

**An exploration of how the Third Chimurenga impacted on the national health-care delivery system in Zimbabwe**

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**Abstract**

*This paper explores how the Third Chimurenga impacted on Zimbabwe's health-care system. It begins by highlighting the inequalities endured by Africans in terms of access to quality health care during the colonial period (1890-1979), particularly during the time of the Second Chimurenga (1966-1979). The next section presents an overview of how Zimbabwe made considerable progress in terms of availing public health care to the general public during the first decade after the Second Chimurenga and attainment of political independence (1980-1990) in a bid to redress the injustices suffered during the colonial era. It then proceeds to chronicle how the fast track land redistribution programme popularly known as the Third Chimurenga/Hondo Yeminda or jambanja (2000-2008) impacted heavily on the country's economy which had ripple effects on service delivery and availability of care in the public health sector. The paper argues that the country's socio-economic and political structure has a strong bearing on the health care system. It reiterates that access to health care is critical in the health dimension, particularly under the HIV and AIDS epidemic environment.*

## **Health-Care System during the Colonial Period (1966-1979)**

Throughout the pre-independence period (1890-1979), the Rhodesian government provided inadequate and inferior health care and education for Africans compared with Europeans. There were enormous discrepancies in the distribution of the health budget; availability of health care facilities and health personnel. The bulk of the government's health budget was channelled towards the urban communities where the minority white population resided (Loewenson, 1989). Zvobgo (1986) and Magezi (2012) reiterate that the rural areas where the majority of the African population lived were largely neglected. Although the African councils and mission hospitals tried their best to provide health care in the rural areas, they could not cover the vast expanses of the rural and commercial farming communities, worse still; they were not adequately funded by the government. This aroused the African ire towards the settler regime (Kriger, 1992).

There were population explosions among most rural communities since Africans were either cramped in tribal trust lands with poor soil and little capacity for producing more than subsistence food which resulted in alarming malnutrition rates (Kriger, 1992). During the peak of the armed struggle, particularly in 1978; hordes of rural populations were forced to flee away from harassment, torture and possible death. They sought refuge in urban areas where they lived under appalling conditions; staying in plastic shelters, deprived of food, water and sanitation. They lacked any form of sustainable livelihood and suffered extremely high infant mortality rates (Auret, 1992). To make matters worse, the Rhodesian Ministry of Health with all its fine hospitals and dedicated staff continued to emphasize curative care which essentially benefitted the high-income white community who suffered less in terms of contracting diseases as compared to the preventive care urgently needed by the lowest income rural peasant and commercial farm worker communities who had the highest

levels of ill health (Hitchens and Stephen, 1991). Such was the *status quo* in the health care system on the eve of independence. Consequently, when the country attained its independence on 18 April 1980 with Robert Gabriel Mugabe as the president, one of the government's major priorities was to address the provision of health care in an endeavour to redress discrepancies engendered by colonialism.

### **Health Care during the First Decade of Independence (1980- 1990)**

As noted above, before independence, there were gross inequalities in terms of access to health care services and quality of care between the affluent white minority populations as compared to the majority less privileged African population. Since access to quality health care has always been one of the fundamental social concerns for most Zimbabwean people, the newly appointed government acted swiftly to address these glaring disparities. Taking into cognisance the link between

the main health problems and poverty, the priority concern of the government's first health policy, *Planning for Equity in Health* was to address these unfair inequalities (Ministry of Health, 1984). The newly formed Ministry of Health envisioned nationwide provision of primary health care with the central aim that no inhabitant would travel more than eight kilometres to a health facility. The main vehicle for improving health care provision was primary health care entailing:

- Health education
- Nutrition education and food production
- The expanded programme on immunisation
- Ensuring adequate generic drug supplies and sanitation (Loewenson, 1998).

Embracing the link between health and development, communities working with the health sector also mobilised and used increased support for education, particularly female education, building safe and accessible water supplies and sanitation, better ventilated and maintained

housing and improved family food production (Hansson, 1996). Much emphasis was placed on essential preventive and simple curative care for instance embarking on immunisation campaigns, environmental health, control and treatment of communicable diseases such as diarrhoea, malaria, TB and STIs (Chibanda, 1996). Mobile clinics extended mother and child care to remote areas so that ante-natal care reached 90% of pregnant women and more than 70% of deliveries occurred under the supervision of trained personnel. The primary mechanism to give effect to a policy of participation in which communities mobilised around their own health needs was the Village Health Worker (VHW), usually referred to as *Mbuya Utsanana/Utano* (advocate for health, well being and hygiene) by the community. They were trained and spread countrywide, each of them covering about 500- 1 000 people. The VHW constituted a link between the patients in the villages and the medical staff at the health institutions (Dahlin, 2001). They were instrumental in implementing

significant changes in their communities, for instance the building of wells and toilets. Furthermore, they helped at clinics, coordinated the feeding of undernourished children and promoted food production. The VHW was backed by a range of other community based stakeholders, including community based distributors in family planning services, health education and STIs. Traditional midwives were trained to perform safe deliveries, recognise complications, promote breast feeding and refer patients to the nearest health centre with the objective of reducing maternal mortality.

Greater access to health care was facilitated through construction of more health infrastructure. This led to a continued increase in the numbers of qualified personnel entering the system in the 1980s and 1990s. All health services in each district, whether administered by the Ministry of Health, the district council or mission, were integrated. Beginning with the patient's local clinic

near their home, patients could be referred from one level to the next (Dahlin, 2001). Health care was provided at primary level through community based structures and rural health centres; at secondary level through hospitals and services; at tertiary level, through provincial hospitals and services; and at quaternary level, through the central referral facilities such as Parirenyatwa hospital in Harare and Mpilo hospital in Bulawayo. Primary health care services were subsidized. To increase access, free medical care was introduced for low-income groups earning less than Z\$150 a month in September 1980. In November 1992, the fee exemption income was increased to Z\$400. Consequently, outpatient attendances increased dramatically (Zimbabwe Human Development Report, 2003). These concerted efforts bore fruit; there were significant improvements in general health standards. For instance, life expectancy at birth went up from 45 years in 1960 to 60 years in 1985 (Zimbabwe Human Development Report, 2003). There was also a considerable decrease in



infant mortality rates, dropping from 96 per 1 000 live births prior in 1980 to 47 per 1 000 in 1990. In 1990 under-five mortality stood at 59.9 per 1 000 live births while maternal mortality was 283 per 100 000 live births (Zimbabwe Human Development Report, 2003). By 1997, immunisation coverage in children under the age of one year stood at 87% for BCG; 85% for polio and 83% for measles. Likewise, maternal mortality was halved to about 168% per 100 000; and diseases like malaria, TB and skin diseases reduced considerably (Loewenson, 1998).

