ZADHR News

ZIMBABWE ASSOCIATION OF DOCTORS FOR HUMAN RIGHTS

zadhr@mweb.co.zw Volume 7, Issue 4 October 2009

Human rights education in medical education

"The protection and promotion of human rights is perhaps one of the most effective means of promoting health and human well-being."
- Human Rights and Health: The Legacy of Apartheid (American Association for the Advancement of Science and Physicians for Human Rights)

Health and human rights are essentially linked. The focus of human rights is the promotion and protection of the dignity of human beings while health is concerned with their physical and mental wellbeing. It is impossible to achieve one without the other. Consequently health professionals should also be equipped with knowledge on human rights during their training.

Although Zimbabwe has a long history of human rights violations predating independence, medical and other health professionals have not actively taken up these violations and their impact on the physical and mental wellbeing of their patients. This has largely been the result of a lack of understanding of the link between health and human rights, the role of health professionals in promoting both and a misconception that involvement in human rights is equivalent to involvement in party politics.

As the World Health Organisation (WHO) definition of health aptly points out, health is not just the absence of disease. It is a state of complete physical, mental and social well-being. The education of health professionals should therefore focus on more than just morbidity and mortality if their practice is to be about more than just the indifferent application of clinical skills.

Human rights provides a useful lens for examining the social, economic and political issues that affect human beings and how this impacts their health. Health professionals will, through human rights education, gain a better understanding of the social causes of ill health and death and the role they can play in addressing these.

As human rights has an essential contribution to make to the manner in which heath professionals carry out their work, it is a subject that should be taught to health professionals and on which they should be examined. Human rights education should also be a required component of continuing medical education for the benefit of those who have not received this education at the start of their careers so that health professionals are kept abreast of developments in the field of human rights.

South Africa's Truth and Reconciliation Commission (TRC) found that, under apartheid, health services in South Africa were delivered in a discriminatory manner and that training of medical professionals was also discriminatory. The TRC concluded that the absence of human rights training in medical education left health professionals ill-equipped to address these human rights violations. Under apartheid there was little or no documentation of the widespread human rights violations, with health professionals remaining silent about widespread torture of political detainees. The racial

Medical students from the University of Zimbabwe Medical School participating in and Health and Human Rights Training Workshop for medical students held by ZADHR and Physicians for Human Rights in September 2008

Inside this issue:

Saturday 28 November 2009

Workshop on A Human Rights Approach to HIV/AIDS
— Crowne Plaza Monomotapa Hotel, Harare — 8:30am to 4:00pm —
Speakers include Mark Heywood, AIDS Law Project, South Africa and
Dr Nelson Musoba, Acton Group for HIV/AIDS and Human Rights, Uganda

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disparities in poverty, illiteracy, unemployment and other social determinants of health also received little attention. The TRC believed this could have been different had the health practitioners had some training on human rights.

In its report of 1998, the TRC recommended that ***'training in human rights be a fundamental and integral aspect of all curricula for health professionals. Knowledge of and competence and proficiency...should be a requirement for qualification and registration."***

Ultimately health professionals are frontline witness of respect for or violation of human rights. They are likely to be one of the first people to encounter the victim after a violation. Whether they are a patient suffering from cholera as a result of a lack of access to adequate sanitation and safe water, or a patient who has sustained a fracture as a result of torture, the health professional is often a first point of contact.

The health professional therefore has an attendant responsibility of calling attention to human rights violations when they occur and working to put and end to them. Health professionals cannot be expected to do this if they have not been equipped with the necessary knowledge. Health professionals must be educated on human rights, how to play a role in promoting and protecting them and how to recognise and respond to violations of human rights when they occur.

What is the way forward for health in Zimbabwe?

