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Introduction

The Health Professions Authority co-hosted the Association of Medical Councils of Africa (AMCOA) 23rd Annual Conference with the Medical and Dental Practitioners Council of Zimbabwe (MDPCZ). The Annual Conference was held at the Elephant Hills Resort in Victoria Falls from 17 to 21 July, 2019. HPA Authority Members, Secretary General, Deputy Secretary General, Public Relations Officer, Finance Manager and Inspector Chengetedzai Gota were part of the delegates who attended the conference.

Members of AMCOA meet on an annual basis to discuss means of ensuring an integrated process of medical regulation across Africa. The theme for year 2019 AMCOA Conference was ‘Role of the Regulator in the Delivery of the Universal Health Coverage’.

The Conference aimed at providing a platform where African and International medical regulators, policy makers and academics share ideas, experiences and learn from each other with a view to enhance the health of the population of Africa.

The conference was characterised by a diverse programme which involved international, African and local speakers underpinning AMCOA’s purpose – to support medical regulatory authorities in Africa in the protection of the public interest by promoting high standards of medical practice, education, registration and regulation, and facilitating the ongoing exchange of information among medical regulatory authorities.

The Conference also provided networking opportunities through a unique social programme and experience majestic feel of the Victoria Falls.

Synopsis of the Conference

There was a wide range of speakers drawn from different medical specialities and regulatory experts. To mention a few, these include Dr Kgosi Letlape from South Africa-President of the Health Professions Council of South Africa and is also the current President of the International Association of Medical Regulatory Authorities (IAMRA), Mr Daniel Yumbya Chief Executive of Medical Council of Kenya and Zimbabwe’s own Dr Adolf Macheka, Specialist Orthopaedics Surgeon and the Chairperson of Medical and Dental Practitioners...
Council of Zimbabwe. Dr Macheka is also the President of the Health Professions Authority Zimbabwe.

The conference attracted approximately 150 delegates from over 20 different countries.

The audience comprised of chairpersons and representatives from medical, dental and health professions regulatory bodies from West Africa (ECOWAS block), East Africa (EAC) and SADC countries who form the Association of Medical Councils of Africa as well as the local health professional Councils.

The Secretariat from the International Association of Medical Regulatory Authority (IAMRA) based in Washington, USA, Chairperson of the Federation of State Medical Boards (FSMB), the regulatory authority of all medical boards in the USA, a representative from the World Medical Association (WMA), the Association of the Osteopathic Medicine based in the USA and the Education Commission for Foreign Medical Graduates (ECFMG) based in Washington USA also attended the Conference.

Conference deliberations were centred around the five components of the theme;

1. Quality assurance as a prerequisite for Universal Health Coverage

The standards of training and health care service- standards are not static but keep evolving requiring the competences of the health care providers to keep updating through in-service continuing health education and review of undergraduate and postgraduate training through evidence-based approaches pegged against health profiles.

- The concept of Universal Health Coverage (UHC) is now considered to go beyond the three dimensions of population, services and costs
- Increasing focus is placed on ensuring level of quality that helps to improve the health of the service seeker.
- In context of low- and middle-income countries, quality refers to access of safe and effective evidence-based treatments, in a timely manner, and without discrimination by socioeconomic and financial status.
- Achieving high-quality UHC is likely to be expensive depending on how UHC is designed
- For UHC to be effective, the quality of care needs to improve across all key dimensions of quality: safety, efficiency, person-centeredness, timeliness/accessibility, effectiveness and equity.
- Quality UHC is achievable with health care services that respond to people's health needs, considering emerging and varied health challenges within each country’s context.
- Education and training of the required human resources for health

2. Patient safety and compensation for harm

The golden tread in legislative framework establishing medical or health regulators of different jurisdiction is that they exist to protect the public.

This public protection is achieved by ensuring that only competently educated and trained health practitioners are allowed to practice their profession.

How do regulators satisfy themselves that a health practitioner is competently educated and trained?

- By setting the standards or get involved in setting the standards for education and training and monitor the implementation of such standards
- By recognizing the qualifications for which the education standards have been set (entitling the holder thereof to practice)
- By ensuring that only registered/licensed persons are allowed to practice their profession in their respective jurisdiction.
- By setting and enforcing the standards for professional practice and professional conduct/ethical conduct.

Financial resource strategies for the delivery of Universal Health Coverage World Health Organisation promulgates that public financing is essential for countries to make sustainable progress towards UHC.

- For UHC financing to be a success, a legal framework must be developed in most African countries.
- As technical advisors help the governments to connect benefits of health financing policy across all sectors - Health benefits translate to strong economic social benefits which in turn, will build resilience and sustainability in health financing.
- Spur governments to address alternative sources of funding for capital improvements and adopting appropriate methods of paying for services.
- Recommend appropriate bundling of health services to save on total costs of ownership.
- Promote sharing of resources among hospitals and healthcare providers and tracking budgetary expenditures.
Human resources planning as a recipe for Universal Health Coverage

- Review the roles and responsibilities of each sphere of government in relation to health services.

- Unified policy on foreign trained medical practitioners to address shortages of skills.

- Put in place mechanisms to address corruption related to the abuse of HR systems.

- Impact of health workforce migration – loss of investment to other countries, weakened quality of care and loss of confidence in institutions that provide healthcare.

The Role of Regulatory Bodies in Universal Health Coverage

Role of regulator is to balance supply and demand.

- Demand side – reinforcement of quality of care and patient safety, grant access to healthcare financing, increased communities demand, etc.

- Supply side – human resources for health, health facilities, commodities and joint health inspections with standardised checklist.

- Other regional blocks are making progress and Southern Africa needs to footprint its SADC Medical and Dental Regulatory Authority.

AMCOA Conference Media Coverage

To publicise the Conference, several articles were published using print, digital and broadcast media for pre-conference, during the conference and post conference.

News stories (all unpaid) to promote the Conference were published in The Herald (four stories) and The Chronicle (one story).

Aired on ZiFM Stereo (two stories), Capital FM (one story) and ZBC News (two stories) as well as on the The Health Times— an online publication (three stories).

For announcement of the Conference, one-minute spot advertisements were running on Power FM (two slots), Capital FM (five slots) and Star FM (five slots) during all the radio stations’ prime times.

Press releases were published in The Herald (two times) and The Chronicle (two times) announcing the Conference and its benefit to the country.

Conference Excursions

During the Conference, two excursions were the major highlight of the activities set aside by the host country for the delegates. These were the Boma dinner and the tour of the Victoria Falls.

Delegates enjoyed a feast of fun at the Boma – Dinner and Drum Show where non-stop entertainment culminating in an interactive drumming show combined to make this a ‘must do’ Victoria Falls experience.

AMCOA delegates were treated to an unforgettable experience through the Victoria Falls rainforest, a journey that not only affords a view of one of the Seven Natural Wonders of the World but provides a great deal of interesting facts about the geology, wildlife and history of Africa’s most famous landmark.

AMCOA Annual General Meeting

AMCOA Secretariat are working on the signed resolutions for circulation to member countries. The year 2020 AMCOA Conference will be held together with the IAMRA Conference in South Africa.
2019 AMCOA in pictures
Honourable Minister of Health lays out Authority vision-Health and Child Care Minister, Dr Obadiah Moyo stresses a point at the 2018 Health Professions Authority Annual Congress in Harare [Photo Credit-HPA]

Health Professions Authority held its prestigious Annual Congress on Friday 23 November 2018. The event was held at Rainbow Towers Hotel in Harare and was attended by over 200 delegates from the health sector.

Honourable Minister of Health and Child Care, Dr Obadiah Moyo presided over the event. In his maiden key note address, Dr Moyo commended the Authority for abiding by the provisions of the Health Professions Act of hosting the Congress annually.

Dr Moyo said that as one of its major functions, the Authority monitors that health standards are being maintained and that patients are receiving quality health in health institutions. "Patient care and quality healthcare are issues at the heart of the Ministry" Dr Moyo said. He added that patient care and quality healthcare meant that people have access to medicines, health service and well-maintained infrastructure. To achieve this, the Minister highlighted that the Ministry of Health and Child Care was liaising with the Ministry of Finance to increase budget allocation to standard international benchmarks.

"Personally, I get concerned by reports that outbound medical tourism continues to increase, as our patients seek access to affordable and cheaper healthcare outside our borders. Health regulators have a role to play here. Regulation has an obligation to protect patients and not solely allow market forces to dictate tariffs because healthcare is a public good and a public good should be accessed by everyone" he emphasised.

The Honourable Minister called upon health professionals to make every effort to make health services and medicines more accessible to the people through fair and reasonable charges. He further encouraged health professionals to be innovative in their practices and put a face to the healthcare of the poor. "I commend medical practitioners who, from time to time, undertake volunteering outreach work to offer free medical services to the less privileged members of our society" he said.
Dr Moyo acknowledged the macroeconomic environment the health professionals are operating in. He said that the freezing of recruitment of health professionals had its own challenges, as it exacerbates the health worker / patient ratios particularly in public hospitals.

He further alluded to the training of health professionals which he said was also being affected by the freeze on internship posts, yet internship was part of the training diet for health professionals. The Minister highlighted that the Ministry was aware of all these hurdles and negotiations were underway to find creative ways of dealing with those challenges. “We are also looking at ways of addressing the issue of duty on medical equipment so that our healthcare delivery system is able to catch up with latest technological developments and reduce operating costs,” he added.

Dr Moyo commended the Authority on the timely processing of applications to register a health institution. “I see on the programme that HPA is introducing online registration and renewal systems. This is very commendable, as this will bring convenience to health professionals. We must strive to do away with loads of paperwork which is both laborious and time consuming. I applaud HPA for this initiative. I hope all Councils are also doing the same,” he said.

The Honourable Minister indicated that the Ministry would engage HPA and the Councils regarding the One Stop Registration Centre in the health sector which the Authority had already started doing some ground work on for Ease of Doing Business. He added that it was his dream to see patients benefiting from increased availability of health institutions and competition in the health sector. He added that patients should have the freedom to choose and go to a health institution of their choice.

Dr Moyo said that as the new Minister, his vision was to reposition and transform the healthcare delivery system in Zimbabwe. He gave a synopsis of this transformation agenda under his 100-day plan as follows:

1. To see a system where the Ministry is able to get more local funding for healthcare.
2. To address the issue of availability of medicines through creation of joint venture partnerships.
3. To motivate health professionals by creating a conducive environment where everything they need is available.
4. To bring back healthcare standards as they were before. The development of five-star quality health service that also looks after the socially disadvantaged.
5. To have continuous quality assessment and quality assurance in every health institution, both private and public.
6. To come up with regulation that takes care of use of technology in...
healthcare and that as an international trend, technology works in favour of and protects the patient.

7. To include aspects such as health outcomes, turnaround time for outpatients department, number of deaths in casualty departments and the like, in the scope of HPA inspections.

8. To have an Authority that is active and knows what is happening within the Councils, calling for regular meetings with them and not just the Chairpersons in quarterly meetings.

The Minister concluded by highlighting that the Ministry would be engaging the Authority to finalise issues to do with Amendment of the Health Professions Act (Chapter 27:19), Ease of Doing Business reforms and the issue of Pharmaceutical Wholesalers.
Self-Regulation and Governance in the Health Sector

Health Professions Authority (HPA) held its Annual Congress on 23rd November 2018 at the Rainbow Towers Hotel in Harare. The prominent event was attended by over 200 delegates from various sections of the health industry. International Guest Speaker at the prestigious event was Dr Tebogo K. Letlape who hails from South Africa. Dr Letlape is the current President of the Health Professions Council of South Africa (HPCSA) and the Chairman of both the Association of Medical Councils of Africa (AMCOA) and International Association of Medical Regulatory Authorities (IAMRA).

Dr Letlape opened his speech by asking the question, “Is there a course in regulation? How important is regulation?” He went on to explain that it was disturbing to note that regulation was being done on a DIY basis as there was no prescribed training. “If you take companies, for example, you have an institute that provides training for the Board of Directors. Training is organised for them to serve as Board of Directors but then you do not think it is a pre-requisite to be trained to work in the health regulatory sector” he said.

