



Tyranny and Disease
The Destruction of Health Care in Zimbabwe

Africa Fighting Malaria Occasional Paper
September 2007

Richard Tren, Archbishop Pius Ncube

Jasson Urbach and Roger Bate

AFRICA FIGHTING MALARIA
1050 Seventeenth Street, NW
Suite 520
Washington DC, 20036
United States

www.fightingmalaria.org

P.O Box 17156
Congella
4013
South Africa

Tyranny and Disease

The Destruction of Health Care in Zimbabwe

Richard Tren^{*}, Archbishop Pius Ncube[§], Jasson Urbach^{*} and Roger Bate[¶]

Zimbabwe's healthcare system has collapsed. Life expectancy is the lowest in the world. Dead bodies accumulate in hospital mortuaries or are buried hastily and surreptitiously in rural areas by poverty-stricken family members. The most recent estimates suggest that between 3,000 and 3,500 die every week from HIV-related diseases although some people believe the numbers are significantly higher. And biblical problems of plague, starvation and its attendant diseases such as kwashiorkor are rife. Few people even try to obtain medical treatment as they cannot afford the exorbitant costs involved in travelling to hospitals (ambulances have no fuel either) nor can they afford to pay for drugs since patients or family members are required increasingly to purchase their own drugs. In many instances, ambulances have been replaced by ox-drawn carts, but animal feed is also in short supply.

The health service like the entire country requires rescuing from the murderous hands of Robert Mugabe. But the African Union and most African leaders seems paralysed by Mugabe's status as one of the last surviving liberation leaders. The West is also paralysed by fears of being charged with neo-colonialism if they attempt to oust Mugabe.

So it is left to Zimbabweans, without the desperately needed support of the region to rid themselves of this increasingly tyrannical regime. Zimbabwe is set to become the world's worst humanitarian disaster over the next few years, as healthy working-age Zimbabweans continue to leave, swelling the ranks of the Diaspora, and the remainder - the elderly, the young and the seriously ill - succumb to poverty, disease and starvation.



Zimbabwean President Robert Mugabe

^{*}Africa Fighting Malaria; [§] Catholic Archdiocese, Bulawayo, Zimbabwe; [¶] American Enterprise Institute, Washington DC

Zimbabwe's health in perspective

For most of human history the average human being could expect to live between 20 and 30 years. It was not until the rise in global prosperity and technological advances of the 20th century that life expectancy began to increase so that by 2003 on average life expectancy was 66.8 years worldwide. The residents of the wealthy countries that make up the Organization of Economic Co-operation and Development could expect to live for 78.5 years.¹ While increasing global prosperity and technological advances continue to drive improvements in health and human welfare for most humans, the residents of some countries, particularly those in sub-Saharan Africa, have seen little improvement and routinely die from preventable diseases.

Zimbabweans once enjoyed rising life expectancies and benefited from improvements in healthcare and wealth creation. Most of the progress made over the past century has now been lost. Life expectancy in Zimbabwe has regressed to a level not witnessed since the 1800s. The once efficient and functioning public health system has been all but destroyed and private healthcare is out of reach for most of the population. Zimbabwe's health and human rights crisis is the direct result of the policies of the government; policies that have received either tacit or explicit approval from most African governments. This report presents a perspective of the increasingly chaotic healthcare situation in Zimbabwe and its impact on neighbouring countries, and concludes with a discussion and policy recommendations for African governments and donor nations.

Much of the data and information that we present has been compiled from media reports from within Zimbabwe and from exiled Zimbabwean reporters. Readers should note that it is often difficult to obtain reliable information about the situation in the country given the severe and oppressive restrictions on the media and on any persons or organizations that oppose the Mugabe regime. Although we have endeavoured to report the most reliable and accurate data by using independent sources, such as the World Bank or United Nations, given the dire situation in Zimbabwe, it is not unreasonable to assume that much of the Zimbabwean government's own data is unreliable, out-dated or biased. Apart from the fact that the Mugabe regime is well known for manipulating data and the truth, so many Zimbabweans have fled the country that population-based data will be unreliable. In many instances we have relied on media reports and first hand accounts of the situation in Zimbabwe.

Background

In March 2005, Africa Fighting Malaria released a report titled, "Despotism and Disease" which exposed the growing crisis in Zimbabwean healthcare. Since that time, the economic and political situation in Zimbabwe has worsened significantly and concurrently, with dire consequences for the healthcare situation.

Zimbabweans once benefited from a functioning and efficient public health system which was a legacy of the colonial and post-unilateral declaration of independence (UDI)

¹ Indur Goklany (2007) *The Improving State of the World* (Cato Institute, Washington DC) p.31

government. After the first elections open to all citizens in 1980 and the defeat of the Ian Smith-led government, Robert Mugabe's government continued to support and fund the public health system. Life expectancy at birth rose by nearly a decade from 54.9 years in 1980 to 63 years in 1988. The Mugabe government's healthcare policies ensured that the rate of child immunization nearly tripled between 1980 and 1988. Childhood immunization for diphtheria, pertussis and tetanus (DPT) increased to 75 percent coverage in 1986, 80 percent in 1994 and 81 percent in 1999, compared with an average of 32 percent, 51 percent and 48 percent respectively for sub-Saharan Africa as a whole. The improvements in primary healthcare ensured that between 1980 and 1998 infant mortality rates fell by 80 percent to 49 deaths per thousand by 1988.

Tragically the impressive investment and support for public health programs by successive pre-Independence governments and by the early Mugabe government has been lost.

While a student at Fort Hare University in South Africa, Mugabe developed a keen interest in Marxism and ordered books by Marx and Engels from London. His Marxist ideology hardened during his 10-year prison term in Rhodesia and was influenced by his Maoist allies in China.

Once in power, his totalitarian ideology was demonstrated by his desire to suppress opposition. In the first few years of his rule, the Zimbabwean Fifth Brigade, trained by North Korea and led by Perence Shiri, massacred suspected members and civilian supporters of the Zimbabwe African People's Union (ZAPU) in the Ndebele provinces of Matabeleland and the Midlands from 1982 to the late 1980s. The massacres, known as Gukurahundi, resulted in between 10 000 and 30 000 civilian murders². The current economic and human rights crisis has its roots in Mugabe's single-minded will to remain in power. Growing opposition to the ruling party Zimbabwe African National Union – Patriotic Front (ZANU PF) hegemony increased during the 1990s and the government's loss of a referendum on constitutional reform in 2000 sparked much of ZANU's subsequent repression and human rights abuses.

Suppression of the political opposition had been a feature of the Mugabe regime for many years, however in 2002 when the Public Order and Security Act (POSA) was passed into law by Parliament, almost any type of dissent was ruled unlawful. For instance, POSA gives the Minister of Home Affairs wide ranging powers to ban public gatherings and even to regulate small private meetings. The Public Broadcasting Act in effect destroyed much of the independent media in Zimbabwe, though two independent weekly newspapers are still published. Since independent journalists face almost constant intimidation, many have fled the country and continue to report from neighbouring states. Regulation of the media, including a requirement for journalists to register with the government, along with other repressive acts such as the Access to Information and Protection of Privacy Act (AIPPA) of 2002, mean that Zimbabwe has one of the least free

² Geoff Hill, *The Battle for Zimbabwe* Zebra Press, 2003, Cape Town

media in the world. In 2006, Freedom House ranked Zimbabwe 187th out of 194 countries based on press freedom³.

While the Mugabe government blames ex-colonial powers and Western governments for the current problems, in truth the economic crisis has its roots in the failed land reform process. Zimbabwean land reform involved reallocating, often with violence and intimidation, privately held land to supposed war veterans in a chaotic and illegal manner. As described by Craig Richardson⁴, the destruction of private property undermined one of the basic and most essential institutions of a market economy. Without secure property rights, individuals were unable to secure the value of their work. Furthermore, the banking and financial systems rely on secure private property to underwrite loans. The knock on effect of the destruction of private property resulted in a banking and credit crisis. This, along with the Mugabe government's deliberate interference with the legal system and undermining of the rule of law, all but destroyed the market system which had previously delivered economic growth and some degree of prosperity to Zimbabwe. Over the period 2000 to 2004 Zimbabwe contracted at an average annual rate of 5.9 percent.⁵ According to the World Bank's African Development Indicators gross domestic product per capita in real terms was lower in 2004 (\$457) than in 1980 (\$599).⁶ Over the period 2000-2004 GDP per capita contracted by 6.5 percent.⁷ For several years unemployment has been reported to be over 80 percent.⁸

In response to the economic crisis, the Zimbabwean Reserve Bank has frenetically printed money to support the corrupt, poorly financed and failing government-owned enterprises and to sustain minimal government services. The high growth in money supply has resulted in hyperinflation, conservatively reported by the Zimbabwean Central Statistical Office to be 7,634 percent in mid August 2007.⁹

The economic and political crisis has had dramatic implications for healthcare. Public healthcare institutions have been starved of funding and with formal employment a rarity in an economy ravaged by hyperinflation, most individuals have been unable to afford the meagre private healthcare available.

