

PHR

Physicians for
Human Rights

HEALTH IN RUINS

**A Man-Made Disaster
in Zimbabwe**



**An Emergency Report by Physicians for Human Rights
January 2009**



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PHYSICIANS FOR HUMAN RIGHTS

Physicians for Human Rights (PHR) mobilizes health professionals and concerned citizens to advance the health and dignity of all people, through actions that promote respect for, protection of, and fulfillment of, human rights.

PHR is an independent, non-profit organization and has a track record of over 22 years documenting health rights violations around the world, including in Afghanistan, Chad, Chile, Chechnya, former Yugoslavia, Kosovo, India, Israel and Palestine, Mexico, Peru, Rwanda, Sudan, and the United States.

Since 1986, PHR members have worked to stop torture, disappearances, political killings, and denial of the right to health by governments and opposition groups, and to investigate and expose violations, including deaths, injuries, and trauma inflicted on civilians in armed conflict; suffering and deprivation, including denial of access to health care caused by political differences as well as ethnic and racial discrimination; mental and physical anguish inflicted on women by abuse; loss of life or limb from landmines

and other indiscriminate weapons; harsh methods of incarceration and interrogation and torture in prisons and detention centers, and poor health stemming from vast inequalities in societies.

As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize.

Physicians for Human Rights
2 Arrow St., Suite 301
Cambridge, MA 02138

T: 617.301.4200

F: 617.301.4250

<http://physiciansforhumanrights.org>

Washington, DC Office:

1156 15th St. NW, Suite 1001

Washington, DC 20005

T: 202.728.5335

F: 202.728.3053

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PREFACE

What happens when a government presides over the dramatic reversal of its population's access to food, clean water, basic sanitation, and healthcare? When government policies lead directly to the shuttering of hospitals and clinics, the closing of its medical school, and the beatings of health workers, are we to consider the attendant deaths and injuries as any different from those resulting from a massacre of similar proportions?

Physicians for Human Rights (PHR) witnesses the utter collapse of Zimbabwe's health system, once a model in southern Africa. These shocking findings should compel the international community to respond as it should to other human rights emergencies. PHR rightly calls into question the legitimacy of a regime that, in the report's words, has abrogated the most basic state functions in protecting the health of the population. As the report documents, the Mugabe regime has used any means at its disposal, including politicizing the health sector, to maintain its hold on power. Instead of fulfilling its obligation to progressively realize the right to health for the people of Zimbabwe, the Government has taken the country backwards, which has enabled the destruction of health, water, and sanitation – all with fatal consequences.

Heedless of concern for the population of Zimbabwe from world leaders and groups such as PHR, the Government has denied access to the country, detained journalists, tortured human rights activists, and even refused visas to former U.N. Secretary-General Kofi Annan, U.S. President Jimmy Carter, and Graça Machel. PHR's team members legally entered the country and were transparent about the purpose of conducting a health assessment. Nevertheless, the Government apparently planned and then falsely reported their arrest at the end of the investigation. Such actions are a desperate attempt by Robert Mugabe to conceal the appalling situation of his country's people and to prevent the world from knowing how his Government's malignant policies have led to the destruction of infrastructure, widespread disease, torture, and death.

This report is yet another wake-up call to Zimbabwe's neighbors and all U.N. member states for urgent intervention to save lives and prevent more deaths.

These findings add to the growing evidence that Robert Mugabe and his regime may well be guilty of crimes against humanity.

Richard J. Goldstone

Former U.N. Chief Prosecutor,
International Criminal Tribunals for
the former Yugoslavia and Rwanda
(ICTY and ICTR)
Current PHR Board Member

Mary Robinson

Chair, Realizing Rights: The Ethical
Globalization Initiative
Former President of Ireland
Former U.N. High Commissioner
for Human Rights

The Most Reverend

Desmond M. Tutu,
OMSG, DD, FKC,
Anglican Archbishop
Emeritus of Cape Town
Chair, The Elders

MAP OF ZIMBABWE



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ACKNOWLEDGMENTS

The lead author of this report is Richard Sollom, MA, MPH, PHR researcher, one of the principal investigators who planned and participated in PHR's assessment in Zimbabwe in December 2008.