Dr Letlape highlighted that the other issue about health regulation was that it is self-regulated, but there were no rules to ensure that it is still proper regulation, that the nation still gets a fair share. “In most instances where there have been complaints, we (health professionals) are described as a private club of boys and girls that protects each other” he said.

He further pointed out that one of the primary functions of the regulator is to accredit institutions to ensure that they are of a good standard. He added that, “…there used to be a concept called minimum standards. Now “minimum standards” is a concept everybody is moving away from and we now have to talk of common standards. If you are going to do a cataract operation, we expect one level of doing that operation and the outcomes we expect are the same,” he explained.

Dr Letlape further revealed that the scenario was such that there was no common standard in the quality of practitioners produced by the different training schools, “…and that is why we...
talk of minimum standards, so how are we able to protect the public and give them assurance that the practitioners we register have the competencies that we require” he queried.

“I have always told the people in Health Professions Council of South Africa (HPCSA) that regulation should be the simplest job to do, because at the front end it has to be regular, that is why we are called a regulator. It cannot be variable, the standards must be the same, so you must create common standards” he clarified.

He illustrated this with a scenario where one has to accredit a school and he or she is the Professor at that school and the most influential person that has to accredit the school. He questioned how one could give quality assurance and that there is fairness and consistency.

“The way we structure ourselves as regulators and the way people come to us becomes important. The common practice when people come into regulation is that they come in from a constituency that needs to be regulated but they represent that constituency. So how can we give assurance that what we are doing is correct when we are both player and referee at the same time. What are the things that can be put in place to ensure that as a regulator we can be trusted by the public we are supposed to protect?” he challenged. He went on to point out that as the Association of Medical Councils of Africa (AMCOA) they have set themselves a task of ensuring that there will be a course in regulation. At International Association of Medical Authorities (IAMRA) they also have the same objectives. “We also have set objectives to try and learn from aviation. In aviation, if you want to be a pilot you get an international license. You can fly planes in Zimbabwe, you can fly planes in the US, you can land anywhere. It’s an international licence. Why are we not creating an international accreditation system for health care professionals?” he expounded.

He further added that, “So that when they call you in the plane ‘is there a doctor in the plane’ there must be some assurance about your competence. Why don’t we have that in health?”

Dr Letlape highlighted that as self-regulators in health, they could ensure that they begin to contribute to the transformation of Africa. “Health care is an investment, if we get our act together, we can create the best training health care institutions in Africa. We can train for other jurisdictions. You know you go elsewhere, if you have a health care practitioner that is trained in Africa, that has practiced in Africa. Even developed countries will trust that practitioner with the health care of their population, that is something that we can convert into an asset in the continent” he added.

He emphasised that It’s something that if done properly, people should be coming to Africa for the best quality affordable health care. It would become part of rejuvenating economies in the continent.
2018 HPA Congress in pictures
The recent successful operation by a team of local surgeons to remove a 12.3kg 11-year-old kidney cyst from a patient goes to show that Zimbabwe has good doctors capable of delicate and complicated medical procedures without sophisticated equipment that is found in developed countries.

We must commend and recognise consultant urologist Dr Shingirai Meki and his team at the University of Zimbabwe’s College of Health Sciences for conducting this successful operation that is of world class proportions.

Their achievement is quite re-assuring and gives us hope and comfort of our country’s medical expertise.

We would like to thank them for a job well done. The crisis that faces the country’s healthcare delivery system has generated vigorous debate.

The problems are well-documented and thankfully the Government is taking practical steps to engage health professionals to improve service delivery.

This latest achievement by local surgeons shows that it’s not all gloom and doom in the country’s medical arena, and gives us hope and confidence in our expertise.

All what our medical professionals need is recognition and respect. Zimbabweans should have faith in local expertise.

It’s a victory over the massive inequities that exist between the poorly funded healthcare system versus the private sector which serves an elite few.

The fact that the operation was conducted at a cost of $2 000 against US$11 000 cost charged in private healthcare institutions outside the country means that healthcare innovations if well supported can save the country foreign currency.

Zimbabweans reportedly spend US$4 million to get treatment abroad, but local innovations and support for local medical expertise could help us save the precious foreign currency.
Money alone and top-notch equipment is not the answer to our deep-seated problems in the healthcare sector.

The availability of resources should also be complemented by a committed medical expertise which can utilise innovation to expand access to health for the majority of the poor.

We must commend Dr Meki and his team for their foresight and proactive approach to rolling out specialist service to save the lives of the poor.

Innovation and commitment to improving access to health for the majority is now yielding positive results.

We need to support our health specialists and expand specialist services for heart, brain, cancer, kidney and other organ operations.

The successful cyst operation is an important milestone that we can build on.

We must commend the College of Health Sciences for continuing to impart important knowledge and skills to our doctors undergoing training in various surgical skills.

It is also important for the Government to support plans to upgrade our theatres to world standards to cater for various surgical capabilities.

The achievement by Dr Meki and his team gives us hope. It goes to show that our country’s healthcare delivery system is not breaking down, but that we need to support our specialists to perform better.

They need motivation and more support to enable them to work more efficiently.

Despite the difficult economic circumstances, the country’s health delivery system has continued to perform. We should encourage and promote medical research innovations to make it work even better.

From this successful operation, we should learn a few important lessons on how to improve our surgical services in the country.

As a country we should know that sustainable investments in the healthcare sector can make a long-term difference for the majority of the poor.

If we don’t have adequate resources, we can still find strategies to improve knowledge, skills and create collaborations and consensus among key stakeholders.

Money matters, but it is not everything. Low cost health innovations can bring high-quality and cost-effective care to the people.

This grass-roots approach can make a big difference. It’s such interventions that can have meaningful impact on our health delivery system.
Tropical Cyclone Idai is regarded as one of the worst natural disasters on record to affect Africa and the Southern Hemisphere as a whole. The storm has caused catastrophic damage over Zimbabwe and its people mostly in Manicaland and parts of Masvingo provinces. The violent Cyclone Idai has left a trail of destruction and desolation. People suffered heavy losses, in terms of property, livestock, homesteads including human life and are now struggling to recover and rebuild.

In an effort to assist fellow citizens who were affected by the Cyclone Idai, the Health Professions Authority donated diclofenac tablet capsules, cloxacillin tablets, crepe bandages and gauze swabs which were among the required drugs and surgicals for the victims in need of medical care. The donating was made through the Ministry of Local Government, Public Works and National Housing. It is said, every donation counts and there is no donation too big or too small. The donated medicines are meant to address health risks for the vulnerable men, women and children who have suffered this tragedy as a short term and sustainable recovery plan to the community, as they rebuild from this disaster.

The Board, Management and Staff of the Health Professions Authority joined the rest of the Nation to assist the victims of Cyclone Idai.

It really was a dark time for our beloved country as lives were lost, homes destroyed and a lifetime of memories destroyed in an instant as Cyclone Idai ravaged the eastern part of Zimbabwe.

It is sad that the lost lives can never be replaced but if the Nation stands together to assist the survivors, they can have a chance to enjoy normal life again. It is with this in mind that the Health Professions Authority joined the rest of the Nation to assist the

By Clotilda Chimbwanda, Deputy Secretary-General

In an effort to assist fellow citizens who were affected by the Cyclone Idai, the Health Professions Authority donated drugs and surgicals for the victims in need of medical care.

The Board, Management and Staff of the Health Professions Authority noted with sadness the tragedy that befell our fellow citizens through Cyclone Idai. The Authority mourns with the nation and those relatives who lost their loved ones and may their souls rest in eternal peace.
Authority Extends Help To Harare Central Hospital

In February 2019 the Health Professions Authority extended its helping hand by donating six laptops to Harare Central Hospital. The Authority was on a programme to replace its laptops and decided to donate those which were in excess to requirements to Harare Central Hospital.

Harare Central Hospital management receive donated laptops from Health Professions Authority former Public Relations Officer, Mrs Linda Nkala [Photo Credit- HCH]

From Public Relations Desk

In February 2019 the Health Professions Authority extended its helping hand by donating six laptops to Harare Central Hospital. The Authority was on a programme to replace its laptops and decided to donate those which were in excess to requirements to Harare Central Hospital.

There were six laptops in total and Harare Central Hospital management appreciated the gesture by HPA and hinted that the donation will go a long way to alleviate some of the challenges faced by the institution in terms of information technology gadgets.
Kariba District Hospital ravaged by fire

By Clotilda Chimbwanda, Deputy Secretary-General

An unfortunate incident destroyed a large section of Kariba District Hospital. It was on 7 March 2019 when the Matron received a frantic call in the middle of the night that the Hospital was on fire!

Efforts were made to try to salvage as much as possible, but all efforts were in vain as the inferno was too intense. The Pharmacy, X-ray Department, TB Office, Human Resources Office were razed to the ground including all contents. The Casualty Unit was also burnt to the ground but as it was the furthest from where the fire started, staff members on site managed to move some equipment to safety before the fire could get to it. It was unfortunate to learn that the X-ray Department had only just received a brand-new digital machine which was left as a heap of rubble.

A visit to the Hospital showed a Hospital in distress and calling on assistance to get back on its feet. The fire also caused electrical faults in the Theatre, Kitchen and Laundry Department.

The following challenges were noted as a result of the fire:

1. Drugs supply was critically low, especially emergency drugs, antibiotics, anti-hypertensives, anti-diabetics and pain killers. Patients were being given prescriptions to buy their own medicine.

2. As the theatre was non-operational, patients requiring theatre were ferried to Karoi District Hospital.

3. Transporting of patients was a major challenge as two ambulances
on site were not working and the Hospital had to beg for transport from well-wishers.

4. Laundry was being taken to Karoi District Hospital and transport was a major challenge. Dirty linen would be kept for some days before being taken to Karoi and clean linen would take time to be collected from Karoi. This resulted in a critical shortage of linen.

5. Autoclaving was being done at Karoi District Hospital and this was a challenge as well because of transport problems.

It was heartwarming to learn that the Community had quickly reacted to the crisis and were coming through with donations as no donation was considered small. The Ministry of Health and Child Care was also playing a big role in assisting the Hospital to get back on its feet and had provided a Mobile X-ray Unit amongst other things.

Secretary General, Mr Shepherd Humure and the Deputy Secretary General, Mrs Clotilda Chimbwanda visited the hospital. They were informed that the Minister of Health and Child Care, Dr Obadiah Moyo had also visited the hospital.

The Authority continues to stand with its health institutions and highlight their plight in order to ensure continued and improved patient care.
HEALTH Professions Authority exhibited at this year’s Zimbabwe Agricultural Show (formerly Harare Agricultural Show) from 19 to 24 August 2019.

For this year’s edition of the Zimbabwe Agricultural Show (ZAS), HPA co-exhibited with the Nurses Council of Zimbabwe and Allied Health Practitioners Council of Zimbabwe.


The Authority’s stand attracted other exhibitors, farmers, health practitioners, high school pupils and the general public.

For this year’s edition, HPA stand displayed various promotional material. These include branded caps, branded round neck t-shirts, branded ball point pens, branded pencils, branded rulers, exercise books, brochures and magazines.

Throughout the exhibition period, Authority staff manning the stand held question and answer activities where various exciting promotional material were won by the visitors.

Of note, the name ‘Health Professions Authority’ seems to scare members of the public away as they perceive it as an organisation entirely for Health Professionals only. They only get to understand and appreciate the work we do after engaging them.

It was a great platform to meet with our health practitioners and members of the public in a more relaxed and less formal environment. Receiving feedback through such platforms has helped inform our strategic direction in a bid to improve on service delivery.

Visitors’ Comments

- I am grateful that as a member of the public I have somewhere to report my grievances if they occur at any health institution in Zimbabwe. I, however fell that more needs to be done in educating and informing the general public about this role- Norman Marima.
- As a health practitioner, I am delighted to know that I can go to HPA when in dispute with my council-
Anonymous Nurse.

- Had a lot of questions that were truthfully answered, and I am now aware of the relationship between my
professor and HPA- Nyasha Nhamo.

