Contributions of Local Authorities to the Realisation of Human Rights in Zimbabwe: The Case of Bindura Rural District Council (BRDC) and the Right to Health Care

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Abstract

The paper examines the contributions of rural district councils towards the realisation of the right to health care in Zimbabwe. Conventional literature has predominantly focused on the contributions of the central government and challenges it has faced in fulfilling the right to health care. However, little is known about the obligations that local authorities as the agencies of the central government have concerning the realisation of this right. The paper aims to fill this gap by focusing on the extent at which BRDC has respected, protected, and fulfilled the right to health care among the rural people in Bindura Ward 16. A mixed methodology was adopted for the study based on a human rights approach. Data emerging from a literature review, in-depth interviews and a survey, demonstrate that the majority of the rural people are aware of health care issues but have little knowledge on the right and the obligations that local authorities have. Despite the limited knowledge, the findings show that the BRDC has played a complementary role to the central government through the construction of the Chiveso clinic, management of the infrastructure, and roads leading to the health point. The central government has provided financial resources, solar power, medicine, and personnel for the clinic. These contributions are worth celebrating as they indicate the milestones that both central and local authorities have achieved with regard to the right to health care in Bindura. Respondents noted that the BRDC has, to some extent, not been effective in contributing towards this right. For example, people still walk long distances to access health points, poor road networks, and critical drugs are scarce. Such factors compromise the quality and accessibility of health care that people are entitled to. The challenges faced by the BRDC cannot be separated from the general macro-economic challenges of the central government. This paper exemplifies that there is need for additional funding towards the BRDC for it to effectively contribute towards the right to health care. Instead, the rural people of Bindura need awareness campaigns concerning the right to health care in order to improve public accountability.

1 Introduction

The 21st century is characterised with inequalities between developed and less developed countries. Moreover, economic disparities are also prevalent within individual countries regardless of their development statuses. Indeed, troubling inequalities continue to define the development trajectory and the associated challenges of exclusion and discrimination remain in most societies a key obstacle that restricts human potential. In the context of these ongoing challenges, an emergent philosophy is that integrating human rights approaches in service delivery has the potential to steer the world towards the collective aspirations of dignified human existence. Among the rights, included under the expanding human rights framework, is the right to health. Experts, such as London avers that the right to health is "both an essential requirement for the realization of health for all … and a *sine qua non* for a world based on social justice".[2] There is no contestation on the importance of the right as it is now widely

[1] The authors are human rights professionals and researchers active in Zimbabwe.

[2] L. London, 'What Is a Human-Rights Based Approach to Health and Does It Matter?', 10:1 *Health and Human Right* (2008) p.66.

recognised in key international human rights instruments.[3] In all the instruments, the right to health is acknowledged as an all-encompassing right that includes both health care and the underlying determinants of health such as access to safe water and adequate sanitation among others.[4]

As signatory to the international human rights law instruments, Zimbabwe has given effect to these international instruments by entrenching explicit provisions in its Constitution (Amendment No.20) that guarantees the right to health as an inclusive right. The country has a strong legal framework protecting socio-economic, civil and political rights. Among the rights clustered under the former category is the right to health care. The right to health is highlighted in Section 29 of the Constitution relating to 'National Objectives' and further emphasised and expounded under Section 76 as one of the fundamental rights.

As the nation is poised to celebrate a decade since the adoption of the Constitution, it is worth to evaluate the extent to which local authorities, in particular the Bindura Rural District Council (BRDC), have contributed or are contributing towards the realisation of human rights. Despite its importance, there is a tendency to consider health care a privilege. The Government and its agencies appear to place less emphasis on the right, leaving nongovernmental organisations and the foreign aid community with the task to provide services. Yet these organisations do not have the primary responsibility to do so according to the Constitution. In addition, a human rights approach is lacking in scholarly research on public health in Zimbabwe.[56] In the few studies that have attempted to focus on the right to health, local authorities have not been studied as much as the central government.[7] It is, therefore, necessary to examine whether the policies, plans, programs and projects of local governments support a rights-based approach to health care. In the absence of an empirical inquiry, the exact contributions of local authorities towards the right to health care, 10 years after the historic promulgation of the Constitution, shall remain the subject of conjecture. Since this study is focusing on a local authority, it is obligatory to clarify the obligations at that level of government. From the onset, it has to be stated that the rights-based framework does not clearly delineate the responsibility of local authorities toward the realisation of human rights. These obligations apply primarily to States who are the subjects of international law.

However, borrowing from London and Krennerich's interpretations,[8] we reason that there is a prominent pattern in which responsibility falls on local authorities. Local authorities are critical

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[3] *See*, for instance, the Universal Declaration of Human Rights, International Covenant on Economic and Social Rights and The African Charter on Human and People's Rights.