It is therefore apparent that the investments made in health in the 1980s produced significant reductions in morbidity and mortality, reduced differentials between urban and rural communities and improved access to preventive and curative services (Loewenson and Chisvo, 1994). However, as will be elaborated in the next section, in the 1990s, the combined effects of several factors led to a stagnation or reversal of all these gains; raising new health challenges against a background of

unresolved environmental, reproductive, communicable and non communicable disease risks. A plethora of these factors include; the negative impact of and the non-realization of the objectives of the Economic Structural Adjustment Programme (ESAP) which resulted in poor economic performance, high levels of poverty & inequality. The other factors are the impact of the HIV and AIDS epidemic, outbreaks of drought and more importantly the political instability precipitated by the controversial government policies such as the sporadic and uncoordinated Land Reform and Redistribution programme (Third Chimurenga) which was the main reason behind the reduction or withdrawal of funding from the international community which used to finance most health programmes (Ministry of Health and Child Welfare, 1997).

An interlocking series of all these factors brought about a massive national health crisis that the country is still struggling to come out of up to now

(2015). Below is an exploration of the series of events and government policies that have impacted negatively on people's health. Although the crux of this paper is to highlight the impact of the Third Chimurenga upon Zimbabwe's health care system, it is important to note that the Third Chimurenga did not occur in a vacuum; instead, various factors were instrumental in the undertaking of this exercise. It is also important at this point to elaborate the fact that the word 'Chimurenga' is a Shona term which can be roughly translated as 'revolutionary struggle.' In specific historical terms, it also refers to the Ndebele and Shona insurrections against administration by the British South Africa Company during the late 1890s—the Second Matabele War, or First *Chimurenga*—and the war fought between black nationalist guerrillas and the predominantly white Rhodesian government during the 1960s and 1970s—the Rhodesian Bush War, or Second *Chimurenga*. The concept is also occasionally used in reference to the land reform programme undertaken by the

Government of Zimbabwe since 2000, which is sometimes referred to as the Third *Chimurenga*. Proponents of land reform regard it as the final phase in what they hold to be the liberation of Zimbabwe through economic and agrarian reforms intended to empower indigenous people. In a modern context, the word may denote a struggle for human rights, political dignity and social justice.

**Economic Structural Adjustment Programme (ESAP) and Disintegrating Health Services (1991-1999)**

Zimbabwe's socio-economic and political situation went through major and tumultuous changes during the period between 1991 and 1999. First, the introduction of ESAP in January 1991 designed primarily by the World Bank negatively affected most people's livelihoods in a way that has remained permanently etched in their memories. Although Zimbabwe's economy was thriving throughout the first decade of independence, resulting in substantial improvements in the

education and health sectors as noted above; unfortunately, it suddenly took a nosedive in the second decade after independence (Chirongoma, 2012). Since the economy was largely dependent on western financial institutions for funding, the adoption of ESAP and consequent liberalisation of the economy was largely a result of the government's attempt to comply with their international funder's expectations. The adoption of ESAP entailed the implementation of the usual prescribed actions as advocated by western financial institutions inter alia; privatisation, deregulation, a reduction of government expenditures on social services and deficit cutting (Zimbabwe Human Development Report, 2003).

Measures protecting local industry from foreign competition were also withdrawn. The result was a disaster for the people of Zimbabwe, especially the poor (Elich, 2002). The previously stable attendance rates at the medical facilities plummeted after the introduction of user fees. Worse still, user fees for

rural clinics in 1992 were instituted during the worst regional drought of the century. Immediately after fees were raised in 1991 and again in 1993/94, declines were noted in outpatient and antenatal attendance, prescriptions dispensed, admissions, X-rays, laboratory and dental services (Hongoro and Chandiwana, 1994). Some of the fee increases were dramatic, exceeding 1 000% and this impacted heavily on the utilisation of health services in both rural and urban areas (Hongoro and Kumaranayake, 2000). The real value of government medical stores drug fund fell by 13% from 1991-1992, while inflation reduced the real value of drugs supplied by 22% between 1990 and 1993 (Chisvo and Munro, 1994).

This move to liberalise the economy had far reaching effects on the country's health-care system. Patrick Bond (2001) cites Zimbabwe's acceptance of strict structural adjustment of the economy in 1991 as an important reason for subsequent declines in social welfare, a stock

market crash and rapid economic decline. Guy Mhone (2002) reiterates how prior to ESAP, the government of Zimbabwe prioritised social infrastructure spending, broadening and enhancing living standards throughout the 1980s which enabled it to significantly extend education and health services to previously marginalized Zimbabweans. However, after giving in to the pressure to restructure in the early 1990s, “all that had been put in place in the previous decade started unravelling; the quality started deteriorating...There was just this assumption that ESAP would deliver through restructuring whereas things were collapsing” (Andreasson, 2002). Bond and Manyanya (2003) reported that 90% of those interviewed during a 1994 survey conducted in Harare felt that ESAP had adversely affected their lives. By 1995, over one third of Zimbabwe’s citizens could not afford shelter, clothing or a basic food basket, resulting in high nutritional deficiency. As a result, people’s health was adversely affected (Potts, 1995). Rise in food prices forced many to

reduce their food intake. Rises in fertiliser prices resulted in lower yields. According to the Poverty Assessment Study Survey of 1995, extreme poverty increased significantly during the 1990s, with an estimated 45% of households below the food poverty line in 1995, compared to about 26% in 1990. Based on the total consumption poverty line (the level of income at which persons can meet their basic food and non-food needs), general poverty increased from around 40% of the total households in the late 1980s to 61% by 1995 (Zimbabwe Human Development Report, 2003).

