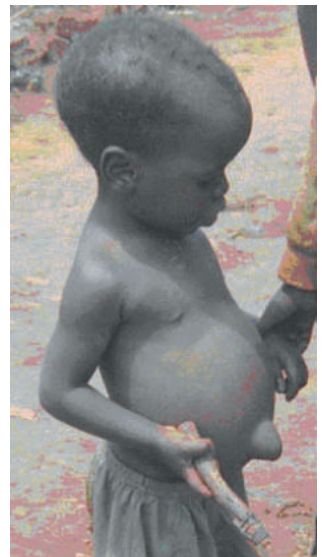


DESPOTISM AND DISEASE

**A report into the health
situation of Zimbabwe
and its probable impact
on the region's health**



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Despotism and Disease

A report into the health situation of Zimbabwe and its probable impact on the region's health

Summary



CIA World Factbook

Life for the average Zimbabwean has become dramatically worse in the past five years. Unemployment is at 80%, inflation is in triple digits and food production has collapsed leading to widespread malnutrition. Violence awaits all those who have the courage to voice criticism, and the election due on 31st March, will be the third in a row that is far from free and fair. While this information is well known, what is less understood is the disastrous impact on the health of Zimbabweans, and soon the region from the mismanagement of the economy.

Infectious disease is rampant among the malnourished majority – malaria once under control is resurging, tuberculosis is thriving in the increasingly HIV-positive environment. Sexual behaviour is poor given the precarious conditions in which people live, HIV rates could well be the highest in the world (official rates are 25% but it could be far higher). But since most qualified personnel have left the country quality estimations are thin on the ground. While this is a tragedy for Zimbabweans, other countries in the region, that have so far not acted on the political mayhem, may soon be left with a choice: Act to establish democracy in Zimbabwe, or have even more HIV in your country. The most mobile Zimbabweans are also those most likely to carry HIV. And while their lives have been nasty and brutish, they are not short enough to prevent transmission of HIV into neighbouring countries.

The time for the ‘quiet diplomacy’ of the West and South Africa has come and gone. Action is required in this outpost of tyranny.

1. Introduction

The political, economic and human crisis in Zimbabwe has been well documented in the world's media. While the relentless targeting of President Mugabe's opponents is well known, less understood is the effect of the political turmoil on the health of all Zimbabweans and the ability of the government to maintain its healthcare services. The breakdown of healthcare services affects not only the politically active and those who oppose Mugabe, but the entire population including innocent children and the elderly.

The collapse of health systems in Zimbabwe is all the more shocking given the fact that at one time the country had an effective, functioning and well-funded healthcare system. This paper analyses the recent official UN and World Bank data on health and welfare in Zimbabwe and also uses anecdotal and media reports to expose the recent healthcare collapse. The destruction of Zimbabwe's health systems can be seen as yet another human rights abuse, to which one can add the many deliberate state-orchestrated acts of violence and abuse. Yet Zimbabwe's health is not simply a domestic problem because Zimbabweans are fleeing their own country, often fearing for their lives. The breakdown in medical services, particularly with regard to communicable diseases, means that Zimbabwe's neighbouring states are undermined. We believe that this is an added reason for swift, unequivocal action by the Southern African Development Community countries and the African Union on Zimbabwe's government. That the political, economic and human rights situation has reached a point where ordinary citizens of neighbouring countries are put in danger highlights the failure of African states' response to the Zimbabwean crisis.

It has taken the African Union three years to adopt a report – compiled by the African Commission on Human and People's Rights and sponsored by the AU – which is critical of President Mugabe's human rights record. Finally adopted last month, the report lambastes the Mugabe government for flagrant human rights abuses.

2. Political background and historic healthcare effort

In 1980 non-racial elections were held in Zimbabwe for the first time in that country's history. The Zimbabwean African National Union (ZANU) party, led by Robert Mugabe, swept to power and, true to his promises about reconciliation, President Mugabe strove to build a good working relationship with his former adversaries. This resulted in a brief period of stability and economic expansion¹. However, the election campaign, fought with so much aggression, had intensified the distrust and animosity between ZANU and Joshua Nkomo's Zimbabwe African People's Union (ZAPU) followers. This rivalry soon affected the workings of the coalition government and Mugabe's closest colleagues began talking of the need to "crush" ZAPU². In 1984, the brutal repression of Mugabe's political opponents in the southern Matabeleland region resulted in the deaths of up to 20 000 people.

While Mugabe attended Fort Hare University in South Africa during the 1950s, he took a keen interest in Marxist ideology and ordered books by Marx and Engels from London. By the time he became President however, he had ostensibly forgotten much of his communist ideology, although latent totalitarian tendencies became more evident by his disrespect for opponents. Although the Zimbabwean economy was far from free, there was no widespread nationalisation of industry and much of private business carried on as usual.

The determination within ZANU to build a one-party state where no form of opposition would be tolerated, whether at the civil society or political level, became increasingly clear. Plans to create a *legal* one-party state were only abandoned in 1990 when the fall of the Berlin Wall created an international political environment hostile to the development of one-party states. However, political parties which sought to challenge the 1990 and 1995 Presidential Elections were systematically crushed and no longer exist.

During the first ten years after independence Mugabe's government invested significant amounts of money into improving health care delivery for all Zimbabweans. Between 1980 and 1987, government expenditure on healthcare increased by 80% and stood at 2.3% of GDP, almost 3 times higher than the Sub-Saharan African average of 0.8% of GDP. The ZANU government also improved educational standards and, as a result, Zimbabwe still has the highest literacy rate in Africa.



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President Robert Mugabe

The Zimbabwean government's commitment to improved healthcare and education paid off, and the indicators of human wellbeing improved steadily during the early years of ZANU rule. 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 immunisation nearly tripled between 1980 and 1988. Childhood immunisation for diphtheria, pertussis and tetanus (DPT) increased to 75% coverage in 1986, 80% in 1994 and 81% in 1999, compared to an average of 32%, 51% and 48% 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% to 49 deaths per thousand by 1988.