³ Only six countries have worse press freedom according to Freedom House; namely Eritrea, Burma, Cuba, Libya, Turkmenistan and North Korea. www.freedomhouse.org Freedom of the Press 2006

⁴ Craig Richardson "How the Loss of Property Rights Caused Zimbabwe's Collapse" Cato Institute *Economic Development Bulletin*. No. 4, 14 November 2005. Available at: <http://www.cato.org/pubs/edb/edb4.pdf>

⁵ World Bank "Africa Development Indicators 2006" *World Bank*, Washington DC, Available at http://siteresources.worldbank.org/INTSTATINAFR/Resources/ADI_2006_text.pdf

⁶ *ibid*

⁷ *ibid*

⁸ Central Intelligence Agency, World Factbook "Zimbabwe" <https://www.cia.gov/library/publications/the-world-factbook/geos/zi.html> Accessed September 10, 2007

⁹ According to the Consumer Council of Zimbabwe it estimated that for an urban family of six, inflation for the month of June was over 13,000 percent. Furthermore, the organisation estimates that a family of six now requires Z\$8.2 million per month to live an average life. The figure shows an increase of 13,445 percent in year-on-year inflation from Z\$61,097 required by the same size family in June 2006 (http://www.zimbabwesituation.com/jul27a_2007.html#Z6).

In 2005, the *Economist's Quality of Life Index* ranked Zimbabwe last among 111 countries surveyed.¹⁰ The countries were judged according to their gross domestic product, health delivery systems, unemployment rate and political stability. According to *Foreign Policy's* annual 2007 *Failed States Index*, Zimbabwe was considered the fourth most likely country in the world to fail.¹¹ The countries with the dubious honour of being ahead are Sudan, Iraq and Somalia respectively.¹²

As though the economic and political crisis had not done enough damage to the Zimbabwean people, on Africa Day, 25 May 2005, the Government of Zimbabwe launched "Operation Murambatsvina". Murambatsvina, translated literally as "getting rid of the filth" was an internationally condemned program that involved the demolition of largely poor urban people's houses, properties and businesses. While the Mugabe regime attempted to promote Murambatsvina as a program to enforce bylaws and prevent illegal trading, it was in fact a calculated move to undermine opposition to the regime and to force people out of the cities and into rural areas where the ruling ZANU PF has greater power and control. Operation Murambatsvina was conducted at the height of the icy Zimbabwean winter and was implemented without warning, targeting both formal and informal structures.

According to the United Nations, more than 700,000 people were left homeless as a result of Murambatsvina and even orphanages were specifically targeted. Following a fact-finding mission, UN Special Envoy Anna Tibaijuka reported that the "scale of the suffering is immense, particularly among widows, single mothers, children, orphans, the elderly and disabled persons. In addition to the already significant pre-existing humanitarian needs, additional needs have been generated on a large scale, particularly in the shelter, water, sanitation and health sectors."¹³

After worldwide criticism of Operation Murambatsvina, the Mugabe government launched Operation Garikai (Operation Live Well), which allegedly aimed to build new houses and resettle the victims of Murambatsvina. By May 2006 only 3,325 houses were built, a fraction of the 92,460 houses destroyed by Operation Murambatsvina¹⁴. In September 2006, Amnesty International reported that of the new houses, about one fifth had been reserved for defence and government officials (Zimbabweans that were not

¹⁰ The Economist Intelligence Unit, Quality-of-life index. Available at: http://www.economist.com/media/pdf/QUALITY_OF_LIFE.pdf

¹¹ Foreign Policy "Failed States Index 2007" available at: http://www.foreignpolicy.com/story/cms.php?story_id=3865&page=7

¹² Each country is given a score out of ten for a handful of political, military, social and economic indicators. These include demographic pressures, refugee numbers, economic growth, external intervention and the legitimacy of its government. The more unstable a country, the higher its total score (http://www.foreignpolicy.com/story/cms.php?story_id=3865).

¹³ United Nations "Report of the Fact Finding Mission to Zimbabwe to assess the Scope and Impact of Operation Murambatsvina by the UN Special Envoy on Human Settlements Issues in Zimbabwe, Mrs Anna Kajumulo Tibaijuka." P 45 United Nations, New York. Available at www.unhabitat.org/downloads/docs/1664_96507_ZimbabweReport.pdf

¹⁴ Ngobizitha Khumalo "Zimbabwe blocks efforts to shelter homeless people: Amnesty" *ZimOnline*, May 29, 2007 Available at: <http://www.zimonline.co.za/Article.aspx?ArticleId=1446>

affected by Murambatsvina)¹⁵. Operation Garikai should be viewed as yet another clumsy and shameless attempt to explain away the human rights abuses that have become the hallmark of the Mugabe regime. Furthermore, senior army and government officials have since been found looting the building supplies supposed to be used for Operation Garikai¹⁶.

Zimbabwe government policies that have forced the economy into freefall, robbing people of their jobs and savings, coupled with specific policies such as Operation Murambatsvina, have done substantial damage to the health status of ordinary Zimbabweans. Perhaps the greatest indictment of the Mugabe regime is that life expectancy at birth for Zimbabwean women is just 34 years and 37 years for men, according to the World Health Organization. WHO officials, speaking anonymously, reported that life expectancy for women is more likely to be only 30 years as the previous estimate was based on data collected in 2005¹⁷.

We focus below on the three most important diseases in Africa, HIV/AIDS, TB and Malaria and discuss the impact of the economic and political policies of the Zimbabwean government on their prevalence and treatment. We then discuss the political violence, malnutrition and the general destruction of health systems that harm all aspects of healthcare in Zimbabwe.

HIV/AIDS

The response from many African governments to the HIV/AIDS pandemic has been, more often than not, less than impressive. For several years, some African governments either chose to ignore or wish away their HIV/AIDS problem. The Zimbabwean government was, on the other hand, one of the governments that formulated policy responses early on. In 1987 the Zimbabwean government established the National AIDS Control Program to lead a national response to the problem. Realising that treatment for those in need would be expensive and would have to be sustained, in 1999 the government introduced a 3 percent levy on all taxable income to fund its AIDS prevention and treatment programs¹⁸.

In 2000, an Act of Parliament set up the multi-sectoral National AIDS Council (NAC) which is supposed to act as an umbrella organisation coordinating the various efforts to prevent transmission and care for those affected by HIV/AIDS. According to UNAIDS, the Zimbabwean National AIDS Council is, “providing leadership in strengthening national coordination within the framework of the ‘Three Ones’ [Three Ones refers to one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad-based

¹⁵ News 24, September 7, 2006, www.news24.co.za

¹⁶ Zimonline “Army officers arrested for looting building materials.” *ZimOnline* December 23, 2006, Available at: <http://www.zimonline.co.za/Article.aspx?ArticleId=673>

¹⁷ Daniel Howden, “Dead by 34: How AIDS and starvation condemn Zimbabwe’s women to early grave” *The Independent*, November 17, 2006

¹⁸ WHO “Summary Country Profile for HIV/AIDS Treatment Scale-Up” December 2005, WHO, Geneva, Available at http://www.who.int/hiv/HIVCP_ZWE.pdf

multisectoral mandate and one agreed country-level Monitoring and Evaluation System]”.¹⁹ While there is some logic to setting up the NAC, as we reported in our previous study, *Despotism and Disease*, the NAC has simply added a layer of bureaucracy to the fight against HIV/AIDS.²⁰ In June 2002, the Government of Zimbabwe declared the lack of access to HIV/AIDS treatment as an emergency and supposedly made US\$700,000 available for treatment in 2003 followed by US\$2.3 million in 2004²¹.

In 2006, UNAIDS reported several activities conducted in Zimbabwe designed to provide support and treatment to those in need. For instance, UNAIDS reported that there has been “increased adoption and maintenance of safer sexual practices particularly among people most likely to be exposed to HIV,” and “increasing coverage and use of high-quality prevention services including voluntary counselling and testing, prevention of mother-to-child transmission, condom promotion programmes and post-testing services that are gender sensitive and appropriate for young people.”²²

Zimbabwe is reported to have achieved a significant reduction in HIV prevalence in recent years though the reported UNAIDS HIV/AIDS prevalence rates among adults between the age of 15 and 49 is still 24.6 percent - one of the highest in the world.²³ Reports of reductions in prevalence could be due to increased migration of young sexually active people out of Zimbabwe as well as men reporting fewer sexual partners. With high unemployment and dramatically increased levels of poverty, epidemiologists report that on average men have fewer sexual partners and are not sustaining extra marital relationships, a view supported by Prof Alan Whiteside, director of the Health Economics and HIV/AIDS Research Division (HEARD) at the University of KwaZulu-Natal, in South Africa.²⁴

While a slight decline in the HIV/AIDS incidence may bring some positive news, for people living with HIV/AIDS and in need of treatment, the situation is often dire. The UN report on Operation Murambatsvina stated, “79,500 persons over 15 years of age living with HIV/AIDS have been displaced.”²⁵ As a direct result of the Operation, “several hundred persons receiving [Antiretroviral (ARV) treatment] have been reported displaced in Harare alone”.²⁶ The UN report continues and makes the important point that, “In cases where ARV treatment has been interrupted, this could result in drug resistance, declining health and ultimately death”.²⁷

¹⁹ UNAIDS, Zimbabwe Country Situation Analysis, 2007. www.unaids.com

²⁰ Richard Tren & Roger Bate, “Despotism & Disease” *Africa Fighting Malaria*, Johannesburg (2005) p14

²¹ WHO (2005)

²² UNAIDS Zimbabwe Country Situation Analysis 2007.