The cumulative outcome is that Zimbabwe continued to experience severe macro-economic instability characterized by unsustainable inflation rates of over 400%; low foreign exchange reserves culminating in a real GDP decline of about 30% between 1999-2002 and a record negative GDP growth rate of -14.5% per annum in 2002 from a high of 7.0% per annum in 1990. Other manifestations of the worsening problem included



erratic supplies of food and essential commodities, high build-up in external debt arrears and a decline in savings and investment (Zimbabwe Human Development Report, 2003). The real cuts in health budgets and reductions in household incomes reversed all past health gains, reduced the quality of health care, demoralised personnel in the health sector and their clients and led people to solve their health problems in ways that are not always effective for their own health or for the long term health of the nation. This is made apparent by the fact that in 1980, the Ministry of Health and Child Welfare reported that it was providing 71% of health expenditure, however, under ESAP, expenditures on health and education fell throughout the 1990s. Furthermore, health expenditure as a share of GDP in real terms increased from 2.2% in 1980 to a peak of 3% in 1990; paradoxically, in 1995 it had declined to 2.2% of GDP (Zimbabwe Human Development Report, 2003). The Consumer Price Index (CPI) also revealed that between 1990 and 2000, the cost of

health and education services rose by 2106.3% and 857.2% respectively, relative to average prices (Zimbabwe Human Development Report, 2004).

The economy under stress continued to experience unprecedented levels of informalization or underground economic activities as the vulnerable population desperately tried to devise survival strategies. A large proportion of the structurally unemployed people, estimated at over 50% of the population in 2003, were earning a living from generally insecure informal sector activities. These include cross-border trading, which is largely conducted by women, mineral panning (commonly known as 'chikorokoza', 'zungura' or 'chiyadzwa' in Shona, one of the local languages) in selected provinces with mineral resources, petty trading, currency trading, and international migration (legal and illegal), among an endless list of survivalist options. Negative outcomes associated with these informal and non-traditional survival strategies include massive brain drain, particularly in the key

social sectors of health and education and the increased risk of exposure to HIV and AIDS linked to high population mobility associated with many of the informal sector activities (Zimbabwe Human Development Report, 2003). By January 2009, approximately 94% of the population were not formally employed, meaning that fewer than half a million people in the country were formally employed.

Based on the information discussed above, one can resonate with the Zimbabwe Human Development Report (2003) which states that when the HIV virus first struck Zimbabwe in 1985, it found already in place, 'fertile socio-economic ground' in the form of widespread socio-economic vulnerability, offering it an ideal environment for spreading in a rapid and ferocious manner. Like her Southern African neighbours Botswana and South Africa, Zimbabwe faced a devastating HIV and AIDS epidemic which saw the economically active age group being decimated and funerals became commonplace in

the 1990s (Chitando, 2002). To add more fuel to the fire, the more the HIV and AIDS epidemic racked havoc on the lives of the Zimbabwean populace from 1990-1995, the steeper per capita spending on healthcare plummeted, falling by 20% in real terms (Zimbabwe Human Development Report, 1999). Loewenson (1998) records how a series of workshops organised by the Zimbabwe Council of Churches (ZCC) on the national budgeting process in Zimbabwe revealed that the national budget had become so unevenly tilted such that the country was now under-spending on health and infrastructure while over-spending on interest, defence and general administration.

GDP growth only reached 5% during one year, 1994 and averaged just 1.2% from 1991-1995. Inflation averaged more than 30% during this period, and never dropped anywhere near the 10% goal. The budget deficit was more than 10% of GDP during this era. Real per capita recurrent expenditure by the Ministry of Health and Child Welfare from

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1991-1995 was declining by 50%. On a per capita basis, health expenditure declined from U\$22 in 1990 to U\$11 in 1996 (Auditor General's Report, 1996). Hitherto, the public health budget was not enough to meet the health needs and since 1991, the per capita budget fell to a level where it could not even pay for prevention, clinics and district hospitals per capita. The decreases in health care spending resulted in reduced maintenance, delayed upgrades of deteriorating health facilities, shortages of essential drugs and the high rate of staff attrition to the private sector and abroad (Dhilwayo, 2001). By 1994, the share of the Ministry of Health expenditure on health had fallen by 29%, with 31% coming from individual direct payments and 12.2% from donor financing (Loewenson, 1996). The fast-growing HIV and AIDS epidemic also added to the crisis with hospitals failing to cope with the demand for services. By 1996, the health allocation on the budget was only 2.1% of GDP at a time when the HIV and AIDS epidemic was devastating the young productive workers. The rural and district

hospitals, where the majority of the people seek health care (about 80 per cent of the population) received less than 49% of the public health budget (Thompson, 2003).

According to the Zimbabwe Human Development Report (2003), the nation experienced a 43% decline in access to health care between 1995 and 2001. This impacted heavily on life expectancy and mortality rates. Although infant and child mortality had declined during the 1980s, it has been on the increase particularly since the mid-1990s. Infant mortality increased from 40 to 65 per 1 000 live births, while under five mortality increased from 59 to 102 per 1 000 live births between 1985-89 and 1995-1999. This implies that one in 15 children will die before their first birthday and that one in ten children will die before attaining the age of five years, respectively. Immunization programmes whose coverage had risen during the period 1992-1994 were also affected negatively and started declining. The decline in vaccinations is attributed

to the weakening health delivery system, shortage of drugs, high staff shortages and the presence of child and grandparent headed households due to the HIV and AIDS epidemic (Zimbabwe Human Development Report, 2003). Maternal mortality continues to pose a major problem for Zimbabwe, with most deaths occurring outside the health institutions i.e. in the community. Maternal mortality figures were estimated to be 283 deaths per 100 000 live births during 1984-1994, rising sharply to 695 per 100 000 live births during 1995-1999. This sharp rise in maternal mortality is largely attributed to the rapid spread of the HIV and AIDS epidemic and the decline of access to health care facilities (Zimbabwe Human Development Report, 1999). The direct and indirect impact of the HIV and AIDS epidemic, the concomitant rise in poverty levels, and a weakened and overburdened health delivery system all combined together to militate against the whole population's access to health care (Zimbabwe Human Development Report, 2003).