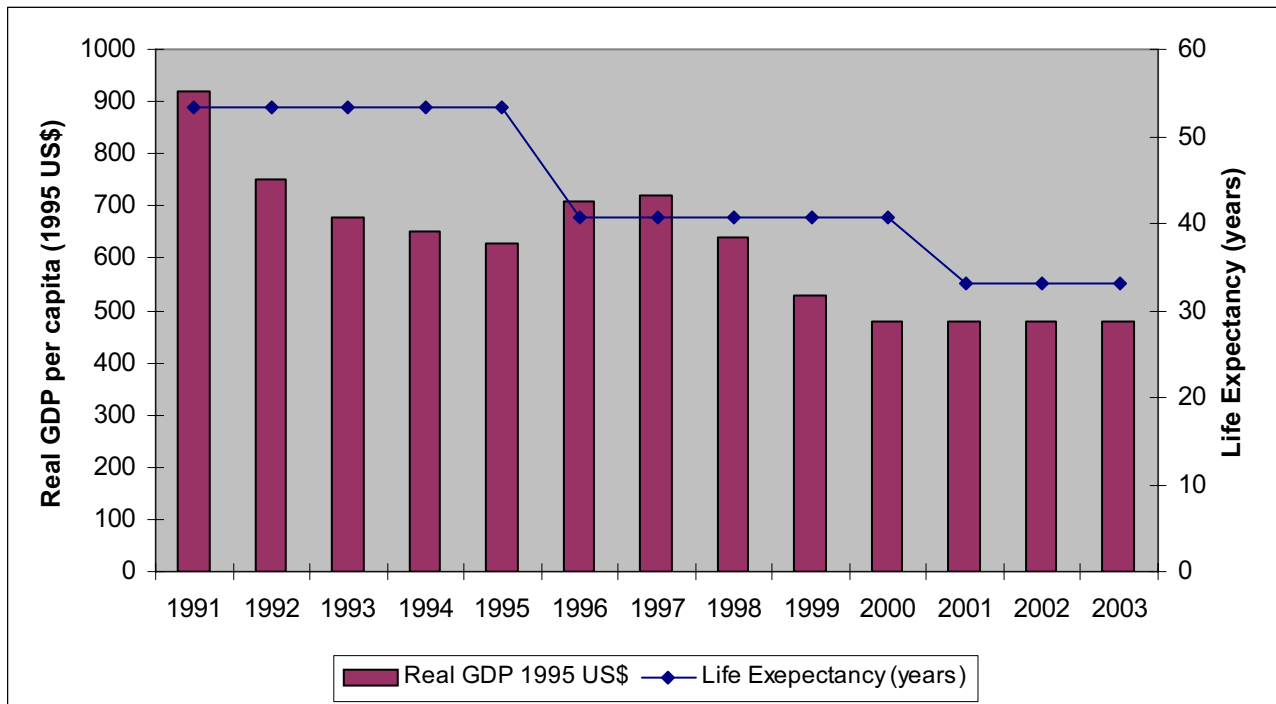
Perhaps Mugabe's lasting legacy would have been of a leader that improved the lives of ordinary people, had he relinquished power several years ago and had he afforded Zimbabweans their constitutional right to free and fair elections. Tragically however, his ruthless grip on power is destroying what he sought to create and the people of Zimbabwe are faced with collapsing hospitals and crumbling schools.

Most of the gains in health and welfare have been undone. By 2002 the immunisation coverage for DPT had fallen to just 58% and most shockingly in 2003, life expectancy had fallen by 23 years from its 1985 level to just 33 years.

By the mid 1980s, government interference in the economy along with cronyism and widespread corruption had begun to take its toll. By the 1990s, economic growth had slowed to a point where the economy was contracting and per capita incomes were falling. By 1995, per capita economic growth was -1.8% and per capita annual GDP was US\$620, marginally below the US\$ 622 level ten

years previously³. The mismanagement of the economy continued throughout the 1990s, as did the continuous contraction of the economy. By the year 2000, per capita GDP was reduced by 9.8% and by 2002 annual per capita income was US\$ 521, almost 15% below the level when Mugabe was voted in as president 22 years previously.

Figure 1: Life expectancy and real Gross Domestic Product per capita, 1991 – 2003
(constant 1995 US dollars)⁴



The current increase in political oppression stemmed largely from President Mugabe's failed attempt to change the constitution in 1999. The proposed changes were voted upon in a referendum during mid February 2000 at a time of mass unemployment, rising poverty, factory closures, crumbling services and corruption scandals. The result was a stunning defeat for Mugabe. Initially he adopted an apparently conciliatory response but reportedly was inwardly furious. In a carefully co-ordinated campaign starting on February 26, just days after the results of the referendum had been announced, the violence-ridden land invasions began. This was the start of President Mugabe's so-called 'land reform' program. This program could more accurately be described as the government orchestrated take-over and often wanton destruction of the productive agricultural sector, including

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Begging along one of Harare's main streets, Tatenda Mwenda, 7, is carrying his 5-month old brother

equipment, crops, homesteads and worker villages along with the intimidation of farmers, farm workers and political opponents. The violent oppression of any organisation or individual opposed to the government and the victimisation of ordinary Zimbabweans – young and old – has been well documented in the international and independent media.

Almost every facet of life in Zimbabwe has been affected by the paranoid and ruthless political oppression. Yet the impact of the Zimbabwean crisis on nutrition and healthcare are possibly the two most drastic and far reaching. An entire generation of children is growing up in hunger and ill health and fear, blighting their cognitive development and their future prospects.

3. Healthcare resources

Although the Zimbabwean government funded healthcare well during the early years, programs are now severely starved of funds. The latest available World Bank data show that between 2000 and 2001, public health expenditure as a percentage of GDP fell from 3.8% to 2.8%. Private healthcare spending fell from 3.6% to 3.4% of GDP, perhaps a symptom of the worsening economic situation. Overall both private and public healthcare spend fell from 7.4% to 6.2% of GDP.