[4] *See* Committee on Economic, Social and Cultural Rights, General Comment No. 14 cited in Centre for Health and Human Rights 2013; OHCHR, 'Fact Sheet No. 31: The Right to Health', 2008, <ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf> (accessed 12 December 2022); E. D. Kinney, 'The International Human Right to Health: What does this mean to our Nation and the World?', 34 *Indian Law Review* (2001), pp. 1457-1475.

[5] A. Chikanda, 'Skilled Health Professionals Migration and its Impact on Health Delivery in Zimbabwe', 32:

[6] *Journal of Ethnic and Migration Studies* (2006), pp. 667-680; S. Shamu. *et al.*, 'Who Benefits From Public Health Financing in Zimbabwe? Towards Universal Health Coverage', 12: 9 *Global Public Health* 12 (2017) pp. 1169-1182; W. Zeng. *et al.,* 'Utilization of Health Care and Burden of Out-of-Pocket Health Expenditure in Zimbabwe: Results from a National Household Survey', 4:4 *Health Systems & Reform* (2018), pp. 300-312; K. K. Kidia, 'The Future of Health in Zimbabwe', 11: 1 *Global Health Action* (2018) pp. 1-4.

[7] Labour and Economic Development Research Institute, 2020.

[8] M. Krennerich, 'The Human Right to Health: The Fundamentals of a complex Right', in S. Klotz, H. Bielefeldt, M. Schmidhuber and A. Frewe (eds.) *Health care as a Human Rights Issue*: *Normative Profile, Conflicts and Implementation* (Beilefeld:Verlag, 2017), pp.23-54.; London, *supra* note 1, p. 68.

components of the central government (the State) and Zimbabwe is no exception. Therefore, anybody, institution or individual directed, controlled or acting on behalf of the State effectively becomes the instrument through which the State upholds the right to health. Those actors, should, consequently, be involved in the respect, protection and fulfilment of the right. Indeed, Section 45(1) of the Constitution supports this interpretation. The provision states that the Declaration of Rights is binding for governmental agencies at every level. It is thus possible for this study to generate new knowledge and policy recommendations on the contributions of local authorities to the realisation of the right to health. The research achieved this through a case study of the BRDC in Mashonaland Central Province.

The major question answered in the study is to what extent local authorities have, in particular the BRDC, fulfilled their obligations as defined in the Constitution, to respect, protect and fulfil the right to health care among citizens under their jurisdictions in Zimbabwe. The subresearch questions were as follows:

- To what extent are public health care facilities and services available to people in the BRDC area?
- How readily and freely accessible are the facilities and services to all the people under the BRDC without discrimination?
- Is information about these facilities and services easily accessible?
- Does the quality of facilities and services meet international and national standards (for instance, trained medical personnel and certified drugs)?

2 Literature Review and Conceptual Framework

To fully implement the right to health, an unambiguous definition is required that can provide policy makers with clear markers in the practical application as well as benchmarking progress, stagnation or failure to fulfil the right to health.

2.1 Definition of the Right to Health

A brief review of the existing body of literature shows that there is convergence on the meaning of the right to health care. Scholarly works on the right largely draw from international legal documents, in particular, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and related treaties on the right. For example, Hunt defines the right to health as "a shorthand for the right of everyone to the enjoyment of the highest attainable standard of physical and mental health as provided in Article 12 of the ICESCR".[9]The broad implication of this definition is that States, as duty bearers, ought to have comprehensive and all-encompassing approaches to respect, protect, and fulfil the right. The aim is to satisfy the requirement to ensure that their citizens as the right holders, are not deprived of the best attainable health facilities and care achievable within their jurisdictions. The right is comprehensive and all-encompassing in the practical sense that the existential condition of being healthy connotes complete physical and mental well-being and not just the absence of diseases. Prior to unpacking the content of the right, it is appropriate to briefly examine the development of the right in the *corpus* of international law. This entails an examination of the key instruments and the interpretation of the right which yielded its extant core elements.

[9] P. Hunt, 'Interpreting the International Right to Health in a Human Rights-based Approach to Health', 18:2 *Health and Human Rights* (2016) p. 111.

2.2 Interpretation of the Right: Its Core Elements

Gleaned from the international instruments and literature in the preceding sections is the fact that the right to health is widely acknowledged as a binding human right. Yet, there are ongoing debates on what elements constitute this right. Bielefeldt *et al*. note that the right to health frequently evokes sceptical reactions and they, consequently, highlight some of those critical voices.[10]The first is that a right to health cannot be universal since health infrastructure is expensive and dependent on the availability of resources. Scarcity of resources in some States can hamper the development of a minimum health infrastructure. The right to health then becomes nothing but a hollow promise.[11] The second is a radical claim. Based on a comparison of civil and political rights, critics posit that since the right to health requires expensive infrastructural investments in health care, it imposes positive duties upon the State such as the obligation to fulfil the right to equality rather than respect and protection. However, this dichotomisation of the right, indeed of all economic, social, and cultural rights (ESCR), against civil and political rights has not been exhausted. The current state of the debate has challenged this conceptualisation. London, for example, argues for the indivisibility of the ESCRs from the civil and political rights arguing that the dichotomisation is artificial and unsustainable.[12]