- Would be grateful to see some health practitioners especially in public hospitals to have a little bit of
patience when dealing with patients-A. Rupapa.

- Doctors are not referring cases to the next qualified practitioner as a way for them to claim more money from
either the patient or medical aid-Anonymous.

- HPA has a huge role, keep up the good work but I would appreciate it if you carry out more inspections in
some remote areas-T. Muronzi.

- I am grateful of the work being done by HPA but may you please ensure more inspections in clinics located in
the high density surburbs- F. Mubazango.

- Expecting mothers are being beaten at Musiso Hospital by nurses who claim that expectant mothers are a
bother. This behaviour by nurses has led many pregnant women around Musiso Hospital to give birth at home-
Anonymous.

- Educating and informing the general public about this role- Norman Marima.

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Anonymous Nurse.

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Anonymous.
Zimbabwe International Trade Fair (ZITF) 23-27 April 2019 Report

By Shamiso Yikoniko, Public Relations Officer

Health Professions Authority (HPA)'s stand at this year's Zimbabwe International Trade Fair (ZITF) was a beehive of activity as over 300 visitors thronged our stand-both local and international visitors.

Most visitors who came to our stand either enquired about investing in the health sector; the requirements for setting up a health institution or complained about the health delivery service in both public and private institutions.

During the period of the Trade Fair, we managed to get an opportunity to have an interview with Capitalk FM for a 10-minute air-time where the Secretary General, Mr Shepherd Humure spoke about the regulatory role of the Authority and the protection of public interest.

And the Deputy Secretary General, Mrs Clotilda Chimbwanda also had an interview with The Chronicle newspaper on the increasing number of ‘quack’ health practitioners as well as health institutions operating illegally.

At this year’s exhibition we had a wide range of promotional giveaways—branded golf t-shirts, branded caps, branded pens, magazines and brochures which made the stand very interesting and attracted the visitors who felt the urge to enquire about HPA.

Instead of just giving away the promotional material, we first explained HPA’s mandate then have question and answer sessions where we asked visitors questions about HPA and a correct answer will get either of the promotional gifts. We employed this tactic to help impart knowledge about HPA to members of the public.

HPA co-exhibited with the Nurses Council of Zimbabwe, Medical Laboratory and Clinical Scientists of Zimbabwe and Medical and Dental Practitioners Council of Zimbabwe.

Allied Health Practitioners Council of Zimbabwe and the Pharmacists Council of Zimbabwe embarked on...
solo exhibitions.

While the Medical Rehabilitation Practitioners Council of Zimbabwe and Environmental Health Practitioners Council of Zimbabwe could not make it to this year’s ZITF due to financial constraints.

The Minister of Health and Child Care Dr Obadiah Moyo accompanied by some directors from the ministry graced our stand and commended our presence at ZITF citing that HPA is taking the regulatory role seriously as we came out to meet both health professionals and members of the public to share and discuss with them various issues concerning them. Dr Moyo was also charmed to note that three Councils were co-exhibiting with us.

Summary of Comments received

- HPA was tasked to embark on periodic health information awareness campaign through broadcast and print media and hold health events at district and province levels. Members of the public are concerned about not knowing where to complain if they are mistreated at health institutions.

- HPA was requested to consider decentralising its services as most people are failing to access our services.

- There was an enquiry on the procedure to follow for a foreign health professional to operate in Zimbabwe.

- Most visitors demanded to see an improvement in the availability of affordable drugs in all health institutions.

- The Authority was tasked to take meaningful action in terms of inspection especially in most public hospitals and clinics as these are said to be no longer meeting expected standards.

- There was a call for councils to consider members who are unemployed but want to remain on the register to at least be exempted on Continuous Professional Development (CPD) points and have a discounted registration fee for that group. Those who enquired on the matter felt that it was long overdue.

- HPA should strive to ensure that there is a culture of customer/patient care in all health institutions as a basic requirement as patient care is appalling.

- A recurring question kept popping up, was on whether the Authority also assesses the conduct of health professionals in health institutions to ensure that quality service is given to patients. The visitor highlighted that inspecting equipment and infrastructure only was not enough.

- HPA was tasked to raise standards of the log book. The log book that is given to interns should be properly printed in a booklet not on bond paper.

- Most visitors complained that most health practitioners do not take time to engage and discuss with patients the pros and cons of the procedures done to patients.

- HPA was asked to look into issues of over-regulation and ways of harmonising payments charged by other regulators.

- The issue of importing medical equipment was also enquired and the procedure to have the equipment certified or approved.

- Members of the public are complaining about the time taken by health practitioners to attend to them at public hospitals.

- Seeing HPA and the Councils together made it easy for members of the public to understand and differentiate the role of HPA from that of councils.

- A visitor applauded the work being done by HPA but called for improvement in services.
The Right to Health and Recourse in the Health Sector - Community Awareness Meeting

The Zimbabwe Association of Doctors for Human Rights (ZADHR) represented by Mr Calvin Fambirai, together with the Health Professions Authority of Zimbabwe (HPA) represented by Mrs Linda Nkala, hosted a health and human rights awareness meeting targeted at the general public. The meeting was intended to raise awareness on the right to health in Zimbabwe and how the right could be promoted, protected and claimed using existing regulatory frameworks in the health sector.

The meeting was held on the 30th of November 2018 in Mbare, Harare. Mbare is the oldest suburb in Harare and is home to some of the poorest members of the society. The meeting was attended by about 40 people who live in the area.

ZADHR is a membership based non-governmental organisation of health professionals formed in 2002. ZADHR believes health professionals are frontline witnesses in the achievement of the right to health and that voices of healthcare workers affect policy development and its implementation. In so doing, the institution regards very highly the cooperation between citizens and the profession to foster a culture of human rights in clinical work through enhancing community knowledge of the right to health, participation in health-related
programs, monitoring the right to health and demanding transparency and accountability in the health sector.

HPA is a statutory body established by the Health Professions Act (Chapter 27:19). HPA “seeks to uphold and promote high standards of health care delivery systems in Zimbabwe through the monitoring, regulation and coordination of activities of all health professionals, health professions Councils and health care institutions in an ethical, efficient and professional manner”. HPA also investigates and takes complaints from aggrieved health practitioners against their Councils and also members of the public against health practitioners for adjudication.

To ensure that participants would uptake redress mechanisms in the health sector, a session to enhance knowledge on the right to health was undertaken. Mr Fambirai explained this as a broader view to help participants understand the context and framework with which health rights are understood.

“The right to health encompasses both clinical related issues and social determinants of health” he said.

As such, for participants to appreciate that the nature of the discussion was to help tackle violations in a health facility setting, they were upraised on the Patients Charter. The Patients Charter is a government of Zimbabwe document designed to standardise and raise awareness on rights and responsibilities of patients in the health sector. Discussions were centred around the rights to hospitality; confidentiality; consent, privacy, non-discrimination, choice, right to redress of grievances and patients’ responsibilities to give accurate information to health practitioners, respect health facility rules, follow agreed treatment plans and also responsibilities not to solicit incorrect information, to keep appointments and not to waste medical resources.

Mrs Nkala took participants through the work of HPA, its relationship with the seven health professions Councils and complaints handling processes in seeking redress. She emphasised that HPA has a “role of protecting public interest through overseeing the activities of Councils to ensure that public concerns issues are addressed, inspecting health institutions to ensure that they meet quality standards and that they do not cause harm to the patient.” She added that HPA also acts as an appealing body for members of the public who are not satisfied with decisions of Councils in handling their complaints. Emphasis was also put on popularising institution-based recourse mechanisms such as the existence of complaints desks and public relations desks at major hospitals and the use of seniority-based complaints handling systems at local clinics.

From the discussions it was clear that communities are generally unaware of the existence of the Patients Charter and neither are they well versed with the knowledge of the right to health and patients’ rights.

The discussion was able to enhance knowledge on health and human rights, patients’ rights and complaints mechanisms existing in the health sector and in popularising the work of regulatory bodies. It is anticipated that identification of violations and reporting of the same will be made easier resulting in increased demand and uptake of services offered by HPA and the Councils. In turn it is believe that an empowered patient will encourage health professionals to enhance their service skills and result in the improvement in quality of care.
Recent decades have seen unprecedented population growth in urban areas worldwide.

Zimbabwe has experienced an upward trend in urban population since the early 1990s.

In 1990, Zimbabwe urban population was three million and as of 2018, more than five million are projected to be staying in urban centres.

The growing urban population is however, linked to urban malnutrition fuelling the cases of diet-related non-communicable diseases (NCDs).

While most nutrition experts agree that a balanced and nutritious diet is the best way to obtain the much-needed nutrients, Zimbabweans have less than a perfect diet-long on calories and short on nutrients.

Unhealthy habits like alcohol abuse and consuming too much fat, salt and sugar have sparked an epidemic of diseases which together constitute the leading cause of death globally.

Alcohol abuse, high-fat diets and physical inactivity—all lifestyle behaviours—have been identified to be the major drivers of NCDs in Zimbabwe.

Diseases linked to lifestyle choices, including diabetes and some cancers, killed 138 000 people in 2017 as morbidity and mortality cases for NCDs continue to increase at an alarming rate.

The four main NCDs are cardiovascular diseases, cancers, diabetes and chronic lung diseases.

Health and Child Care ministry’s family health director, Dr Bernard Madzima contends that this ‘lifestyle disease’ epidemic causes a much greater public health threat than any other epidemic known to man.

“The increase in NCDs is a slow-motion disaster, as most of these diseases develop over time. But unhealthy lifestyles that fuel these diseases are spreading with a stunning speed,” he said.

“Most of these diseases are preventable to a degree. By becoming informed, making conscious diet and exercise decisions, and being proactive about their health, individuals can do a lot to prevent NCDs.”

The burden of these diseases is rising explicity among lower income countries and populations. NCDs kill 40 million people annually and cause almost two thirds of all deaths in the developing world, which is about 23 million each year.

NCDs are a medical condition or disease which is non-infectious. NCDs are diseases of long duration and generally slow progression.

Besides being preventable, these diseases are now the leading cause of death and disability. In addition, they are not replacing existing causes of illnesses such as infectious disease and trauma, but are adding to the
disease burden.

This leaves Zimbabwe facing the double burden of infectious disease and NCDs.

The primary solution is disease prevention; that is lifestyle behaviour modification.

Cancer Association of Zimbabwe monitoring and evaluation officer, Mr Lovemore Makurirafo challenged the nation to adopt healthy diets.

“Cancer, like most NCDs are lifestyle related diseases and I strongly feel that it’s high time that people take responsibility of leading healthy lifestyles,” he said.

“I also challenge the nation to revert back to the traditional diets that our ancestors used to have and also implement diets high in vegetables, fruits and roughage content.”

The Micro-nutrient survey (2012) indicated that stunting stands at 30 percent, Vitamin A deficiency at 21 percent, iron deficiency at 72 percent and anaemia at 31 percent in children under five.

A lot of attention in the health sector world over has been diverted to HIV/Aids, tuberculosis and malaria while the most chronic diseases were being side-lined.

66 percent of the world’s population is projected to be urban by 2050 an additional 2, 5 billion urban residents will live in Africa and Asia.

Malnutrition increases the likelihood of NCDs in later life, such as cancer, diabetes and cardiovascular disease.

Dr Madzima urges the nation to revise their lifestyles for the better.

“NCDs are no longer the diseases of the wealthy. Anyone can succumb to NCDs simply because they are lifestyle diseases-which are controllable,” he added.

“When drugs are available to reduce blood pressure, lower cholesterol, and improve glucose metabolism, the situation looks somehow under control. This appearance is misleading and blunts the urgent call for lifestyle change.

“People should adopt a health seeking behaviour which is not yet part of our culture. All epidemics are preventable and the strategies are already in place but it’s only that people don’t want to follow them,” he said.

To answer this call, Government devised Statutory Instrument 120 of 2017-Mandatory Food Fortification Programme—where food processing companies were compelled to add nutrients to everyday foods such as bread, mealie-meal, cooking oil and sugar to enrich consumers’ diet.

Healthy Living

A healthy diet is one that helps maintain or improve general health. It is important for lowering many chronic health risks, such as obesity, heart disease, diabetes, hypertension and cancer.