While the government may claim that the country's worsening economic situation necessitates cutbacks in public expenditure, it has maintained its military expenditure at 3.2% of GDP in both 2001 and 2002. Furthermore in late 2004 the government announced a six-fold increase in the budget for Mugabe's hated secret police, the Central Intelligence Organisation. The allocation, which is not subject to parliamentary approval, is set to increase from Zim\$ 62 billion (US\$ 8.6m) to Zim\$ 395.8 billion (US\$ 55 million).

As a result of low pay and poor working conditions, many Zimbabwean nurses and doctors have left the country to work in Europe, North America or South Africa. According to Mr. Mike Cotton, a Bulawayo surgeon, the loss of expertise is crippling the health system and even the most basic procedures can no longer be undertaken. Says Mr Cotton, for the approximately one million residents of Bulawayo there are only three general surgeons and one gynaecologist. A few years ago there were seven general surgeons, four orthopaedic surgeons, one neurosurgeon and four gynaecologists. The Community Working Group on Health estimates that around 2,000 nurses leave the country every month⁵.

Mr Cotton explained to the authors that with the lack of personnel many patients have lost confidence in the medical system and are simply not trying to reach treatment. He further states that since most people are aware that there are often no spare parts for ambulances, no petrol and few drivers (since many have died from violence and AIDS), and there are not enough drugs in hospitals, it's pointless to seek treatment.

The future of this cerebral palsy child is in jeopardy because a suitable rehabilitation centre cannot be found in Zimbabwe



Meanwhile at the morgue at Harare Central, the main public hospital in the capital, the refrigerators frequently break down and there is no space for the bodies that constantly arrive. The government no longer has any forensic pathologists, which means that the bodies of murder victims requiring autopsies are simply accumulating, holding up police investigations and stopping families from burying their relatives.



Lacking dignity in death – bodies pile up at Mpilo Hospital mortuary, Bulawayo

Apart from the lack of personnel, there are numerous reports of facilities being totally out of stock of drugs and basic medical equipment. A 2004 report speaks of a patient at Parirenyatwa hospital in Harare who died because the doctors had no saline with which to treat her⁶. In an almost comedic move in 2004, the government announced an innovation in patient transportation when it introduced ambulances drawn by oxen in the rural areas.

In January 2005, one of the government-controlled newspapers, the Herald, reported that the country's second largest hospital, the Harare Central Hospital was itself "in intensive care". Lifts at the 1,428-bed facility were not functioning and laboratory and dialysis machines were out of order. The government was forced to allocate a Zim\$100bn lifeline, with well-wishers providing a further Zim\$230m⁷.

While the healthcare system suffers catastrophic shortages, the political elite continue to live astonishingly profligate and extravagant lives. President Mugabe and his wife Grace make frequent shopping trips to Malaysia; one of the few countries where they are still welcomed. Air Zimbabwe planes have been commandeered for this purpose on more than one occasion without prior notice, forcing passengers to make alternative arrangements. Other members of Mugabe's inner circle are often seen in neighbouring South Africa purchasing properties, expensive electronics and luxury goods. Meanwhile in 2003, builders completed Mugabe's luxury, 25 bedroom mansion in Harare which, including furnishings, is estimated to have cost US\$ 6million. It is most likely that public funds were used to construct the private mansion as officially Mugabe has only earned a total of US \$ 1million in his 23 years in power⁸.

4. Nutrition

During the 1980s and 90s, much of Zimbabwe's economy was reliant on agriculture. Apart from the country's main foreign exchange earner, tobacco, in most years the country was a net exporter of maize and many other products. Since the highly controversial and often violent 'land reform' program, which involved moving commercial farmers off their land and replacing them with numerous unsupported, ill-equipped peasants, jobless people and, increasingly, government ministers and Mugabe cronies, food production has plummeted. The World Food Program estimates that around 55% of the Zimbabwean population requires food aid.

In 2000, in the initial phase of the 'land reform' programme the country had an estimated 1.4 million head of beef cattle. In early 2005, the Cattle Producer's Association reported that the number of cattle stood at fewer than 125,000, a decline of around 91%. The cattle herd has not only declined because of the forced removal of farmers from their land, but because of increased cattle theft, a symptom of the general lawlessness in the country. Along with the decline in the beef herd, the United Nations reports that milk production has also fallen sharply. The country's dairy herd stood at 96,000 cows in 1997, but had fallen to 70,000 in 2001 and to just 50,000 in 2002. In 1998 Zimbabwe had 586 milk producers but by December 2004 the number had diminished to 164. The few commercial farmers still producing milk are required to pay exorbitant prices for cattle feed and often cannot afford to import milking equipment⁹.

The country's maize production has suffered a similar catastrophic decline. As the commercial farmers have been driven off the land, maize planting has become impossible. The enormous grain silos in Banket and Chinhoyi stand testimony to the once highly productive agricultural areas north west of Harare. However when one of the authors (Tren) recently travelled through the area, the silos were empty and the surrounding lands barren. Despite the patently obvious shortfall in food production, the government announced during August 2004 that the country would have a bumper maize harvest of 2.4 million metric tons. But by October 2004 a Parliamentary portfolio committee on lands reported that just over 16% of the government's forecast (388,588 metric tons) had been delivered to the Grain Marketing Board (GMB), the state marketer of maize¹⁰.

On 16 November 2004, ZimOnline reported that High Court Judge President, Paddington Garwe, police commissioner Augustine Chihuri and two senior government ministers were among top officials who had not delivered more than 50,000 tons of seed maize to a local seed company which helped them grow the crop (on farms that they had taken over illegally) for the local market. A senior manager at SeedCo said the politicians and government officials had taken advantage of prices in the region to make extra cash at the expense of the local market, which had virtually run out of seed maize.

The credibility of the Mugabe government's ongoing assurances of normality in food supply is undermined not only by independent analyses but also by the sharp increase in food prices. The US-based Famine Early Warning System (FEWSnet) reported that in November 2004, inflation of food prices had reached 143%¹¹. The Zimbabwean government can and does control many aspects of life in Zimbabwe; however they cannot change the basic laws of economics which predict that when supply decreases, prices will rise in the face of unchanged or increasing demand. According to the Consumer Council of Zimbabwe, the minimum industrial wage in Zimbabwe of Zim\$ 500,000 only covers 31% of the basic household basket of goods¹². The United Nations reported that the rural population would become food insecure when the price of maize reached Zim\$ 750/kg, however by December 2004 in many rural areas the price had already reached Zim\$ 2,000/kg¹³.