Increasing poverty, poor environments, lack of access to health care and the rising tide of the HIV and AIDS epidemic fuel the resurgence of TB, which thrives on immune systems weakened by chronic infections and by malnutrition. A combination of all these factors also impacts negatively on human development through lowering life expectancy. Between 1990 and 2000, TB cases in Zimbabwe are estimated to have increased five-fold, from 9 132 cases in 1990 to 30 831 cases in 1995, and 51 918 cases in 2000. Life expectancy also decreased drastically during the same period ranging from -17 years in Midlands province, -16 in Matabeleland North and South, -15 Mashonaland East, -14 Masvingo province and the overall decline for the whole country is -14 during the same period (Zimbabwe Human Development Report, 2003). It is therefore apparent that ESAP robbed the country of gains in the economic and health sectors that were achieved during the first decade of political independence. These structural adjustment policies



also impacted heavily on employment conditions in the public health sector which led to the first nationwide strike by the public health staff in 1996 and the subsequent strike by public health personnel in 1999 as will be discussed below.

### **Intensifying Grievances Culminating in the 1996 and 1999 Public Health Staff Strikes**

Prior to the economic meltdown in the 1990s, public health institutions were the most commonly utilised health services. Although employment in the health sector grew by an average of 5% per year to reach 25 000 by 1990, however, the concentration of health workers in major cities meant that this general improvement did not translate into improvement for everyone, especially the rural population. By 1998, about 60% of registered doctors were in the private sector, mainly in the urban areas. This unequal distribution of personnel in the private/ public sector was even worse in the case of specialists because there were only 29% of specialists in government between

1989 and 1998 (Loewenson, 1998). A further obstacle is that most of the doctors registered with the Ministry of Health also engage in private practice and spend much of their time in their private surgeries to the disadvantage of patients in the public institutions. This particularly presents a great cause of concern as staff- patient ratios in the public sector continue to fall (Dahlin, 2001).

The health personnel situation in Zimbabwe did not improve substantially in the 1990s despite growing population needs. Personnel problems intensified due to the loss of trained personnel through the brain drain of doctors and nurses into the private sector and also into neighbouring and far away countries offering better salaries and conditions. The total number of registered health staff in the country as of March 1995 stood at about 24 625. Public health institutions were facing a critical shortage of pharmacists with only 72 out of the 450 pharmacists posts filled. Of the existing personnel in 1995, most continued to be concentrated in

private practice, including 59% of doctors, 92% of pharmacists, 39% of general nurses and 38% of state certified nurses (USAID, 1996). By 1996, the number employed in the health sector had risen by only 1 000 to 26 000 and therefore reducing the number of health workers to one for every 454 Zimbabweans, a ratio approaching the situation in 1980. It is apparent that the overall per capita supply of health workers has continued to decline (Loewenson, 1998).

The loss of staff to outside countries and the private sector left the establishment in the public sector very small, with very few health personnel to deliver adequate care (Nzenza, 1988). The quality of care perpetually declined, and poor staffing, inadequate recurrent resource allocations and a massive increased workload due to HIV and AIDS compounded the loss of morale and added strain among the health staff. The Ministry of Health and Child Welfare Human Resource Master Plan, covering the period from 1993 to 1997, compared

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the number of actual posts within the Ministry with the identified requirements and noted the need for:

- 1 219 additional doctors
- 6 328 additional nurses (all grades and types)
- 139 pharmacists and 247 pharmacy technicians
- 294 scientists/ lab technicians and 122 laboratory technologists (Loewenson, 1998).

In 1995, the Ministry of Health estimated that in a situation where government needed 400 more doctors, the medical school produced 85 annually, making training a necessary but insufficient approach in meeting the need. Over 450 doctors were lost between 1990 and 1997 to neighbouring countries, almost the same number as those trained during the same period. The Ministry noted that the causes of staff attrition needed to be addressed, including uncompetitive salaries. The

permanent secretary in the Ministry of Health in 1995 stated: “No one wants to go and work when he [sic] knows he [sic] can get a better salary elsewhere... Health care has a sense of ethics and goodwill and we cannot call for goodwill if a person is disgruntled” (Loewenson, 1998). The health sector was also prejudiced by the fact that the country imports inputs, for instance drugs and equipment; however they produced for and were paid in the domestic market. As such, they lost rather than gained from the currency devaluations under ESAP. The health sector wages declined mainly because the price for services in the sector are subject to public sector regulation which attempts to keep down costs of health service provision by not letting health service charges rise in line with inflation. This put a lot of pressure on health workers’ wages and they ended up earning much less compared to other sectors such as manufacturing and finance. An assessment of the wages in terms of the Consumer Price Index revealed that health workers’ wages declined from

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\$2 870 per year in 1980/84 to \$1 788 in 1995/96. Resultantly, the average health worker's wage in 1996 bought 62% of what it could in 1980/84 (Loewenson, 1998). Gaidzanwa (1999) asserts that the sharp cutbacks in Zimbabwe's health sector with which most doctors and nurses have had to cope affect their capacity to carry out their work effectively. Factors such as poor infection control, poor work environments, inadequate pay and benefits, new demands with inadequate inputs and high job stress caused immense pressure on the public health workers. All these grievances in the health sector culminated in a nation-wide strike by health personnel in 1996, a move that literally crippled the public health sector. The government's response to the strike (i.e. firing several personnel and threatening all of them with dismissal) further infuriated most of the already disgruntled workers who were demoralised by the fact that conditions were unlikely to improve within the public sector pushed them to leave and join the private sector or migrate to other countries. Consequently, many

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nurses and doctors have migrated to neighbouring countries which offer better working conditions, especially to Botswana, South Africa, Mozambique and others have gone further away as far as Canada, United States and the United Kingdom (Clarinet News, 2003).