The dispute over the interpretation of the right is not resolved by the composite sources of the law. A general and conclusive interpretation of the right is thus never easy. Nonetheless, the premise of departure is the Committee on Economic, Social and Cultural Rights (CESCR) and the comments from the UN Committee on Economic, Social and Cultural Rights, established in 1988 both of which guide the interpretation and structure of the right.[13] The comments guide the interpretation of the right as a human right. "The right to health is a fundamental part of our human rights and of our understanding of a life in dignity".[14152] In a summative way, the right refers to the following core elements:[16]

a) Inclusivity: According to WHO, the right to health extends beyond access to health care and related facilities. It also contains a range of factors and underlying determinants identified by the Committee. These include safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; and gender equality.
b) Freedom of choice with respect to one's health and body as well as freedom from interference with decisions on one's health. This element underscores the importance of individual agency. London comments that "agency is critical to a human rights approach. In order to address conditions that create vulnerability, a human rights approach must seek to give voice to those who are vulnerable and enable them decision-making scope to change their conditions of vulnerability".[17] Thus, individuals, groups, and communities whose rights have been or are likely to be violated have choices and

[10] H. Bielefeldt *et al.,* 'Health Care in the Spectrum of Human Rights: An Introduction', in S. Klotz, H. Bielefeldt, M. Schmidhuber and A. Frewe (eds.), *Health care as a Human Rights Issue*: *Normative Profile, Conflicts and Implementation* (Beilefeld:Verlag, 2017), p. 23.
[11] *Ibid*, p. 23.
[12] London, *supra* note 1, p. 67.
[13] C. Ngwenya, 'The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?' 5:
[14] *Health and Human Rights* (2000), p. 27.
[15] OHCHR, *supra* note 3, p. 1.
[16] Nunes, R., *Health Care as a Universal Right: Sustainability in Global Health* (Routledge, New York, 2022.) p.7.; London, *supra* note 1, p. 68; Krennerich, *supra* note 6, p. 30; OHCHR, *supra* note 3, p. 3.
[17] London, *supra* note 1, p. 67.

capabilities, and a human rights-based approach enables them to exercise this agency. In addition, citizens must enjoy the freedom from nonconsensual treatment such as medical experiments and degrading treatment.[18]

c) Entitlements: This relates to conditions established or maintained to enable people to lead a healthy life. The entitlements include equality and accessibility to the highest attainable standard of health; the right to prevention, control and treatment of diseases; access to essential medicines; the provision of health-related education; and the participation of people in health-related decision-making at all levels. Entitlements also extend to access to safe water and adequate sanitation, and an adequate supply of safe food, nutrition, and housing. To give effect to the entitlements, the UN Committee for ESCR uses the categories of availability, accessibility, acceptability, and quality in order to substantiate the right.[19]

Availability refers to the provision of functioning health care facilities and medical care. However, the actual conditions of these are dependent on many factors such as infrastructure and economic resources.

Access to health care services must be delivered on the basis of non-discrimination, economic affordability – including among the poor and socially disadvantaged groups; and information on all health-related issues.

Acceptability requires respect of medical ethics and standards when providing medical facilities and care.

In terms of quality, medical services should be of appropriate and adequate quality. For example, be reflected in the availability of trained personnel, drugs and facilities that are comparable to the current medical standard.

The above elements show that the right has a structure that allows one to measure its realisation.[20] In other words, the core elements defined in the instruments, together with the obligations of States, provides a conceptual framework for this study to compare progress concerning the implementation of the right in Zimbabwe.

The realisation of the right in the aforementioned dimensions is dependent on States respecting their obligations and budgeting for the provision of health care services.

2.3 State Obligations

In its General Comment No.3 of 1991, the Committee pronounced that the notion of progressive realisation in accordance with maximum available resources set out in Article 2(1) ICESC, "should not be misinterpreted as depriving the obligation of all meaningful content […] the phrase must be read in the light of the overall objective, indeed the *raison d'etre*, of the Covenant which is to establish clear obligations for States parties in respect of the full

[18] OHCHR, *supra* note 3, p. 3.

[19] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, E/C.12/2000/4, 11th August 2000, para. 12.