The result of the severe food shortages and consequent inflation is, unsurprisingly, malnutrition. The UN's Children's Fund, UNICEF, reports that "whilst marked improvements characterized the first decade of post independence, chronic malnutrition levels are now around 27%"¹⁴. On 5 February 2005, the ZimOnline website reported on a health report issued by the Bulawayo city council. According to the report, at least 14 people, most of them children aged between three and four years old, died of malnutrition-related illnesses in January, compared to four such deaths recorded the previous months.



One of Zimbabwe's many emaciated children



© Solidarity Peace Trust
Zimbabwean child suffering from kwashiorkor

Apart from the general shortages of food in the country's stores and the high prices of what is available, the Mugabe government has, for several years, been using food as a political weapon. Reports abound of people that are denied food at aid distribution points if they cannot produce proof that they are ZANU PF members. In addition, the police and army regularly stop the transport of food from the north of the country to the predominantly opposition supporting south. In November 2004, the authors witnessed two such roadblocks on the main road from Harare south to Bulawayo where buses, trucks and vans were stopped and searched by the police. The deliberate denial of food to the Matabele population that lives in the south of the country can be seen as nothing short of genocide.

In August 2002, when commenting on the food shortages, senior ZANU PF politician Didymus Mutasa said: "We would be better off with only six million people, with our own people who supported the liberation struggle"¹⁵. The sinister implication was that Mutasa would approve of half of Zimbabwe's 12 million people either starving or fleeing so that ZANU PF could retain power. In October 2002, Tony Hall, the special US Ambassador to the World Food Program, said to July Moyo, the Minister responsible for the food aid program in Zimbabwe: "Why do I get the impression that I have to beg you to feed your people?"

On May 24, 2004, Mugabe told Sky News in an interview that the country would have enough food, with a surplus, despite reports of an estimated 800,000 tons shortfall by the World Food Program. Mugabe said: “We are not hungry. (The food) should go to hungrier people, hungrier countries than ourselves.”



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The Chisvo family of Chinhoyi situated 60 kilometres west of Harare, take time to enjoy mice which have become a delicacy since they cannot afford meat. The family has put up a makeshift granary due to lack of proper storage facilities.

Less than a year later, a report issued during January 2005 by FEWSnet noted that 5.8 million Zimbabweans or about half the 12.5 million people would need emergency food aid between now and the next harvest around March/April 2005. The Zimbabwean government rejected the FEWSnet report and, until recently, has stood by its claim that maize production had reached 2,4 million tons. Zimbabweans consume 1.8 million tons of maize per year and only in February 2005 did the Zimbabwean government admit that they may have to import maize.

An alarming increase in cases of kwashiorkor, a condition caused by a lack of adequate protein has been reported among children in Zimbabwe. The condition, which results in a bloated stomach and spindly limbs, can be fatal if not treated. Apart from the devastating conditions that occur as a direct result of malnutrition, the lack of adequate nutrition leaves children and the elderly at greater risk from opportunistic diseases. Predictably three of Africa's biggest killers, HIV/AIDS, TB and malaria have become more prevalent and pose an even greater threat to the health of ordinary Zimbabweans.

5. Infectious diseases

5.1 HIV/AIDS

Zimbabwe is rated a “heavily infected AIDS country” (HIAC) because more than 20 per cent of the population is infected with HIV. The HIV/AIDS prevalence rate among adults in Zimbabwe is approximately 24.6 percent in 2003¹⁶ although this is likely to be an underestimation. In the ten year period between 1995 and 2004 a minimum of 1.1 million people is estimated to have died from AIDS related diseases¹⁷. In 2003 alone, an estimated 170,000 deaths can be attributed to HIV/AIDS, although the figure could far higher¹⁸. UNAIDS estimated that by the end of 2001 more than 750,000 children were orphaned, a higher percentage than anywhere else in the world, and at least 3,000 were dying of the disease every week. Although the prevalence of HIV has remained fairly static in recent years, this is likely to be because the number of deaths related to HIV/AIDS is approximately equal to the number of new infections.

With the disintegration of the country’s healthcare system, it is estimated that the death rate attributed to HIV/AIDS will reach 23 per 1,000 deaths in 2005, up from 10 per 1,000 deaths in 1993/94¹⁹. As in most of southern Africa, the impact of HIV is most severe among adults, particularly women, and young children under the age of 5. According to Zimbabwe’s Ministry of Health and Child Welfare, 57% of HIV positive people are women. Anecdotal evidence suggests that the scale of the disease may be substantially worse than the official statistics suggest. Dr Mark Dixon of Mpilo Hospital in Zimbabwe’s second city, Bulawayo estimates that around 70% of the patients he sees are HIV positive and suffering from an AIDS related illness²⁰.

Table 1 below summarises the estimated number of people living with HIV/AIDS by age cohort.

Table 1: Estimated number of adults and children living with HIV/AIDS, end 2003²¹

Adults and Children	1,800,000
Adults (ages 15 – 49)	1,600,000 (Adult rate 24.6%)
Women (ages 15 – 49)	930,000
Children (ages 0 – 15)	120,000

As the adult death rate continues to rise, so does the number of children orphaned by the pandemic. UNAIDS estimates that 980,000 children had either lost one or both parents to HIV/AIDS by the end of 2003. In the current economic climate and with around 80% of the workforce unemployed, the prospects that these young children will be cared for adequately and receive sufficient nutrition, clothing and education are slim. Adding to the high HIV prevalence is the widespread and systematic rape of women and young girls by the country’s so-called youth militia, which was set up by the Mugabe regime. Rape is a favoured means of torture or punishment for those that are seen as disloyal to the ruling ZANU PF party. In addition, according to the Zimbabwean



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A grave digger prepares a fresh grave at a cemetery in Harare

Women Lawyers' Association, in 2002, there were over 1,000 female sex slaves being held in 56 military camps²². As the spread of HIV in the country is predominantly sexual, the high incidence of rape, which by definition is violent, increases the probability that HIV will be transmitted thereby adding the already high HIV prevalence.