Charles Todd, Sunanda Ray, Farai Madzimbamuto, David Sanders

(This article was first published online in The Lancet www.thelancet.com on 13 October 2009 DOI:10.1016/S0140-6736 (09)61498-7)

Zimbabwe's Government of National Unity (GNU), established on Feb 13, 2009, faced immense challenges: a collapsed economy with 94% of the population without a job[1] and almost 50% needing food aid;[2] a severe cholera epidemic;[3] HIV/AIDS prevalence of more than 15% in adults aged 15–49 years;[4] and a collapsed health system.[5] The GNU responded to the issues of the health sector by holding an inclusive summit and adopting an ambitious 100-day recovery plan for the health sector.[6,7] Here, we describe the recent health crisis and its causes, and make proposals for an effective and sustainable health system.

Zimbabwe was once a beacon of hope in Africa, improving health tremendously after independence in 1980. A declining national income, a huge national debt, economic structural adjustment, recurrent droughts, widespread HIV/AIDS, and a weakening health system all contributed to the deterioration of Zimbabweans' health since 1990. Between 2000 and 2005, the gross national income (GNI) per head declined by 54%.[8] The latest estimate of US$340 places Zimbabwe among the world's poorest countries:[9] all the income gains of the past 56 years have been wiped out.[10] Economic decline has driven the exodus of Zimbabweans, with over 3 million of the total population of 13·5 million estimated to be living outside the country;[11] the funds remitted by them are the main source of income for many families. For those having no access to external funds the situation is dire.

Between 1990 and 2006, life expectancy at birth plummeted from 62 to 43 years, mostly from increased young adult mortality from HIV-related conditions.[12] Mortality rates of children younger than 5 years and infants rose from 77 and 53 per 1000 livebirths in 1992 to 82 and 60 in 2003, respectively.[13] Maternal mortality rose from 168 per 100 000 births in 1990[14] to 725 per 100 000 in 2007.[15] Tuberculosis incidence increased from 136 per 100 000 in 1990 to 557 per 100 000 in 2006.[16] These indicators are related to the high prevalence of HIV/AIDS, which was estimated at 26% in 2000 in adults aged 15–45 years but declined to 15.3% by 2007.[4] In 1994, 80.1% of children aged 12–23 months had received all basic vaccines compared with 74.8% in 1999 and only 52.6% in 2006–07.[13] By early 2009, hospitals in the country were hardly operating, with massive shortages of essential medicines and supplies.[5] Although most hospitals are now functioning again, shortages are still commonplace and patients usually need to buy medicines, intravenous fluids, and sutures. Women delivering in rural clinics must bring candles, cotton wool, methylated spirit, gloves, and even fresh water. The physical infrastructure of most government health facilities is decrepit, and ambulances sparse.

The recent cholera outbreak further exposed Zimbabwe's collapsed infrastructure and its health system. Between August, 2008, and July, 2009, 98 591 suspected cholera cases were reported, including 4288 deaths.[17] The epidemic resulted from the breakdown of urban water and sanitation systems, leading to contamination of piped water and shallow wells.[5] The case-fatality rate peaked at almost 6%,[3] greatly exceeding the 1% WHO norm, indicating the weakened health system and poor access in rural areas.[5]

Total health expenditure per head fell by 56% between 2000 and 2005 to $21, of which $9 was government expenditure.[12] External funding contributed 21% of total health spending, a low proportion compared with that in most African countries. Under the previous government, which was led by Zimbabwe African National Union-Patriotic Front (ZANU-PF) party, bilateral donors channelled funds to specific activities such as HIV programmes and family planning. Therefore, 58% of currently married women use modern contraceptive methods,[13] and about 100 000 people were receiving antiretroviral treatment by the end of 2007.[4] However, antiretroviral treatment coverage at 17% is the lowest of any country in southern Africa, with an estimated 570 000 people needing treatment.[4] Furthermore, HIV-positive patients displaced by political violence and those affected by stock-outs of common AIDS

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medicines or closure of treatment facilities have been unable to re-establish treatment.[5]

In 2005, Zimbabwe was losing an estimated 20% of its health-care professionals every year; 18 000 nurses have left since 1998.[18] Although some heroically continued to work for minimal rewards, by the end of 2008 many had stopped working. By this time, a government doctor's salary had fallen to less than $1 per month.[5] Many health workers witnessed violence and some were harassed for treating victims of violence.