Other field investigators of the PHR delegation and co-authors of the report are Chris Beyrer, MD, MPH, PHR Consultant and Director, Johns Hopkins Center for Public Health and Human Rights; David Sanders, MBChB, MRCP, DCH, DTPH, PHR Consultant, and Professor of Public Health, University of the Western Cape, Cape Town, South Africa; and A. Frank Donaghue, MA, MS, Chief Executive Officer of PHR. Helen Potts, LLB, MTH, PhD, PHR Chief Program Officer for Health, is author of the legal sections, with contributions from John Bradshaw, JD, Chief Policy Officer and Director of PHR's Washington office. Susannah M. Sirkin, MEd, Deputy Director of PHR served as lead editor and contributed to analysis of the findings. Paul Caruso, MD, Instructor at Harvard Medical School, contributed to charts and graphs. Gurukarm Khalsa, PHR Web Editor/Producer, prepared the report for publication.

The report has benefited from review by Frank Davidoff, MD, Editor Emeritus of Annals of Internal Medicine and PHR Board member; Justice Richard J. Goldstone, PHR Board member and former United Nations Chief Prosecutor, International Criminal Tribunals for Yugoslavia and Rwanda (ICTY and ICTR); Jennifer Leaning, MD, SMH, PHR Board member and Professor at Harvard School of Public Health; and Leonard S. Rubenstein, JD, PHR President.

PHR is deeply indebted to its courageous colleagues and many dozens of ordinary citizens and government officials in Zimbabwe who shared their observations and experiences with our team, assisted our field researchers with logistics in a most challenging environment, and who care deeply for the lives and well being of their fellow Zimbabweans. For their own protection, they shall remain nameless. This report is dedicated to them.

ACRONYMS

ARV	Antiretroviral
BRIDH	Beatrice Road Infectious Diseases Hospital
CDC	United States Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of Discrimination against Women
CFR	Case fatality rate
CIDA	Canadian International Development Agency
C-SAFE	Consortium for Southern Africa Food Security Emergency
DFID	United Kingdom Department for International Development
ECHO	European Commission's Humanitarian Aid Office
FAO	Food and Agriculture Organization of the United Nations
FOLIWARS	Foreign Exchange Warehouse and Retail Shops
GFATM	Global Fund to Fight AIDS, TB and Malaria
HDI	United Nations Development Program Human Development Index
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HRC	United Nations Human Rights Committee
ICC	International Criminal Court
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
MDC	Movement for Democratic Change
MDR-TB	Multi-drug resistant tuberculosis
MSF	Médecins Sans Frontières
NGO	Nongovernmental organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PEM	Protein-energy malnutrition
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHR	Physicians for Human Rights
RBZ	Reserve Bank of Zimbabwe
SADC	Southern African Development Community
TB	Tuberculosis
UFW	Unaccounted for water
UN	United Nations
USAID	United States Agency for International Development
USD	United States dollar
WFP	United Nations World Food Program
WHO	United Nations World Health Organization
XDR-TB	Extremely drug resistant tuberculosis
ZADHR	Zimbabwe Association of Doctors for Human Rights
ZANU-PF	Zimbabwe African National Union – Patriotic Front
ZINWA	Zimbabwe National Water Authority

EXECUTIVE SUMMARY

INTRODUCTION AND OVERVIEW

Physicians for Human Rights sent an emergency delegation to Zimbabwe in December 2008 to investigate the collapse of healthcare. The health and nutritional status of Zimbabwe's people has acutely worsened this past year due to a cholera epidemic, high maternal mortality, malnutrition, HIV/AIDS, tuberculosis, and anthrax. The 2008 cholera epidemic that continues in 2009 is an outcome of the health systems collapse, and of the failure of the state to maintain safe water and sanitation. This disaster is man-made, was likely preventable, and has become a regional issue since the spread of cholera to neighbor states.

The health crisis in Zimbabwe is a direct outcome of the violation of a number of human rights, including the right to participate in government and in free elections and the right to a standard of living adequate for one's health and well being, including food, medical care, and necessary social services. Robert Mugabe's ZANU-PF regime continues to violate Zimbabweans' civil, political, economic, social, and cultural rights.

The collapse of Zimbabwe's health system in 2008 is unprecedented in scale and scope. Public-sector hospitals have been shuttered since November 2008. While some facilities remain open in the private sector, these are operating on a US-dollar system and are charging fees ranging from \$200 USD in cash for a consultation, \$500 USD for an in-patient bed, and \$3,000 USD for a Cesarean section. With fees in reach for only the wealthy, the majority are being denied access to health care.