The Sunday Times (UK) reported that boys of 15 years of age were being raped at "youth-training centres" in what appeared to be part of the government's plans to crush dissent²³. Fifty two male Zimbabweans who had fled to South Africa after claiming they had been tortured were interviewed. Thirty-eight said they had been raped or forced to engage in anal sex with other victims. One man who refused to take part had his eardrums punctured.

Zimbabwe's jails are severely overcrowded and life for those imprisoned there is harsh and often life threatening. Apart from inadequate food, unsafe water and inadequate sanitation, prisoners are at risk from exposure to HIV. The US government's report into human rights practices in Zimbabwe notes that HIV prevalence is reported to be as high as 60% among prisoners and that AIDS is a major cause of death for those in detention²⁴.

The use of sexual torture and rape as retaliatory political tools by the Mugabe government was recorded extensively towards the end of 2001. On 7 January 2002, the Amani Trust, an NGO documenting human rights abuses, released a statement on sexual torture in Zimbabwe. It noted that over the previous few months there had been increasing evidence that members of youth militia involved in organized violence were receiving formal training in torture techniques. The statement also noted that a new and very disturbing form of torture had emerged in the previous few weeks, with even more long-term ramifications for the victims than the physical and psychological trauma sustained with physical torture. Torture victims were forced to rape other victims, both male and female, while the youth militia supervised. The result of this in each case documented had been a victim with a severe genital infection and marked psychological trauma.

The report pointed out that the long-term consequences to each of these victims, both partners in the forced sexual act, was life threatening, to them, their spouses and their future children with the very real risk of the victims contracting HIV.

The Amani Trust weekly update of 6-10 May 2002 reported dealing with six rape cases that had occurred over the previous two months, the youngest being a thirteen year old girl raped after Zanu-PF youths came to the farm she was living on in Marondera and, the eldest being a thirty two year old married mother, who was raped in front of her husband, by Zanu PF youths in Mount Darwin. The women were raped because either they or their family members were alleged to support the opposition Movement for Democratic Change, or simply as terror tactics.

But where the government is not directly complicit in spreading HIV/AIDS, its response to the pandemic has been woefully inadequate. Typical of the Mugabe regime, rather than doing something useful to combat the disease, in July 1997 he introduced legislation that enabled criminal proceedings to be taken against any deliberate transmitter of HIV²⁵. Then in January 2000, in an apparent response to the problem, the Zimbabwean government added 3% to income tax in order to fund anti retroviral treatment and to care for those affected by the disease, such as the AIDS orphans. Local AIDS activists and healthcare workers supported the notion of a national AIDS fund, but did not necessarily support the notion of a direct tax on all Zimbabweans to raise the required money.

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. While there is some logic to setting up the NAC, the reality, according to Lynde Francis, the director The Centre, an AIDS treatment and counselling project in Harare, is that it simply added a layer of bureaucracy to the fight against HIV/AIDS²⁶.

Although the NAC is made up of some token representatives from NGOs and AIDS treatment organisations, it is dominated by political appointees from the ruling ZANU PF party. Francis is among numerous AIDS activists outraged by the waste of funds on high salaries, the purchasing of four-wheel drive vehicles and, most worryingly, the selective distribution of food to card-carrying members of ZANU PF. Although the NAC is dominated by ZANU PF members, the organisation is currently in conflict with the political party as ZANU PF is attempting to take over the NAC in its entirety. Should this happen, the ruling political party would have direct control of the AIDS funds and undermine whatever non-ZANU PF activities remain within the NAC.

In 2002, the government declared AIDS to be a national emergency, a move which was welcomed by some²⁷. The declaration allowed the government to import cheaper, generic versions of AIDS medicines, which theoretically could improve access to treatment. At the time however, Zimbabwean AIDS activist Jeffer Mxotshwa was sceptical of the value of the emergency declaration, claiming that the government had done little to improve basic infrastructure to deliver medicines. In any event, fewer than half of the available antiretrovirals were actually patented in Zimbabwe and those that were patented had already been offered to the Zimbabwean government at reduced prices or even for free.

It was not until 2003 that the Zimbabwean government actually purchased any drugs to treat HIV infections with ARVs, and most drugs are not being used effectually, or consistently, with non-clinical changes in drug regimens common. Incredibly the IMF believes that by 2010, on current trends, 83% of the total teacher work force alive in 2003 will have died²⁸.

UNAIDS estimates that more than 160,000 Zimbabweans are in desperate need of antiretroviral treatment, however Lynde Francis considers that the figure is closer to 3 million. According to UNAIDS, the NAC earmarked US\$ 2.5 million purely for the procurement of antiretroviral therapy²⁹. Yet AIDS experts working on the ground estimate that fewer than 3,000 individuals are



These AIDS orphans living near Harare, are being cared for by their aunt, who is suffering from AIDS-related illnesses

currently being treated in government facilities, including those on trial programs and those on short courses to prevent the transmission of HIV from mother to child.

Around 8,000 Zimbabweans receive HIV/AIDS treatment via NGOs, faith based groups or pay for treatment directly out of pocket. According to Lynde Francis, about 90% of the cases that are treated at The Centre are related to malnutrition and not necessarily to HIV/AIDS. Yet even though the private sector and non-governmental organisations are far more effective at delivering treatment to those in need, they are penalised by state imposed import duties. According to Francis, The Centre imports Triomune, a generic antiretroviral triple therapy from Cipla, an Indian generic drug manufacturer and pays Zim\$ 180,000 (US\$ 25) for a month's treatment. The Centre could however pay just Zim\$100,000 (US\$ 14) for the drugs were they not required to pay Zimbabwean import duties on the drugs.

