio/demise-zimbabwes-health-system-2010-04-13

[24] www.wma.net/en/30publications/10policies/a29/index.html

[25] www.amnesty.org./en/library/asset/AFR46/002/2011/en/c4c077aa-f4d9-47ce-b644-134b3b8513ca/afr460022011en.html

success will be contingent on firmly re-establishing the principles of social justice, equity, and public participation." This is still true today.

5 Conclusion

The economic melt-down in Zimbabwe in the first decade of the 21st century was caused by inappropriate policies and massive human rights violations. The right to health has not been respected, protected or fulfilled by the government. The country still heavily relies on international donors to meet the needs of patients. Progress has been made in reducing the HIV and AIDS pandemic, but other millennium developmental goals cannot be met. Retention and return programmes for health professionals are needed. The country urgently needs a period of peace, economic growth and adherence to the rule of law.

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Zimbabwe in Numbers – 2009 statistics[a]

- Population 13 Million
- Life expectancy at birth 46 years
- Adult (15-49 yrs) HIV prevalence rate 14.6%
- Number of people living with AIDS 1.2 Million (half of which are women)
- Orphans 0-7 years old (all reasons) 1.4 Million
- Orphans (due to AIDS) 1 Million
- Government expenditure to health (1998-2008) 8%
- Life time risk of maternal death 1:42

[a] *taken from the UNICEF web page*

Table 1:
Number of hits found in PubMed searching for "Zimbabwe AND…" [a]

Search keyword	number of hits (hits excluding HIV)	Prevalence of disease in Zimbabwe
Human Rights	114 (79)	not applicable
Health and human rights [b]	74 (52)	not applicable
HIV	1066	15.3%
Cancer	336 (283)	283
Schistosomiasis/Bilharzia	229 (213)	
Malaria	192 (167)	8%
Tuberculosis	179 (89)	0.98%
Diarrhea	123 (100)	
Maternal mortality	122 (84)	

Malnutrition	113 (89)	
Hepatitis	79 (62)	62
Cardiovascular	77 (71)	
Diabetes	64 (60)	
Cholera	38 *(28 after 2008 outbreak))*	
Fistula	10 *(all before 1995)*	
Stunting	8 (6)	

[a] search done March 19, 2011 on http://www.ncbi.nlm.nih.gov

[b] for comparison, the same search for Botswana gave 29(11), and for Namibia 19 (11), for the Democratic Republic of Congo 35 (27)

Table 2: Vacancy levels for health professionals in 2008[a]

Profession	**vacancy level**
Physicians	68%
Nurse midwives	80%
Nurse tutors	60%
Radiographers	69%
Pharmacists	75%
Nutritionist	44%

[a] pers. comm. by Zimbabwe Doctors for Human Rights