» **International human rights framework**

Zimbabwe is a party to the International Covenant on Economic, Social and Cultural Rights (ICESCR or the Covenant), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the African Charter on Human and Peoples' Rights. The Government has a legally binding obligation to respect, protect, and fulfill these rights for all people within its jurisdiction.

The right to health imposes core obligations, which require access to health facilities on a non-

discriminatory basis, the provision of a minimum essential package of health-related services and facilities, including essential food, basic sanitation and adequate water, essential medicines, and sexual and reproductive health services, including obstetric care. Even with limited resources, the Government is required to give first priority to the most basic health needs of the population and to the most vulnerable sections of the population.

» **Methods for this investigation**

During a seven-day investigation to Zimbabwe (13-20 December 2008) conducted by four human rights investigators, including two physicians with expertise in public health and epidemiology, PHR interviewed and met with 92 participants, including healthcare workers in private and public hospitals and clinics, medical students from both of the medical schools in Zimbabwe, representatives from local and international NGOs, representatives from U.N. agencies, Zimbabwean government health officials, members of parliament, water and sanitation engineers, farmers, and school teachers. The PHR team visited four of the ten provinces in Zimbabwe, in both urban and rural areas. Provinces visited included Harare, Mashonaland Central, Mashonaland West, and Mashonaland East.

FINDINGS

» **The economic collapse**

A causal chain runs from Mugabe's economic policies, to Zimbabwe's economic collapse, food insecurity and malnutrition, and the current outbreaks of infectious disease. These policies include the land seizures of 2000, a failed monetary policy and currency devaluations, and a cap on bank withdrawals. Mugabe's land seizures destroyed Zimbabwe's agricultural sector, which provided 45% of the country's foreign exchange revenue and livelihood for more than 70% of the population. Hyperinflation has ensued while salary levels have not kept pace. A government physician in Harare showed PHR her official pay stub; her monthly gross income in November 2008 was worth 32 U.S. cents (\$0.32 USD). The unemployment rate is over 80%. Low-income households have had to reduce the quantity and quality of food. The Mugabe ZANU-PF government must be held accountable for the violation of the right to be free from hunger.

» **Public health system collapse**

The Government of Zimbabwe has abrogated the most basic state functions in protecting the health of the population – including the maintenance of public hospitals and clinics and the support for the health workers required to maintain the public health system. These services have been in decline since 2006, but the deterioration of both public health and clinical care has dramatically accelerated since August 2008.

› **Healthcare and healthcare delivery**

As of December 2008, there were no functioning critical care beds in the public sector in Zimbabwe. The director of a mission hospital told PHR:

“We see women with eclampsia who have been seizing for 12 hours. There is no intensive care unit here, and now there is no intensive care in Harare. If we had intensive care, we know it would be immediately full of critically ill patients. As it is, they just die.”

Life expectancy at birth has fallen dramatically from 62 years for both sexes in 1990 to 36 years in 2006 – 34 years for males and 37 years for females, the world’s lowest.

› **Limits to access: affordability, transportation, closures**

Since the dollarization of the economy in November 2008, only a tiny elite with substantial foreign currency holdings have any real access to healthcare. Transport costs, even within Harare, have made getting to work impossible for many healthcare employees. A rural clinic staff nurse reported that since he lived at the clinic, he had no difficulties in getting to work; however, since bus fare to get to the nearest town to collect his monthly salary cost more than the entire salary, it made no sense to collect it. He had not done so since April 2008. A senior government official said: *Government salaries are simply rotting in the bank.* When asked about how the absence of healthcare workers was affecting HIV treatment, the official said: *This is not a strike. The problem is the staff and the patients cannot come due to travel costs.*

Between September and November 2008 most wards in the public hospitals gradually closed. The most abrupt halt in healthcare access occurred on 17 November 2008, when the premier teaching and referral hospital in Harare, Parirenyatwa, closed along with the medical school.

› **Essential medicines and supplies**

Access to essential medications was raised by nearly all providers interviewed. In addition to drug shortages, medical supplies (including cleaning agents, soap, surgical gloves, and bandages) were also in critically short supply—or absent altogether. A rural clinic nurse reported:

“Right now I have no anti-hypertensives, no anti-asthmatics, no analgesics, nothing for pain. ... I have a woman in labor right now, and I have no way to monitor blood pressure ... and I have no suture material to do a repair if she tears.”