Hence, the 1996 public health personnel strike did not reap any anticipated positive rewards for the workers. Instead, the medical personnel continued nursing the same grievances - long working hours, low salaries and inadequate equipment. This ignited another industrial action in September 1999, led by junior doctors who complained of broken equipment resulting in bloodstained linen from HIV&AIDS patients being hand washed, exposing the doctors to the danger of infection. One doctor at Parirenyatwa Hospital, the major referral centre in the country, described the situation as follows:

There is not even soap for doctors to wash their hands...and even if we could, there are no towels to dry them on. You can't examine patients properly because

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you don't have the right equipment. One week there will be no intravenous drips, next week, no blood supplies or x-ray films (Bartlett, 1993).

The president of the Hospital Doctors' Association, Nyasha Masuka reiterated that they were striking not only for better salaries but for an overhaul of the entire health system which had reached a stage where they watched patients die because of lack of essential supplies. He was quoted saying, "junior doctors are doing the work of five doctors because the health service is so short-staffed. We sometimes work 56 hours continuously" (Bartlett, 1993). The Health Minister Dr Timothy Stamps indicated that his efforts to win a bigger budget for health services and better pay for staff had failed. He expressed his sympathy with the junior doctors in these words; "we exploit them. We have been taking advantage of them for too long. You cannot get people to work as slaves" (Bartlett, 1993).

The impact of the 1999 strike was seriously felt by patients because, unlike in 1996 where army



medical staff was brought into the hospitals to maintain basic services, in this case, that option was not open to the government. This is because most army medics were with Zimbabwe's troops in the Democratic Republic of Congo (DRC) where they were sent to support President Laurent Kabila against a rebellion (Bond and Manyanya, 2003). Further socio-economic and political developments also impacted on the health care system and these are explicated below.

### **Socio-Economic and Political Turmoil Impacting on the Health Care System (1997-1999)**

The economic situation worsened in July 1997 when the former freedom fighters popularly known as 'the war veterans' led by the late Chenjerai Hunzvi, a medical doctor, started demanding compensation from the ruling government and went as far as demonstrating in the streets. They would settle for nothing less than a pension for life, a piece of arable land for each war veteran and an

immediate payment of Z\$50 000 (US\$5 000). They caused such commotion, perpetrated massive destruction and threatened to invade white farms and take land by force if their demands were not met. As a result President Mugabe eventually gave in to their demands. By Christmas 1997, all 50 000 of the people calling themselves war veterans, most of whom had suspect credentials (it was later revealed that most of those who claimed to be war veterans had never fought in the liberation struggle; worse still, some of them were even too young to have ever participated in the liberation struggle), would receive a once-off sum of Z\$50 000, followed by a monthly pension of Z\$2 000 (US\$ 200) each, which was subject to future review in line with the inflation (Hill, 2003).

The World Bank questioned the feasibility of such an undertaking, in view of the lack of funds in the coffers of the government. Unfortunately, the government unwittingly ordered the Reserve Bank to print enough money to cover the payouts. In

order to fund this programme, sales tax was raised from 15 to 17.5 per cent, the tax on electricity was increased and a fuel surcharge of 20 cents a litre was imposed. This was the beginning of Zimbabwe's economic plunge. International and local financiers pounded the Zimbabwe dollar; the reasons ranged from punishing Mugabe, to urgently transferring their Zimbabwe dollars to hard currency, to making money from selling the Zimbabwe dollar through a common form of currency speculation. On 14 November 1997, popularly known as the "Black Friday," the local currency tumbled from around Z\$10 to below Z\$30 to the US\$ over four hours of trading time. The currency crash was so severe, the worst ever experienced in such a short time in modern history. This made life unbearable for the working class which was already struggling to survive on meagre salaries. The trade union movement responded rapidly and organised the country's first post-independence national stay away to protest against this move. On "Red Tuesday," 9 December 1997, Morgan Tsvangirai the

secretary of the Zimbabwe Congress Trade Union (ZCTU), who later became the leader of the major opposition party Movement for Democratic Change (MDC), led a general strike (Bond and Manyanya, 2003). Thousands of people in Harare thronged the streets. The police reacted violently to the peaceful demonstrators who in turn became violent and started overturning cars and looting the shops. The Zimbabwe dollar again fell from around 21 to 40 against the US\$, leaving the economy in further disarray (Hill, 2003).

By January 1998, price increases had been implemented on most basic goods but the hardest blow was maize meal, the staple food which would cost 36 per cent more. The sending of troops into the DRC later in the same year was another major setback to Zimbabwe's economy since it was spending approximately US\$1 million a day into the DRC. Involvement in the war triggered a precipitous decline in Zimbabwe's economic performance and the value of the Zimbabwean dollar. In addition, it

caused severe shortages of hard currency (Bond and Manyanya, 2003). Doctors pointed to the cost of such a military intervention as outrageous in the face of the collapsing health services. Workers were more disgruntled as salaries had lost 75 per cent of their real value since 1980, and food prices had escalated by 500 per cent. It was also revealed that at 38 per cent, Zimbabwe had one of the highest average personal income tax rates in the world. All this led to further strikes and protests from the workers and the University students as well (Alexander, 2000).

By February 1999, the ZCTU had approved the formation of a union-based political party, MDC and the secretary Morgan Tsvangirai and his colleague, Gibson Sibanda resigned from the union executive to lead the movement, along with a well-known constitutional lawyer, Professor Welshman Ncube (Hill, 2003). The MDC through the opposition newspaper, (The Daily News) launched in March 1999, denounced Mugabe's rule as a

disaster for the working class, pointing out that the social conditions were far worse than they had been at UDI, highlighting that 700 000 workers had lost their jobs since 1991. The public response was enormous; some academics, lawyers, human rights activists, university students as well as white Zimbabweans were attracted to the new party. In the past, people had suffered in silence but now their anger had a voice (Meldrum, 2004). Amidst all this socio- economic and politico turmoil, the health care system continued to endure a massive strain, further degradation and collapse.

