

HUMAN RIGHTS BULLETIN

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The right to health in Zimbabwe

What the right to health entails

The right to health is the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health. This right is guaranteed not only by timely and appropriate health care but by also determinants such as access to safe and potable water, adequate sanitation, an adequate supply of safe food, nutrition and housing and access to health - related education and information.

This Human Rights Bulletin has been prepared against a background of the collapse of basic service delivery such as health, education and food in Zimbabwe. The aim of this particular Bulletin is to examine the collapse of the health system in Zimbabwe and to consider the Government of Zimbabwe's (GoZ) international obligations in terms of guaranteeing the right to health for its citizens, and the internationally accepted benchmarks that the Inclusive Government must aim to achieve to ensure the attainment of 'the highest standards of living' for all Zimbabweans.

The Right to Health and Zimbabwe's International Obligations

Zimbabwe is party to legally binding treaties such as the ***International Covenant on Economic Social and Cultural Rights*** (ICESCR) and the ***African Charter on Human and Peoples Rights*** among other treaties that observe the right to health. Article 12 of the ***International Covenant on Economic Cultural and Social Rights*** states that:

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Under the general obligations clause of Article 2 (1) of the ***International Covenant on Economic, Social and Cultural Rights***, a State Party is required to take legislative and other steps to the 'maximum of its available resources', with a view to achieving 'progressively' the full realization of the rights recognized in the Covenant, including the right to health. This means that the Government of Zimbabwe has a legal obligation to all its citizens to be concerned about their health needs.

Furthermore, the 1998 ***Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*** notes in Guideline No. 10 that "resource scarcity does not relieve States of certain minimum obligations in respect of their implementation of economic, social and cultural rights". Thus if the Zimbabwe government should argue that it is unable to meet its minimum obligations to the right to health for its citizens because of a lack of resources, it must at least be able to demonstrate that every effort has been made to use all resources that are at its disposal in an effort to satisfy those obligations.

Apart from these obligations, international law creates a number of legal obligations on every state to ***respect, protect, promote and fulfill*** the enjoyment of human rights by all those under its jurisdiction. The obligation to ***respect*** health rights requires the Government of Zimbabwe, and thereby all of its organs and agents, to desist from carrying out any discriminatory and retrogressive practices or sponsoring or tolerating any practice, policy or legal measure violating the rights of the individual to health. In Zimbabwe's case the responsibility to respect health rights

requires the State to refrain from such acts as sending away patients from health centres because they are members of an opposition political party.

Concurrently, the obligation to **protect** the right to health obliges the State and its agents to prevent the violation of any individual's right to health by any other individual or non-state actor. The Government of Zimbabwe, therefore, has a duty to protect its people by making sure that the privatization of health services does not interfere with access to such facilities by poor people, and that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct.

Clarifying what governments are not obliged to provide

The Committee on Economic Social and Cultural Rights in General Comment 14 (2000) clarified that ***the right to health is not to be understood as a right to be healthy***. The Comment notes that the aspirations to the highest attainable standard of health should be balanced between an individual's state of health and a state's available resources. Notwithstanding a state's access to financial resources or otherwise, a state cannot provide protection against every possible cause of human ill-health some of which can be as a result of genetic factors and the adoption of risky or unhealthy lifestyles by individuals. However, the GoZ is obliged in its provision of the right to health to guarantee the availability, accessibility, acceptability and quality of health services. These fundamentals are elaborated on below:

a) Availability – *Functioning public health and health care facilities, goods and services have to be available in sufficient quantities. These will include the adequate provision of safe water, hospitals, trained medical personnel receiving domestically competitive salaries and essential drugs.*

b) Accessibility – *All the determinants mentioned above have to be accessible in all dimensions, which include a guarantee to non-discrimination on any grounds be they political, or otherwise. Moreover, health facilities, goods and services must be within safe physical reach for all sections of the population even in rural areas. Health facilities and services must also be affordable to all citizens.*

c) Acceptability – *Health facilities, goods and services must be respectful of medical ethics, culturally appropriate as well being designed to respect confidentiality of those concerned.*

d) Quality – *Health facilities must also be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs, safe and portable water, and adequate sanitation.*

The collapse of health service delivery in Zimbabwe

Since 2000, the GoZ has failed to provide an efficient and effective basic health care system. A myriad of factors caused by poor governance and the collapsed economy have manifested themselves in the flight of qualified health workers, poor remuneration, insufficient funds for the Ministry of Health and Child Welfare to run health programmes, lack of drugs in health institutions, poor water and sanitation facilities right across the country and expensive, unaffordable health care. All these problems have culminated in various crises such as the cholera epidemic, the partial or complete closure of central referral and district hospitals, and the general collapse in the health delivery system.