²³ According to the CIA world fact book Zimbabwe has the fourth highest HIV/AIDS prevalence rate in the world. Swaziland, Botswana and Lesotho occupy first, second and third places respectively (<https://www.cia.gov/library/publications/the-world-factbook/rankorder/2155rank.html>)

²⁴ IRIN “Africa – Falling HIV rates tell a complex story” *IRIN* August 2, 2007, Available at: <http://www.afrol.com/articles/26312>

²⁵ United Nations, p. 39

²⁶ Ibid p. 40

²⁷ Ibid

A consequence of Operation Murambatsvina and the broader Zimbabwe government policies that have severely hampered public health programs is that over 3,500 people are reported to be dying due to AIDS-related illnesses every week.²⁸

In 2004, the Zimbabwean government authorised the domestic production of generic versions of ARVs, utilising active pharmaceutical ingredients (API) from India with a goal of increasing access to affordable therapy. In June 2004 Varichem, a local pharmaceutical company, reported that it would produce nine different ARVs.²⁹ However, far from securing cheaper ARVs by September 2005, the price of the medicines had quadrupled. Between July and September 2005 the price of ARVs in pharmacies increased from Z\$450,000 to Z\$ 1.2million (US\$17 to US\$46 at 2005 exchange rates) for a month's supply.³⁰

In April 2007 media reports found that ARVs routinely cost between Z\$400,000 (US\$ 1,643 at the official rate, or approximately US\$11 at the more realistic market rate) and Z\$500,000 (US\$ 2,054 at the official rate or approximately US\$14 at the market rate) per month.³¹ On the face of it these prices appear reduced from the 2005 level, however at the end of July in 2006 the Zimbabwean government re-valued the currency, effectively deleting 3 zeros; these prices would formerly have been Z\$ 400 million to Z\$ 500 million.

Prices of ARVs jumped yet again in September with the locally produced Stanalev selling for Z\$5.9 million (US\$ 201 at the official rate or approximately US\$ 21 at the market rate). When one considers that the average wage, for the 20 percent of Zimbabweans that have some form of formal employment is only Z\$200,000 (USD 821 at the official rate or just US\$ 0.71 at the market rate) ARV treatment is out of reach for ordinary citizens, as are most basic commodities.^{32 33}

The Zimbabwe AIDS Network estimates that over 800,000 people are in urgent need of ARVs.³⁴ Yet a counsellor at The Centre, a Harare-based non-governmental organization that counsels infected people and offers training on long-term survival, maintains "...there are an estimated 40,000 people currently receiving anti-retroviral treatment at the Opportunistic Infection (OI) clinics."³⁵

²⁸ "HIV/AIDS rate falls", REUTERS March 20, 2007

²⁹ Plus News "Zimbabwe: Manufacture of cheap AIDS drugs starts." *Plus News*, Johannesburg, June 9, 2004. Available at <http://www.plusnews.org/PrintReport.aspx?ReportId=37090>

³⁰ Plus News "Zimbabwe: Price of ARVs rockets in declining economy" *Plus News*, Johannesburg September 30, 2005. Available at <http://www.plusnews.org/Report.aspx?ReportId=39012>

³¹ Stephanie Nolan, "I need tablets, but I can't have them" April 3, 2006 *Globe & Mail*

³² Reuters "Zim unions threaten new strikes over wages" May 2, 2007

³³ Zimbabwe Congress of Trade Unions "Workers Day Message by ZCTU President" May 1, 2007. Available at <http://www.zctu.co.zw/html/stmts/21920.shtml> accessed September 16, 2007

³⁴ April 22, 2007 Zimbabweans' desperate quest for AIDS drugs IWPR

³⁵ Matilda Chivasa "Zimbabweans' desperate quest for AIDS drugs," *Institute for War and Peace Reporting* April 22, 2007 http://www.iwpr.net/?p=acr&s=f&o=334975&apc_state=henh

With shortages of foreign currency, the local generic drug manufactures are unable to import API and stock-outs of ARVs and most other medicines have become commonplace. The Zimbabwean Congress of Trade Unions (ZCTU) has accused the authorities of reserving HIV/AIDS treatments for those that are politically well connected as opposed to those who most urgently require treatment.³⁶ Treatment for HIV is not required, especially in a severely resource constrained environment, until it has reached a certain stage (CD4 count lower than 200). In some instances, people who registered more than six months previously for the ARV roll-out have still not been given the drugs and many have lost hope of ever receiving them.³⁷

An important component of any HIV/AIDS treatment program is the ability to run CD4 counts, which essentially determines the state of a person's immune system. Yet the machines that measure CD4 counts at Parirenyatwa Hospital, the largest state hospital in Harare, routinely break-down. Patients are required to obtain CD4 tests privately which in most cases are prohibitively expensive, and hence most are not tested, which often leads to inappropriate drug regimes even for the fortunate few who receive any treatment. Local HIV/AIDS activists have reported that patients from Harare travel to Karanda Mission Hospital 16km away in Mt. Darwin, where the process is faster and where most ARV combinations are readily available.³⁸ Francesca Benza of the Zimbabwe Aids Network has noted that in some instances, people are travelling hundreds of kilometres to mission hospitals to get ARV treatment, which has the knock on effect that local residents could miss out on treatment that is planned for them.³⁹

The 2005-06 Demographic and Health Survey (DHS) for Zimbabwe finds that adult mortality has tripled between 1994 and 2005-06. Much of this is due to HIV/AIDS but the failure of treatment programs has meant that adult mortality has risen by around 40 percent among women and 20 percent among men between 1999 and 2005-06.⁴⁰

As an obvious consequence of the rise in adult mortality, the number of orphans and vulnerable children (OVCs) has increased sharply. The 2005-06 DHS finds between 1994 and 2005-06, "the proportion of children orphaned, i.e., with one or both parents dead, more than doubled between the two surveys, from 9 percent to 22 percent." The survey further finds that the proportion of children with both parents dead more than doubled between 1994 and 2005-06 from less than one percent to over 6 percent. In Zimbabwe, three in ten children are considered orphaned or vulnerable⁴¹. The situation is likely to be more acute since the publication of the Demographic and Health Survey as the economic crisis has worsened considerably.

³⁶ Reuters "Zim unions threaten new strikes over wages" 1 May 2007

³⁷ Matilda Chivasa, *IWPR*, 2007

³⁸ *ibid*

³⁹ *ibid*

⁴⁰ Zimbabwe Demographic and Health Survey, *Central Statistical Office*, Harare and *Macro International Inc.* Maryland, USA. p. 237

⁴¹ *Ibid* p. xxiii



"Alice", a desperately ill HIV positive Zimbabwean without access to ARVs. (source: The Zimbabwean)

Years of under-funding in the public health system, a chronic shortage of qualified healthcare professionals as well as stock outs and shortages of treatment have left those living with HIV/AIDS in desperate situations. Deputy Minister of Health, Edwin Muguti reported that although the Zimbabwean government plans to roll out HIV/AIDS treatment, it has neither the money to buy drugs nor the personnel to administer treatment. In the words of one HIV/AIDS activist, Emmanuel Masuke, "people will just drop out of treatment and wait to die in silence".⁴²

Tuberculosis

According to the World Health Organization, the tuberculosis epidemic in Africa, "grew rapidly during the 1990s, but this growth has been slowing each year, and incidence rates now appear to have stabilized or begun to fall".⁴³ The prevalence of TB in Africa is still the highest in the world, increasing 64 percent in 2005 with 511 cases per 100,000 persons (up from 310 cases per 100,000 persons in 1990) compared with the global average of 217 cases per 100,000 persons⁴⁴.

The prevalence in Zimbabwe rose from 254 cases per 100,000 persons to 631 cases per 100,000 persons over the same period (an increase of 148 percent). The incidence (new cases annually) of TB increased from 149 to 343 cases per 100,000 persons (an increase of 130 percent) while in Zimbabwe the incidence of TB increased from 135 to 601 cases per 100,000 persons (an increase of 345 percent).

TB mortality in Zimbabwe meanwhile increased by 189 percent (from 45 deaths per 100,000 persons in 1990 to 130 deaths per 100,000 persons in 2005). TB mortality for Africa as a whole increased by 89.7 percent over the same period.

While the Zimbabwean government should not be held responsible for all of the increase in prevalence of TB and consequent mortality, it must be held accountable for a significant portion of this increased burden. Controlling TB and effectively treating TB patients requires secure supplies of antibiotics and sufficient trained medical personnel to

⁴² Plus News "Zimbabwe: Costs of ARVs spiral" *Plus News*, Bulawayo, January 26, 2007

⁴³ WHO "Tuberculosis fact sheet, No.104" Revised March 2007. Available at: <http://www.who.int/mediacentre/factsheets/fs104/en/index.html>

⁴⁴ World Health Organization, Stop TB Partnership, www.who.int

monitor patients on the DOTS, or Direct Observed Treatment Short-course. According to the WHO, among the components of an effective Stop TB program are:⁴⁵

- Political commitment with increased and sustained financing
- Case detection through quality-assured bacteriology
- Standardized treatment with supervision and patient support
- An effective drug supply and management system
- Monitoring and evaluation system, and impact measurement.

The above components require a functioning health system and most importantly personnel that can fulfil these functions. Yet the WHO's tuberculosis country profile for Zimbabwe cites among the challenges that the government faces:

- Overcoming severe shortage of staff at all levels, especially at the central level, partly resulting from the movement of experienced National TB Program staff to the private sector and to other countries.
- Carrying out the plan for laboratory supervision, including quality assurance, with limited numbers of staff
- Preventing the loss of experienced managers at all levels in the public health sector that has reduced managerial capacity and contributed to a breakdown in the referral hospitals as primary care providers
- Ensuring adequate ordering and distribution of anti-TB drugs to prevent future stock-outs.⁴⁶

Despite the severe challenges that face patients and medical professionals with regard to TB, the Zimbabwean government has reduced the overall budget for the various TB activities from US\$16 million in 2005 to US\$13 million in 2006. No funding data were available for 2007⁴⁷.

