Health and Politics in Zimbabwe and the Diasporas
St Antony's College, Oxford, June 2016

The 2016 BZS Research Day was exceptionally successful in bringing together researchers, policy makers, administrators and practitioners, to explore a range of issues around Health in Zimbabwe and the Diaspora. It was particularly useful to see how some challenges – notably those created by private-sector provision – are common to Zimbabwe, South Africa and UK. There is much potential for mutual learning. In particular, in the UK we can learn how to find effective but more grassroots, less expensive, forms of therapy: innovative spending, rather than spending on innovation, as our final speaker, Dr **Julius Mugwagwa**, of the Open University, put it. In this report, I will highlight nine themes that ran throughout the day, which raise issues for further work and consideration.

1. <u>The Role of the Academic.</u>

   The role of the external researcher in defining and commenting upon local issues is always problematic, but particularly so in the case of research into health, where there are very significant ethical implications.

   During the day, we frequently found ourselves faced with the question of why researchers are carrying out this work: for what purpose?

   - Is the quest for knowledge and information an adequate justification for the work? If not – if there is an ethical obligation towards those whose health and illness is being studied – then what is the nature of that obligation? For example, is their role to help find ways of healing?
   - Is there an obligation when working on health issues to engage in politics? And, if so, to what end? To inform? To provide policy advice?
   - Or is it better to keep research away from politics, to ensure that its findings are seen as neutral; and to protect the participants in the research?

   We recognised that academics have obligations to their local partners within government and the medical services; and to the subjects of their research.

   Most importantly, we recognised the primary obligation not to *occlude* the voices and work of these local partners and subjects.

2. <u>Medical imperialism/cultural imperialism</u>

   The recognition that external researchers should not occlude the work of practitioners, partners and patients fed into another major theme of the day: the need to recognise and challenge medical and cultural imperialism that can distort local and global responses to health problems.

This is a big subject and we were only able to touch on some aspects of it. There were contributions from both the floor and the platforms that recognised the need for some nuance: it is not helpful to typify all external interventions as necessarily imperialist/neo-colonial in nature.

Nonetheless, there was a clear understanding that medical and cultural imperialism is a significant and under-discussed issue. Key points to consider included:

- Who defines the health problem? Where do diagnostic categories come from?
- What are the consequences of using diagnostic categories developed in other contexts and different cultures?
- How far are diagnostic categories and health approaches in the global North driven by the interests of big pharma? Are the dominant global diagnostic categories predicated on a diagnosis-&-dispensing-medicine model that is not necessarily appropriate for countries that rely more on primary health care, with populations that have limited access to clinics and medicine? Are different diagnostic models available?
- How far do donor interests and approaches drive health policy?

Many of these points were addressed by our keynote speaker, Dr **Portia Manangazira**, Director of Disease Control, Zimbabwe Ministry of Health. She observed how international donor projects may damage wider health provision, even when they match local priorities. The Ministry of Health in Zimbabwe is constantly trying to find a balance between, on the one hand, donors who are interested in providing significant sums for specific projects; and, on the other hand, the lack of local capacity to *deliver* those projects, without taking capacity away from other work.

This is a problem even without the bigger issue of whether international donors take local priorities sufficiently into account when designing and proposing projects.

3. <u>Communicable and Non-communicable illness</u>

Following on from the question of how far local priorities are taken into account, we began to recognise how international bodies give excessive attention to headline-grabbing communicable diseases in Africa (notably HIV and, more recently, ebola) and also control responses to them. **Annie Holmes** showed how there are other ways to understand and represent HIV, based on local stories and structures, and these should be given more attention.

Focus on HIV also overshadows the need to pay attention to more prosaic communicable diseases such as malaria, bilharzia and cholera. This was highlighted in presentations from **Simukai Chigudu** and **Seth Amanfo**.

Even more significantly, we saw how focus on communicable diseases takes attention away from the embedded and chronic problems associated with non-communicable illness. We heard from Dr Manangazira how workplace accidents, road accidents, gender-based violence, and childbirth are all sources of major health problems. For example, there is a need for many more A&E units along the roads with the highest levels of road accidents. Yet non-communicable illnesses attract negligible donor attention and are inadequately resourced.

Taurai Kadzviti, from the Epilepsy Support Foundation, Zimbabwe, described the specific problem of epilepsy, which is categorised as a non-communicable disease, or as a mental health problem, neither of which definitions meet sufferers' needs. He highlighted how people's work self-organising and fund-raising was essential to improving the life of epileptics in Zimbabwe.