Health training in Zimbabwe has suffered badly and the country's principal medical school—the College of Health Sciences of the University of Zimbabwe in Harare—closed from November, 2008, to May, 2009. Only 40% of academic posts are filled; Bulawayo's new medical school faces even greater staff shortages. Nursing and midwifery schools struggle with 60% of nurse tutor posts vacant.[7]

Disregard for human rights has long featured in Zimbabwe's history. After the elections in March, 2008, thousands of people were beaten or tortured in an attempt to subdue support for the opposition.[19] Political abductions and intimidation continue despite the establishment of the GNU. National recovery cannot take place without addressing human rights and ending the culture of impunity.

To restore Zimbabwe's health sector, the priority must be to meet the population's most urgent health needs by re-establishing well-managed primary health-care programmes within functioning district health systems, providing cost-effective essential services such as immunisation, integrated care of sick children, nutrition programmes, maternity services, improved management of tuberculosis, malaria, and sexually transmitted infections (including HIV/AIDS), and basic curative care including surgery. Inter-sectoral work addressing determinants of health and involving agriculture, education, water, and sanitation should again become a core activity of district health systems.

Zimbabwe's macroeconomic situation is critical with a national debt exceeding $3 billion.[1] Therefore, initially funds for the health sector should come from donors. The UK, the European Union, the USA, other bilateral donors, the Global Fund, and UN agencies are all providing substantial funding that now includes retention allowances for health workers, essential drugs, vaccines, laboratory supplies, and HIV commodities. However, a substantial increase in funding will depend on clear progress of political and human rights, improved transparency, and an end to economic mismanagement and corruption.

Implementation of the 100-day health action plan[7] has led to the return to work of health workers and health facilities are functioning again. There is a renewed sense of hope. 2 million children were vaccinated in June, 2009, through national immunisation days. The cholera epidemic is finally under control.[17] The 50% decline in HIV/AIDS prevalence over the past decade should soon translate into reduced AIDS-related deaths.[4] Although mortality of children younger than 5 years has increased, it remains low compared with that of other countries with similar GNI.

Priority must now go to the re-establishment of essential services such as effective emergency obstetric care in all districts. This challenge will mean refocusing the work of central and provincial hospitals to providing secondary health care. Presently in the public sector, specialised services such as cancer care, dialysis, and advanced imaging are unaffordable. An early policy of the GNU was to impose substantial foreign-currency user fees at government hospitals[6] to generate funding for health services. Accepting that cost-recovery initiatives frequently disadvantage the poorest people,[20] the Ministry of Health is now reviewing such fees.[7]

Although Zimbabweans inside and outside the country are more optimistic now, many believe that tangible, universal health and social improvements will only follow radical change to the current political dispensation. Recent South African humanitarian assistance worth $30 million, which was meant for agriculture inputs, went mainly to areas loyal to ZANU-PF.[21] The new Minister of Health has to establish greater accountability and commitment within the public health service and revitalise the former sense of collective responsibility among health workers. Zimbabwe built a strong human resource base after independence, and the expertise and dedication of the health workforce was key in achieving and sustaining Zimbabwe's health service. Challenges that must be addressed include: attracting back health workers who have emigrated, improving the role of mid-level health workers such as clinical officers, ensuring the quality of health training, and providing continuing education to the existing workforce.

During the recent political upheavals, civil society groups were fundamental in highlighting health and human rights abuses. During Operation Murambatsvina (drive out trash) in 2005,[22] the effects of evictions in Zimbabwe were documented by civil society organisations; their reports and satellite pictures appeared on websites around the world, resulting in an international outcry at this destruction. Consequently, the UN appointed a Special Rapporteur to investigate the situation.[23] Similarly, the cholera epidemic was predicted by a residents' association monitoring water supplies and refuse disposal. Human-rights organisations, such as the Zimbabwe Association of Doctors for Human Rights rather than professional groups, such as the Zimbabwe Medical Association, emphasised the serious breakdown in health services. The Community Working Group on Health, a network of 35 organisations promoting equitable and accessible health care through local community mobilisation,[24] has remained active throughout. These groups should be full and active partners in remodelling the health system.