The next major and transformative phase in Zimbabwe's socio-economic and political history is the land invasions (Third Chimurenga) and the consequent economic decline which pounced heavily on an already ailing national health care system as explicated below.

**The Third Chimurenga and the Consequent Economic Decline: Zimbabwe's Health System in Shambles, 2000-2001**

As has been chronicled in the preceding discussion, the socio-economic and political environment in the country on the eve of 2000 had become so volatile, leaving the ruling government very vulnerable, causing it to lose popularity among the masses and amassing support for the MDC. As a result, when it proposed to amend the country's constitution giving more powers to the executive; increasing and consolidating the presidential powers which culminated in a constitutional referendum in order to give the electorate more power to express their opinions through a vote, the majority out rightly resisted such a proposal and voted against it. The February 2000 constitutional referendum was promoted by the ruling government as "the people's chance to take Zimbabwe's democracy into the new millennium" (Meldrum, 2004). Conversely, the proposed draft constitution was described by the

MDC as “a ruse to keep the ruling party in power” and they conscientized the whole population to vote “No” to this draft (Hill, 2003). The civic coalition also called for a vote against the proposed constitution. On Monday 14 February 2000, the first results leaked out and although some rural areas had voted “Yes,” some “No,” however, in Harare and Bulawayo, the vote against the constitution had topped 70 per cent. The following night, Mugabe appeared on state television, announced the results and thanked people for voting peacefully and highlighted his acceptance of the referendum verdict. The people’s reaction to the proposed new constitution was a clear sign that they were all fed up with the present government. Most people had not even read the draft document but they used the opportunity to send a message to the government (Hill, 2003). Clearly, Zimbabwe’s voters had delivered an unprecedented rejection of Mugabe just four months before the crucial parliamentary elections (Meldrum, 2004).



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The challenge to Mugabe's rule spread even within his own party, just a week after the referendum defeat, members of the Central Committee pressed him on when he intended to retire. In response, Mugabe insisted that it was not yet time for a discussion about his retirement. Andrew Meldrum (2004:125) chronicles the dramatic course of events during this fateful period:

Although Mugabe had merely put up a façade of acceptance of the referendum results, he was busy working on a strategy for reversing the referendum defeat... Within two weeks of the rejection of his constitution, he had come up with a new strategy that would crush his opponents, quell the stirring of unrest within his party and reinvigorate his image as the most radical African leader: the land invasions.

Despite the country's having experienced two decades of land-reform failure, Mugabe managed to evoke the memory of an anti-colonial struggle and invoked the hope that only ZANU could resolve Zimbabwe's land inequality. Bond (2003:75) depicts the scenario in the following words:

In desperation, Mugabe resurrected ZANU's most militant, often virulent strain of nationalist demagoguery, attempting as time ran out to

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simultaneously 'solve' the long-standing land distribution problem, terrorise supporters of the opposition, and pass the buck for his own failings to the country's small white population, foreign countries (especially Britain and the US), imperialism in general and the IMF in particular.

One evening, at the end of February 2000, the lead headline on the nightly news was 'Zimbabwean people reclaim the land that is their heritage'. The report revealed a parade of people dancing, waving the national flag and marching down a country lane onto a white-owned farm (Meldrum, 2004). This was Mugabe responding to the defeat of his constitution as well as revenging against the white commercial farmers who had been in the forefront of the campaign against the constitution. It was also a strategy of 'buying' votes from the land hungry peasants and small farmers who since the colonial era had been relegated to the country's worst soils and driest regions, alongside vast under-utilised arable land on more than 4 000 white-owned commercial farms (Bond and Manyanya, 2003). Apparently, Mugabe used the land issue as his trump card, earmarking the rural

votes where an estimated 80 per cent of the population lived. For the first time since independence, ZANU PF faced serious and highly organized opposition. The MDC enjoyed the support of urbanized workers as well as the backing of the affluent white community; this included the white farmers, with their 'perceived influence' over thousands of farm workers. ZANU PF's best chance of winning the June 2000 elections was to capture the rural vote, including that of the farm workers, and to create a climate of hostility against Zimbabwe's white population. To this end, within months of the formation of MDC, Mugabe announced that he was to commence a comprehensive land distribution programme and planned to seize white commercial farms to give to the 'landless poor'. For many years, rural black people had been living on overcrowded communal land. The promise of highly productive, fertile land which for years had been giving white farmers a more-than-comfortable life-style was irresistible. At the same time, Mugabe sought to placate the

dissatisfied war veterans by giving them the long-awaited land (Hudleston, 2005).

Although land starved peasants and farm-workers who invaded a few white owned commercial farms during 1997-1998, egged on by the uproar over the land designation exercise, were regularly cleared off by the authorities, nonetheless, the 2000 land invaders had the full backing of the government. The government provided Z\$20 million (US\$500 000) to fund the war veterans who were the ring-leaders in the farm invasions (Hill, 2003). State-owned buses prowled Harare's industrial estates looking for employment seekers whom they offered "Z\$50, a meal and a plot of land in exchange for joining the war veterans. They would be transported to a rural area close to town, where the real veterans would tell them what to do. They were ferrying people to the farms using stocks of chronically scarce fuel" (Hill, 2003). Army officers and agents of the Central Intelligence Organisation were seen at the farms, speaking on mobile phones

and organising the logistics of the invasions. The severity of attacks ranged from courteous negotiation to total occupation of the farmer's home, forcing him and his family to withdraw to a neighbouring property or the safety of the nearest town. Meldrum (2004:126) depicts the whole exercise in the following words:

White-owned farms in every province were occupied by a motley of war veterans, ZANU -PF loyalists and unemployed youths. Within a few days the number of farms occupied grew from a handful to a few dozen and then a few hundred. Brandishing clubs wrapped with barbed wire, axes and iron bars, the war veterans threatened the farmers and forced many to flee their properties. They slaughtered cattle and sheep for feasts and set up shanty camps on the properties; they disrupted planting and harvesting; they also beat farm workers and chased many of them away.