The Cholera epidemic

The August 2008 cholera outbreak became the latest blow on Zimbabwe's ailing health delivery system. The epidemic caused a huge strain on the health facilities that were still functional. The World Health Organization estimates that as at the end of February 2009, 3 879¹ patients out of 83 631 cholera cases had died while the disease has now spread to rural areas where conditions

¹ At the time of printing this report, 8 April 2009, 4 182 deaths had been recorded.

in terms of access to health care are even worse and the death toll is likely to be higher than recorded. A person may get cholera by drinking water or eating food contaminated with the cholera bacterium. In an epidemic, the source of the contamination is usually the faeces of an infected person. The disease can spread rapidly in areas with inadequate treatment of sewage and drinking water. A large-scale outbreak of cholera was inevitable in Zimbabwe following serious problems with the provision of safe water and adequate sanitation in most urban areas for several years. Suburbs in most urban areas can go for months without a drop of water coming out of the taps. Others such as Mabvuku and Tafara have gone for years. Broken down sewerage systems and burst sewer pipes have resulted in raw sewage flowing daily in drainage systems and in the streets of densely populated residential areas.

After a period of denial and a deliberate violation of citizens' right to information, the GoZ eventually declared cholera a national emergency on 4 December 2008, four months after the outbreak began. This resulted in increased efforts to combat the outbreak by both international and local non-governmental organizations. However, the GoZ continued to flagrantly violate the right to health for Zimbabweans affected by cholera by making false pronouncements that were clearly intended to mislead people and the international community that the epidemic was over. On 11 December 2008, the government declared the cholera epidemic over. By failing to provide citizens with useful information about the epidemic the GoZ could be found in breach of the obligations as it gave people false information regarding the epidemic.

Closure of public medical institutions

The epitome of the collapse of the health delivery system was the closure of the major referral hospitals in Zimbabwe. First it was the closure of Parirenyatwa and Harare Central Hospitals and then other major hospitals countrywide. The Medical School stationed at Parirenyatwa Hospital, the major supplier of student doctors, was equally affected as it was shut down along with the teaching hospital. These two institutions are major referral centres thus their closure would affect a huge number of citizens seeking medical attention. With most small clinics that operate in the rural and urban areas functioning with the barest minimum of staff and supply of drugs, they too were as good as closed. Reasons that were given for the closure of the hospitals were, among others, lack of running water, toilets overflowing and non-availability of essential medicines and supplies. All these reasons point to the lack of seriousness on the part of GoZ to prioritize health service delivery in Zimbabwe. The closure of major public health institutions subjected patients (including the poor who have no access to foreign currency) to private medical care that was beyond the means of many Zimbabweans. Medical fees in private hospitals range from US\$200 cash for consultations to US\$3000 for operations such as Caesarean section.

“Dollarization” of the economy and health care in Zimbabwe

Since the Governor of the Reserve Bank of Zimbabwe's 10 September 2008 introduction of payment in foreign currency for certain services, many other services providers have sought licences to do so. What has transpired is that, the GoZ has proceeded to have the whole economy dollarized such that even health services are now being charged in foreign currency. This move has pushed health care beyond the reach of many Zimbabweans who do not have access to foreign currency. Both government and private hospitals and any other health institution are now charging in foreign currency with charges in local currency being determined on a daily basis in line with the prevailing exchange rate of the US dollar against the Zimbabwe dollar. In addition, virtually all pharmacies are selling their drugs in foreign currency. This is a huge blow to most Zimbabweans considering that only less than 10 % of the population has direct access to foreign currency. In any case, the exorbitant prices being charged by the service-providers also inhibit those who might have access to the foreign currency. This situation increases vulnerability for the sick especially those infected by HIV/AIDS as they need constant medical attention and medications which are now placed at restrictive costs.