There are examples of doctors who help poor people by running clinics from their homes and dispense drugs donated by friends abroad. This spirit of volunteering is crucial to encourage bridge-building with excluded communities. Communities need a mandate and resources to actively participate in primary health-care activities, and thus hold government accountable for the quality of services.

We therefore suggest the following priorities for restoring Zimbabwe's health service and health training institutions:

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- The Ministry of Health, together with leading civil society groups, UN agencies, and donors, should evaluate implementation of the 100-day action plan[7] and craft a budgeted, medium-term health-care recovery plan including priority actions to tackle Zimbabwe's major health issues. The focus should be the re-establishment of district health systems based on primary health care. International advocacy is needed to rapidly secure substantial resources of the Global Fund to fight AIDS, tuberculosis, and malaria already earmarked for Zimbabwe[25] and other global health funds.
- The Health Services Fund—originally established in the 1990s to retain user fees at local level and later used for increased donor support to district health services—should be resuscitated. This would provide directly accessible funds for district health teams to maintain effective health services. The Health Services Fund should be jointly managed by the Ministry of Health and donors to ensure its probity and accountability. Donor funding will start flowing for strengthening the health system, and, with the joint planning process, catalyse a sector-wide approach in health.
- The training of specialist mid-level workers (ie, clinical officers and nurse anaesthetists) should be rapidly restored and expanded, taking the lead from Malawi and Mozambique where such workers perform key frontline health functions.[26,27] The existing health workforce cannot meet Zimbabwe's needs so any resistance to specialist mid-level workers from professional associations must be overcome. Similarly, the once successful Community Health Worker programme needs reorganisation and expansion to ensure community coverage.[28]
- The return of health professionals to Zimbabwe should be encouraged, but without disadvantaging those who have remained. Diaspora groups, including regional and overseas institutions, already supporting training institutions and health service provision, should be part of a dialogue with the Government and Zimbabwean health professionals. The Government must remove bureaucratic hurdles to the return of professional Zimbabweans, such as the time-consuming and costly registration process.
- The Ministry of Health should continue to promote an inclusive and cooperative ethos. Voluntary organisations and missions should be further supported. Civil society organisations involved in health should be formally recognised, and their advocacy of human rights and monitoring of donor funds encouraged.
- The political will to tackle the deep-rooted culture of violence and impunity should be nurtured and translated into legislation, including the establishment of a Healing and Reconciliation Commission and permitting human rights' organisations to run programmes for community-based mental health care of survivors of organised violence.

Zimbabwe's once proud achievements in health have been undermined over the past 20 years by increasing poverty, bad governance, poor economic policies, widespread HIV/AIDS, and a weakened health system. Success in the 1980s was built on widespread community mobilisation accompanying a protracted struggle for human rights. Since then, Zimbabweans have been systematically deprived of these rights, including the right to health. A new opportunity now exists to rebuild the health-care system; its success will be contingent on firmly re-establishing the principles of social justice, equity, and public participation.

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Prison Health Protection Programme

Training on health and human rights in prisons

The Prison Health Protection Programme aims to raise awareness of the health and human rights among prisoners and prison staff and to work towards increased realisation of access to health care and social determinants of health within the prison system.

A pilot of the Prison Health Protection Programme commenced at Harare Remand and Harare Central Prisons 24 August 2009 and will run through to the end of November 2009. During the first 5 weeks of the programme, training sessions on the right to health were conducted for prisoners. This included an introduction to human rights in general and the right to health in particular. Inmates were also provided with a forum for discussion about the challenges they face in realising the right to health in prison. Inmates participated enthusiastically in the trainings and expressed an interest in further training on the subject.