With hyperinflation, shortages of food and electricity, and the breakdown of medical services, it is likely that TB patients will not receive the care and treatment that they need. The development of drug resistant TB and perhaps the highly resistant strain of extremely-drug resistant TB could ensue. As reported in the Zimbabwean Standard newspaper, the failed land reform program forced many people to settle in areas where there are no health services, which makes DOTS impossible or easily interruptible and could further exacerbate resistant TB⁴⁸.

Given the fact that TB is an infectious bacterial disease easily spread by coughing or sneezing, the ongoing emigration of Zimbabweans to neighbouring states should be seen as a matter of concern.

⁴⁵ World Health Organization, Stop TB Partnership, http://www.who.int/tb/feWHOatures_archive/stop_tb_strategy/en/index.html

⁴⁶ ibid

⁴⁷ WHO, Zimbabwe TB country profile, 2007, www.who.int

⁴⁸ Zim Standard "Drug resistant TB plagues Zimbabwe" September 9, 2007. Available at http://www.zimbabwesituation.com/sep9a_2007.html Accessed September 10, 2007

Malaria

As in much of southern Africa, malaria in Zimbabwe is seasonal and not prevalent year round.⁴⁹ Because of this, individuals living in malarial areas do not build up the partial immunity to the disease, as happens in areas that have year round transmission of malaria. The seasonal nature of the disease means that the country is prone to epidemics, with often rapidly spreading and intense outbreaks and high case fatality.

Malaria control is conducted through the use of insecticide treated nets and more prominently through indoor residual spraying (IRS), which involves spraying tiny amounts of insecticides on the inside walls of houses. While these insecticides are safe for humans and the environment, they are remarkably effective at killing the female adult *Anopheles* mosquitoes that spread malaria. IRS has been conducted in Zimbabwe since at least 1950 and for decades ensured that malaria was a minor health concern.

According to the 2005-06 DHS, 7 percent of children in Zimbabwe slept under any type of net, 4 percent slept under a net that had been treated with insecticide at some stage and only 3 percent slept under a net that was properly treated with an insecticide by the net manufacturer.⁵⁰

In recent years however, the Zimbabwean malaria control program has been starved of funds which has compromised malaria control activities and has interfered with sustained, regular interventions. As we reported in *Despotism and Disease*, in 2004 only 3.4 percent of the structures that were targeted for spraying were actually sprayed. The malaria control teams not only lacked insecticides, but also couldn't obtain the fuel that they required to drive into the malarial areas. The 2005-06 DHS notes that "among households reporting that spraying had taken place, there was also considerable variation in the length of time since the walls had last been sprayed."⁵¹

The result of this lack of control had been a sharp rise in malaria cases, possibly in excess of two million cases in 2004, five times higher than the low of 400,000 cases in 1992.⁵² Recognising the importance of cross border initiatives the South African government has assisted Zimbabwe with their malaria control programme on two fronts. First, it has provided technical assistance in the form of programme co-ordination, spray-operator training, advice and some support to run entomological studies. Second, it has provided some commodities, such as insecticides, necessary to conduct an effective malaria control programme.

⁴⁹ According to Zimbabwe's national malaria control program approximately half of the population are at risk of malaria (East and Southern African Annual Malaria Conference 2007, Entebbe, Uganda).

⁵⁰ Zimbabwe Demographic and Health Survey, *Central Statistical Office*, Harare and Macro International Inc. Maryland, USA. p. 175

⁵¹ Ibid p. 181

⁵² Estimates based on Zimbabwean government data and anecdotal evidence from health workers.

Specifically, in 2004 the SA government donated 10 tons of DDT for their IRS programme as well as 10,000 doses of anti-malaria treatment. Over the last few years the SA government has also provided various items such as spares for spray pumps used in the IRS process and protective clothing for the spray operators. Last year the SA government continued to assist the programme by providing a further four tons of DDT for their IRS programme. Since 2004 the Zimbabwean Ministry of Health has managed to improve coverage of IRS but with shortages of fuel and personnel, the activities have been conducted in a more haphazard way than would be advisable.

According to data recently presented at the East and Southern African Malaria Conference (ESAMC) held in Entebbe, Uganda, Zimbabwe reported a decline in the number of outpatient cases from 1.8 million in 2005 to approximately 1.5 million in 2006. Similarly, Zimbabwe reported a decline in the number of inpatient cases from approximately 45,000 cases to approximately 22,000 cases. Reported deaths also halved from approximately 1,800 to 900 over the same period.

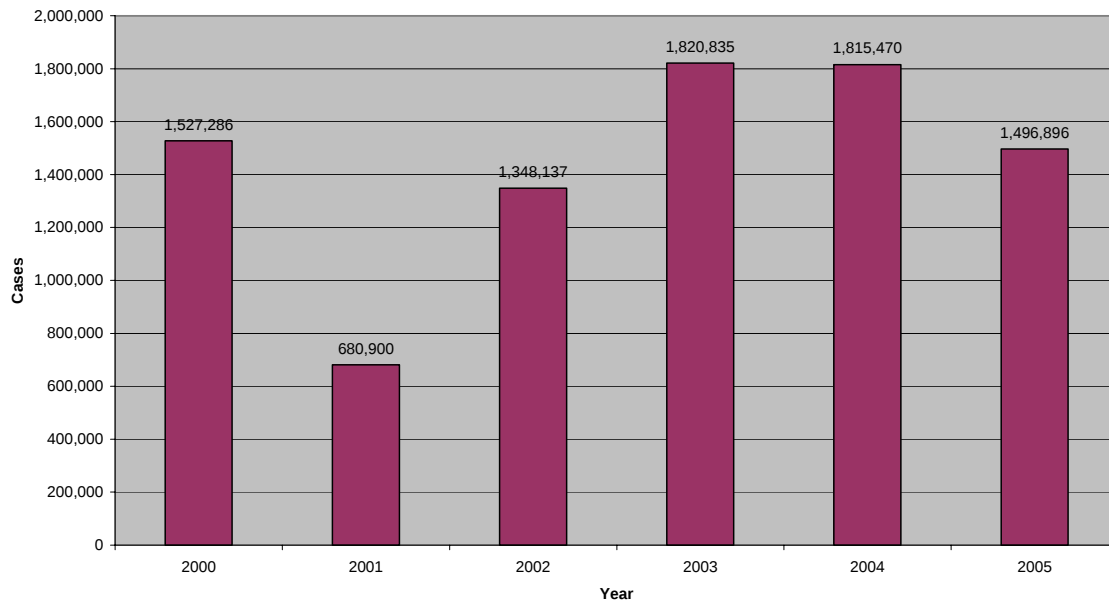
However, these statistics should not come as a surprise, particularly when one considers the mass exodus of Zimbabweans to neighbouring states coupled with the significant number of deaths of Zimbabweans from other immediate causes. Furthermore, the prohibitive costs of travel for the average Zimbabwean may simply preclude a visit to the clinic and people may be trying to cope with the disease at home. Unfortunately, there are no data available pertaining to stocks of anti-malaria treatments in the Zimbabwean government presentation at the ESAMC. Thus several different variables could account for the dramatic declines in the number of cases and deaths and the data should not necessarily be viewed as an improvement in the control programme.

The 2005-06 DHS provides some insight into the state of malaria treatment in Zimbabwe. The DHS finds “eight percent of children under age five had a fever in the two weeks preceding the survey. Among those sick with fever, 5 percent took antimalarial drugs, and 3 percent of the sick children received the drugs the same day or on the day after the fever started. Around seven in ten children whose fever was treated with an antimalarial drug were given chloroquine and the drug was available in the home when the child became ill in 34 percent of all cases.”⁵³

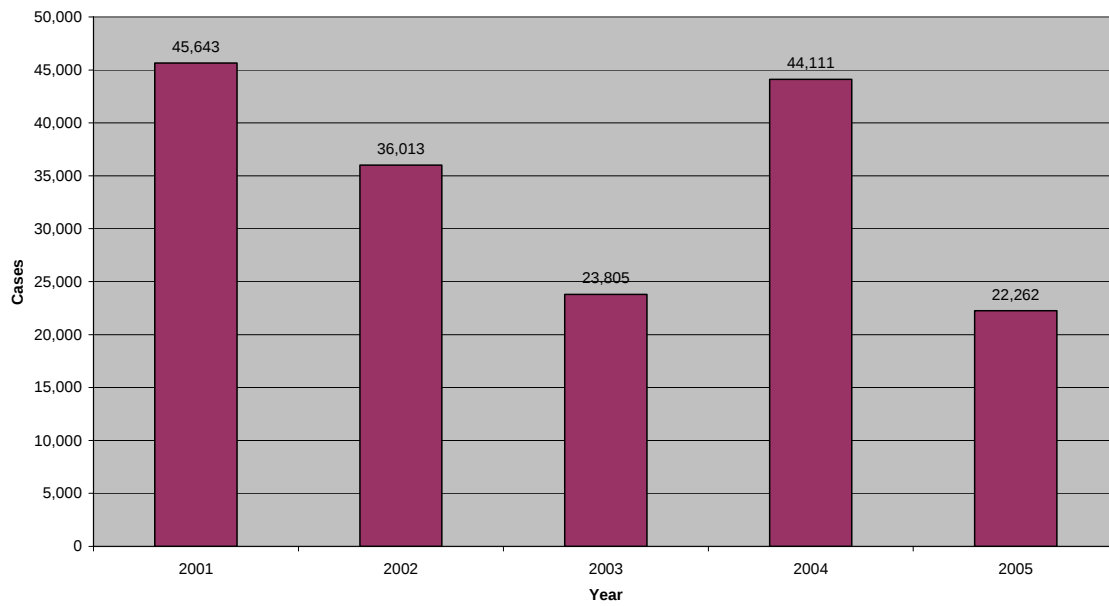
It is disturbing to note that chloroquine is being used to such a high degree in Zimbabwe as there is widespread drug resistance to chloroquine in almost all southern African countries. Treating with this medicine may reduce fevers, but will not clear the parasites out of the child’s body and will further exacerbate the resistance problem by selecting resistant strains of the parasite.