The private sector sells the locally produced triple therapy, Stanalev, at around Zim\$ 360,000 (US\$ 50) for a month's treatment, which while relatively cheap by international standards, the drug alone represents around 70% of the minimum industrial wage³⁰. This means that private treatment for AIDS related illnesses is the preserve of the very wealthy.

Although antiretroviral therapy is available in the private sector, pharmacists who were interviewed by the authors in Bulawayo, but who preferred not to be identified, lamented the fact that patients are often forced to change their therapy for non-clinical reasons. For instance, shortages in the availability of a certain regimen means that patients are forced onto an alternative, or try to conserve their medicines by taking fewer pills than indicated. The authors interviewed one patient receiving antiretroviral therapy from Mpilo Hospital who was forced to change her drug regimen to the child dosage, fundamentally because she was not receiving enough nutrition to cope with the full adult dosage.

In 2004 the Global Fund for AIDS, TB and Malaria (GFATM) rejected the Zimbabwean government's application for funding in its 4th round of allocations. Although the GFATM rejected the application on "technical grounds" the Zimbabwean government accused it of political bias. Whether or not political bias did play a part, the clear failure of the government to use existing funds effectively could not have worked in its favour.

5.2 Malaria

Malaria was once well under control in Zimbabwe, however in recent years it has become a dramatically more prominent public health problem. Zimbabwe's Ministry of Health and Child Welfare estimates that malaria is the primary reason for hospital admission and the second most frequently treated disease for outpatients³¹.

As in much of southern Africa, malaria in Zimbabwe is seasonal and not prevalent year round. 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.

The main method of malaria control in Zimbabwe is known as 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 practiced in Zimbabwe since at least 1950 and for decades ensured that malaria was a minor health concern.

In recent years however, the Zimbabwean malaria control program has been starved of funds and has been unable to carry out even the most basic malaria control activities. In 2004 only 3.4% 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 result of this lack of control has been a sharp rise in malaria cases, possibly in excess of 2 million cases in 2004, five times higher than the low of 400 000 cases in 1992³².

Along with the increase in malaria cases, the number of people dying from the disease has risen sharply too. Despite the fact that malaria is entirely curable, in 2002 around 5% of in-patient malaria cases died. By comparison, in neighbouring South Africa, the case fatality rate is normally below 1%.

There could be several reasons for this high case fatality rate. First, patients could be presenting at clinics and hospitals too late; the later a patient presents for treatment, the greater the likelihood of severe malaria developing and of the patient developing the more fatal cerebral malaria. Second, anecdotal evidence from health workers in Zimbabwe points to a severe shortage in medicines in the public hospitals. Although several private pharmacies that the authors visited in Zimbabwe had good stocks of malaria drugs, the public healthcare facilities are likely to be experiencing shortages. Even if the basic malaria treatment, such as sulphadoxine-pyramethamine is available in clinics, doctors will also need quinine, drips and other essential inputs to treat severe malaria cases. Any shortage of these essential inputs will, unsurprisingly, lead to a higher case fatality rate.

Another reason for the increased death rate is likely to be the severe shortage of trained and experienced personnel in both the private and public health sectors which will clearly reduce the quality of treatment and increase fatalities. Lastly, with the country's high prevalence of HIV, people contracting malaria are far less likely to survive as their immune system is compromised.

Perhaps as worrying as the loss of medical personnel available to treat patients, is the loss of public health personnel in the malaria control program. Many of the experienced and qualified malaria control staff have abandoned the government's malaria control program in recent years, leaving a vacuum where there once was a highly competent and organised team. Replacing that expertise has not been easy and has undoubtedly compromised malaria control.

The long term prospects for malaria control in the country are also unfavourable, even if peace, stability and democracy return. The Blair Research Institute in the country's capital city, Harare, was once a dynamic and cutting edge malaria research facility. In recent years however much of its staff has left and the essential, ongoing research needed to strengthen malaria control has fallen away³³.

As with so many aspects of life in Zimbabwe, it appears that malaria is being politicised. In December 2004, one of the authors (Tren) travelled to Zimbabwe to attend a malaria education and advocacy rally near Kariba Dam. While malaria certainly did feature as part of the program, the attendees from the area were subjected to chants from local ZANU PF party members of "Forward with Mugabe" and "Down with the MDC".

Minister of Health and Child Welfare, David Parirenyatwa who attended the rally gave a lengthy speech at the rally which, absurdly, began with him chanting "Down with the MDC ... Down with mosquitoes". While there is little evidence of malaria control program managers deliberately denying non-ZANU PF members protection from malaria (such as IRS) as has been the case with the denial of food to non ZANU PF card holders in numerous areas, Parirenyatwa's behaviour certainly makes it a possibility.

5.3 Tuberculosis

Tuberculosis (TB) is the most common opportunistic infection in people living with HIV/AIDS. The high HIV prevalence rates along with increasing poverty means that TB is becoming an ever more serious health concern. In 1998, the TB prevalence rate in Zimbabwe was 416 per 100,000 people, almost three and a half times higher than the average of 121 per 100,000 for Sub-Saharan Africa³⁴. By 2002, the prevalence rate had increased to 452 cases per 100,000.

As with malaria control, Zimbabwe once had a highly effective TB control program. According to Ellen Ndimande of the Zimbabwean Association for the Rehabilitation and Prevention of Tuberculosis, the TB control program was so successful that at one point her association declared the war on TB won. The economic and social crisis of the past few years has, however, severely worsened the TB situation.

TB in the southern province of Matabeleland South is considered to be particularly bad. The Ministry of Health and Child Welfare's own Nicholas Sizaba reported in 2004 that the number of cases had risen to 3,000 from 2,000 in previous years. Matabeleland South, which predominantly supports the opposition MDC party, is particularly hard hit with food shortages as the Zimbabwean government ties access to food to support of Mugabe's ZANU PF party. Malnutrition, poor sanitation and overcrowded conditions exacerbate the spread of this infectious disease and as health facilities struggle to cope with even the most basic health problems, the chances that TB sufferers will access effective treatment is slim. As multi-drug resistant TB spreads around the world, the increase in incidence of TB in Zimbabwe along with the inadequate healthcare facilities is alarming.