By becoming informed, making conscious diet and exercise decisions, and being proactive about their health, individuals can do a lot to prevent NCDs.

Health-promoting foods which include fruits and vegetables, whole foods, whole grains, fibre, beans and legumes and low-fat foods can significantly reduce the risk of NCDs.

Health experts also discourage the intake of ‘junk foods’ as most of these are processed foods, thus they are no longer in their natural state as they will be stripped of certain essential nutrients.

Experts on health caution on the avoidance of behaviours that will raise risk factors for certain diseases.
Round Table Indaba On The Public Procurement And Disposal Of Public Assets Act

By Patricia Jengera, Finance Manager

The Procurement Regulatory Authority (PRAZ) jointly held a workshop with the State Enterprises Restructuring Agency (SERA) on 15 March 2019, whose main objectives were to: discuss implementation of the Procurement and disposal of assets Act; assist on ensuring compliance with the law and inculcate and sustain a culture of effective and efficient procurement.

The Finance Manager of Health Professions Authority Ms Patricia Jengera attended the workshop on behalf of the Authority. It was highlighted that the basic principles of the Act were to promote openness, transparency, efficiency, public confidence, quality and fairness of process, eliminate corruption in procurement, accountability, confidentiality, value for money, access to information, accuracy of information and waste reduction.

**Transitional Arrangement provisions**

The PRAZ officials stated that state enterprises should achieve 100 percent compliance by the end of the two-year transitional period which expires on 31 December 2019. By the end of the transitional period, Procurement Management Units (PMUs) should be manned by people with the requisite professional skills.

The Act became operational on 1 January 2018 and therefore all procurement processes starting from that date should comply with the Act. It was emphasized that following of processes was not covered under transitional arrangement provisions. What was covered is the registration of the entity with PRAZ. All procuring entities are to apply for authority to conduct procurement. Procurement should move from other departments to the Accounting Officer assisted by the PMU.

PRAZ advised that new regulations were going to be published soon, which would include establishment of Procurement Council of Zimbabwe. The Council will be responsible for
certifying Officers and the Officers will be required to obtain licences to be able to conduct procurement business. PRAZ further explained that the size, structure and location of the PMU was the Accounting Officer's decision. The Procurement Officers could be assigned other duties, but however procurement should be their core function. It was highlighted that the Evaluation Committee was an ADHOC Committee set up to address specific requirements.

**Role of the Board and management in procurement**

The role of the board is on policy, monitoring and evaluation while management’s role is implementation. Procurement decisions should be taken by the Accounting Officer. If the decision does not come from the Accounting Officer, it should be in writing so as to shift accountability. A procurement plan should be authorised by the board. Quarterly board meetings should review implementation of the procurement plan.

**Role of the Special Oversight Committee (SPOC)**

The SPOC is chaired by the Attorney General, the Accountant General is the Vice Chair and the Principal Director Public Works and Auditor General are members of the Committee. The SPOC reviews process, it does not award contracts.

**Sanctions:**

PRAZ emphasised that the following attract a jail term, fine or both.

1. Procurement without authorisation.
2. Disclosure of information to people who are not concerned about the review process.
3. Awarding a tender before SPOC review where required.
4. Procurement without a plan.
5. Use of wrong procurement method.
6. Failure to observe bidding periods.
7. Contract terms different from tender (excluding other bidders for the same reason).
8. Failure to preserve records.

**Appeals procedure**

Appeals procedure is set out in section 73-77 of the Act. Bidders can challenge a decision through a written notice. No complaints are allowed after the signing of the contract. A contract shall not be signed until at least 14 days have passed following the giving of notice.

**Conclusion:**

In concluding the workshop, the Accountant General stated that PRAZ does not carry out any procurement but is only there for regulation and PRAZ monitors the process. The key component on procurement is planning, planning and planning. Bad contracts start at planning. There is need to have the right people in the right positions. Accounting Officers need to support the PMUs and there also need to take a holistic approach to procurement.
By Shamiso Yikoniko, Public Relations Officer

First Lady Auxillia Mnangagwa swore to continue working hard to ensure that there is affordable and quality health care for everyone in the country.

She echoed these sentiments after being conferred with a new role of becoming the Health and Child Care Ambassador at the Rainbow Towers Hotel on 06 May 2019 by the Health and Child Care Minister.

The First Lady was honoured for the great work she is currently undertaking to improve the health fraternity.

“It’s not an easy task but fortunately it’s within my nature that when I focus on a task, I make sure that it is done. A very special thanks to the Ministry of Health and Child Care for recognising the works that I am doing in the communities which I believe persuaded them to appoint me Ambassador for Health and Child Care,” she said.

“I make this solemn pledge today that I will work even harder to ensure there is affordable, accessible, and quality health care services for all.”

Amai Mnangagwa was previously an Ambassador for Maternal and Child Health.

“Aer realised that my works are not limited to maternal issues only, the ministry decided to appoint me to this new role,” she added.

The First Lady was accorded her new role at an event where she also launched the ‘Nursing Now Zimbabwe Project’ aimed at recognising nursing and midwifery’s role towards achieving universal access to health.

The Nursing Now project is a global campaign run in collaboration with the International Council of Nurses and the World Health Organization which aims to improve health globally by raising the profile and status of nurses worldwide – influencing policymakers and supporting nurses themselves to lead, learn and build a global movement.

Amai Mnangagwa said nurses and midwives contribute significantly to the reduction of maternal and neo-natal morbidity and mortality.

“Nurses are often under resourced and there’s need to capacitate them as they have a key role to play in contributing towards socio-economic development,” the First Lady said.

“There’s also need to give a voice to nurses and ensure they are given leadership positions in the health sector.

“Today we celebrate nursing and midwifery’s contributions towards”
achieving health for all and universal health coverage in Zimbabwe. The nursing services take eclectic models of care that are conceptualised within the context of primary health care.

“Nurses and midwives represent half of the professional health workforce. They play a critical role not only in delivering healthcare to people around the world but also in transforming health policies and promoting health in communities.

The launch of the Nursing Now Zimbabwe project signals a new chapter in the health delivery sector.

Health and Child Care Minister Dr Obadiah Moyo said they accorded the First Lady the new role to honour the work she is doing and pledged to improve service delivery in hospitals and respect the dignity of all patients.

“Amai has been championing and leading programmes that are to do with health across the country including the underprivileged,” Dr Moyo alluded.

“Primary health care and comprehensive services must be provided. And negative attitudes among workers can threaten the achievement of universal health coverage hence there should be good customer care and quality provision of services.”

World Health Organisation (WHO) country representative Dr Alex Gasasira who graced the occasion also congratulated the First Lady.

"On behalf of WHO director-general, regional director, the United Nations family in Zimbabwe, we would like to congratulate the First Lady for her recognition," he said.

Nurses are the cornerstone of health teams, playing a crucial role in health promotion, disease prevention, treatment and care.

WHO estimates that nurses and midwives represent nearly one-half of the total number of health workers around the world.

However, for all countries to reach Sustainable Development Goal 3 of health and well-being for all at all ages, WHO estimates that the world will need an additional 9 million nurses and midwives by 2030.

Dignitaries from the Health Professions Authority and all health councils also graced the occasion.

International Nurses’ Pledge

In the full knowledge of the obligations I am undertaking, I promise to care for the sick with all the skill and understanding I possess, without regard to race, creed, colour, politics, tribe or social status, sparing no effort to conserve life, alleviate suffering and to promote health.

I will respect at all times the dignity and religious beliefs of the patients under my care, holding in confidence all personal information entrusted to me, and refraining from any action which might endanger life and health.

I will endeavour to keep my professional knowledge and skill at the highest level and to give loyal support and co-operation to all members of the health team.

I will do my utmost to honour the international code of nursing ethics and to uphold the integrity of the professional nurse.
Health Ambassador conferment in pictures
IT OUTSOURCING ALLOWS YOU TO FOCUS ON WHAT IS CORE TO YOUR BUSINESS, LET US MANAGE IT FOR YOU

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The ethics of death

By Shepherd Humure, Secretary General

Medicine and biological sciences have taken the enormous strides over the past century. This progress has given medical practitioners an unprecedented ability to control human destinies, not least to exercise significant control over matters of life and death. But the fact that lives can be prolonged, and deaths postponed does not necessarily mean that the extra life gained is valuable or worth living.

Today many people live many years longer than they did a century ago. Diseases that were once a death sentence are now routinely cured, babies that would never once have reached full term can now survive for decades. However, for the elderly and infirm, living longer is not always living better. We have become adept at prolonging life though we are not always so good at putting a proper value on it. Is a life always worth living, or is it sometimes better to bring it to an end if it becomes unbearable?

Religious versus Secular Perspective of Life

In some religious traditions, life (human life) at any rate is sacrosanct. According to Christian teaching, life is a gift from God. Each body is the physical temple of the soul, an immaterial spirit that is the innermost aspect of our being. Therefore to bring a life to an end is to play God, in the sense that by doing so we take ourselves a prerogative that belongs only to the one who created us. It is sinful not to respect the sanctity of life, to show ingratitude to God by failing to cherish the priceless gift he has bestowed upon us.

Taking a secular perspective, many philosophers reject the idea that life is intrinsically valuable, or good in itself. They believe, rather, that there are sometimes circumstances in which it would be better to bring life to an end. In reaching decisions of this kind, the autonomy of the individual is usually paramount. Each person is generally presumed to be in the best position to assess the value of his/her own life and hence to decide, ultimately, if there is a life worth living.

Abortion
Religious convictions often exacerbate the dispute between those who support abortion (pro-choice) and those who oppose it (pro-life). The main bone of contention between them is the moral status given to the embryo. At the birth, it is (few would dispute) a distinct person with basic rights and interests that deserves full moral consideration. Most would say that to kill a baby at full term is wrong, but when does the embryo attain the status of being a person in the sense of having rights and interests? How are these right and interests to be weighed against those of the mother?

The Christian, more particularly Catholic, view is that an embryo is endowed with a soul at the point of conception and it is having a soul that makes it a person worthy of moral consideration. From this perspective, there is never a point at which the mother’s interests can trump those of the embryo. Termination of the embryo is never permissible, abortion is murder.

A biologist, by contrast, understands human gestation as a gradual process of development over time. There is no one point when an embryo can be said to turn from a collection of dividing cells into a human being. For the first two weeks, the embryo is a ball of cells with no central nervous system. So there is no possibility that it has any consciousness of pain. At this time, it cannot properly be said to have an individual identity and indeed may still develop into two or four distinct embryos. From this point the embryo gradually develops as the brain and spinal cord, then the limbs become increasingly apparent. The value we attach to the embryo is also incremental, growing as the inchoate (beginning to develop or form) life moves closer to a recognisably human form and person wood. In countries where abortion is permitted, this developmental understanding is usually reflected in legislation that is more permissive of early termination.

Doctor Assisted Termination of Life

The idea that human life is sacrosanct (very holy) and to be protected at all costs is no less relevant in the matter of euthanasia, where life that is already underway is brought to an end. Let me explain euthanasia in a rather pedestrian language. Euthanasia is the practice where, for instance, a very old or very sick person asks to be voluntarily killed because the old age or sickness is now unbearable. Indeed, the distinction between euthanasia and abortion is not very great.

The most significant difference, in the case of euthanasia, is that it may be voluntary. A patient, typically someone with a terminal condition and suffering pain that can no longer be adequately managed by drugs, may feel that her/his life is no longer worth living and requests assistance from the doctor in bringing it to a painless and (what she/he regards as) dignified end. Theoretically, the position here is that the state has no business to interfere with the considered views of its citizens in matters that do no harm to others. In such cases, an individual’s autonomy and her/his right to make decisions that affect the course of her/his own life should be paramount and the wishes should be respected. However, certainly the doctor’s autonomy should be respected no less than that of her/his patient. There should not be any pressure or obligation to carry out euthanasia if the doctor’s conscience suggests that she/he should not do it.