› **Health information and suppression**

The Mugabe regime intentionally suppressed initial reports of the cholera epidemic and has since denied or underplayed its gravity. The Minister of Information and Publicity, Sikhanyiso Ndlovu, reportedly ordered government-controlled media to downplay the cholera epidemic, which he said had *given the country’s enemies a chance to exert more pressure on President Robert Mugabe to leave office.* The Minister instructed the media *to turn a blind eye to the number of people who have died or [have become] infected with cholera, and instead focus on what the Government and NGOs are doing to contain the epidemic.*

PHR heard from several sources in Zimbabwe that the Government has intentionally suppressed information regarding increasing malnutrition. PHR asked a nurse staffing a public-sector clinic in a rural district if there had been cases of malnutrition. The nurse became visibly anxious and then replied:

“Malnutrition is very political. We are not supposed to have hunger in Zimbabwe. So even though we do see it, we cannot report it.”

DETERMINANTS OF HEALTH

» **Failed sewerage and sanitation systems**

Before the ZANU-PF government nationalized municipal water authorities in 2006, water treatment and delivery systems worked, although suboptimally. The Mugabe regime, however, politicized water for political gain and profit, policies that proved disastrous, and which have clearly contributed to the ongoing cholera epidemic.

All Harare residents PHR interviewed reported that trash collection has effectively ceased. Throughout Harare, and especially in the poor high-density areas outside the capital, PHR investigators saw detritus littering streets and clogging intersections. Steady streams of raw sewage flow through the refuse and merge with septic waste. A current Ministry of Health official reported to PHR: *There is no decontamination of waste in the country.*

» **Nutrition and food security**

The U.N. Food and Agricultural Organization (FAO) predicts that some 5.1 million (45% of the population) who will require food aid by early 2009 in order to survive. Agricultural output has dropped 50-70% over the past seven years. The ZANU-PF government has exacerbated food insecurity for Zimbabweans in 2008 by blocking international humanitarian organizations from delivering food aid and humanitarian aid to populations in the worst-affected rural areas. Patients with HIV/AIDS and TB are especially vulnerable to food insecurity.

In the months following the March 2008 elections, the Mugabe regime used food as a weapon of war against MDC supporters and the rural poor. On 31 December 2008, a government official in Chivhu prevented WFP from distributing food aid: "The villagers accused the chief of being corrupt and diverting donor aid and distributing it along party lines. They indicated that ... the chief and his ZANU-PF supporters used to source

maize from the nearby Grain Marketing Board and then sell it to the poor villagers." A leader of a health NGO reported that:

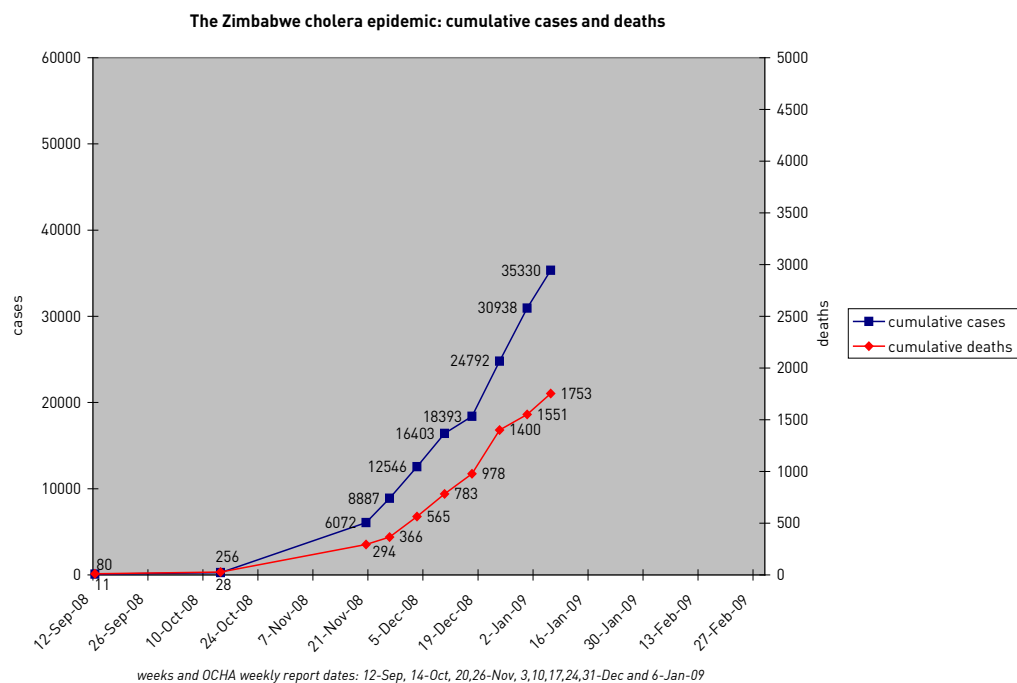
"There is no food in many of the hospitals and there is starvation in the prisons."