⁵³ 2005-06 DHS, p. 178

Zimbabwe: Annual OPD malaria cases



Zimbabwe: Annual Inpatient Malaria Cases



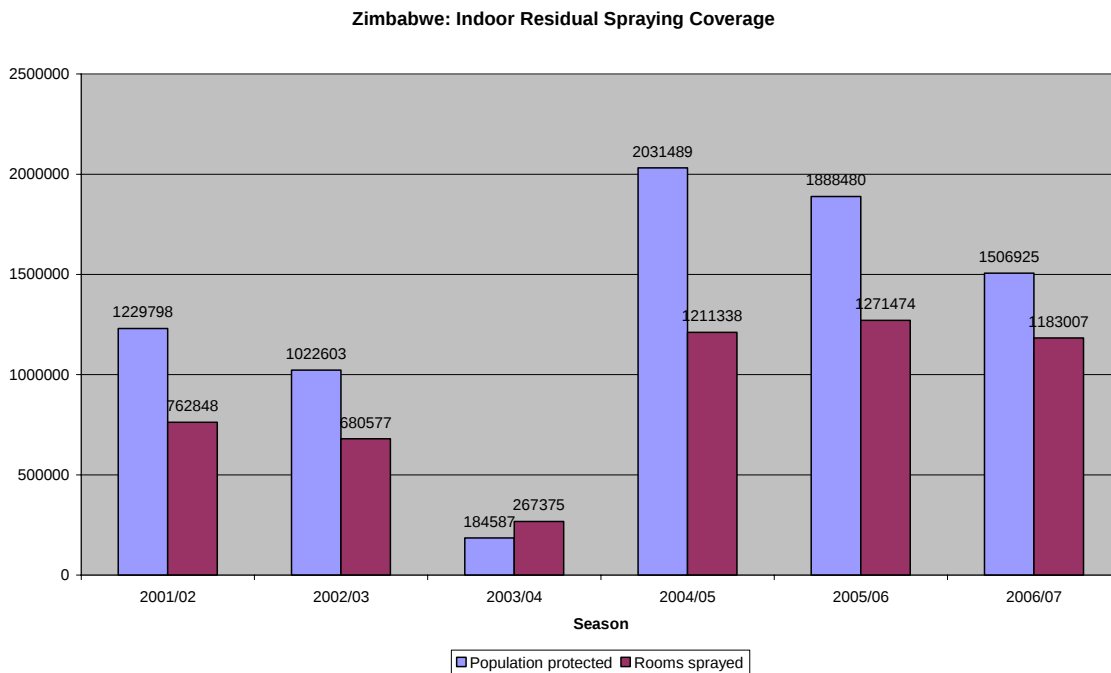
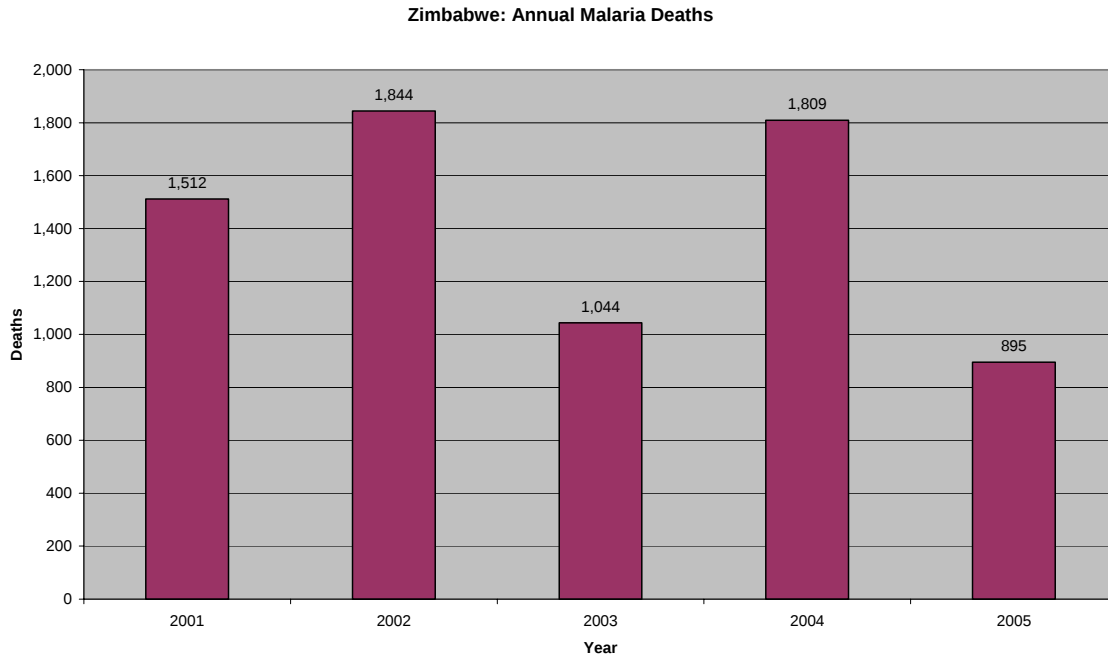


Table 1 below shows the malaria cases in Limpopo province as a percentage of the total number of cases in South Africa. After the political and economic turmoil in Zimbabwe starting in 2000, the province has accounted for a higher number of cases than other parts of the country. While some variation in cases can be accounted for in delayed spraying activities, changes in rainfall and climatic variability, the steadily increasing numbers of Zimbabwean refugees must account for a significant portion of this higher burden.

Table 1 Malaria cases in Limpopo Province as a percent of total South African malaria cases

Year	Limpopo province malaria cases as percent of total SA cases
1999	22
2000	15
2001	27
2002	31
2003	52
2004	37
2005	45
2006	53

Source: South African Department of Health

Considering the large number of Zimbabweans fleeing the country we could expect a higher level of malaria transmission on a regional basis.

The Zimbabwean government's ability to treat malaria cases has been compromised by the economic and political crisis. Malaria is entirely curable and as long as patients seek diagnosis and treatment early, no deaths should occur. South Africa, which has a functioning and efficient malaria control and treatment program, consistently reports a case fatality rate of below 1 percent. Zimbabwe on the other hand has a case fatality rate around four times higher, at around 4 percent for the period 2002 to 2005.

Political violence

Torture, assault, unlawful detention and other violations of human rights are increasing rapidly in Zimbabwe, according to a new report released in August 2007 by the independent Zimbabwe Human Rights Forum.

In its analysis, the Zimbabwe Human Rights Forum said the violations documented, between January 1 and July 31, 2007, included two politically linked deaths, 508 cases of torture, 657 assaults by state personnel and militants, 1,077 cases of unlawful arrest and detention, 950 incidents of political victimisation and intimidation, and 2,233 violations of freedom of expression and movement. Forum officials said the increases this year came primarily in state-orchestrated rights violations. Reported human rights violations between January 1 and July 31 2006 totalled 3,468; the reported violations over the same period in 2007 have increased by almost 90 percent to 6,527 incidents⁵⁴.

⁵⁴ [Zimbabwe](http://www.hrforumzim.com/frames/inside_frame_monthly.htm) NGO Human Rights Forum. Political Violence Report, July 2007. Published September 10, 2007. Available at: http://www.hrforumzim.com/frames/inside_frame_monthly.htm Accessed September 10, 2007

Emboldened by the lack of public censure from the African continent, the Mugabe government's most savage attack on opposition members took place in Harare on Sunday March 11, 2007.

As officials, supporters and church groups began gathering at Highfield township for a Save Zimbabwe prayer meeting, the area was stormed by riot police. People were rounded up, made to lie down in rows and then beaten viciously in relays by police armed with iron rods, rubber truncheons and wooden batons.

The victims included a woman who was seven months pregnant and lost her baby as a result.



MDC leader Morgan Tsvangirai (left) and Lovemore Madhuku after being beaten and tortured by Zimbabwean police. (Sokwanele)

More than 200 opposition Movement for Democratic Change (MDC) members were arrested, separated and taken to at least 15 police stations where the assaults continued. The long list of injuries included serious eye damage, deep lacerations, severe blunt-force trauma to the abdomen, ruptured bowels, fractured limbs, broken ribs, shattered joints, burst eardrums, gunshot wounds and excessive damage from blows to the back, shoulders, buttocks and thighs.



Opposition MP, Nelson Chamisa after he was beaten by suspected agents of the state at Harare International Airport. (Daily Mail.)