However, the principal objections to doctor’s assisted termination of life (voluntary euthanasia) are practical ones. Those who object question whether adequate safeguards are put in place to prevent abuse. Relatives of a patient or a patient’s enemies can come through the back door and may frame an agreement with the doctor to terminate the patient’s life, while records would still show voluntary euthanasia with forged or patient forced signatures.

Perhaps the commonest objection raised against voluntary euthanasia is that it represents the first step towards accepting the practice of doctor assisted suicide, carried out at the request of the patient. Fear is that if this practice is allowed, this will lead to other more offensive practices such as non-voluntary euthanasia. The crucial point about voluntary euthanasia is that it represents the first step towards accepting the practice of doctor assisted suicide, carried out at the request of the patient. Fear is that if this practice is allowed, this will lead to other more offensive practices such as non-voluntary euthanasia.
patient consent. Complications arise, certainly, when patients due to high illness lose the ability to give consent. In these circumstances, safeguards need to be put in place to make sure that the system is not abused as highlighted above. Such things as living wills suggest a way forward but the adequate safeguard is for the practice of doctor assisted suicide to remain illegal, as it is today in most countries including Zimbabwe. One common objection to doctor’s assisted termination of life is simply that the active taking of life is incompatible with doctor’s role and purpose to provide cure and care for patients. Killing has never been part of the job description of a medical doctor.

What is in it for Death and what is Death itself

Nothing in life concerns us so much as the ending of life through death. Death comes in many different forms including evil witchcraft (Uroyi). In his book, The Spiritual Beliefs of the Shona, under Muroyi (Witch), Michael Gelfand wrote that; “there are three kinds of witches (Varoyi) known to the Shona people. (1) Poisoning food (this is called chepfu or huroyi hunoshandisa mishonga. (2) Muroyi wemasikati – a witch who traps people by placing medicine on their path. When the victim steps on it he or she contracts a painful rheumatic disorder of his/her knees and joins called chipotswa. (3) Muroyi wedzinza – witchcraft carried out when possessed”. We thus live constantly in the shadow of death and much of what we do and think is coloured by the fact that our lives are finite and will inevitably end sooner or later. This is a universal truth. The word death has two quite distinct meanings. The death that we finally meet is an event or more precisely a process that brings life to an end. While death in this sense is the process of dying, it is by definition the termination of life and it is very much part of life too. There is no doubt that it befalls us when we are still alive. Death may also, however, refer to the state or condition that we are in after death. It describes a state in which there is no “us”, because the being that we once were is no longer existing.

Following the above, the question then is should we be afraid of death ? Is it rational to have such fear ? These questions mean very different things, depending on whether we mean the process of dying or the state of being dead. There is nothing irrational about fearing the process of dying, the final episode in our lives. We may die suddenly and painlessly in our sleep, but, unfortunately dying is often a nasty painful and undignified business. Some people may accept things without complaining than others when faced with the prospect of an unpleasant death, but it is clearly something that might reasonably make anyone feel apprehensive.

But what is the state of being dead ? or having ceased to exist ? or having ended our life on earth ? Some people believe that the end of our earthly existence is a point of transition to some kind of afterlife, another life that may be better or worse than our life on earth. Others, without religious or spiritual belief, think of dying as the end of life, plain and simple. They feel that beyond death nothing awaits us except physical annihilation. The implications of these two views are great and let me go deeper.

African Culture, Christianity, Islam, Hinduism and Buddhism

Believing that life on earth is not all there and there is some life after death may give grounds for fear or hope, depending on what is expected after death. Many cultures suppose that we have a spiritual component, a soul that survives the death of our physical body. Writing in The Spiritual Beliefs of the Shona, Michel Gelfand wrote that; “Each individual or nuclear family has its own ancestral spirits or spirit elders (vadzimu). These are members of the family who, when they die, become the guardian spirits of their children on earth. They are the spirits of the grandfather (sekuru) or the grandmother (ambuya)”. Many cultures, including African culture, perform complex rituals to prepare the dead for the afterlife. Anthony J. Dachs (University of Zimbabwe) in his book, Christianity South of the Zambezi, wrote that; “Kurowa guva (the bringing of the spirit home) is a very important event in social life of the
African. The custom is kept not only by those who are still pagans but also by many who claim to be Christians. As the churches have condemned this custom, those Christians who practise it do so secretly. The ceremony takes place one or two years after burial of the dead. The main reason for performing this ceremony is to bring the spirit home. If this is omitted, wittingly or unwittingly, there is a strong belief that the spirit of the deceased person will sooner or later bring misfortune to the family as a revenge for this gross neglect. In this sense the ceremony should be regarded as an appeasement of the spirit because it is based on fear of possible revenge. The belief is that the soul existed before and after the physical demise of the body. Modern Hindus, Christians, Jews and Muslims all have elaborate beliefs about post-mortem survival.

In each case, there is an explicit connection between the quality of an individual’s earthly life and the fate that awaits him or her in the hereafter. Hinduism and Buddhism, for instance, believe that each individual undergoes repeated rebirths, the length and form of which are determined by their karma (past life) according to the balance sheet of their good and bad deeds. African culture, Christianity and Islam, on the other hand, have elaborate visions of heaven and hell, where individuals are rewarded and punished for their behaviour on earth. Michael Gelfand in his book, The Spiritual Beliefs of the Shona wrote that; “If a person is murdered, his spirit becomes a vengeful one (ngozi) and seeks to destroy the murderer and his family. It demands compensation. There are three types of Ngozi and all three are believed to be able to bring disaster upon the guilty person; (1) Ngazi yekumutsira paguva – one that seeks to revenge through the living. (2) Ngazi yowakafa – the Ngozi spirit of a dead person. (3) Chikwambo – a ngozi which can be sent through a baboon (bveni), a hare (tsuro) or a snake (nyoka) to recover a stolen wife or property or retrieve a debt”. For followers of these religions and beliefs, the prospect of life beyond earthly death gives reasons for both fear and hope and is likely to have profoundest influence on their moral outlook during their time on earth. Once again let me go deeper into this.

The Philosophy of Death

Should people who do not believe in an after life fear death? Does it make sense to entertain fears about a future state of the world in which one simply does not exist? A famous argument to show that such fear is misplaced is that though death is regarded as the most awful of evils, it should in fact mean nothing to us. Why? Because death cannot touch us when we have ceased to exist and it cannot therefore harm us. It is foolish to fear something that cannot harm us. Indeed the time after we died is no different from the time before we were born.

Not everyone is convinced by this argument. Those who are not convinced may argue that death is bad for us because it damages our interests. They argue that it is not the state of being dead or non-existent that makes death bad, death is bad because it prevents us from having the various good things that we should have if we had not died. They argue that death leaves us worse off than we would otherwise have been, because some of our central desires are inevitably left unrealised. They further argue that some of the projects and plans that give value to our lives are left unfinished. They thus believe that death is harmful because it is a curtailment of life and thus a deprivation of good things. It is for this reason that they take a different view of the time before our birth and time after our death. They believe that the time before our birth does not deprive us of anything. We are not cut off from enjoying things that we might otherwise have had.

However, whilst the above arguments may stand, one would also argue that of course and by the same token, death may do us good by preventing us from suffering bad things that we would have suffered if we had lived (the wakafa wakazorora syndrome).

In conclusion, if death does the above harms, the best way to reduce the damage of death is to die later. We might well manage this by living healthier lives, for instance taking few risks. But these are matters of prudence, not morality. Beyond such prudential considerations, there may be nothing we can do to influence the time of our death. To the extent that it is pointless to concern ourselves with things that are beyond our control. If death is an inevitable deprivation of good things, then regret, rather that fear, might be the most appropriate response to it. Indeed, best of all would be to follow the advice that do not be afraid of death, live life to the full. We should live life to the full, making the most of the opportunities that life gives us and attending more to what we do than what we leave undone. Thus live life to the full, seize all the opportunities, go on holidays, marry a beautiful wife of your best choice and vice versa so that you will have nothing to regret when you die.

Acknowledgement:
Ethic Ideas – Ben Dupre
The Spiritual Beliefs of the Shona – Michael Gelfand
Christianity South of the Zambezi – Anthony J. Dachs
Surgeons at Parirenyatwa Hospital have conducted a world record operation after successfully removing a 12.3kg 11-year-old kidney cyst from a patient, a feat that speaks volumes of the country’s medical expertise and services.

The cyst becomes the largest to be removed in the world, with the previous record in Japan where a similar one weighing 11.5kg was removed.

The complicated surgical procedure was conducted by a team of local doctors led by consultant urologist Dr Shingirai Meki, who is also a lecturer at the University of Zimbabwe’s College of Health Sciences.

If conducted outside the country, the procedure costs upwards of US$11 000, but it was performed for just $2 000.

Addressing members of the media at Parirenyatwa Hospital yesterday, the institution’s clinical director, Dr Aspect Maunganidze, urged Zimbabweans to have faith in the country’s public health delivery system, saying it had competent medical professionals that are able to carry out most of the services sourced externally.

“We encourage the members of the public with various ailments to seek medical attention in our health institutions because we still have the experts who can provide such services,” he said.

The sentiments were shared by the head of the medical operating team, Mr Meki, who said with enough support, the majority of such services could be accessed locally, cutting on foreign medical tourism.

Speaking at the same occasion, the patient, Mrs Milka Gwatiringa, said she once sought services from South Africa as she doubted the efficiency of the local institutions.

She blamed the media for concentrating on negative coverage of the health delivery system, saying at times the media discourage patients from seeking help.

“I had so many fears because the media reports about our public health system,” said Mrs Gwatiringa. “I wanted to go to South Africa because the reports and the news that we sometimes hear about our public institutions leave a lot of doubt, especially when you are sick.

“After getting assurance from peers and friends and because it was expensive for me to get the services outside the country, I came to Parirenyatwa and here I am, the 11-year-old tumor has been removed.”

This is not the first time the country’s public health system has broken medical records.

In 2014 at Harare Hospital, a 50-member medical team successfully performed the first major operation to separate Siamese twins who were co-joined from the lower chest to the upper abdomen and shared a liver.
REPRODUCTIVE cancers for both males and females account for high percentages of morbidity and mortality as compared to other cancers, the latest cancer report has revealed.

According to the Zimbabwe National Cancer Registry (2013) (published August 2015) among black women, the most frequently occurring cancer is cervical cancer accounting for 32.1 percent of all cancers. And the leading cause of death in the country is cervical cancer contributing 13 percent.

The high percentages have been attributed to lack of health seeking behaviours.

To this effect, the Chinese Government, through Hunan Provincial Maternal and Child Health Care Hospital, partnered with the Ministry of Health and Child Care and donated equipment to be used for early cervical cancer detection.

The First Lady Auxillia Mnangagwa on 07 May, 2019 officially opened a third phase early cervical cancer screening camp at Parirenyatwa Group of Hospitals where women will be screened for free in a move aimed at fighting the scourge and encourage women to get screened for cervical cancer.

Officiating the event yesterday, the First Lady urged women to take advantage of the newly opened clinical camp and get screened early for cervical cancer.

"Today is a significant day for me as I witness two great hospitals from different parts of the world walking the talk in addressing this global health challenge," she said.

"As such, I would like to commend the kind gesture made by China through Hunan Provincial Maternal and Child Health Care Hospital to continue partnering Parirenyatwa Group of Hospitals in this noble cause.

"I have also noted that Harare tops the provinces in terms of the number of women with confirmed cervical cancer. It is therefore befitting that this screening and treating camp is done here at an institution in Harare."

The First Lady thanked the Chinese Government for donating the equipment.
“I would like to appreciate the equipment that you donated to this organisation and other resources that you have channelled towards this programme,” she added.

Cancer is a disease caused by an uncontrolled division of abnormal cells in a part of the body. When cancer starts in the cervix, it is called cervical cancer.

Human papillomavirus (HPV) is the main cause of cervical cancer. HPV is a common virus that is passed from one person to another during an intercourse.

Early on, cervical cancer may not cause signs and symptoms while advanced cervical cancer may cause bleeding or discharge from the vagina.

The developed world has managed to reduce the incidents of cervical cancer through the use of cytology-based screening - a great breakthrough in modern medicine.