» **Current health crisis: Cholera**

The current cholera epidemic in Zimbabwe appears to have begun in August 2008. As of this writing, more than 1,700 Zimbabweans have died from the disease and another 35,000 people have been infected. The U.N. reports that cholera has spread to all of Zimbabwe's ten provinces, and to 55 of the 62 districts (89%) and that the cumulative case fatality rate (CFR) across the country has risen to 5.0% - five times greater than what is typical in cholera outbreaks. Control has not been reached: There has been a doubling of both cases and deaths during the last three weeks of December, 2008.

» ***Cholera infectivity, epidemiology, and treatment***

The origin of the current cholera epidemic appears to stem from the failure of the Mugabe regime to maintain water purification measures and manage sewerage systems. Civic organizations in Harare warned of a *cholera time-bomb* in 2006, but the Mugabe regime ignored the warning signs. Not until 4 December 2008 did Zimbabwe's Ministry of Health and Child Welfare finally request aid to respond to the cholera outbreak



by declaring a national emergency. This negligence represents a four-month delay since the start of the cholera outbreak, but at least a three-year delay in responding to the water and sanitation breakdowns, which have allowed cholera to flourish.

Death rates from cholera are usually under 1%; however, in the current Zimbabwe epidemic, the cumulative death rate for the country is around 5%, and more than 40% of all districts have case fatality rates above 10%. PHR asked a senior government official responsible for cholera surveillance why Zimbabwe's case fatality rate was more than five times greater. She attributed the high death rate to three causes. First, in the initial phase there simply were no supplies, such as ORS and IV fluids. Second, few clinic or hospital staff were sufficiently experienced or trained to respond to cholera, and many patients died even in facilities that had adequate supplies. Finally, the issue of transport costs for patients and staff, exacerbated by the closure of the public hospitals, meant that many patients either could not reach care, or reached care in advanced dehydration, and could not be saved.

» **Current health crisis: Anthrax**

WHO has reported some 200 human cases of anthrax since November 2008 with eight confirmed deaths. These cases were attributed to the ingestion of animals (cattle and goats) that had died of anthrax. Zimbabweans avoid eating animals that have died of disease – but these cases appear to have occurred in starving rural people scavenging carrion.

PHR was told that veterinary anthrax control programs in Zimbabwe, which had included regular monthly control programs, have been dramatically curtailed in the economic collapse. The surviving herds are now much more vulnerable to infectious diseases.

» **Current Health Crisis: HIV/AIDS**

UNAIDS figures show that Zimbabwe has a severe generalized epidemic of HIV-1, with an overall adult (ages 15-49) HIV prevalence rate of 15.3%. An estimated 1.3 million adults and children in Zimbabwe are living with HIV infection in 2008. Of these, some 680,000 were women of childbearing age. In 2007, some 140,000 Zimbabweans died of AIDS, and the current toll is estimated at 400 AIDS deaths per day. Access to HIV/AIDS care and treatment is threatened by the current collapse and HIV programs are currently capped: some 205,000 people are thought to be taking Anti-Retrovirals

(ARVs), but no major program is currently able to enroll new patients. Some 800,000 Zimbabweans are thought to require therapy, or will require it in the coming months-years.

PHR investigators received corroborating reports from donors and HIV/AIDS patients in Zimbabwe that ZANU-PF government officials had plundered \$7.3 million USD in humanitarian aid for HIV/AIDS treatment – part of \$12.3 million USD from the Global Fund for AIDS, Tuberculosis and Malaria. Following public outrage over the scandal months later in November 2008, the ZANU-PF-controlled reserve bank returned the stolen funds to the Global Fund.