6. Discussion – the regional danger of the Zimbabwean diaspora

The political and economic crisis in Zimbabwe has left the lives of ordinary Zimbabweans under assault from many different directions. Unemployment is over 80%, inflation is currently running at over 400% and there are severe shortages of basic goods. Life, according to Catholic Archbishop Pius Ncube of Bulawayo, has never been as bad. Apart from the hardship of ordinary life, many Zimbabweans have to contend with state sponsored violence and abuse.

The alarming increase in infectious disease is both a consequence of the economic hardship and the deliberate policy decisions of government to support the military and secret police at the expense of the healthcare sector. As if the increased prevalence of HIV/AIDS, TB and malaria were not enough to contend with, Zimbabweans cannot access adequate treatment at the public healthcare facilities, thereby worsening the health situation.

Yet Zimbabwe's healthcare situation is not purely a domestic issue. The exodus of Zimbabweans for political and economic reasons means that the poor health status of Zimbabweans threatens the country's neighbouring states. The Botswana government reports that around 1,600 Zimbabweans who enter the country illegally are repatriated every month, only to return again³⁵. It is almost impossible to estimate the number of economic and political refugees residing in neighbouring states, but it could be anywhere between 3 and 5 million.

It is hardly surprising that HIV has flourished in Zimbabwe, and skyrocketed in the past two years. Nobel Laureate Gary Becker³⁶ explained how people with dangerous low income lives were more likely to exhibit undesirable even criminal behavior since their time horizons become very short. Applying the logic to Zimbabwe, when life is extremely precarious and dangerous, your friends are starving and beaten and you have no job and little hope, concerns about possible death years in the

future from a disease called HIV, are not uppermost in your mind (especially if you're a teenager or young adult). In other words where life is nasty and brutish in Zimbabwe, the financial and emotional cost of contracting AIDS is not sufficient to prevent reckless behavior.

One study found that 79% of Zimbabwean females said they would not avoid infecting their partners if they knew they were HIV positive, and that over a third of men with HIV said knowledge of the disease had made no difference to their behavior³⁷. With amazingly brazen, if understandably short sighted, attitudes like that, it is not difficult to imagine HIV rates may be much higher than is currently estimated – based on data that is about three years old.

The effect that the Zimbabwean crisis will have on neighbouring countries should not be underestimated. The HIV infection rate in neighbouring Zambia and Mozambique is 16.5% and 12.2% respectively. Zimbabwe, with its far higher adult HIV infection rate of at least 24.6% therefore could export HIV elsewhere, weakening neighbouring countries' economies and health care systems and even destabilizing the region.

The worst cases of AIDS are of course tragic; the sufferers have no drugs and face a bleak future. Many of these cases are too sick to travel and to seek treatment abroad. The only positive aspect is that they will not carry the virus elsewhere. Younger HIV positive Zimbabweans who are in better health, though malnourished, leave the country if they possibly can. This age group, which has the highest HIV infection, exports the virus when they leave.

According to Amnesty International Zimbabwean refugees are constantly abused in transit and where they find sanctuary³⁸. Since they are not recognized as legitimate asylum-seekers, Zimbabwean refugees live illegally and are often forced into poorly paid and dangerous jobs. Peril awaits the majority, with many women and young girls lured into prostitution³⁹.

With the partial exception of Botswana, no neighboring state acknowledges the despotism of the Mugabe regime⁴⁰. In 2003, South Africa's Minister of Foreign Affairs, Nkosazana Dlamini Zuma stated that the South African government would "never" condemn its Zimbabwean counterpart⁴¹. This denial of the Zimbabwean crisis means that no country accepts Zimbabwean migrants as political refugees. Despite Botswana's criticism of the Mugabe government, Zimbabweans fleeing their country into Botswana have been treated harshly, some flogged publicly, by the Botswana police^{42 43}.

A few Zimbabweans are lucky enough to reach safe havens, places like Bishop Paul Verryn's church in downtown Johannesburg, where around 60 refugees live and sell wares to parishioners and passersby. But most of the estimated 2 to 3 million Zimbabweans in South Africa lead an existence that is nasty and brutish, though not short enough to prevent transmission of HIV. To make matters worse, some of the Zimbabwean strains of HIV are probably resistant to drugs that were used in trials in Zimbabwe⁴⁴.

Even so, South Africa, with its 42 million people, is perhaps big enough and rich enough to accommodate these Zimbabwean neighbors. Other countries are not so well placed. According to figures from nongovernmental organizations working in the region, Botswana, with a population of just over a million, may be destabilized by the thousands of Zimbabwean immigrants that stream into the country, legally and illegally⁴⁵.

The failure of Zimbabwe's neighbours to both respond adequately to the political crisis and deal with the refugee problem has therefore probably worsened the health status of their own countries. Even though the AIDS situation in other nearby countries is unclear, the time lag for HIV to take its fatal toll means that the Zimbabwean influx will make the problem worse. It is therefore incumbent on the SADC states, but particularly South Africa, given its political and economic power, to recognise the crisis in Zimbabwe and exert pressure on the Mugabe regime to reform, restore democracy and reduce political violence. Anything less will destabilise the region and imperil the health status of ordinary citizens in all neighbouring states.