Of the 275 000 cervical cancer deaths recorded annually worldwide, 85 percent occur in developing countries. And efforts in the Third World to replicate similar results have been setback by lack of resources.

Health and Child Care Minister Dr Obadiah Moyo said he was pleased that cervical cancer, which is a dreaded non-communicable disease among women, was receiving much attention in the country.

“I want to assure you that my ministry will continue to fight this plague and we shall not relent in this fight,” he said.

“This is the third time in three consecutive years that such a clinical camp has been held at Parirenyatwa Group of Hospitals and we hope that this phase will see over 3 000 women being screened and some receiving the necessary treatment.”

Speaking at the same event, Chinese Ambassador to Zimbabwe Mr Guo Shaochun said: “In response to the call for assisting in health delivery in developing countries including Zimbabwe, President Xi Jinping announced at the 2015 UN Sustainable Development Summit that China will implement 100 maternal and child health projects in developing countries, especially in Africa.

“This commitment is echoed by the presence of the First Lady Amai Auxillia Mnangagwa today whose devotion in women and children’s welfare has strengthened our faith in contributing towards Zimbabwe’s public health undertakings.”

HPV vaccine for prevention of cervical cancer was launched by the Government in 2014 and it will be administered to girls under the age of 10 years.
VIRAL hepatitis has been recognised by the Ministry of Health and Child Care as a condition of public health concern. World Health Organisation (WHO) estimates that at least 1.5 million people globally succumb to the ‘silent killer’ annually. Of concern is that Zimbabwe as a country does not have up to date data on the prevalence of hepatitis B and C for planning purposes; neither does it have a functional hepatitis programme.

In addition, the country does not have hepatitis plans to guide implementation of hepatitis activities. The process of designing and setting up a viral Hepatitis control programme requires concerted efforts from several stakeholders within the private and public health sector.

It is against this background that the Zimbabwean Government in partnership with the World Health Organisation (WHO) and other various stakeholders are working towards developing a National Viral Hepatitis Strategic plan (2019 – 2022) to bring the rising epidemic under control in the country.

Acting Permanent Secretary of the Health and Child Care ministry, Dr Gibson Mhlanga, speaking during a Stakeholder Consultative Meeting on Development of the National Strategic Plan Towards Ending Viral Hepatitis in Zimbabwe held in Harare in May, said a national strategy is required to tackle this neglected public health challenge.

Viral hepatitis is an infection that causes liver inflammation and damage. Inflammation is swelling that occurs when tissues of the body become injured or infected. Inflammation can damage organs. Researchers have discovered several different viruses that cause hepatitis, including hepatitis A, B, C, D, and E.

Symptoms of hepatitis include fatigue, loss of appetite, fever and jaundice.

Ministry of Health and Child Care’s director of AIDS and TB Unit, Dr Owen Mugurungi, shares an insight on the different types of hepatitis and risk factors.

“Hepatitis A and E are typically spread through contact with food or water that has been contaminated by an infected person’s stool. People may also get hepatitis E by eating undercooked pork, deer, or shellfish,” explained Dr Mugurungi.

“Hepatitis B, C, and D spread through contact with an infected person’s blood. Hepatitis B and D may also spread through contact with other body fluids. This contact can occur in many ways, including sharing drug needles or having unprotected sex.

“Moreover, chronic infection with hepatitis B and C viruses results in severe damage to the liver, which may lead to cirrhosis and hepatocellular cancer, the burden of which is particularly high in the African region.”

In November 2017, the Ministry of Health and Child Care conducted a rapid assessment of the status of viral hepatitis prevention, treatment, care and control implementation in the country.

Among the key findings were that there is strong political will and commitment to establish viral hepatitis services at all levels. Hepatitis B vaccine is part of the national infant immunization schedule and coverage has been increasing, estimated to 87 percent in 2015.
However, no Hepatitis B vaccination birth dose is included in the schedule and there is no policy on vaccination for health workers. There are no national guidelines for the assessment and treatment of acute and chronic viral hepatitis and no medicines specifically for the management of viral hepatitis in the public sector.

According to the WHO 2015 Global Hepatitis report, hepatitis B and C viruses are among some of the leading infections responsible for the greatest burden of disease at a global level.

WHO country representative Dr Alex Gasasira speaking at the same occasion hailed Zimbabwe for being among the first countries in Africa to set up a program for the prevention and treatment of this important public health disease.

"Viral hepatitis is an important international public health challenge, comparable to other major communicable diseases, including HIV, tuberculosis and malaria but despite the significant burden it places on communities across all global regions has been largely ignored as a health and development priority until recently," he said.

WHO recommends infants be administered an initial vaccination against Hepatitis 'B' within 24 hours of birth to prevent Hepatitis 'B' virus infection in the initial weeks of life.

In other parts of the world, Hepatitis 'A' immunisation is administered to children twice and may be routinely administered in areas with high incidence of Hepatitis.

In May 2016, the World Health Assembly adopted WHO’s first "Global Health Sector Strategy on viral hepatitis", with elimination as its predominant vision.

"Immunisation for Hepatitis 'B' is given three times within a period of one to six months, added Dr Mugurungi.

"Studies in Africa suggest that the transmission rate of infants born to HBV-infected mothers is currently between two and 30 percent. "And, because of general ignorance with regards to viral hepatitis, most people get diagnosed at a very late stage at which the virus would have become chronic, affecting the liver and consequently resulting in death."

Health experts concluded that the Hepatitis infection can be prevented by providing safe food and water, vaccination, screening of blood donations, provision of sterile injecting equipment and the use of condoms to prevent transmission of Sexually Transmitted Infections (STIs).

For success in the Viral Hepatitis program in Zimbabwe, still, at an early phase, Dr Gasasira, called on partners to consider supporting different components of this important public health intervention.

He said it was important to draw lessons and leverage on the strengths of pre-existing programs such as that for HIV to provide an effective response to the challenge.

He hailed Zimbabwe for being among countries that have made good progress in keeping the blood supply safe and improving injection safety in health-care settings which substantially reduces the risk of hepatitis C virus infections.
EMOTIONAL wellness is one of the seven dimensions of wellness, according to the University of California. It is the ability to successfully handle life’s stresses and adapt to change and difficult times. Being emotionally well is more than just handling stress. It also involves being attentive to your thoughts, feelings and behaviours, whether positive or negative and being able to understand how to handle these emotions. Wellness entails having an optimistic approach to life and enjoying life despite its occasional disappointments and frustrations. Emotional wellness inspires self-care, relaxation, stress reduction and the development of inner strength.

Evaluation of own emotional wellness

The following may be indications that one is emotionally unwell:

- Inability to maintain a balance between work, family, friends and other obligations.
- Lacking ways to reduce stress in one’s life.
- Inability to set priorities.

Strategies for improving emotional health:

- Brightening your outlook: People who are emotionally well have fewer negative emotions and they can bounce back from difficulties faster, they hold on to positive emotions longer and appreciate the good times.
- Reducing stress: Everyone feels stressed from time to time, stress can give a rush of energy when its needed most.
- Coping with loss: Learning healthy ways to help through difficult times such as talking to loving friends, joining support groups and talking to a doctor can help improve emotional wellness. Grieving is not an overnight process and therefore there is need to be patient with the grieving process.
- Strengthening social connections: Social connections might help protect health and lengthen life. There is need to build strong relationships with family, friends and community.

How a person feels can affect their ability to carry out everyday activities, manage relationships and overall mental health. Therefore, emotional wellness is a vital part of a human being’s wellbeing.

Adapted from National Institutes of Health- US Department of Health and Human Services- www.nih.gov
Zim’s road carnage curse

From the Public Relations Desk

HEALTH Professions Authority’s public relations officer attended a planning meeting at a local hotel in May 2019, which brought together all relevant stakeholders to spearhead a campaign aimed at reducing road carnage in Zimbabwe.

A meeting organised by the Ministry of Health and Child Care in conjunction with Traffic Safety Council of Zimbabwe (TSCZ) intended to address the road carnage menace as Zimbabwe continues to experience unacceptably high carnage on its roads as a result of numerous road traffic accidents.

The meeting was held under the theme; ‘Towards Reducing Road Traffic Deaths by 50 percent by the year 2030’.

According to TSCZ, about 90 percent of road accidents are a result of human error, speeding, overtaking errors, poor judgment, inattention, reversing errors and unlicensed drivers. Sadly, these can be avoided.

A total of 1 986 people died last year due to road accidents compared to 1 838 deaths which were recorded in 2017, while 10 489 were injured in 42 430 crashes that occurred in the same year, translating to 153 deaths monthly.

The 2017 accidents reveal a 10 percent rise from 2016 figures, which had 38 620 crashes that killed 1721 travellers.

In loose terms, five people die every day due to road accidents in Zimbabwe.

TSCZ managing director Mr Obio Chinyere warned public road users to observe caution.

“Pedestrians also need to be observant when crossing any road.”

Crashes have been identified both globally and domestically as a socio-economic challenge, a huge economic burden for developing countries like Zimbabwe.

The rising rate of fatal accidents, besides destroying families, is costing the economy millions of dollars.

“The country loses about $406 million every year due to road traffic accidents. This is almost three percent of our Gross Domestic Product (GDP) which is estimated at $14 billion,” added Mr Chinyere.

Health and Child Care ministry’s chief director of curative services, Mr Sydney Makarawo added that road carnage robs the nation of the productive age-
"Deaths and injuries from road traffic crashes affect medium and long-term growth prospects by removing prime age adults—those between 15 and 64 years—from the work force, and reducing productivity due to the burden of injuries," Mr Makarawo said.

However, Zimbabwe's health care system has been characterised with delays in attending to the victims.

"Shortages of resources and delays in detecting the scene of crash have been the hiccup of the health system," added Mr Makarawo.

"Hospital care has also been affected by lack of appropriate emergency care mainly due to lack of necessary resources, for example, lack of suture materials.

"Health care systems have also been affected with brain drain; many experienced human resources have moved out of the country for greener pastures leading to poor hospital care," Health Professions Authority public relations officer, Ms Shamiso Yikoniko, told the meeting.

According to the Zimbabwe Health Workforce Observatory, accessibility to services is also influenced by the economic status of the individuals so that those who afford to pay for the services are better cared for.

The 2030 Agenda for Sustainable Development recognizes that road safety is a prerequisite to ensuring healthy lives, promoting well-being and making cities inclusive, safe, resilient and sustainable.

Currently, the Zimbabwean Government is in a process of putting in action, the Decade of Action for Road Safety 2011–2020. Guided by the Global Plan, the Decade of Action offers a framework for policy, practice and advocacy to help countries achieve the Sustainable Development Goals.

"The Decade of Action seeks to save millions of lives by building road safety management capacity; improving the safety of road infrastructure; further developing the safety of vehicles; enhancing the behaviour of road users; and improving post-crash response," said Mr Chinyere.

The Decade of Action as proclaimed by the United Nations General Assembly is guided by five pillars which are:

Pillar 1: Road safety management
Encourage the creation of multi-sectoral partnerships and designation of lead agencies with the capacity to develop and lead the delivery of national road safety strategies, plans and targets, underpinned by the data collection and evidential research to assess countermeasure design and monitor implementation and effectiveness.

Pillar 2: Safer roads and mobility
Raise the inherent safety and protective quality of road networks for the benefit of all road users, especially the most vulnerable (e.g. pedestrians, bicyclists and motorcyclists). This will be achieved through the implementation of road infrastructure assessment and improved safety-conscious planning, design, construction and operation of roads

Pillar 3: Safer vehicles
Encourage universal deployment of improved vehicle safety technologies for both passive and active safety through a combination of harmonization of relevant global standards, consumer information schemes and incentives to accelerate the uptake of new technologies.

Pillar 4: Safer road users
Develop comprehensive programmes to improve road user behaviour. Sustained or increased enforcement of laws and standards, combined with public awareness/education to increase seatbelt and helmet wearing rates, and to reduce drink-driving, speed and other risk factors.

Pillar 5: Post crash response
Increase responsiveness to post-crash emergencies and improve the ability of health and other systems to provide appropriate emergency treatment and longer-term rehabilitation for crash victims.