Many of the victims were denied access to medical attention at government hospitals, necessitating expensive treatment at private clinics. Those with the most serious injuries had to be flown to South Africa for emergency surgery. They included 64 year old Sekai Holland, Deputy Secretary for Research and Policy. By mid April 2007, more than 800 men and women of all ages had been abducted, beaten and in numerous cases, tortured.

During July, 160 people, including nursing mothers and grandmothers, were rounded up at the offices of the National Constitutional Assembly (NCA), an organisation dedicated to constitutional reform, after activists tried to hold a demonstration. They were taken to Harare central police station where they were beaten continuously with metre-long, heavy rubber sticks for up to five hours. This was the largest mass assault yet carried out by Zimbabwean police.

In an article published on March 26, 2007 in South Africa's Mail & Guardian, the newspaper's publisher, Trevor Ncube, wrote: "Examination will show us that to chronicle this as the work of a desperate regime is inaccurate. It is the deliberate strategy of President Robert Mugabe, whose bid to extend his rule until 2010 has failed. He therefore believes violence might secure him extended political tenure."⁵⁵

The destruction of the wider health services has affected ordinary Zimbabweans, most of whom will not be politically active. The ongoing political violence and victimization of any opponent of the Mugabe regime and the specific denial of healthcare should be viewed as state-sponsored terror.

Malnutrition and other diseases

With Zimbabwe's failing infrastructure, safe water supplies are becoming increasingly rare and the residents of most towns and cities can no longer depend on the once potable water or the sewage treatment services. Thanks to contaminated water, Harare's Director of Health Services, Prosper Chonzi notes that around 900 cases of diarrhoea are reported every day in the city. In the town of Kadoma to the southwest of Harare, the deaths of 20 children in July 2007 were traced to contaminated water supplies⁵⁶. Water shortages in Zimbabwe's second city, Bulawayo, have resulted in "record high numbers of diarrhoea" as well as cholera and dysentery, according to the Bulawayo City Council.⁵⁷

In addition to the specific diseases detailed above, many Zimbabweans face severe food shortages. Food has been used in Zimbabwe as a political weapon and the denial of food and food aid to areas and to individuals that do not support the Mugabe regime is well documented.⁵⁸ A lack of adequate nutrition will, naturally, compromise the immune system of any individual and make him or her more susceptible to diseases, such as HIV/AIDS and TB.

As a result of starvation, malnutrition-related diseases, such as kwashiorkor, are increasing. A report released during August by the Harare City Council's Department of Health Council states that cases of kwashiorkor (acute under-nutrition or wasting), increased by 43.7 percent in 2006 over the previous year's figures. The report notes most

⁵⁵ Trevor Ncube, "Quo Vadis Zimbabwe" March 26, 2007 *The New Zimbabwe*
<http://www.newzimbabwe.com/pages/opinion252.16174.html>

⁵⁶ Reuters "Zimbabwe water woes spark diarrhoea outbreak" *Reuters*, August 21, 2007

⁵⁷ Nqobizitha Khumalo "Cholera, dysentery break out in water-starved Bulawayo." *ZimOnline*, September 17, 2007.

⁵⁸ Human Rights Watch "Food Used as a Political Weapon" October 24, 2003. available at:
<http://hrw.org/english/docs/2003/10/24/zimbab6477.htm>

of the cases were recorded in Harare's working class suburbs of Dzivarasekwa, Kuwadzana, Mabvuku and Mbare, where there is widespread poverty. Grade Three children were found to be worse off than Grade Ones. In an article published in The Telegraph (UK) on September 13, 2007, journalist Sue Lloyd-Roberts described a child's skin as raw and pink, as if she had been severely burned. The ward sister explained, "It is the most extreme form of kwashiorkor – vitamin deficiency." The child was so malnourished she was literally losing her hair and skin, the journalist wrote.⁵⁹

The United Nations Children and Education Fund (UNICEF) reported in 2006 that there had been a serious deterioration in care for Zimbabwean children, resulting in many deaths of children under the age of five.⁶⁰

The US based Famine Early Warning System (FEWS) reported in August 2007 that the Zimbabwe government maize imports are ahead of schedule with almost 115,000 metric tons imported from Malawi. While FEWS finds this progress encouraging, the report goes on to state:

"The Grain Marketing Board's (GMB) ability to distribute available grain is a serious concern, as in the past, GMB distributions have been erratic and have not been coordinated with relief efforts and local shortages have been common."⁶¹

As FEWS explains, the price controls on basic commodities introduced by the Mugabe regime resulted in severe shortages of almost all products and in "some cases the price controls are making operations for producers non-viable altogether."

Allegations by Zimbabwean human rights campaigners that the price controls and subsequent importation of food will be used as a political weapon are credible, given the history of such action in Zimbabwe in the past⁶². During mid August it was reported that the Mozambican government was withholding 36,000 tonnes of wheat destined for Zimbabwe pending payment of US\$15 million owed by the Zimbabwean government for the grain. The wheat had arrived two months previously.⁶³

Collapse of Zimbabwe's health care service

In June 2007, the Zimbabwean Association of Doctors for Human Rights (ZADHR) reported the country's health service was no longer in danger of collapse, but had indeed

⁵⁹ Sue Lloyd-Roberts "Zimbabwe families forced to beg for scraps" *Daily Telegraph*, London. Available at: <http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2007/09/13/wzim113.xml> Accessed September 14, 2007

⁶⁰ Prince Nyathi, "10 percent of Harare's school children suffering from kwashiorkor: report." *ZimOnline* August 11, 2007, Available at: <http://www.zimonline.co.za/Article.aspx?ArticleId=1831>

⁶¹ Famine Early Warning System "Zimbabwe Food Security Update" August 15, 2007. FEWS, <http://www.fews.net/centers/innerSections.aspx?f=zw&m=1002519&pageID=monthliesDoc>

⁶² Sokwanele, Zimbabwe Election Watch No. 4, August 17, 2007 www.sokwanele.com/thisiszimbabwe

⁶³ Kumbirai Mafunda "Mozambique: Govt Seizes Zimbabwe Wheat." *Financial Gazette*, Harare, Available at: <http://allafrica.com/stories/200708170516.html> Accessed September 14, 2007.

collapsed⁶⁴. Most staff could no longer afford to reach their posts since transport fares exceeded monthly incomes and Zimbabwe was facing acute shortages of drugs and basic medical supplies. The blame for this collapse, lies, according to ZADHR, with the government of Zimbabwe."⁶⁵

The escalating crisis was confirmed by the Catholic Health Association of Southern Africa (CATHCA), which reported that the breakdown of the government health system was resulting in church hospitals and clinics being overburdened with patients.

Following a visit to Zimbabwe, CATHCA director, Tom Smith, recounted that the problems included "very little electricity supply, little water, lack of medicines, lack of staff, and lack of some of the basics such as bed linen, gloves and syringes."⁶⁶

State hospitals lack the means to pay for even the most basic drugs such as anti-inflammatory painkillers and pills to battle hypertension. They have no functioning radiotherapy machines and rely on donations from churches for chemotherapy drugs. Families of hospitalised patients are informed they will have to purchase intravenous drips before the patients can be operated on, but the cost of an IV sachet is out of reach of most. People are now taking their seriously ill relatives out of the government hospitals, preferring that they die at home⁶⁷.

BOX 1 Tragic shortages of basic supplies

Anecdotal evidence describing the devastating and shocking conditions in Zimbabwe's failing public health care system was recently portrayed in an article by Sebastien Berger entitled *Zimbabwe's hospital system beyond help*. The article appeared in The Daily Telegraph (UK newspaper) on 2 August 2007.

The journalist interviewed a doctor in the back seat of a car outside one of Zimbabwe's five central hospitals, which the journalist describes as one of the biggest and supposedly best equipped healthcare centres in the country that is now in a desperate state of decay.

The doctor who refused to be named for fear of reprisals cited the example of a young girl admitted after a falling rock crushed her thigh and broke her shin. "I couldn't clean the wound except with tap water. She needed surgery but there were no anaesthetic drugs. After three days we could operate but by that time gangrene had set in. We had no antibiotics and ended up amputating her leg. She is a 10-year-old girl".

⁶⁴ Zimbabwe Association of Doctors for Human Rights (ZADHR) "Prevailing Health Sector Emergency" June 1, 2007, available at

http://www.kubatana.net/html/archive/hr/070601zadhr.asp?orgcode=zim065&year=0&range_start=1
accessed August 21, 2007

⁶⁵ ibid

⁶⁶ Catholic Information Service for Africa "Catholic Hospitals Burdened as Public Health Services Collapse" *Catholic Information Service for Africa*, August 3, 2007. Available at:
<http://allafrica.com/stories/printable/200708031002.html>

⁶⁷ Norman Chitapi "Grim Harare Hospitals Highlight Hospital Crisis" *Institute of War and Peace Reporting*, http://www.iwpr.net/?p=acr&s=f&o=335112&apc_state=heniacr2007, April 25, 2007

The doctor went on to list some basic medicines and devices that are simply no longer available in the hospital such as: penicillin, insulin, painkillers, bandages, hydrogen peroxide, gauze, plaster, X-ray film, sterile gloves, surgical blades and intravenous fluids.

The doctor noted, “Patients have to wait for hours to see a doctor and must buy all their own medical supplies. If they cannot pay they cannot be treated” he said, pointing out that the first litre of intravenous fluids and a set of equipment to administer it costs Z\$1.5 million – half a civil servant’s monthly salary”.