[20] M. Da Silva, 'The International Right to Health Care: A Legal and Moral Defence', 39: 343 *Michigan Journal of International Law* (2018), p. 347.

realisation of the rights in question."[21] The general rule, applicable to all human rights, is that any right provided for in international law is binding on all States and their agencies.[22] With respect to the right to health, the substantive obligations of States are threefold and these are extracted from the core elements of the right:

a) Obligations to Respect – States are precluded from undertaking any action that jeopardize the enjoyment of the right. This includes any action that obstructs availability, accessibility, acceptability, and quality, to the effect that people's health is endangered.
b) Obligations to Protect – The obligations to protect are not prohibitions but rather requirements to act (positive duty). For instance, a State must not fail to regulate and control the training of medical personnel carried out by private institutions.
c) Obligations to Fulfil – The State obligation here relates to creating the prerequisites for the realisation of the right to health through respective statutes (new laws or amendments of existing ones), institutions and procedures as well as through State provisions in the form of money, goods, or services. London asserts the importance of recognising the indivisibility of civil and political rights and socio-economic rights as he urges states to spend substantial effort and resources on developing health care policies.[23] Commenting on these obligations, Bielefeldt *et al.* surmise that:

> [t]he right to health, as in other types of human rights, is internally differentiated. On one hand it implies an obligation to respect and on the other [the obligation to] fulfill. This makes the distinction between the right to health and civil and protection rights simplistic and unsustainable. The right to right is linked to both negative and positive duties… In the context of human rights, freedom and equality are two closely interwoven principles. Neither can exist without the other. Without a due account of equal implementation, freedom would end up as the privilege of the happy few, and without the spirit of freedom, equality could easily be mistaken for sameness, uniformity or homogeneity.[24]

The ICESCR and the CESCR's interpretation of the Covenant define several procedural obligations which ought to guide states in the domestic concretisation process of the substantive obligations. These are as follows:[22]

a) The participation of the population in all health-related decision making must be ensured at all levels. This means that states should provide for a mechanism that allows for participation in political decisions relating to the right to health taken at both the community and national levels.
b) The adoption of domestic laws must be advanced to specify the minimum core right and corresponding duties at the national level. Article 2(1) ICESCR refers, in particular, to the adoption of legislative measures to achieve the progressive realisation of the right to health. The parliament is explicitly obligated to create such an enabling legislation.
c) States need to pay particular attention to the health needs of vulnerable and marginalised peoples. This could imply an obligation for the agents of the State to consult on the health priorities and primary health care needs of these groups prior to formulating and implementing decisions.

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[21] A. Müller, 'The Minimum Core Approach to the Right to Health: Progress and Remaining Challenges,' in S. Klotz, H. Bielefeldt, M. Schmidhuber and A. Frewe (eds). *Health care as a Human Rights Issue*: *Normative Profile, Conflicts and Implementation* (Beilefeld: Verlag, 2017) p. 57.

[22] Krennerich, *supra* note 6, p. 33.

[23] London, *supra* note 1, p. 69.

[24] Bielefeldt *et al*., *supra* note 8, p. 24.

[22] Müller, *supra* note 18, p. 76.

d) Decisions about the scope of health care services need to be transparent and backed by credible data from health professionals and experts.
e) The provision of effective remedies of the alleged violations of the minimum core of the right to health. This obligation implies that states should provide judicial and administrative remedies within a democratic framework of separation of powers. The remedies may come in various forms but a human rights-based approach to promote the right to health usually emphasises the following aspects:[25]

- Adversarial approaches such as holding the government and its agents accountable. This includes activities such as public critiques to litigation.
- Proactive development of policies and programs so that health care related objectives can be operationalised in ways that are consistent with human rights. This approach includes mechanisms to allow rights holders to incorporate their input to policy formulation.
- In cases of violations, there ought to be enough remedies to redress violations. In the case of Zimbabwe, the judiciary and Chapter 12 commissions such as the Zimbabwe Human Rights Commission may be particularly valuable in securing redress of violations.
- The use of human rights frameworks to mobilise civil society action to achieve the realisation of the right to health.[26]

2.4 Conceptual Framework

The conceptual model proposed in this paper merges and builds on the provisions of international instruments, interpretations by treaty bodies, and commentaries from the research bodies introduced in the preceding sections. In order for the BRDC to contribute meaningfully to the realisation of Section 76 of the Constitution relating to health care, enabling factors must favourably converge. These factors are summarised in the research questions presented in the introductory section of the paper. In particular, variables under investigation are availability; accessibility; acceptability and quality. These variables are dependent on the State and its agencies (in the case of the study of the BRDC) implementing its constitutional obligations that are derived from international instruments. The interrelation of the dependent variables (entitlements) and the independent variables (State obligations) contributes to the realisation of the right. This framework was the basis upon which the field research findings were analysed and discussed.

2.5 The Right to Health in Zimbabwe: The Research Gap

The right to health is relevant to all states considering that every State has ratified at least one international human rights treaty recognising the right to health. Moreover, States have committed themselves to protecting this right through international declarations, domestic legislation, policies, and during international conferences.[27] As already noted in the introduction, Zimbabwe has developed a strong legal framework protecting socio-economic and political rights. However, research and a relevant body of literature on the right to health in Zimbabwe continues to be disappointingly scarce. This is, most probably, a direct

[25] London, *supra* note 1, p. 70.
[26] *Ibid.*
[27] OHCHR, *supra* note 3, p. 1.

consequence of the decreasing importance of ESCR in research agendas, especially in comparison to civil and political rights.