Through participation of the Authority's public relations officer at the meeting, was selected to be part of the Secretariat which will organise a Road Safety Indaba scheduled to be held soon.
Parirenyatwa Group of Hospitals held the 2019 Nurses and Midwives Graduation and Prize Giving Ceremony on the 27th of September at the Old Hararians Sports Club.

The event was graced by Health Service Board ViceChairperson Prof. A Chideme-Munodawafa who handed out certificates and prizes to graduates and was also the Guest of Honour for the occasion. She was the representative of the Minister of Health and Child Care, Dr Obadiah Moyo. Prof. A Chideme-Munodadwafa read Dr O Moyo’s speech.

The Minister appreciated the work being done at Parirenyatwa Group Of Hospitals in the fight against non communicable diseases by providing the necessary knowledge and skills. We now have specialized nurses to handle cancer patients, mental health patients and diabetes mellitus just to mention a few.

My ministry is currently working on assisting in the training of specialized nurses in Accident and Emergencies,” said Dr O. Moyo.

He also said that Nurses must keep abreast with new technology, knowledge and skills as today's patients are techno-savy making them powerful to even challenge clinical processes.

On the same occasion, Parirenyatwa Group of Hospitals’ Principal Nursing Officer Ms Nomazulu Mpande presented her 2019 Report where she urged the government to increase the employment rate of qualified nurses in Municipal Clinics to decongest the central hospitals. She also said that workload in Central Hospitals has increased by 32 percent compared to last year and there were about 1000 unemployed but qualified nurses.

The ceremony saw the graduation of 240 graduands which is an increase from 2018’s 230 graduands. The event witnessed the graduation of Registered General Nurses, Midwives as well as specialist nurses in Ophthalmic Nursing, Intensive Care nursing, Nurse Aesthetics, Operating Theatre Nursing, Oncology Nursing, Renal Nursing, Mental Health Nursing, Community Nursing and Nursing Administration. Some of the graduands were from other health institutions throughout the country, because Parirenyatwa is a national training institution.- Parirenyatwa Group of Hospitals excerpt
Community Health Workers: A Priority for Universal Health Coverage?

By Shamiso Yikoniko, Public Relations Officer

AFTER recognizing the current gaps and challenges in the formal health delivery system and the critical role the individual, family and community play in promoting health, preventing diseases and successfully treating ailments, the Ministry of Health and Child Care in collaboration with other ministries, civil society, and development partners is working on developing a Community-based Health Strategy.

Health Professions Authority’s public relations officer was part of the team that worked on the consultation and validation of the Zimbabwe Community Health Strategy 2019 – 2023 in Mutare in August, 2019.

According to the National Health Strategy for Zimbabwe 2016-2020, the Government of Zimbabwe is reported to be committed to the involvement and participation of communities in the planning, implementation and evaluation of health services in the country. Some of the significant health sector achievements in Zimbabwe to date can be attributed to the contribution of communities in the implementation of health services.

However, the Government has realized that the efforts to empower communities have been done in the absence of an overall national strategy to guide all stakeholders on activities aimed at building the capacity of and involving communities. This has resulted in duplication of effort, inefficient use of resources and sometimes confusion.

The community health strategy (2019-2023) is poised to guide Government ministries and all other stakeholders that contribute or seek to contribute to empower and build communities to contribute to health services planning and implementation.

As Zimbabwe joins the world in the revival of the Alma Ata declaration of 1978 on Primary Health Care, health experts are challenging the
Government to take stock of our experiences to see what has worked well and what needs to be improved in our efforts to engage communities in health services.

From the early years of primary health care, community-based health workers and volunteers (CHWs) have played a key role in satisfying the need and demand for essential health services. The Alma-Ata Declaration states that primary health care “relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community” (WHO, 2013).

The values and principles set down at Alma-Ata continue to be relevant today, even though the primary-health-care movement has encountered difficulties in many countries and at many levels when seeking to put them into practice. With the growing momentum for making universal health coverage (UHC) a core strategy for shaping the post-2015 global health agenda, health experts are of the view that known barriers to coverage and access must be overcome.

Zimbabwe, like many other developing countries faces many challenges in its health system that prevent it from achieving the goal of universal health access for its citizens. Some of the key challenges are (a) inadequate professional health personnel like doctors, nurses, pharmacists, environmental Health Officers, Health Promotion and Education Officers and others; (b) reaching people living in remote areas or hard to reach areas (National Health Strategy for Zimbabwe 2016-2020).

WHO reports that international evidence indicates that meeting these challenges and addressing health disparities calls in part for a health system, particularly at primary care level, that is proactive, oriented to communities, families and individuals, comprehensive, participatory and linked with other services and activities that improve population health.

Thus the, Zimbabwe Community Health Strategy 2019 – 2023 comes in handy to cover the existing gaps identified in achieving universal health coverage. The strategy serves to address seven thematic areas based on the WHO Health Systems Framework: Community Health Service Delivery, Human Resources for Health (HRH), Community Engagement, Health Commodities, Medicines and Technologies, Financing, Governance, Leadership and Coordination, and Health Information Systems, Monitoring and Evaluation.

Financing Alliance for Health personnel told the meeting that universal health coverage is high on the global agenda as a means to ensure population health, equity and social development. In most countries where current access to essential health care is limited, introducing UHC prompts serious concerns among Government leaders on the growing expenditures and demands for public resources. As such, priority setting is indispensable and has been applied at various levels, to ensure that finite health resources can be used in the most cost-effective ways, to provide a high quality and appropriate package of healthcare for the population.

"Many low- and middle-income countries rely on a robust community health workforce, but few are self-sustaining, and many rely heavily on external donors. CHWs fill critical gaps while delivering quality, affordable services closer to underserved patients. Even during epidemics, CHWs can ensure the continuity of services while helping to stop epidemics," said Mr Tonderai Kadzere, deputy director for Policy and Planning in the Ministry of Health and Child Care.

"WHO posits that expanding access to community services could prevent up to 3 million deaths annually while substantially reducing patients' out-of-pocket costs."

Global Health Now (2017) reports that in Ethiopia, Community Health Extension Workers (CHEWs) prove instrumental in reducing maternal and child deaths. Countries including Ghana and Sierra Leone are training and deploying a combined 35,000 CHWs to bridge gaps. Even in American cities like Philadelphia, CHWs are delivering evidence-based health interventions to high-risk patients while reducing overall health care costs.

Mr Kadzere added that Zimbabwe has had a long history of community health services (CHS) planning and delivery dating back to 1980, when the then new government adopted Primary Health Care (PHC) as its chosen approach to health services delivery. Some of the notable achievements in health outcomes and impact can be attributable to the involvement of communities and use of CHWs include the high levels of family planning utilization, decreases in new HIV infections and deaths from AIDS.

In conclusion, the National Community Based Health Strategy 2019-2023 aims to empower frontline health workers. The strategy outlines that the CHW role should also be institutionalized in national health systems. Along with clearly defined responsibilities, they should receive ample recognition, incentives, and professional development opportunities. By doing so, countries can improve the quality of service delivery, ensure greater accountability to their communities, and increase CHW retention.
Coping with Hyperinflation

By Patricia Jengera, Finance Manager

In economics, hyperinflation refers to high and typically accelerating inflation. It quickly erodes the real value of the local currency as the prices of all goods increase. Hyperinflation can occur when a country increases its money supply while its gross domestic product stagnates or shrinks.

Hyperinflation effectively wipes out the purchasing power of private and public savings; distorts the economy in favor of the hoarding of real assets. This causes people to minimize their holdings in that currency as they usually switch to more stable foreign currencies, often the US Dollar.

The International Accounting Standards Board has issued guidance on accounting rules in a hyperinflationary environment. It does not establish an absolute rule on when hyperinflation arises. Instead, it lists factors that indicate the existence of hyperinflation and these are:

- The general population prefers to keep its wealth in non-monetary assets or in a relatively stable foreign currency. Amounts of local currency held are immediately invested to maintain purchasing power.
- The general population regards monetary amounts not in terms of the local currency but in terms of a relatively stable foreign currency. Prices may be quoted in that currency.
- Sales and purchases on credit take place at prices that compensate for the expected loss of purchasing power during the credit period, even if the period is short;
- Interest rates, wages, and prices are linked to a price index; and
- The cumulative inflation rate over three years approaches, or exceeds, 100 percent.

Most effects of hyperinflation are negative, and can hurt individuals and companies alike, below is a list of negative and "positive" effects of hyperinflation:

Negative effects are:

1. Hoarding of food and other commodities creating shortages of the hoarded items.
2. Distortion of relative prices.
3. Increased risk - uncertainties in business always exist, but with inflation risks are very high, because of the instability of prices.
4. Existing creditors will be hurt because the value of the money they will receive from their borrowers later will be lower than the money they gave before.
5. Fixed income recipients will be hurt because while inflation increases, their income doesn't increase, and therefore their income will have less value overtime.
6. Illusions of making profits - companies will think they were making profits while they're losing money if they don't take into consideration the inflation rate when calculating profits.
7. Causes an increase in tax bracket - people will be taxed a higher
percentage if their income increases following an inflation increase.

8. Causes mal investment - in inflation times, the data given about an investment is often deceptive and unreliable, therefore causing losses in investments.

9. Many companies will go out of business because of the losses incurred from inflation and its effects.

10. Currency debasement - which lowers the value of a currency, and sometimes cause a new currency to be born.

11. Rising prices of imports - if the currency is debased, then it’s purchasing power in the international market is lower.

"Positive" effects of inflation

Most positive effects of inflation are only positive to a few elite, and therefore might not be considered positive by the general public. However, it might relatively benefit borrowers who will have to pay the same amount of money they borrowed plus fixed interests, but the inflation could be higher than the interests, therefore they will be paying less money back.

How to Survive Inflation

Tips to avoid the negative effects of inflation include:

1. Be wise when holding cash, whether in your home or in your savings account, if you’re earning 5% interest on the money you have in your bank, and inflation rate is 10% then you’re losing 5% and not earning anything.

2. Invest in durable goods or commodities rather than in money.

3. Invest in things that you’re going to use anyway and will serve you for a long time.

4. Invest for long-term capital gains, because short term investments tend to give deceptive results or sense of making profits while, you’re not making profits.

5. Learn about bartering which is trading goods or services without the exchange of money.

6. Manage wisely your recurring monthly bills such as phone bills and cable TV as well as ephemeral items such as movies, restaurants, hotel rooms, it would help to reduce them or eliminate some of them.

7. Ask yourself, do I really need these things I’m spending my money on? Think how much and how often you will need something before buying it.

8. Reduce your consumption of things that are rising rapidly in price without having to reduce your consumption of goods that are rising less rapidly or even falling in price.

9. Buy only what you need, especially objects that have multi-tasks, and are considered durable goods.

10. Invest in real estate and inflation-indexed securities.

11. Invest in stocks that pay dividends. Dividend-paying stocks allow you to receive a regular pay out even as hyperinflation rages. Look for companies that have historically paid dividends to investors, regardless of economic conditions.

12. Buy Treasury Inflation-Protected Securities, or TIPS. These securities are bonds that are indexed to inflation, so their principal value rises with inflation, even if if it spirals out of control. The interest from the bonds also increases with the rate of inflation.

13. Acquire a primary residence. Owning a home protects you from soaring rent in times of hyperinflation. Lock in a fixed-rate mortgage and no matter how much the value of your property increases, your mortgage payment will remain the same. Furthermore, once you’ve paid off the mortgage, your fixed expenditures will be much lower, as housing costs will include only taxes, insurance and maintenance. According to the Los Angeles Times, “average real estate prices do appear to rise over long periods and, in recent decades, faster than the rate of inflation.”

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www.crisistimes.com
Introduction

The Health Professions Authority was invited to attend the first HPCSA Conference that was held at the Emperors Palace in Johannesburg, South Africa, from 18 to 20 August 2019. The conference was attended by the President of the Authority, Vice President and Secretary General. The focus of the meeting was for the HPCSA to meet the profession and inform them about the Council as well as getting their buy in on the Government Policy of National Health Insurance (NHI). The aim was to highlight the role of the regulator in the implementation of the NHI, to achieve universal health coverage (UHC) as well as looking at the regulator’s contribution towards advocating for good health and well being of the public of South Africa.