Brain drain of health professionals

Over the past years, Zimbabwe has been experiencing a massive exodus of health professionals. Doctors, nurses and other medical professionals such as radiologists are leaving the country in search of greener pastures. These medical practitioners are leaving for countries such as the

United Kingdom, South Africa and Botswana. This massive exodus has resulted in most public health institutions being under-staffed with the remaining staff failing to cope with huge amounts of work. It is difficult to establish the number of health professionals who have left the country, but a previous study done in 2002 suggests that Zimbabwe was the United Kingdom's fourth largest supplier of overseas nurses then². That same study quoted the Minister of Health and Child Welfare saying that Zimbabwe was losing an average of 20% of its health care professionals every year and that 18,000 nurses had left since 1998. The rapid economic decline since this study was conducted, only suggests that the number of health professionals leaving the country has increased greatly.

The remaining health personnel usually serve in private hospitals where they are also overwhelmed with work which means that those patients who go to the Government hospitals will remain exposed to institutions which do not have adequate medical staff.

HIV and AIDS

The collapse of the health care delivery system has dealt a major blow to HIV and AIDS patients. Zimbabwe is one country in Sub-Saharan Africa that has a high rate of HIV prevalence. According to UNAIDS, Zimbabwe's HIV prevalence rate is 15.3% for those aged between 15 and 49. It is estimated that 1.3 million people are living with HIV in Zimbabwe and that 3 200 people die every week because of AIDS. The collapse of the health care system coupled with the dire economic situation in Zimbabwe, has caused huge suffering to HIV and AIDS patients particularly those who were on medication. Patients who are on Anti Retroviral Therapy are experiencing difficulties in accessing their medication due to the non-availability of subsidized drugs from the GoZ. People living with HIV/AIDS have special nutritional requirements which they cannot afford to meet in the current economic climate. They can no longer afford to have proper and sufficiently nutritious meals. This has resulted in a higher mortality rate for people living with HIV/AIDS as the inadequate nutrition further compromises their immune systems.

Recommendations

Under articles 16 and 17 of the ***Covenant on Economic Social and Cultural Rights***, States parties are expected to submit periodic reports to the Committee on Economic, Social and Cultural Rights within two years of the entry into force of the Covenant for a particular State party, and thereafter once every five years. These reports are to outline the legislative, judicial, policy and other measures, which States would have taken to ensure the enjoyment of the rights contained in the Covenant. States parties are also requested to provide detailed data on the degree to which the rights are implemented and areas where particular difficulties have been faced in this respect. Zimbabwe last furnished this Committee with a report in 1995. There is an urgent need to take stock of the realization of economic, social and cultural rights in general and the right o health in particular and report on the outcome to the ***Committee on Economic Social and Cultural Rights***.

On 30 January 2009, the Movement for Democratic Change (MDC) agreed to form an inclusive government with Zanu PF and the other MDC formation. This was a landmark decision as it gives impetus to the implementation of the Global Political Agreement signed by the political parties on 15 September 2008. There is a lot of work to be done by the inclusive government in terms of restoring the right to health of the Zimbabwean citizens. Below are core obligations and recommendations of which the inclusive government in Zimbabwe should take note:

- ensure the equitable and non-discriminatory access to health facilities especially for vulnerable and marginalized groups;
- ensure access to the minimum essential food which is nutritionally adequate and safe;

² See Abel Chikanda, 2005 *Medical Leave: The Exodus of Health Professionals From Zimbabwe*, Southern African Migration Project Series

- ensure access to basic sanitation and an adequate supply of safe and portable water;
- provide essential drugs to take measures to prevent, treat and control epidemic and endemic diseases;
- provide education and access to information on health problems affecting communities including methods of preventing and controlling them;
- adopt and implement a national public health strategy and plan of action which includes health indicators and benchmarks by which progress can be monitored.

Ends//

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