The dominant voice in research has tended to approach health issues from a policy perspective, with a tendency towards challenges and prospects of recovery of the health sector and health care issues. Scholarly work on public health research confirms this observation. A few examples will suffice to demonstrate the point. One piece has investigated the magnitude of migration of health professionals from Zimbabwe, the causes of such movements, and the associated impacts on health care delivery.[28] Others have explored beneficiaries of public health financing and expose the lack of universal health coverage.[29] Recently, Kidia attempted to broaden of knowledge on public health issues by tackling the health reform debate in the post-2017 period with key policy recommendations centred on repairing relations with the international community, strengthening the health work force, and community engagement.[30]Zeng *et al.* have also added their voices in literature by revisiting the utilisation of health care services and health care expenditure patterns among ordinary citizens.[31] Equally, Nhapi has analysed the health policy administration.[32] The work applies social work tools to examine the socioeconomic barriers to health care among vulnerable groups. The common threads adjoining these scholarly works are the lack of interest in the rights-based approach to public health and the obsession and fascination with the obligations of the central government.

There are few exceptions with regard to research on the rights-based approach to health care. One such is the longitudinal research, covering the period of 1980 to 2018, undertaken by the Labour and Economic Development Institute of Zimbabwe in 2020. The research explores the struggles of the State in fulfilling its international and national obligations towards the right to health. The scope of the study is limited to the duties and responsibilities of the central government. The agents of the central government, including the regional and local tiers of government that exercise devolved and decentralised functions are excluded from the study. The proposed research aspires to plug this lacuna in scholarship by recognising the agentic role of local authorities in fulfilling the rights of citizens at that level of governance.

This study focused on a local authority, making it necessary to clarify the obligations at that level of government. The rights-based framework does not clearly delineate the responsibility of local authorities toward the realisation of human rights since human rights obligations appear to apply primarily to states as the main subjects of international law. Therefore, anybody, institution or individual directed, controlled or acting on behalf of the State, should be involved in the respect, protection and fulfilment of the right.

Indeed, local authorities are agencies at the centre of action with a clearly defined and constitutionally entrenched duty to advance and protect human rights. Section 44 of the Constitution explicitly states that "[…] every institution and agencies of the government at every level must *respect, protect, promote and fulfil* the rights and freedoms set out in Chapter 4." Understanding the role of local authorities from this legal perspective necessitated this inquiry. The study seeks to enhance the understanding of the actors who are duty bearers on the right to health care and encourage a better understanding of the contributions of local

[28] Chikanda, *supra* note 4, pp. 667-680.
[29] Shamu, *supra* note 4, pp. 1169-1182.
[30] Kidia, *supra* note 4, pp. 1-4.
[31] Zeng *et al.*, *supra* note 4, pp. 300-312.
[32] G. T. Nhapi,'Socioeconomic Barriers to Universal Health Coverage in Zimbabwe: Present Issues and Pathways Toward Progress', 35:1 *Journal of Developing Societies* (2019), pp.153-174.

authorities to the realisation of the objectives of Chapter 4 of the Constitution. These are tiers of the government that are considered to be outside and beyond the traditional realms of decision-making processes. Yet, there is unjustifiable to ignore their agency and significance for the full realisation of the right to health care.

3 Research Methodology

The study triangulated quantitative and qualitative research methods. In order to understand the contributions of local authorities for the advancement of the right to health care, the research design utilised a case study of one local authority, the BRDC.

3.1 Target Population and Sampling Procedure

The research was conducted in Bindura rural. The BRDC has a total adult population of 124.160 (18 years and above) in 21 wards.[33] The target population for the survey was 26 randomly selected respondents from ward 16, which has a total population of 9550 people. The rural council clinic in the ward is Chiveso. The ward was selected based on a random selection procedure. In addition, key-informants included health administrators and officers, village health workers, select public servants, community leaders, women, youth and men who were purposively selected. To preserve the anonymity of the respondents they will hereinafter be referred to through numerical description such as Participant 1, 2 etc.

Respondents who are rights holders (citizens) were randomly selected to enhance representativeness. Random selection of respondents allows for every right holder to have a chance to participate in the study. The sampling procedure was two-staged with an initial selection of households in ward 16 followed by the selection of interviewees in the selected households. One interviewee was selected in each household. In cases where there was more than one adult per household, simple random selection of a respondent was done after assigning numbers to all the potential interviewees. The key informants were known in advance and, therefore, purposively selected by virtue of the offices they occupy in the BRDC political and administrative structure.

3.2 Data Collection Methods and Analysis

Secondary sources were used to review relevant literature on human rights instruments and the right to health as a prelude to field research. The reviewed literature helped refine the research by taking contextual information, emerging issues, debates, and methods on human rights research into account. The literature review also helped in the development of the conceptual framework used to analyse the findings of the study. Quantitative data was collected through a survey. The survey gathered data on the availability of public health care facilities and services. These include hospitals, clinics, or other health-related buildings as well as services such as trained medical and professional personnel, and essential drugs. A structured questionnaire was administered to gather quantitative data. Data on the accessibility of services and facilities; and the quality of said factors rendered by the BRDC were gathered through interviews with citizens from randomly selected households. An openended interview guide was used to collect qualitative data.