Official Opening by Minister of Health

This conference was officially opened by the Honourable Minister of Health, Dr Zweli Mkhize. In his presentation the Minister emphasized the need for the HPCSA to facilitate and organize the profession to ensure the full implementation of the universal health coverage, given the Ministry commitment in coming up with a Bill that will actualize the National Health Insurance (NHI). The Minister emphasized the need to adopt and embrace change in order to move forward. He thanked HPCSA for partnering with other health regulators in Africa in promoting quality healthcare delivery. The Minister spoke of inequality in health which was now believed as normal and is very worrying. He said the principle of social solidarity should be adopted where the young should subsidise the old, that is cross subsidization principle which was universal globally. He said this was a Universal Health Coverage value and it should see a factory employee sharing the same hospital ward with the country’s Prime
Minister.

The Minister said Private Public Partnerships (PPPs) were important for primary health care to reach NHI. He said NHI facilities should be of first choice and should appeal to the people. The Minister also emphasized the need for healthcare service providers to go out to patients to eliminate queues in public hospitals, instead of waiting for patients to come to hospitals.

Opening address Chairman of HPCSA

In his opening address the Chairman of the HPCSA, Dr Letlape, spoke on the need for the profession to be ethical by putting the interest of the patient first. He expressed deep concern about the ethical erosion that was apparent in the medical practice in S.A. He said ethics is above law and when law conflicts with ethics, we should change the law.

An example of medical trainees during internship who could not find their supervisors, poor communication, which was compromising care of patients. He spoke of the reputation of health regulation as a retirement village for practitioners in preparation for the grave. He said there was no an educational system for regulators and it was always a game of reaction and no follow ups to complaints. He said regulators were not acting as enablers of ethical behavior. He spoke passionately about the managed health care system that was prevalent in South Africa which was at the detriment of the vulnerable citizens of S.A. He said the Profession was now full of traders of health care, breach of confidentiality, all this happening at the watch of the regulators. Dr Letlape said as health service providers, we were seeing patients as clients. He said when we see patients as clients, we tailor the treatment according to the patient's wallet. He said Dr Chris Barnard never negotiated fees with patients he wanted to do heart transplant. He said Dr Chris Barnard applied universal healthcare system and his heart transplant system was the best healthcare system on planet. Dr Letlape said the rate of deprofessionalisation was very worrying, as health service providers were no longer patient focused. He said health service providers were no longer taking time to discuss with patients so that patients understand their diseases. He said in most cases patients were seen as irritating diseases and not people or human beings. He said if we are not professional, we will be replaced by Dr Google, as patients would simply google to understand their diseases better. He went on to say practitioners were now spectators and leave patients to health advisors. It was his view that the regulator should be an advocate for patients, he urged the regulators to find their pathway back to ensure that doctors gain their respect from society.

Keynote Speaker Director General National Department for Health : Role of the Regulator in Universal Health Coverage

In her key note address the Director General of the Ministry of Health, Ms Precious Matsotso, emphasized to the regulator to play its critical role of ensuring quality accessible care. Regulation in the 21st century should create an environment for quality health care by ensuring high quality systems embedded in Universal Health Coverage. Effective regulating systems are driven by professionals who believe in patient centred teams based on the values of respect for patients, education systems and Universal Health Coverage, transparency, quality patient safety and professionalism etc. She urged the HPCSA to review the Bill for National Health Insurance and advise the Ministry on its effective implementation. She urged healthcare regulators to guard against under regulation and self regulation.

2) National Health Insurance Dr Patel

Dr Patel explained to the profession the contents of the National Health Insurance Bill, which basically was about financing health care to South
African citizens. Thus, the citizens could access health care from both private and public health providers who will be paid from the NHI. Patients will also be accessing specialist health care which currently was not possible due to high costs. In this event HPCSA would have to take up the role of accreditation of health institutions, ensuring that there are group practices. The issue of ethical practice was emphasized. There would also be a need for HPCSA to ensure enhanced training of health human resources to address the issue of shortages. Private sector should also be taken on board in these reforms.

During Question and Answer session, the profession appeared reluctant as they had issues with the efficiency of HPCSA in taking up this extra responsibility. It was the view of the profession that HPCSA did not have the capacity to implement the NHI.

**Health as A Human Right :Professor Khama Rogo**

Professor Rogo spoke on the need for the HPCSA and the medical profession to embrace the government policy meant to enhance UHC which would improve the health care of the citizens of SA.

He also, amongst other things, challenged the profession to take advantage of the government Policy of NHI and provide leadership and governance in this initiative. He wondered why medical insurance was called medical aid in Africa when it was medical insurance globally. He said a study that was conducted showed that out of pocket was a big funder for health than health insurance. He said there were 85 % people not covered by health insurance in South Africa and yet this 85 % was seen as a problem, instead of a marketable and bankable population. He said instead of asking do I have a product that these 85 % of people need, we see them as an irritating population. He said that is why this 85 % irritating population is now running to India and business is now about East and West, whilst we remain South and North. He said India saw a business opportunity in this 85 % of the population we see as a problem and they came up with a pricing model of charging less to more people. He said this happened when South Africa was maintaining a business model of charging more to a few people. Professor Rogo said it was not about getting less, it was about getting more. He said if we look at even cancer, most patients with cancer go to India for palliative care than cure and India makes more business out of this. Where we see a problem, India sees an opportunity.

He said Africa’s health delivery system was not seen as a bankable area. He said in Africa, a healthcare building can be properly put up. The building is given the name of somebody and an opening ceremony is done and that is all. He said all what you hear about Africa’s health delivery system is strike, either people are planning to go on strike, people are on strike or people are coming out of strike. He said Africa was a poor continent that trained health professionals so well but the continent does not know where the trained people are. As a result, United States of America was full of South African doctors.

He said what we say and what we do is different. We set ourselves targets and said by year 2015 we would achieve Millennium Development Goals (MDG). Come year 2015, these were not achieved and we changed them to Sustainable Development Goals (SDG) with new targets. He urged South Africa to wake up.

**Dr Munyadziva Kwidza HPCSA Ombudsman**

In his presentation Dr Kwinda urged the profession to observe the ethical practice for public good

**Ethical Consideration in Telemedicine**

Professor A J Mbokadzi presented on the ethical consideration of Telemedicine consultations. The model of telemedicine presented was for the public sector. He emphasized on the importance of obtaining a signed consent on all telemedicine consultation or a verbal recorded consent which substituted a signed consent form. The patient and the consultant should be acquainted. The special consent form should be on a letterhead of the health care provider. It should also state who should be present during the consultation as well as type of information that will be transmitted. He further spoke on the pitfalls of telemedicine consultation that included:-

- Lack of adequate preparation.
- Lack of preparation of the patient.
- Falling short of patient expectations.

He emphasized that the consultant should ensure that all the paperwork has been done as well as familiarising themselves with the patients and meeting the expectations of the patients. They should ensure that there is a technician on site to fix any system challenges. Fundamentally confidentiality and privacy of the patient should be maintained.

He also indicated that there should be emergency medicine available in the background all the time. He warned against examination of private organs and to always check the patient satisfaction.

**STATEMENT OF COMMITMENT BY HPCSA**

"The HPCSA sees itself playing a pivotal role in aspects of the NHI in the following:
- The HPCSA, as the regulator, will support the NHI by ensuring quality assurance for universal health coverage and enforcing Professional Codes of Conduct and Ethics anchored on universally accepted principles on natural justice.

- The contracting of private health care providers through providing input on the general practitioners contracting model; as well as advocating for proper regulation of private hospitals.

- Enhancing the Human Resources for Health as the key component and driver of universal health coverage for health by ensuring that there are adequately qualified professionals trained and registered that meet the needs of the country by effectively carrying out its mandate of providing for control over the education, training and registration for and practising of health professions registered under the Act.

- The involvement of the public in ensuring the success of the NHI will be critical, thus the HPCSA will ensure continued community engagement and dialogues for empowerment on rights and responsibilities and the role of health regulators in health care; as well as ensure continued community engagement and dialogues for empowerment on rights and responsibilities.

- In terms of the Information technology, the HPCSA will ensure up to date regulations and accurate registers.

- In all of the above, the HPCSA and its Professional Boards commits to ensuring that the professions at the HPCSA contribute to the effectiveness and success of the NHI.

Lessons Learnt

1. Improve on Telemedicine Policy by including the ethical guidelines.

2. Continue to educate the profession on ethical and professional guidelines.

3. To improve on stakeholder relationships by attending professional meetings.
NOTICES AND REMINDERS

2020 Renewal

Due date for year 2020 renewal of Registration Certificates was 31 December 2019 and a non-compliance fee will be payable together with the renewal fee. Continued non-payment will lead to closure of the institution.

Kindly note that you can either swipe at the HPA Office or pay via Ecocash- Biller Code: 90741, or alternatively pay through mobile banking platforms or through bank transfer and submit proof of payment. Please ensure that you correctly write the name of your Institution as registered with HPA on the proof of payment and not the name of person making the deposit. This will enable us to quickly identify your institution payment on the bank statement and credit your account as paid in our books and update your file appropriately.

Our Bank details are as follows:

Account Name: Health Professions Authority
Bank: First Capital Bank (Barclays Bank)
Account Number: 6306148.
Branch: FCDA
Branch code: 2157

For purposes of updating the institution file, we require you to fill in the 2020 renewal form and return together with proof of bank deposit payment and the copy of the practitioner in charge’s 2020 practising certificate. Renewal forms can be downloaded on our website address given below. We also accept scanned documents through electronic mail.

If you have any queries, please contact Mrs Clotilda Chimbwanda, Deputy Secretary General on 0783137242, email: inspectorate@hpa.co.zw

Collection of HPA Certificates

All those that have received communication to collect their 2020 certificates please make arrangements to do so. Please remember that certificates are to be displayed within your health facility and in a conspicuous place. It is an offence to fail to display certificates as stated in the Health Professions Act (Chapter 27:19).

Closed and moving institutions

Practitioners that would have closed their facilities are urged to inform HPA so that their file and account is updated accordingly.

Those that intend to change location are required to notify the Inspectorate department and complete Material Change forms so that the new premises are inspected and that their certificate reflects the new address.

Reminder

The Health Professions Authority through its Public Relations department regularly sends out reminders and notices through newspaper advertisements and email notices.
In a bid to ensure that communication to you our valued practitioners is effective and received on time, we urge you to make sure that you supply us with a working email address that you also regularly check so that you do not miss any update from us. We will also be making use of Short Message Service (SMS) to alert you of any activities taking place in the Authority.

**Please get in touch with our Inspectorate Office on 0783 137 242 or 0772 613 429 or email inspectorate@hpa.co.zw to update your contact details.** Your continued support in this regard is greatly appreciated

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**HPA INITIAL INSPECTIONS**

HPA would like to advise Practitioners wanting to open practices of the following:

1. Only have an initial inspection appointment confirmed once you are sure that all the minimum requirements in the Health Institutions Registration, Inspection and Renewal Manual have been met.

2. Such confirmation should be in writing (can also be via e-mail inspectorate@hpa.co.zw)

3. Please be advised that should an inspection be confirmed and minimum requirements not be met, the Practitioner will bear the re-inspection costs.

4. The Health Institutions Registration, Inspection and Renewal Manual is available on the HPA website, www.hpa.co.zw or a hard copy can be obtained from the HPA offices...for free!
Congratulations!

The Board, Management and Staff of the Health Professions Authority wishes to congratulate Dr Agnes Mahomva on her new appointment as the Permanent Secretary in the Ministry of Health and Child Care.
We wish her every success in her new role.

Congratulations, Makorokoto, Amhlope!

Dr Agnes Mahomva
We have a moral obligation to provide healthcare solutions to the Zimbabwean populace

OUR SERVICES DIVISIONS
• Diagnostic Division
• Retail Division
• Healthcare Division
• Hospital Division

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Integrated Family Healthcare Under One Roof