- 1 GDP per capita growth was around 10% in 1980, a great improvement on the 5% contraction in per capita GDP per capita growth in the late 1970s when sanctions were in place. By 1985 however, per capita GDP growth had fallen to just 2.9% (World Bank)
- 2 Martin Meredith, "Robert Mugabe – Power, Plunder and Tyranny" P. 60
- 3 GDP per capita figures are given in constant 1995 US Dollars. (Source: World Bank)
- 4 Source: World Bank Development Indicators; United Nations Population Division, World Population Prospects: The 2002 Revision Population Database
- 5 Daily Telegraph "Welcome to Zimbabwe's NHS" 25 January 2005, London
- 6 *ibid*
- 7 News 24, South Africa, 29 January 2005
- 8 Daily Telegraph "Mugabe's new palace in a land of hunger" 23 August, 2003, London
- 9 News 24 "Food crisis: Infants at risk" News24, South Africa, 5 November 2002
- 10 IRIN (UN) "Malnutrition and related diseases expected to rise" 10 January 2005, IRIN.
- 11 The Star "Zimbabwe could be facing food disaster" 13 January 2005, The Star, Johannesburg.
- 12 IRIN (UN) 10 January 2005
- 13 *ibid*
- 14 UNICEF 2005 "At a glance: Zimbabwe" <http://www.unicef.org/infobycountry/zimbabwe.html>. Accessed 7 February 2005.
- 15 Daily Telegraph "Dora, 12, gang-raped by Mugabe men for four hours" 25 August 2002, London.
- 16 UNDP "Human Development Report 2003" UNDP http://hdr.undp.org/statistics/data/cty/cty_f_ZWE.html. Accessed 7 February 2005
- 17 www.stoptb.org
- 18 www.plusnews.org
- 19 www.stoptb.org
- 20 Personal communication, Dr Mark Dixon, Mpilo Hospital, Bulawayo, 5 November 2004

- 21 WHO/UNAIDS epidemiological fact sheets on HIV/AIDS and Sexually Transmitted Infections, 2004 Update. Note: These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 2003
- 22 Sunday Telegraph "We were the sex slaves of Mugabe's men" 31 March 2002
- 23 The Sunday Times (UK) "Savage beatings for Mugabe opponents" 30 March 2003
- 24 US Department of State (2004) "Country Reports on Human Rights Practices – 2004. Zimbabwe." Bureau of Democracy, Human Rights and Labor, US Dept. of State. Washington.
- 25 AIDS Weekly Plus, 14 July 1997
- 26 Personal Communication, Lynde Francis, The Centre, Harare. 14 February 2005
- 27 The Nobel prize winning Medicines Sans Frontiers welcomed the Zimbabwean government move, despite the fact that local AIDS activists were skeptical. "Zimbabwe government takes emergency action against HIV/AIDS" MSF press release, May 29, 2002
- 28 IMF Zimbabwe: 2003 Article IV Consultation – Staff Report, July 2003. UNAIDS statistics from IMF report.
- 29 UNAIDS, Zimbabwe Country Report, <http://www.unaids.org/en/geographical+area/by+country/zimbabwe.asp>. Accessed 14 February 2005
- 30 The authors found a wide variation in both the prices and availability of antiretorival medicines which would make it extremely difficult for patients to plan their treatment and also to ensure that they are able to take the drugs regularly and as prescribed.
- 31 In 2002, over 1 million malaria cases were treated on an outpatient basis. Source: Zimbabwean Department of Health and Child Welfare, Zimbabwe Country Presentation, Southern Africa Malaria Control Conference, Gaborone, Botswana, July 2004.
- 32 Estimates based on Zimbabwean government data and anecdotal evidence from health workers.
- 33 Malaria is a complex disease and its control requires a thorough understanding of human behavior, mosquito behavior and of parasites. Successful malaria control therefore requires ongoing operational research
- 34 UNDP, Human Development Indicators, 2002
- 35 Mail and Guardian "Botswana buckles under illegal immigrant influx" 30 January 2003, Johannesburg
- 36 <http://nobelprize.org/economics/laureates/1992/becker-lecture.pdf>
- 37 Cited by Craig Richardson, The Collapse of Zimbabwe, Mellen Press, 2004
- 38 For instance, Amnesty International reports that "Zimbabwean citizen Thabani Ndlodlo was awarded damages in 1999 after the state conceded that two police officers had unlawfully assaulted him and shot him in the legs following an attempt to extract a bribe from him as a suspected illegal immigrant. They had also maliciously prosecuted him on criminal charges and wrongfully detained him for 446 days." Amnesty International (2002) "Policing to Protect Human Rights – A survey of police practice in countries of the Southern African Development Community, 1997 – 2002" Amnesty International Publications, London
- 39 Even Zimbabwean Minister of Labour and Social Welfare expressed concern about the abuse of Zimbabwean refugees. When commenting on a transit centre at the border town of Beitbridge to assist vulnerable youths, Minister Mangwana noted that "deportees, especially girls, had been victims of abuse and sexual harassment in Beitbridge" UN IRIN News, "Zimbabwe: Centre to help vulnerable child deportees" January 07 2005, www.irinnews.org/report.asp?ReportID=4975
- 40 Botswana's President Mogae broke ranks with other southern African leaders when he openly criticised Zimbabwe in 2002. President Mogae noted that the Zimbabwean crisis was caused by "a drought of good governance." Source: Business Day (South Africa) "Mogae Tilts at Mugabe in UK-based magazine" 25 November 2002.
- 41 BBC News "South Africa's 'silent' diplomacy" Carolyn Dempster, BBC Harare, 5 March 2003, <http://newswww.bbc.net.uk/1/hi/world/africa/2818297.stm>
- 42 East African Standard "State orders probe in flogging incident" 20 January 2004
- 43 As the Botswana based human rights group, Ditshwanelo (www.ditshwanelo.org.bw) points out, Botswana (and in fact all of Zimbabwe's neighbouring countries) ratified the UN International Convention on Civil and Political Rights, which obliges them to protect the fundamental rights of all individuals within its territory regardless of their nationality or statelessness. This includes asylum seekers, refugees and migrant workers. The abuse and violence to which Zimbabweans are subjected in neighbouring countries shows that these countries are not living up to their UN obligations.
- 44 Although there are no comprehensive surveys, powerful anecdotal evidence suggests that non-clinical changes in anti-retroviral regimens are routine in Zimbabwe, which is a recipe for rapid resistance build up.
- 45 The Migration Policy Institute notes that "Botswana was largely unprepared for the unprecedented volume of new immigrants and the reported influx of Zimbabweans in particular, in terms of physical infrastructure and border controls, as well as social absorption and integration strategies." MPI (2004) "Botswana's Changing Migration Patterns" Migration Information Service, September 2004, <http://www.migrationinformation.org/Profiles/display.cfm?ID=246>