In the first few days of the crisis, the police responded to calls for help and turned the veterans away; however, the police commissioner Augustine Chihuri then sent out word that his officers should not intervene in 'political matters', and rural communities were left to fend for themselves (Hill, 2003). Mugabe also commented that no action would be taken against the war veterans "because

they were only demonstrating for their right to the land” (Meldrum, 2004).

By the middle of March 2000, approximately 500 farms had been occupied, and the Commercial Farmers’ Union (CFU) had opened dialogue with the government. Union members offered to hand over a total of five million hectares for resettlement, without payment of any compensation but the offer was rejected. The Reserve Bank of Zimbabwe gave Mugabe a confidential report criticising the farm occupations and predicting major fall-out on three fronts:

- all foreign investment would disappear
- there would be no further money from the IMF
- Many farmers had mortgaged their properties, and unless they could grow and sell crops, they would default on their loans to the commercial banks, creating a financial crisis (Hill, 2003).

In spite of all the warnings, Mugabe turned a deaf ear and allowed the land invasions to continue in full swing. Many people who were injured during this chaotic period struggled to access medical care at government medical institutions because the staff refused to admit people who had been beaten up by ZANU PF thugs, fearing to lose their jobs. Public health care workers were under strict instruction from the ZANU PF thugs not to attend to these politically motivated medical cases. This is because, the *status quo* had been declared to be in a state of war, the farm invasions process was codenamed *Hondo yeminda* [War/Struggle for Land] (Meldrum, 2004).

By 19 May 2000, about 1 477 farms had been occupied, twenty people had been killed during the exercise and more than a thousand cases of torture were reported. One common form of torture that was enforced during the farm invasions was rape, most farm workers were women and children and the farm invaders used rape as a weapon to

intimidate and force them out of the farms. Some male farm workers were also violated with sodomy. This also added the risk of further spreading infection of the HIV virus (Meldrum, 2004). By June 2000, when the parliamentary elections were held, so much violence between ZANU PF and MDC had erupted such that many had died and thousands had been injured. The elections were held on 24 June 2000 (Hill, 2003). Immediately as elections began, there were numerous accounts of intimidation and irregularities from around the country. These reports ranged from war veterans barricading polling stations to harassing, attacking or abducting polling agents. Some polling stations were issued with wrong voters' rolls; in other cases, the voters' rolls were missing altogether. Some voters were told to return the next day. Amidst all the chaos, intimidation and other electoral problems, the MDC scooped 57 seats as compared to the 62 ZANU PF seats. This was not sufficient to form a new government for Zimbabwe, but the seats won were more than the required third to block any



changes that Mugabe might attempt to implement on the country's laws and constitution (Hudleston, 2005). More than 1 000 white owned commercial farms continued to be occupied by settlers in the months after the June 2000 election, with ongoing invasions in the northern and eastern-central parts of the country through 2001. Unfortunately, with resource shortages of fertilisers, pesticides, marketing support and credit, the sustainability of resettlement operations was rapidly thrown into question (Bond and Manyanya, 2003). The land invasions also added problems to the pre-existing economic crisis by destroying a substantial portion of commercial agriculture, which provided 45% of the country's foreign exchange revenue and livelihood for more than 70% of the population. This caused a sharp decline in foreign earnings as well as severe food shortages. Since the Zimbabwean government decided to redistribute land without compensating the white commercial farmers who had the land, the international community retaliated by withdrawing aid to a

variety of activities including agriculture. As land invasion continued, the fiscal deficit continued to rise (Zimbabwe Human Development Report, 2003).

All these fuelled the raging fires within the health sector which was already under siege because of increased burden of diseases; particularly the increasing numbers of HIV and AIDS related illnesses and deaths. Bryan Callahan catalogues the hardships and tragedies that have shaken the country for years on end:

Since independence in 1980, Zimbabwe's citizens have staggered under the weight of multiple burdens, including economic recession, IMF sponsored structural adjustments, government corruption, political violence, ethnic tensions, land scarcity, drought, and an HIV/AIDS epidemic that has killed many of the country's brightest and most productive people (Callahan, 2001: 83-88).

By the end of 2000, the bankrupt government allocated even less of a declining overall budget to rural clinics, only 20%. The government also reduced grants to church related and local authority hospitals. Spending on preventive health

care fell from its peak of 15% of the total health budget in the mid-1980s to 9.9% in 2001 (Loewenson, 2000). This had far-reaching repercussions, especially in the light of the HIV and AIDS epidemic. Zimbabwe has experienced one of the world's most severe HIV and AIDS epidemics. In 2000, nine out of the eleven provinces in the country had HIV prevalence rates of 30% and above, with Masvingo and Midlands provinces being top of the list. Prevalence increased from 17.4% in 1995, to 25.1% in 2000, and to 33.7% in 2002. It was the second highest in prevalence after Botswana at 36% in 2002 (UNAIDS, 2002). By 2001, the country was suffering from a critically high infection rate of HIV and AIDS as one out of four adults in a population of approximately 11 million in Zimbabwe was living with the virus, that is a total of 2.0 million adults were infected, translating into an adult prevalence of 33.7% (Noguera et al, 2004). This figure was the third highest in the world, behind Botswana at 38.8% and Swaziland at 34.5% (Zimbabwe Human

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Development Report, 2003). HIV and AIDS has severely affected the overall health of the people in the Southern Africa region by impacting directly on individuals and their families and by placing additional burdens on economies, social structures and health services. Poorer people are disproportionately affected because they have fewer resources to deal with the impact of the epidemic on their daily lives (Ray and Kureya, 2003). Mary Ndhlovu chronicles it all:

Not only goods, but also services are either not available or unaffordable. Starved of government finance, social welfare has long collapsed as a point of last resort for the destitute. Hospitals have no equipment or medicines and few qualified staff. A patient with a fracture is told to bring plaster of paris before his [*sic*] bone can be set...Doctors' fees, hospitals and medicines are unaffordable except for the elite and many procedures are no longer provided in the country. Employees on medical aid are not better off as the medical aid societies quarrel over rates and payment procedures, leaving the patients to pay cash and claim later. When a simple consultation, laboratory test and prescription may cost half a salary, or more, it will be rational for a worker to terminate medical aid subscriptions...leaving health care accessible only to the very rich (Ndlovu, 2004).