Stella Allberry, health spokesman for the opposition Movement for Democratic Change (Mutambara faction) said, “People are letting their families die at home rather than trying the hospitals. In our country you are an old man if you are 55.”



Due to a lack of anaesthetic drugs and antibiotics, this little girl’s leg had to be amputated.

(Daily Telegraph)

The situation at clinics around the country is even worse. Rural hospitals are particularly disadvantaged and frequently have no drugs at all, not even a bottle of cough mixture or a box of over-the-counter pain killers. After waiting in queues for hours, patients are told to return with their own drugs or dressings. Most patients cannot afford either the transport costs to the nearest town or what are for them, exorbitant medical costs.

At Chidamoyo Christian Hospital, about five hours’ drive from Harare, the staff has learnt to make do with very little. Bicycle handlebars are used to make a traction bar for a broken arm and banana leaves for colostomy bags. Intravenous bags double as Foley catheter bags and, when available, Foley catheters also serve as chest tubes. Almost everything, including bags and gloves, is sterilized in pressure cookers, heated over an open fire, and reused⁶⁸.

Hundreds of women are now forced to give birth in the dark as state and council-run urban hospitals and clinics have started demanding packets of candles or paraffin lamps and gallons of water from expecting mothers in the face of biting electricity and water shortages.

⁶⁸ Mission Possible, June 5, 2006

At Chegutu District Hospital, more than 100 kilometres southwest of Harare, a nurse reported that many newly born babies were dying during birth because the erratic electricity and water supplies made it almost impossible to deliver babies. Deputy Health Minister Edwin Maguti denied the conditions existed but a nurse at Warren Park clinic, run by the cash-strapped Harare City Council, confirmed that they too were affected by the electricity cuts and there was no fuel to run the electricity generator⁶⁹.

BOX 2 Food crisis at hospitals

According to a news article published on July 26 by the news agency IRIN entitled: *Hunger bites the health and education sectors*, a kitchen worker at a government hospital in Chitungwiza, who declined to be named said the food shortages were so bad that there were “realistic chances of starvation” among patients.

The International Committee of the Red Cross (ICRC) recently reported to IRIN that the deterioration of health delivery had reached “war situation” levels. The organisation cited the causes as industrial action coupled with economic recession and hyperinflation, which was resulting in the closure of critical medical units.

During the hospital staff strike, kitchens were no longer operational and visiting relatives were told to bring food for patients. The situation has been further exacerbated by the government’s chaotic price-control policies, which have brought widespread shortages of basic commodities.

With the government adamant that the price blitz would continue until inflation was arrested, Dan Toole, director of United Nations Children Fund (UNICEF) said, “What we do know in Zimbabwe is that malnutrition is growing rather radically...there is a shortage of medicine, there is a shortage of doctors and nurses and thus the healthcare system has been devastated”.

The chaotic conditions have resulted in mortuaries overflowing with corpses. “Often bodies are just left lying on the floor and are not collected because the relations have no money to transport the body, hold a funeral or pay for a grave, said an AIDS expert. “Buses are not allowed to carry coffins and private transport is prohibitively expensive. This is extremely distressing for the families.”

Another critical problem is the shortage of ground for burials. “Harare has run out of space,” she said. “Years ago, members of our AIDS program suggested cremation, which is taboo with the African culture. However, even this is no longer feasible as gas is seldom available. The other option we suggested was vertical burials, which is also not acceptable culturally.”

A young man whose mother died at a Harare hospital during June when there was no consulting doctor to attend to her, had to help carry her body to the overcrowded mortuary. To his horror, he found piles of corpses lying on top of each other on the floor. “We had no option but to dump her in a corner to wait for a post-mortem, which has not been conducted up to now,” he told IRIN.

⁶⁹ Farisai Gonye, “Zim clinics demand paraffin lamps, water from pregnant women”. *ZimOnline* http://www.zimbabwesituation.com/aug16a_2007.html#Z2 August 16, 2007

“I strongly believe my mother would not have died if the situation was normal. We are losing many of our beloved relatives and friends because health centres are now rotten,” he said.

A 60-year-old gardener who went to the morgue at Mpilo Hospital in Bulawayo earlier this year to collect the body of his baby girl also found that bodies were piled up on top of each other like sacks. “The relatives were just lifting up the bodies to look at the names. You couldn’t see the face. The faces were rotted away.”⁷⁰

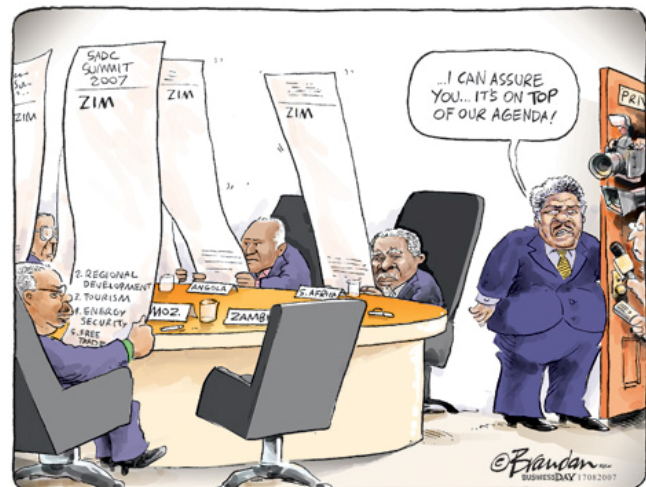
Discussion

Along with the brutal suppression of individual rights and the destruction of the fundamental institutions of a free society, the collapse of the health system and the shortest life expectancy in the world will be the legacy of the Mugabe regime.

The current humanitarian disaster in Zimbabwe is the product of the failed economic, political and social policies of the Mugabe regime. In the face of the growing crisis, neighbouring countries, most particularly South Africa, have only occasionally voiced concerns about the situation in Zimbabwe and have on the whole have given tacit and often explicit support to the Mugabe government.

In late March 2007, Southern Africa Development Community (SADC) heads of state met in Tanzania to discuss the growing crisis in Zimbabwe following the beating and torture of opposition MPs. South Africa’s President Mbeki was charged with finding a solution to the Zimbabwe crisis, yet six months later, the situation has only deteriorated.

Indeed at the SADC Heads of State Summit held in Lusaka, Zambia in August 2007, regional heads of state downplayed the crisis in Zimbabwe. Zambian president, Levy Mwanawasa even went as far as saying that the “problems in Zimbabwe are exaggerated”,⁷¹ despite the fact that in March 2007, Mwanawasa likened Zimbabwe to a “sinking titanic.”⁷²



Business Day, Johannesburg

⁷⁰ Robyn Dixon “In Zimbabwe health costs take toll on patients, families.” *Boston Globe*, April 8, 2007

⁷¹ Mutumwa Mawere “Zimbabwe Problems Exaggerated” *ZimDaily.com* Available from <http://www.zimdaily.com/news/117/ARTICLE/2015/2007-08-20.html>

⁷² CNN World “Zambia: Zimbabwe “sinking Titanic” CNN March 21, 2007
<http://www.cnn.com/2007/WORLD/africa/03/21/zimbabwe/index.html>

Since the start of the Zimbabwean meltdown in 2000, by some estimates, as many as four million Zimbabweans have left the country. A recent survey by the University of Johannesburg, however, finds that there may in fact be fewer than 1 million Zimbabweans residing in South Africa. The study authors warn though that these figures should be viewed with caution as the study was based on a small sample survey. Interestingly, most refugees interviewed were under 40 years of age and cited political and economic reasons for leaving Zimbabwe⁷³. Despite the fact that many of these exiles flee political violence and intimidation, the South African government does not recognize them as political refugees. Section 3(b) of South Africa's Refugee Act of 1998 states that a person qualifies as a refugee:

“[If that person] owing to external aggression, occupation, foreign domination or events seriously disturbing or disrupting public order in either a part or the whole of his or her country of origin or nationality, is compelled to leave his or her place of habitual residence ...”⁷⁴

Given the well documented state-sponsored human rights abuses, collapse of social and economic infrastructure and economic collapse, it is difficult to understand why South Africa chooses not to grant Zimbabweans refugee status.

Events, caused by the Zimbabwean government, have seriously disturbed and disrupted public order and have forced people to flee the country either in fear of their own safety or simply in order to obtain enough food to sustain life.



President Mbeki embraces Mugabe (source: AP)

Yet, in keeping with the South African government's policy of supporting the Mugabe regime, South Africa's Minister of Home Affairs denied that Zimbabweans are asylum seekers. Minister Nosiviwe Mapisa-Nqakula is quoted as saying:

“These are people who still want to go back to their country. They are not asylum seekers ... Asylum seekers do not jump borders: they know where to go to seek asylum. People who jump borders are economic migrants.”⁷⁵

⁷³ Peter Biles “Zimbabwean exodus to SA lower” BBC News, September 25, 2007, available at: <http://news.bbc.co.uk/2/hi/africa/7012368.stm>

⁷⁴ Refugee Act, 1998, Available at www.info.gov.za/gazette/acts/1998/a130-98.pdf

⁷⁵ UN Integrated Regional Information Networks “A Cold Reception for Zimbabwean Migrants” August 16, 2007. IRIN Available at <http://allafrica.com/stories/200708160951.html?page=2>

Any response by donor nations or the United Nations to the Zimbabwean crisis will have to involve the countries that neighbour Zimbabwe and the African Union. South Africa is probably the most important nation in finding a solution to the political, economic and humanitarian crisis in Zimbabwe given its economic might, political power and proximity to Zimbabwe. Some might find cause for optimism in reports that President Mbeki has brokered a deal between the Mugabe regime and the opposition Movement for Democratic Change (MDC) that would result in reforms to the Zimbabwean electoral process. The reforms that are being tabled would include suffrage to the Zimbabwean Diaspora, the removal of the Public Order and Security Act (POSA) and a truly independent electoral commission⁷⁶. Yet it must be borne in mind that the South African government has sided consistently with the Mugabe regime and has endorsed elections in the past that were unfair and fraught with pre-election government-sponsored violence. It is therefore not unreasonable to be sceptical about this agreement and even if the provisions are adhered to, to expect the Mugabe regime to continue to find ways of intimidating voters and maintaining its control of the country.