ZADHR Programme Assistant, Calvin Fambirai, speaking to inmates at Harare Central Prison about the right to health

On the 13 and 14 October 2009, ZADHR conducted a training for staff of the Zimbabwe Prison Service (ZPS) from the 2 prisons under the title **"The Right to Health—Opportunities for Zimbabwe's Prisons".** Two groups of officers were trained each day including middle management, rehabilitation and medical staff from Harare Central and Harare Remand Prisons and senior health and administrative officials from Mashonaland Region.

The International Federation of Health and Human Rights (IFHHRO) "Stepping into Human Rights" introductory board game was used as a training tool for participants to grasp basic human rights principles and facts about the right to health. This interactive tool was an effective means of demystifying human rights and received positive reviews from participants.

The Prisons Act [Chapter 7:11] is the chief law governing operations in Zimbabwe's correctional institutions. Ms Tecla Ponde of the Zimbabwe Association for Crime Prevention and Rehabilitation of the Offender (ZACRO) facilitated a session to examine this legislation and to analyse the efficacy of the Prisons Act as a tool for the protection and fulfilment of the right to health.

Participants reviewed the provisions in the Act related to health care and the determinants of health and whether these complied with basic principles of the right to health. Participants felt that although the policy framework could be improved upon, the lack of implementation of the law already in place was the main reason the right to health was not being realised in prisons. A lack of resources and high vacancy rate were cited as major limitations in meeting minimum standards. For example, erratic supply of stationery makes it difficult to consistently keep medical records for inmates in the prisons. The reasons cited above also resulted in exit medical examination not being conducted at times although this is a requirement under the Prisons Act.

Participants were then taken through international instruments relating to penal reform by Tawanda Zhuwarara of Zimbabwe Lawyers for Human Rights (ZLHR). *The UN Standard Minimum Rules for the Treatment of Prisoners of 1955 (SMR)* gives guidelines for minimum standards for hygiene, adequate food and nutrition, clothing which preserves dignity and medical care. Further detailed provisions for protection and fulfilment of the human rights of prisoners can be found various other international and regional instruments including the *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988)* and *the Basic Principles for Treatment of Prisoners (1990).* However, the SMR set down basic fundamental human rights principles which countries should comply with in their national legislation and practice. While it may not be possible to implement all the minimum standards set out in the SMR immediately, prison systems should at all times be working to improve policy and practice to achieve these standards.

UNAIDS has identified prisoners as one of the four ***"major at-risk and neglected populations"*** in the HIV/AIDS pandemic (2006 Report on the Global AIDS Epidemic). The gaps in policy and practice in terms of HIV/AIDS management in Zimbabwe's prisons were reviewed and identified as an area requiring urgent attention. While ZPS is providing anti-retroviral therapy for infected staff and inmates, the problems of inadequate nutrition and inadequate psycho-social support following voluntary counselling and testing need to be addressed. Participants suggested that ZADHR set up a policy dialogue on HIV/AIDS, human rights and prisoners involving officials from the Zimbabwe Prison Service, Ministry of Health and Child Welfare, health professionals and other interested stakeholders.

If you are interested in participating in a policy dialogue around HIV/AIDS, Prisoners and Human Rights please contact ZADHR on (04) 703430 or 0913254295 or info@zadhr.org

Harare Students and Junior Doctors Workshop Report

Human Resources for Health: A Rights' Based Approach

The workshop was held on the 29 August 2009 at Bronte Hotel in Harare and attended by 50 junior doctors and medical students. A summary of the presentations and recommendations made by participants follow below:

Health Systems and Right to Health Approach: A Framework for Thinking: ***Primrose Matambanadzo.***
The World Health Organisation defines health systems as ***"all institutions, people and actions whose primary intent is to promote, restore or maintain health."*** Human resources for health (HRH) are a key element of the health system and are frontline witnesses of the progress in achievement of the right to health. For enjoyment of the right to health - enjoyment of facilities and conditions that are necessary for good health – it is necessary to have an effective and integrated health system with human resources for health of adequate number and skill.