Access to ARVS also became an issue of major concern. Among the 2 million who were HIV positive, with approximately 600 000 having progressed to AIDS and needing life prolonging antiretroviral drugs, virtually the only ones who got them are the 5 000 who could afford them. Relief workers estimated that less than 1 000 Zimbabweans were receiving antiretroviral drugs through government or charitable programs, with little hope of expanding that number (UNAIDS, 2002). Worse still, inadequate food supplies jeopardized the administering of medication since most of the medications require observing a properly balanced diet. Children and HIV positive breast feeding mothers are sometimes given low priority in food distribution, leading to their rapid decline. People who live with HIV are precipitated into AIDS if faced with poor nutrition and stress, shortening their life expectancy and diminishing their quality of life. This has ripple effects in failure to properly treat TB, STIs and malaria, leading to drug resistant strains and continued transmission

of infection (Zimbabwe Human Development Report, 2003). By 2001, about 3 500 Zimbabweans were dying through a combination of poverty, malnutrition and HIV and AIDS per week in an estimated population of 11 million (Loewenson, 2000). About 200 000 people (adults and children) are estimated to have died in 2001. These many deaths have important implications on the economy as a whole, by reducing population growth and life expectancy; lowering worker productivity and raising dependency ratios in rural areas since most patients retire to recuperate and sometimes die in the privacy of their rural homes receiving home based care from their families. According to the Global Human Development Reports, Zimbabwe's human development index (HDI) which peaked at 0.621 in 1985, declined to 0.551 by 2000 (Zimbabwe Human Development Report, 2003). Population growth stagnated; for instance, the official population figures for Zimbabwe were 10.4 million in 1992 and 11.6 million for 2002, giving a population growth rate of 1.1% between 1992 and

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2002, down from nearly 3% in the first decade of independence, 1982-1992. This is a huge drop, considering that the population was still at 11.6 million in 2002 and yet according to projections, in the absence of the HIV and AIDS epidemic it was expected to have grown up to more than 14 million by 2002 (Matinhure, 2003). Life expectancy at birth declined from 61 years in 1990 to 43 years for the period 2000-2005. The impact of HIV and AIDS on life expectancy cannot be over-emphasized; the estimate of 43 years for Zimbabwe in 2000-2005 is 26 years lower than it would have been without HIV and AIDS (Zimbabwe Human Development Report, 2003). This figure has been slashed to 33 years for women and 37 years for men during the period 2005-2009- the world's lowest (ZADHR, 2008).

### **Further Deterioration of the Health-Care System, 2003-2008**

From the foregoing discussion, it is apparent that growing international isolation resulting from

controversial government policies led to greatly reduced donor funds for the country with far reaching repercussions on an already crumbling public health care system precipitating a humanitarian crisis which had been brewing for many years. For instance; in 2003, the doctors went on strike three times in the same year complaining about the same old grievances, salaries and working conditions. The chronic shortage of foreign currency for equipment and essential drugs worsened the situation. In the September 2003 strike, nurses who shared the same grievances with the doctors also joined the strike (Integrated Regional Information Networks, 2003). Ndhlovu (2004) clearly depicts the crisis, “in a month prices double in the shops and 20 000 Zimbabweans die of AIDS. In a year inflation soars from 220% to 620%....the public mood changes from hope and expectation of relief from the madness to deep, debilitating despair.” These difficulties further worsened the health crisis by forcing more health personnel to migrate to greener



pastures. A United Nations Development Programme-funded study released in 2004 estimated that doctors, nurses and pharmacists constituted about 25% of the 500 000 Zimbabweans in the Diaspora. Some 24% of all posts in all categories of staff (doctors, clinical officers, pharmacists and nurses) in all provinces were vacant (HARP, 2002). By 2004, the country had just about 800 doctors, way below the required number of about 2 200 (Zenda, 2003). A 2004 report released by an NGO monitoring group, the Food Security Network (FOSENET) based on information drawn from 52 districts noted that only half of the clinics in three Zimbabwean provinces had access to safe water and the majority of the districts faced shortages of essential drugs. It also noted that only 58% of the selected monitoring sites in 53 districts spread across the country had access to health facilities within five kilometres of their homesteads (IRIN News, 2004). The high cost of drugs was identified as another barrier to health services and FOSENET's report noted that the fee

levels in clinics varied widely from Zim\$120 (US 0.02 cents) to Zim\$45 000 (US \$ 8.43). Primary clinics and district hospitals did not provide medicine for HIV and AIDS related illnesses and patients had to travel to larger towns to access such treatment (IRIN News, 2004). Both the public and those in the health sector had hoped that the 2004 budget would allocate a specific budget for HIV and AIDS, a pandemic that was declared a national disaster in 2002, but unfortunately this was not the case (Hope Foundation Zimbabwe Inc., 2003). The humanitarian crisis was compounded by the severe food shortages, and by the understandable reluctance of donor countries to commit to a radical programme of anti-retroviral treatment (as elsewhere on the continent) because of the regime's record of tampering with aid programmes (Sokwanele, 2008). The outbreak of a cholera epidemic in 2008 which infected 80 000 people and claimed more than 4 000 lives was the proverbial last straw on the Carmel's back within the public health care system (ZADHR, 2008).

## **Conclusion**

In conclusion, several factors impacted negatively on Zimbabwe's health care system. The adoption of ESAP whose negative socio-economic effects continue to be felt today in the health sector, followed by the various political policies such as the sending of troops into the DRC and finally the Third Chimurenga land reform programme which pounced on the country's agricultural and economic stability all intensified the humanitarian and health care crisis as has been discussed above. Hence, there is wisdom in the activists' continued calls for the government to reconsider its policies and work towards effectively addressing the nation's health needs.

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