For HIV/AIDS the most severe threat has been the interruption of regular supplies of antiretroviral drugs. Multiple key informants, patients, and providers told PHR that ARV supplies had become irregular due to breakdowns in drug delivery, distribution, provision, and theft of ARV drugs by ZANU-PF operatives. Most troubling were reports that some physicians were switching patients on established ARV regimens to other regimens based not on clinical need, but on drug availability. This can lead to drug resistant HIV strains. These dangerous practices constitute a significant threat to public health since the development and transmission of multi-drug resistant variants of HIV in Zimbabwe could undermine not only Zimbabwe's HIV/AIDS program, but regional programs as well.

» **Current health crisis: Tuberculosis**

PHR asked an expert working with the national program to describe the status of the program in December 2008: "There is no politically correct way to say this – the TB program in Zimbabwe is a joke. The national TB lab has one staff person. There is no one trained in drug sensitivity testing. The TB reference lab is just not functioning. This is a brain drain problem. The lab was working well until 2006 and has since fallen apart. The DOTS program in 2000 was highly effective, but that has broken down now too. There is no real data collection system for TB. This stopped in 2006 as well."

Both MDR-TB and possible XDR-TB (a largely fatal and often untreatable form) have emerged in Zimbabwe, but the critical capacity to diagnose and manage these infections has collapsed.

» **Current health crisis: Maternal morbidity and mortality**

Maternal health in Zimbabwe has deteriorated

greatly over the past decade. The maternal mortality rate has risen from 168 (per 100,000) in 1990 to 1,100 (per 100,000) in 2005. The major contributors are HIV/AIDS and a significant decline in availability and quality of maternal health services. PHR interviewed several Harare mothers at a distant Mission Hospital who had sought obstetric care. One went to Mbuya Nehanda Government Maternity Hospital for a cesarean section on 14 November 2008. She was told that the operation could not be performed because there were no nurses, doctors, or anesthesiologists at work. Another woman said:

“I wanted to have my baby in Harare but Parirenyatwa hospital was closed. I was having my prenatal care with my own doctor at [a private clinic] but they wanted so much money. They wanted only U.S. dollars, in cash. \$3,000 dollars for the surgeon, \$140 dollars for the nurse, and \$700 dollars for the doctor who puts you to sleep.”

CONCLUSIONS

The health and healthcare crisis in Zimbabwe is a direct outcome of the malfeasance of the Mugabe regime and the systematic violation of a wide range of human rights, including the right to participate in government and in free elections and egregious failure to respect, protect and fulfill the right to health.

The findings contained in this report show, at a minimum, violations of the rights to life, health, food, water, and work. When examined in the context of 28 years of massive and egregious human rights violations against the people of Zimbabwe under the rule of Robert Mugabe, they constitute added proof of the commission by the Mugabe regime of crimes against humanity.

RECOMMENDATIONS

1. Resolve the political impasse

The UN Security Council and the South African Development Community should call on the Mugabe regime to accept the result of the 29 March election and allow the MDC to assume its place. Governments should end their support of Mugabe's regime, engaging in intensive diplomacy to assure a democratic political transition. They should maintain and strengthen targeted bilateral sanctions until Mugabe cedes power and a stable government is established.

2. Launch an emergency health response

The government of Zimbabwe should yield control of its health services, water supply, sanitation, disease surveillance, Ministry of Health operations, and other public health functions to a United Nations-designated agency or consortium. Such a mechanism would be equivalent to putting the health system into a *receivership* pursuant to the existence of a circumstance that meets the criteria for the Responsibility to Protect. If the government of Zimbabwe refuses to yield such control, the U.N. Security Council, acting pursuant to its authority under Article 39 of the Charter, should enact a resolution compelling the Government of Zimbabwe to do so.

3. Refer the situation in Zimbabwe to the International Criminal Court for crimes against humanity

The U.N. Security Council, acting pursuant to its authority under Article 41 of the U.N. Charter, should enact a resolution referring the crisis in Zimbabwe to the International Criminal Court for investigation and to begin the process of compiling documentary and other evidence that would support the charge of crimes against humanity.