[33] ZimStats 2012 survey.

Statistical analysis was utilised for the analysis of quantitative data. Thematic analysis was applied in the analysis of qualitative data. Combining the two methods is appropriate for the mixed methodology that the study adopted.

4 Findings and Discussion

The ensuing section presents the findings in thematic form. The findings from the interviews are reinforced with literature from documentary review.

4.1 Defining the Right to Health Care

Respondents had varying definitions for the right to health care. Most of the interviewees acknowledged that rights are found in the Constitution but had little to no knowledge on what this specifically entails. From this view, respondents chose to define health care without linking it to the right. In response to the question of how the participants would define health care, the following answers were provided:

> Participant 1 said: "Health care a system that is put in place by local authorities to serve health needs of the people in a particular jurisdiction, the system must be accessible and meeting the set standards by World Health Organisations".
>
> Participant 2 noted that: "It is a situation when a patient receives treatment and care at health point of choice."
>
> Participant 3 understood it as: "The presence of a medical facility accessible to all people in a given ward (school teacher). I associate it with free health that we received in the first decade of independence."
>
> Participant 4 noted that: "This is when our children under five receive immunization at schools and nearby clinics or hospitals."
>
> Participant 5 articulated that: "Health care is associated to the COVID-19 vaccines that were given to the people by the government and local clinics."

The recurring themes from the responses are that health care is the presence of a medical facility, treatment of patients, and the vaccination of people by the government. It is clear that respondents held the belief that the government is the key actor concerning any health care related topic. Local authorities as well as private and missionary health facilities were not mentioned except by the health officer. The health officer brings a dimension of linking services to WHO standards and the question of accessibility. From the findings, the study conceptualises health care as the presence of medical facilities, personnel, funds, and information that is required by people in a reasonable distance within a ward. Health care can be provided by the central and local government as well as by private and church related institutions. This paper narrows the discussion to the local authorities as they are agencies of the central government charged with the same health care responsibility.

4.2 Role of the BRDC in the realisation of the Right to Health Care

It was important to unpack the views of the respondents on the role that the BRDC has concerning the right to health care. Results from the survey showed the following:

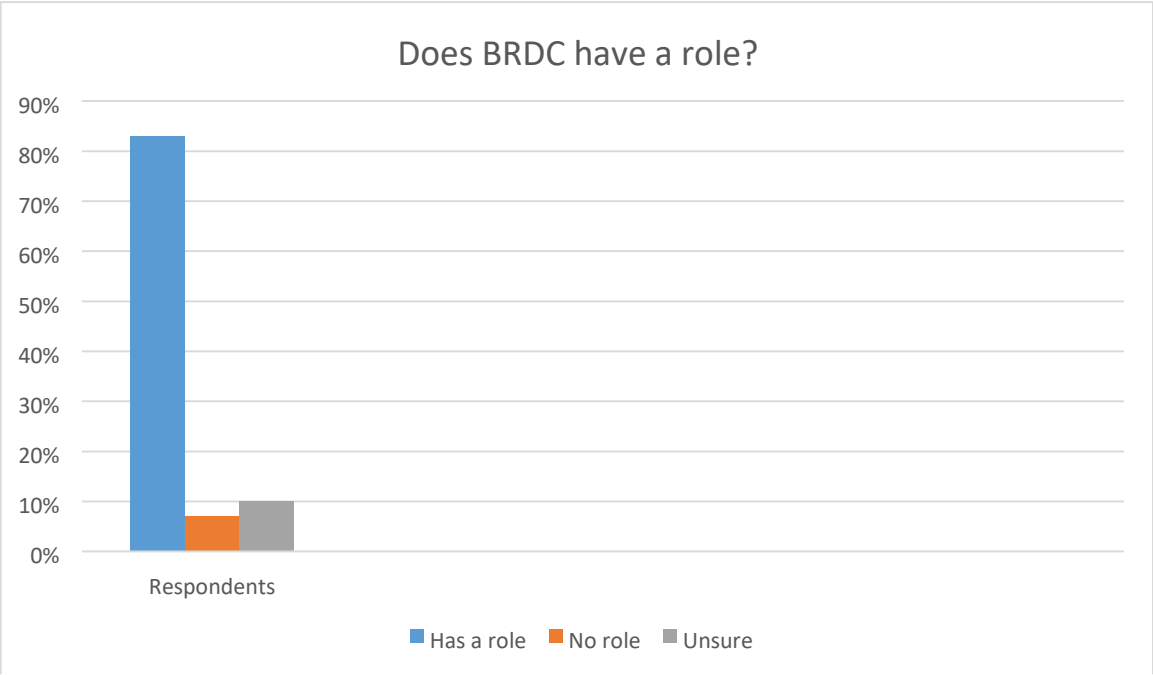

Figure A: Role of BRDC towards the realization of the right to health care

From a qualitative perspective, respondents had this to say:

> Council has clinics in some of the rural wards where we stay (Participant 6).
>
> Give the elderly free medication like BP drugs (Participant 1).
>
> Conduct health campaigns in schools and at shops about immunization (Participant 4).
>
> They are present in times of pandemics like COVID-19 where they had tents vaccinating the people (Participant 4).
>
> My wife is employed as a nurse at BRDC's clinic (Participant 2).
>
> All local authorities, BRDC included, complement central government's provision of health care. This is becoming more pronounced in devolution system that the government has been following. BRDC runs clinics that fall under their jurisdiction (Participant 5).

The responses show that people have an understanding of the role that the BRDC has in the context of health care. This is consistent with the data from the quantitative survey. Participant 3 brought in the devolution dimension which has made it possible for the BRDC to play a more visible role in health care. However, most of the interviewees did not tie the role to the right as provided for in the Constitution. This confirms the findings from the survey that people have an understanding of health care and not the right to health care (see figure A below). In short, they acknowledge that the BRDC plays a role through medical infrastructure, vaccines and employment of staff. On the employment aspect, Participant 6 noted that rural council clinics salaries are met by the central government as RDCs have small budgets that can enable them to cater for all the expenses. However, part of the responses provided explain the role of BRDC towards the realisation of the right.

Figure B below shows the levels of the right to health care as provided for in the Constitution.

Participants were asked whether they know about the existence of the right as provided for in the Constitution. 88.9 per cent said no, while 6.1 per cent said yes and 5 per cent were unsure. The findings are consistent in that the few people who are knowledgeable about rights as enshrined in the Constitution are administrators, and other selected professionals. The majority, 88.9 per cent who were not familiar with the constitutional right to health care, consisted of people who are not working within the health care sector or in related administrations. This may possibly explain why there is lack of public accountability for the delivery of health care.

4.3 Effectiveness of the BRDC in Contributing to the Realisation of the Right to Health Care

The study sought to assess the effectiveness of BRDC in advancing the right to health care from the respondents. The following issues emerged:

> We only see posters at shopping centres on immunization dates and messages around preventing HIV/AIDS. The posters will be in English and Shona (Participant 6).
>
> Normally village health workers move around our ward announcing outbreaks of diseases affecting children and the dates for immunization (Participant 2).
>
> BRDC complements central government efforts in the health sector. In fact, their effectiveness mirrors that of the ministry or central government. For example, access to health care is free to children under five and adults above 65. Where people pay they can pay between usd$1 or usd$5 for services offered. The fees are meant to cover for costs running a health point. It is also critical to note that rural council clinics receive funding to boost their contribution towards health care through the Results Based Funding model where money is allocated based on performance ratings and needs per clinic (Participant 1).
>
> They are not, these days they open late and can start lunch anytime (Participant 4).
>
> The workers appear less motivated and however, drugs are sometimes available depending on the dispatches that would have been made by NATPHARM which is run by the government (Participant 3).
>
> Health points are not close to us, as such BRDC is not effective. The issue of long distance tends to discriminate access to health in particular by people living with disabilities and the elderly who may not have transport (Participants 3 and 4).

There are mixed feelings on the effectiveness of BRDC in promoting the right to health care. Some of the respondents believe that it is playing an effective role in ensuring information dissemination and immunisation of children while others noted that the health personnel appear to be compromising the effectiveness of the BRDC. Participant 4 implied that the BRDC is not effective because people travel for unreasonable distances to have access to health care services. Long distance indirectly leads to discrimination in form of inaccessibility to medical facilities since younger generations and those with access to motor vehicles and scotch carts are at an advantage while the older generations suffer due to a lack of resources and insufficient support systems. This issue resonates with the need to ensure that health facilities must be closer to people for the right to be fully enjoyed by everyone.

The study also aimed to answer the question from a quantitative perspective as it asked participants to rank their perceptions on the effectiveness of the BRDC against set variables that ensure the right to health care. It can be noted that the BRDC performance lies in the average in its contribution to the right to health care. The council has poorly performed in terms of availability of drugs, reasonable access of the clinic, and quality of services. The council has performed above average to near best in the fields of non-discrimination, dissemination of information in an understandable language, and professionalism among staff members. The

study argues that effectiveness can only be measured by looking at the totality of the performance of the BRDC in all the areas stipulated above. No single factor can be used to make a conclusive assessment since a variety of variables are critical and interrelated. Thus, the survey points to an average performance which is close to the mixed reactions from the in-depth interviewees conducted. The study sought to assess the challenges that may prevent the full contribution of the BRDC to the right to health care and the following emerged.