4. Trauma and mental health

Although epilepsy is a neurological condition, in Zimbabwe it is put in the same category as mental illness. Mental illness is a huge problem: we recognised it as perhaps the most significant non-communicable disease in Zimbabwe today.

The need for better understanding and treatment of illnesses associated with trauma and mental health was a theme that recurred in many different contexts throughout the day. It became clear that there is an epidemic of mental health problems in Zimbabwe, many associated with trauma. Some trauma dates back to the liberation war and the *Gukurahundi*, but traumatic environments have continued through to recent times with economic meltdown and political violence.

Moreover, these problems are closely shared with the diaspora, as vividly described in **Jenny Cuffe**'s presentation. This is an issue that we have covered in previous BZS/Oxford African Studies Centre Research Days, notably in the presentations from Dominic Pasura in 2014 and Ushehwedu Kufakurinani in 2012, both of which looked at family stress associated with migration and displacement to the UK. Throughout the day, it was clear that migration itself is a health risk factor.

We also heard how the WHO is advocating a movement towards global health treatment, raising again the question of whether categories of mental illness imported from elsewhere are meaningful for Zimbabwe; and whether pill-based strategies designed for high-income countries are what a low-income country needs.

It was good to see practical proposals for addressing these problems at the Research Day. In particular, we learned from **Dorcas Gwata**, of Zimbabwe Health Training Support, about the Friendship Bench project in Zimbabwe. This not only provides cost-effective and culturally-appropriate support and treatment for

people with mental health problems; it also rejects a medical-diagnostic approach that can leave people dependent upon expensive pills.

The Friendship Bench provides a model that is transferable to people in traumatic situations in the UK, and to many other communities around the world, particularly to reach chaotic and hard-to-reach communities for whom clinic-based treatment is inappropriate.

5. Involvement of the Diaspora

Zimbabwe Health Training Support is one way in which people in the diaspora are providing help for health services back home. A very powerful theme throughout the day was the extent to which people in the diaspora want to be involved in healthcare issues in Zimbabwe. This was partly a response to *shared* problems arising out of shared experiences of private medicine, overstretched services and lack of accountability in both the UK and Zimbabwe. But it was also a response to our recognition of *different* problems.

We heard how Zimbabwean health professionals in the diaspora face challenges within the UK health services. **Roselyn Masamha** described her on-going research project with Zimbabweans training in healthcare in the UK, which reveals systematic disadvantage based in the poor international profile of Zimbabwe; different vocabularies; and cultural differences in pedagogic approaches. Similarly, a presentation delivered on behalf of **Ruponiso Shire**, who has worked for many decades in caring for vulnerable adults in the UK, highlighted how cultural misunderstandings and institutional racism create challenges for Zimbabweans, particularly Zimbabwean women, working in the care sector here.

Throughout the day we saw a huge desire for a health partnership with Zimbabwe, and an uncomfortable feeling about being in the diaspora while there is a public health crisis in Zimbabwe. This was combined with a clear sense that health is a dangerous topic, particularly when outsiders want to intervene in areas where the government might be seen to be failing the population. We heard in many different ways about the need to identify political allies in government, without making enemies.

It is difficult to highlight endemic health problems without being interpreted as attacking the government. This difficulty is exacerbated by the historical context in which the British government has been hostile to the Zimbabwean government, and members of the diaspora have been interpreted as being complicit in that hostility. At present, UK-based medics cannot get clearance to contribute their expertise. The particular political sensitivities of health issues create obstacles for those in the diaspora who want to help.

6. Politics and Policy

These political contexts, in which healthcare policies are formulated and implemented, provided the backdrop for much of what was discussed during the day. The superb keynote presentation from Dr Manangazira was both honest and discreet in acknowledging political sensitivities affecting Zimbabwe's health provision.

Policy-making depends on both effective data and political will. One of the biggest difficulties in designing health policies in Zimbabwe, particularly regarding non-communicable diseases, is the lack of data. Civil servants need to be able to demonstrate a need if they are to request allocation of public funds.

Yet resources to monitor and survey the geographic and demographic prevalence of non-communicable diseases remain inadequate. For example, data about epilepsy (and its costs to wider society if untreated) cannot be collected, because it is not even identifiable as a category under current legislation. Similarly, there is no data about mental health needs in prisons and asylums, making it impossible to plan and budget to meet mental health needs. Politicians may be unwilling to invest public money in data collection that might draw attention to health problems rooted in widespread poverty and/or reveal the extent of crisis in the country. However, a positive initiative has been the involvement of the private sector, with Econet enabling the collection of some health data via mobile phones.