4. Convene an emergency summit on HIV/AIDS, tuberculosis and other infectious diseases

Donor governments and the Global Fund should consider this crisis as a first test-case of the collapse of a health system in a country that is a recipient of emergency AIDS and TB prevention and treatment programs. The Obama Administration, together with the Global Fund and other donors, should convene an emergency summit to coordinate action to address the current acute shortfalls in AIDS and Tuberculosis treatment and care.

5. Prevent further nutritional deterioration and ensure household food security

To prevent further deterioration of nutritional status, especially among the most vulnerable (young children, mothers, HIV/AIDS, and TB sufferers), the international community needs urgently to fully fund the 2009 Consolidated Appeal (CAP) for Zimbabwe of \$550 million USD. Importantly, donor governments must ensure non-interference by the current regime in obstructing, diverting, politicizing, or looting such humanitarian aid. The US as well as other donor governments and private voluntary organizations should increase donations of appropriate foods to the responsible multilateral agencies, such as WFP, to meet the impending shortfall in the coming 3-6 months.

INTRODUCTION

Physicians for Human Rights sent an emergency delegation to Zimbabwe in December 2008 to investigate the collapse of healthcare in the country. The health and nutritional status of Zimbabwe's people has acutely worsened this past year due to a raging cholera epidemic, high maternal mortality, malnutrition, HIV/AIDS, tuberculosis, and now anthrax. The cholera epidemic is an outcome of the health system collapse and of the failure of the Government to maintain previously operative safe water and sanitation and provide prompt infection control and patient care. The cholera epidemic, now a humanitarian emergency, is a man-made disaster, was likely preventable, and has become a regional health and security issue because of the failure of the state to respond to the health and basic living needs of its people.

Viewed through a human rights lens, the health and healthcare crisis in Zimbabwe is a direct outcome of the abrogation of a number of human rights, including the right to participate in government and in free elections and the right to a standard of living adequate for one's health and well being, including food, medical care, and necessary social services. The ZANU-PF regime and its security forces continue to violate Zimbabweans' civil and political rights as well as economic, social, and cultural rights.

The collapse of Zimbabwe's health system in 2008 is unprecedented in scale and scope. Public-sector hospitals have been shuttered since November 2008. The basic infrastructure for the maintenance of public health, particularly water and sanitation services, have abruptly deteriorated in the worsening political and economic climate. Hospitals, clinics, schools, and even key border crossings have no water, no functioning toilets or sewerage systems, and limited medical supplies. Still open facilities lack everything from running water and electricity to sterile gloves and suture materials, essential medicines, and communication capacity.

In addition to such inadequate supplies, healthcare staff are unable to work. Salaries are fixed in the virtually worthless currency and can be withdrawn from local banks only in quantities sufficient to pay for one-way travel to work. Staff willing to work for free often cannot afford transport to their posts and cannot adequately feed their own families. The healthcare facilities that remain open are critically understaffed

and overwhelmed by patients sent from closed facilities. Howard Mission Hospital, an 80-kilometer drive from the capital – the last 12 kilometers over rugged dirt roads – is one of few hospitals open for the people of Harare. And the vast majority of people, making less than \$2 USD a day, cannot afford the cost of transportation to this rural hospital.

While clinics and even a few hospitals remain open in the private sector, these facilities are operating on a US-dollar system and are charging fees that are substantially higher than would be seen even in developed-world settings: \$200 USD in cash for a consultation, \$500 USD to secure an in-patient bed, and \$3,000 USD for a Cesarean section. These fees are within reach of only the wealthy elite in Zimbabwe. Consequently, the civilian population is denied access to public health and medical care.

This report describes key aspects of the current health and healthcare crisis in Zimbabwe; it also analyzes what data are available, shares the stories of physicians, nurses, medical students, healthcare officials, patients, as well as representatives of NGOs and other health and humanitarian organizations as they have struggled to survive in a collapsing system. Finally, this report presents recommendations for ways forward out of the collapse. An emergency is upon us. The people of Zimbabwe are needlessly dying due to violations of human rights including the right to health.

» International human rights framework

Zimbabwe is a party to a wide range of international and regional human rights treaties (also known as covenants or conventions), which contain important provisions related to the right to health,¹ and the rights to food, water and work, including the International Covenant on Economic, Social and Cultural Rights (ICESCR or the Covenant), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the African Charter on Human and Peoples' Rights.² These treaties highlight the particular importance

1 The full formulation is: the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In this report, the right to health and the right to the highest attainable standard of health are used synonymously.