4.4 Challenges Inhibiting BRDC Contribution to the Right to Health Care

The central goal of the study was to understand the factors that could prevent the BRDC from ensuring the full realisation of the right to health care. The qualitative responses were as follows:

> Brain drain at local and national level. Some of the health personnel are leaving rural wards to the towns and cities and others are flocking to greener pastures in neighboring countries and the United Kingdom (Participant 3).
>
> Poor road networks that connect villagers to the clinics. Some of the roads are in a poor state that makes accessibility of ambulances to ferry patients difficult or in some cases it delays the delivery of medicine (Participant 3).
>
> Macro-economic environment. An unstable macro-economic environment affects the budgetary allocations which have a bearing on the quality of services offered by local authorities (Participant 6).
>
> Shortage of essential drugs and delays in dispatch from NATPHARM (Participant 1).
>
> Lack of vehicles that can be used in effective door to door or road show health advocacy campaigns (Participant 4).

Generally, the respondents have attributed the poor performance of the BRDC to the national economy. The macro-economic environment plays a critical part for most of the variables needed for the right to health care to be respected, protected and fulfilled by the BRDC. The study tried to tackle the question from a quantitative perspective and the following emerged:

Factors Affecting BRDC's Contribution to the Right to Health Care

Inhibiting factors	**Yes**	**No**	**Not Sure**	**Total**
Macro-economic issues	75%	20%	5%	100 %
Management of BRDC	11%	85%	4%	100 %
Budget	90%	10%	0%	100 %
Health personnel	40%	45%	15%	100 %
Health care information	6%	90%	4%	100 %
Rights-centred health care administration	4%	30%	66%	100 %

Corruption	91%	3%	6%	100 %

Figure B: Factors Impeding the Right to Health Care by BRDC

From the results, we can note that budgetary issues and macro-economic issues affect the functionality of the BRDC in promoting access to health care. The same finding emerged from the in-depth interviews. Corruption is also key concern that was noted by most participants. The tendency to engage in corruption can also be tied to poor working conditions or low performance of the economy. An interesting factor is the rights-centred health administration to which few people said 'yes'. This can be explained by the fact that most of the people are not aware of what it is and the 66 per cent figure of 'not sure' confirms this observation. Other factors that are believed to have an impact on health care include health care information, management of the BRDC and health personnel. Additional barriers stated by the respondents in the survey, but not listed on the table, are brain drain and low remuneration. The two can be tied to the performance of the national economy.

4.5 How Can These Challenges Be Mitigated?

The following issues were suggested by the respondents to mitigate the challenges faced by the BRDC in complying with its duties to respect, protect and fulfill the right to health care. Most of the participants argued that the BRDC should create various funding models through Private-Public-Partnerships. This would enable them to limit their over-reliance and dependency on the government and donors. Participant 2 articulated that "community projects like food-for-work were handy in the maintenance of roads that connect clinics to the main roads which ambulances and medical delivery trucks would use". Accordingly, food-for-work programs or other community-led projects need to be resuscitated. There is a need to improve the macro-economic stability which has a huge impact on the performance of the BRDC, as emphasised by most of the participants. Attached to this "is the improvement of working conditions and recruitment of more nurses per rural clinic. Most rural clinics have four nurses that are provided for by the central government through the ministry of health" (Participant 6). There is a need to build more clinics within the rural wards (Participant 1). This suggestion could help to reduce the distance travelled by patients within the rural wards run by the BRDC.

5 Conclusion and Recommendations

The discussed literature and evidence arising from the in-depth interviews and the survey point to the fact that local authorities have a vital role to play towards realisation of the right to health care. The case of the BRDC shows that it is one of the agents that complements the central government's primary responsibility to respect, protect and fulfill this right. There are mixed perceptions on the contributions of the BRDC. The downside of it has been explained by the performance of the national economy, unfavourable working conditions, low remuneration, corruption, and lack of essential drugs. The study notes that the full contribution of the BRDC to the realisation of the right to health care is possible through addressing these multiple variables as they are interrelated. The study, consequently, proposes the following recommendations:

1. The Ministry of Health and Child Care in collaboration with the Ministry of Local Government and Public Works should conduct capacity building workshops for the

health and the BRDC personnel on a rights-centred approach in health administration. This emerges from the results that only a few respondents had substantial knowledge about this.

2. Non-governmental organisations in the health sector, human rights and the World Health Organisation should conduct awareness campaigns among the broader population who are not part of the health care workforce on the right to healthcare, the obligations of the state and the BRDC. This enables a rights culture that people can use to hold authorities accountable for the provision of health care.
3. The Ministry of Finance and Economic Development should raise more funding for the construction of clinics in rural wards to reduce distances between people and health care centres. This will also address indirect discrimination against the elderly and people living with disabilities who may not be able to walk long distances for treatment.

The Ministry of Health and Child Care and the Ministry of Local Authorities and Public Works should recruit more nurses and other health officers for rural council clinics.