Implementation of policy requires trained people, whether internal or external, and suitable forms of co-operation between them. Yet, in both UK and Zimbabwe, political appointments to health portfolios do not require medical expertise. Moreover, political interests define the scope within which new initiatives and core funding will be allocated. Even where evidence is available that conclusively demonstrates the need for new initiatives, there is limited scope within which civil servants can operate. Politicians are reluctant to approve expansion of a ministry's mandate when it will make heavy demands on expenditure.

One of the biggest political and policy challenges is private provision of health services. Government lacks the means to make private providers answerable or regulated. For example, private providers won't provide records of treatment data without payment, even for government monitoring of essential programmes such as the delivery of child vaccines. These providers have no incentive to align with government health priorities, either at the grassroots level (traditional and spiritual healers), or at the corporate level; and government has no way to enforce this.

This was a problem that was fully recognised in Oxford, as it is one that the UK shares with Zimbabwe.

7. The importance of primary health care

   The WHO's Alma Ata Declaration of September 1978 shifted global health priorities from clinic/hospital based provision towards primary health care. These priorities were re-inscribed in the Millennium Development Goals. Yet targets for primary health provision are still not being met.

   Some recent investment in electronic systems for managing patient care can enable distance diagnosis for people in remote communities, and also monitor their care by allowing easy access to individual treatment plans. This also reduces opportunities for corrupt spending on medicines. Such 'spending on innovation' is to be welcomed. But it still relies on people getting to clinics for treatment plans to be put into place. Perhaps more important is 'innovative spending', which requires better recognition of where people already go to access primary health care.

   In the corporate private sector, profits are to be made in prescribing treatments and charging for surgery. Referrals in the private sector tend to bypass primary care and go straight to surgery, even in the case of manageable conditions such as diabetes.

   Elsewhere in the private sector, spiritual healers supply by far the largest primary health care provision: significantly more than the state. Their work is not encompassed by the textbooks, and is largely unmonitored and unregulated. (It seems impossible to design an enforceable regulatory system for a therapeutic based on the intervention of supernatural forces.) Nonetheless, spirit-based healing is almost always the first choice for treatment: people will present at clinics only after using spirit-based approaches first, within both local ('traditional') and global faiths. This tendency is reinforced by the prevalence of mission hospitals that combine the two approaches. (Again, this is an issue that we have covered in previous BZS/Oxford African Studies Centre Research Days, notably in 2010, when Prof Gordon Chavunduka of the Zimbabwe National Traditional Healers Association was our keynote speaker.)

   The clear message from our 2016 Research Day was that innovative grassroots approaches and solutions, from the Friendship Bench to the traditional healer, probably provide the best way to deliver effective primary health care. A shift away from global medicine towards grassroots healing is likely to empower health professionals and provide the best projects for innovative spending.

8. Gender dimensions

   We have found in almost all our recent BZS/Oxford African Studies Centre Research Days that full analysis of an issue requires attention to gender. This was also the case in 2016.

   Women are at the heart of all health issues. They experience greater vulnerability to ill health, not only because of the risks connected with

childbearing and gender-based-violence, but also because they tend to be more economically disempowered than men.

Women are also the primary providers of health care, for all aspects of illness, including mental illness. The Friendship Bench project, for example, trains mature women because they are the most culturally-appropriate group to do the work.

However, women often need better education in effective health provision.

9. Education in health and wellbeing

The attention to women's role leads directly into the final theme that ran throughout the day: the need for better understanding and education in health issues. On the one hand, there is a need to find new ways to think about health, healing and illness – challenging the medical/surgical/clinic-based models. On the other hand, there is a need to find new ways to embed health thinking and understanding into citizens' education.

This does not only cover issues of hygiene, primary health care and gender equality. It also links to better understandings of nutrition and food cultivation for health. As we know from the BZS Awaydays in Bristol in 2000 and in London in 2002, there are inspiring experts on nutrition and farming for health in Zimbabwe, and there is much that the UK can learn from the Global South. Nutrition, food, farming and health may be a good topic to explore in a future Research Day.

Overall, it was notable that discussion of HIV did not dominate the 2016 Zimbabwe Research Day. Far more attention was paid to non-communicable diseases, particularly those associated with mental health and wellbeing. Significant attention was also paid to the economics of health provision and the problems that arise from a private healthcare sector that is not answerable to government priorities and policies based in national need. The challenges facing the state were also given full and detailed consideration, both in preventing communicable diseases and in treating non-communicable illness. There were many parallels with health challenges in the UK.

For me, the two biggest messages coming out of the day were the wish of people in the diaspora to be able to contribute more to resolving public health crises in Zimbabwe; and the importance of innovative grassroots approaches and solutions to delivering effective primary health care.

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