Examining Factors Aggravating the Degraded State of our Health System and their impact on Human Resources for Health: ***Dr Nemache Mawere***
A racially biased health system that was overly dependent on Mission Hospitals to serve the bulk of the population was inherited at independence. A primary health care approach was adopted in the mid 80s which yielded results with a good referral system in place, increased community participation and lowering of indicators.

Allocation of resources for health was reduced during the years of ESAP and in the mid to late 1990s further pressuring a health system struggling to cope with the added disease burden of HIV/AIDS. This period was also fraught with frequent strikes by health workers which were met with a harsh response and dismissals by the government. Brain drain, especially of nurses sharply increased in the late 1990s, with further massive exodus of health professionals in the early 2000s. The departure of teaching staff from the Medical School impacted the quality of medical education. This was mirrored by an increase in intakes in a bid to replace lost human resources with newly trained cadres.

During the last decade strikes by health workers became even more frequent. The situation came to a head at the end of 2008 when hospitals were forced to close as was the University of Zimbabwe's Medical School.

Zimbabwe's Medical Training: Challenges and opportunities: ***Perspective of the lecturer: Prof. Chidzonga (Dean of the College of Health Sciences)***
Currently the intake into medical school is around 200 students per year for facilities that can accommodate only 60 – 80 students. This is mainly an attempt to address the shortage of doctors in the country.

Laboratory space is too small for the number of students and clinical teaching is minimal. Furthermore, there is no transport for students thus consuming some of their time travelling on public transport. Vacancy rate of up to 100% has been seen in some departments within the institutions. Salaries for lecturers are quite low thus low morale among lecturers.
Upon graduation more than 90% of the trained doctors leave the country and this further worsens the situation of depleted human resources for health in the country.

Zimbabwe's Medical Training: Challenges and opportunities ***Perspective of the cadre: Dr. Chizhande (President, Hospital Doctors Association)***
The medical training has been marred by brain drain and collapse of the health system. Final year students at the medical school complain that some of their lecturers fail them unjustifiably.

There is little mentorship for the junior doctors and conditions of service are quite poor and the remuneration is pathetic. Grievances are not addressed in a timely manner contributing to frequent strikes. Punitive measures such as bonding should be avoided with the focus on improving conditions of service to retain staff.

Human Resources for Health: Strategies for Retention and Development: ***Mr. Sande Director (Condition of Service and Industrial Relations –Health Services Board)***
The following remedies have been embarked on to retain and develop Zimbabwe's human resources for health:

- Lobbying for 15% of the national budget to be allocated to health
- Limiting bureaucracy by resuscitating of Health Management Boards and decentralising of decision making to enhance efficiency;
- Providing accommodation (institutional accommodation and an affordable housing scheme);
- Providing transport (affordable transport for, car loan schemes and duty free certificates for health professionals);
- Defining career pathways after training
- Dialoguing with health professionals in and outside the country

Recommendations

- The Dean should facilitate the resuscitation of the medical students association, which was banned some time ago, as a channel for students to air their grievances.
- The Dean should investigate allegations that some lecturers who are failing final year students unjustifiably.
- There is need to standardize final year examinations as is the case with Part 3 exams.
- Housemanship should be standardized to levels comparable to those in the SADC region.
- Bodies representing health professionals should speak with one voice in raising concerns with the functioning of the health system.
- Grievances by health professionals should be resolved amicably without fear of losing employment.
- Strategies should be put in place to encourage specialisation as there are a few specialists in the country at the moment.
- The HSB should focus on improving working conditions for health personnel to retain them instead of taking punitive measures such as an unnecessarily long bonding period.

Contact Us

If you have any comments or stories related to health and human rights issues that you would want to share with ZADHR please contact us on:
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Produced with support from AusAID