Any truly free and fair election will undoubtedly unseat Mugabe and his ZANU PF party and therefore this agreement may simply be a stalling tactic designed to temporarily win credibility. It is possible that President Mbeki pressured the Mugabe regime into making these concessions so as to justify Mugabe's presence at the upcoming EU-Africa summit, to be held in December in Lisbon. UK's Prime Minister Gordon Brown has specifically stated that he will not attend the summit if Mugabe is invited⁷⁷ while African leaders such as Zambia's President Mwanawasa have made it clear that they will boycott the summit if Mugabe is not invited.⁷⁸ Further evidence that this agreement could merely be a ploy is found in the remarks of a senior Zimbabwean soldier Brigadier General David Sigauke, who, subsequent to the announcement of the agreement, told soldiers at a graduation ceremony:

“...As soldiers, we are privileged to be able to pursue this task [the defence of Zimbabwe] on two fronts, the first being through the ballot box and the second being the use of the barrel of the gun should the worse come to the worst.”

“I may therefore urge you as citizens of Zimbabwe to exercise your electoral right wisely in the forthcoming elections in 2008, remembering that ‘Zimbabwe shall never be a colony again.’”⁷⁹

⁷⁶ BBC News “Zimbabwe diaspora ‘may get vote’” *BBC News*, September 24, 2007. Available at : <http://news.bbc.co.uk/2/hi/africa/7010372.stm>

⁷⁷ Gordon Brown “It is right that I make clear our position. We will not shirk our responsibilities.” *The Independent*, September 20, 2007, Available at: <http://news.independent.co.uk/world/africa/article2979887.ece>

⁷⁸ BBC “Mugabe shrugs off Brown boycott” *BBC News*, September 21, 2007, Available at: <http://news.bbc.co.uk/2/hi/africa/7005957.stm>

⁷⁹ The Herald “Army urged to defend Zim’s sovereignty.” *The Herald*, Harare, September 25, 2007. Available at: <http://allafrica.com/stories/200709250185.html>

Sigauke went on to blame the economic hardships and shortages of basic goods on “the illegal regime change inspired sanctions imposed by the British and their allies in response to the land reform program.”

It is the continued support for the Mugabe regime by fellow African leaders that has exacerbated and prolonged the crisis. Few African governments publicly recognise the scale of the humanitarian disaster in Zimbabwe. Without their support and cooperation, there is little that the international community can practicably do. In addition, without recognition of the culpability of the Mugabe regime in the crisis and the withdrawal of political and economic support of that regime from the AU and in particular from SADC states (most especially South Africa), the humanitarian crisis will simply be prolonged and will worsen.

In responding to growing outrage and alarm at the collapse of the healthcare system, Minister of Health, David Parirenyatwa acknowledged that the health system was bankrupt, yet in one of the state-controlled newspapers he appealed to businesses and corporate interests to “rescue” the service. Parirenyatwa opined that: “It is a question of social responsibility.”⁸⁰

For a senior Mugabe regime official to state that it is the “social responsibility” of the private sector to “rescue” the health system is not only impertinent but borders on the bizarre and demonstrates how Orwellian Zimbabwe has become. The Mugabe regime has systematically undermined the rights of the private sector and businesses and has made it all but impossible for them to conduct business in Zimbabwe. Through its various policies and via direct action, the Mugabe regime has itself destroyed the healthcare system and if there is any responsibility for the state of the system, it must surely lie with the Mugabe government.

RECOMMENDATIONS

Given the Mugabe government’s stated policies and attitudes as expressed by Minister Parirenyatwa, it is clear that there can be no reconstruction or rescuing of the healthcare system while the Mugabe government is in power. The following policy recommendations are based on the assumption that the Mugabe regime will come to an end, either through external pressure, internal strife or via a palace coup. In order to restore basic healthcare needs to Zimbabweans and to rebuild the public healthcare system, some dramatic and far reaching political and economic reforms will be needed. Humanitarian aid will also be required in the short and medium term. Below, we give some suggestions for the government or administration that succeeds the Mugabe regime.

1. No lasting progress in health and welfare in Zimbabwe can occur without a growing economy and without the basic institutions of a free society that provides the basis of wealth generation. It is beyond the scope of this study to describe these institutions, however it must ensure that private property is protected and that individuals and companies are able to retain the fruits of their labours. The

⁸⁰ Associated Press “Zimbabwe health service has collapsed, doctors’ group says” June 5, 2007

rule of law must be upheld where everyone is considered equal before the law and no agent of the state can interfere in the legal process. Policies should be developed that encourage private enterprise, the engine of economic growth; these should include low taxes, predictable rules and regulations, freedom to trade and exchange goods, low import tariffs and access to foreign exchange.

2. Price controls must be removed immediately and the Zimbabwean dollar must be replaced by a stable currency, such as the US Dollar or the South African Rand, so as to curb hyper-inflation.
3. In order to cope with the immediate health emergencies, urgent humanitarian aid for Zimbabweans living inside and outside Zimbabwe will be needed. An assessment of the capacity within the existing hospitals in Zimbabwe and in targeted sites in neighbouring countries will be required to conduct triage and to provide assistance in a rational and feasible way.
4. Development partners, private healthcare providers, research-based drug companies and other 'stakeholders' should consult the post-Mugabe administration to develop a plan for the reconstruction of the healthcare system. The post-Mugabe regime should realise that it is not in a position to re-create a state controlled national healthcare system and that utilising the private sector is likely to be the most efficient and effective way of delivering healthcare needs to the most needy in a sustained manner. Grants and vouchers for essential healthcare that can be used in private clinics and hospitals should be developed. This will be particularly important since many healthcare workers have left the state system, as well as the country.
5. Given the scale of the HIV/AIDS crisis, the administration that replaces the Mugabe regime should consult development partners and the private sector with a view to urgently providing ARVs to those in need. Adopting a model similar to that in Botswana, which is based on a true public-private partnership with private drug manufacturers, research organizations and the Gates Foundation.
6. Donor nations and the UN need to recognize that the crisis in Zimbabwe is entirely a creation of the political leadership. The support for these policies from neighbouring countries, such as South Africa and Zambia, translates into and implies a tacit approval of the outcomes of such policies – such as the destruction of healthcare. Therefore we recommend a firm policy of making donor aid to countries immediately bordering Zimbabwe and to other African countries contingent on rhetorical opposition to the Mugabe regime and condemnation of the human rights abuses and humanitarian disaster in Zimbabwe. Donor aid to the countries bordering Zimbabwe should also be contingent on those countries establishing a coherent and workable plan to deal with the humanitarian crisis facing millions of Zimbabwean refugees in these countries. To date Zimbabwe's neighbours have viewed most Zimbabwean refugees as criminals and have treated

them as such. This policy must change and donor nations should exert as much influence in this regard as possible.

7. In order to achieve a situation where there is a peaceful transition to a post-Mugabe Zimbabwe, more pressure on the Zimbabwean leadership and on the African countries that support and enable the Mugabe regime will be needed. We concur with the Archbishop of York, Dr John Sentamu, who maintains that “it is time for the sanctions and campaigns that brought an end to apartheid in South Africa to be applied to the Mugabe regime.”⁸¹ The limited and targeted sanctions currently applied to Zimbabwe’s political elite could be extended. Given the scale of human suffering in Zimbabwe, there is little prospect that wider sanctions will cause more human suffering and if they bring about a swifter political transition, the suffering could indeed be alleviated. We call on civil society in the countries neighbouring Zimbabwe as well as in Europe and North America to begin to think of innovative ideas to put pressure on the SADC and AU governments to take a tougher stance against the Mugabe regime and to halt any support given to that government.

For instance, AFM recommends that boycotting the 2010 FIFA World Cup, to be held in South Africa, would be an appropriate and meaningful response to South Africa’s continued support of the Mugabe regime. The right to host the 2010 World Cup is highly prestigious and the South African government has used the World Cup to improve its image globally. Were FIFA to withdraw the rights to host the 2010 World Cup in South Africa, it would send a strong and unequivocal message that the regional support for the Mugabe regime is unacceptable and the global football community will not be a party to the human rights abuses and the healthcare crisis that has been the result of this support. Commercial sponsors of the FIFA World Cup should immediately withdraw their support as their brand will be linked to the government that enables despots and ignores human suffering and gross human rights abuses. AFM would also encourage musicians and other performing artists to cancel performances in countries that neighbour Zimbabwe. Sport and cultural boycotts were ultimately a successful tool in forcing political change in Apartheid South Africa and similar tactics should now be employed for the Zimbabwean crisis.

⁸¹ John Sentamu “Saving Zimbabwe is not colonialism, it is Britain’s duty” *The Observer*, London. September 16, 2007, Available at: <http://observer.guardian.co.uk/comment/story/0,,2170244,00.html>