2 The Government of Zimbabwe acceded to the ICESCR and CEDAW on 31 May 1991 with no declarations or reservations. The Government ratified the CRC on 9 November 1990, again with no reservations or declarations. There is no ICESCR report submitted by Zimbabwe listed on the Committee web site. The last report

that human rights have for disadvantaged people and populations, including those living in poverty.

Although a state party to the ICESCR, the Government of Zimbabwe has not incorporated economic, social and cultural rights into its Constitution. Nevertheless, as a party to the ICESCR and other international human rights treaties, the Government has a legally binding obligation to respect, protect, and fulfill these rights for all people within its jurisdiction.

Human rights are interdependent. For example, the right to health is closely related to realization of other human rights such as life, food, work, water, the prohibition against torture, and the freedoms of association, assembly and movement. Although these and other human rights address integral components of the right to health,³ it is beyond the scope of the current report to provide a legal framework and analysis of them. This report focuses on the right to health, per se, the content of which is addressed below.

» **Right to health**

Though first formulated in the World Health Organization (WHO) Constitution (1946), the central formulation of the right to health is contained in Article 12 of the ICESCR.⁴ Article 12 provides:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - b. The improvement of all aspects of environmental and industrial hygiene;
 - c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

- d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In 2000, the U.N. Committee on Economic, Social and Cultural Rights released General Comment No. 14, which provides an authoritative understanding of the content and the right to health.⁵ The General Comment sets out a way to analyze the right to health, thereby making it easier to identify government obligations.

The right to health is an inclusive right extending to both medical care and the underlying determinants of health, such as adequate sanitation, safe water, adequate food, and access to health-related information.⁶ It encompasses both freedoms and entitlements. The freedoms include, for example, the right to make decisions about one's health, including sexual and reproductive freedom.⁷ The entitlements include, for example, the right to emergency medical services, and to the underlying determinants of health such as access to safe water, adequate sanitation and adequate food.⁸ In all its forms and at all levels, the right contains the interrelated and essential elements of available, accessible, acceptable health facilities, goods and services that are appropriate and of good quality.⁹ For example, good quality health facilities require skilled health workers who receive domestically competitive salaries and whose own human rights are protected (e.g., safe working environment and freedoms of association, assembly and expression).¹⁰ Participation by individuals and groups in all health-related decision-making at the national and international levels is also essential.¹¹ Equality and non-discrimination are fundamental elements of the right to health. Governments have a legal obligation to ensure that a health system is accessible to all without discrimination, including those living in poverty.¹² If health facilities are accessible to the wealthy, but inaccessible to the rest of the population, the

under the ICCPR was submitted in 1998. The last report under the CRC was submitted in 1996.

3 Committee on Economic, Social and Cultural Rights, The right to the highest attainable standard of health: 11/08/2000. E/C.12/2000/4, CESCR General Comment 14, Twenty-second session Geneva, 25 April-12 May 2000 Agenda item 3, para. 3. <http://www2.ohchr.org/english/bodies/cescr/comments.htm> (accessed 8 Jan. 2009).

4 International Covenant on Economic, Social and Cultural Rights, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 Jan. 1976); Constitution of the World Health Organisation, opened for signature 22 July 1946, 14 UNTS 185, (entered into force 7 Apr. 1948).

5 General Comment No. 14 supra, note 3. See also Backman G, Hunt P, Khosla R, et al (2008) Health systems and the right to health: an assessment of 194 countries, *Lancet* 372: 2047-2085.

6 Id. para. 11.

7 Id. para. 8.

8 Id.

9 General Comment No. 14, supra note 3, para. 12.

10 Hunt P and Backman G, Health systems and the right to the highest attainable standard of health (Human Rights Centre, University of Essex, 2008).

11 General Comment No. 14, supra note 3, para. 11.

12 Id. paras. 18, 19.

Government can be held accountable and be required to take remedial action.¹³

The right to health is subject to both progressive realization and resource availability.¹⁴ Put simply, progressive realization means that a country must improve its right to health performance steadily, while resource availability means that what is required of a developed country is of a higher standard than what is required of a developing country.¹⁵ The corollary to the obligation to progressively realize the right to health is that there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible.¹⁶ If any deliberately retrogressive measures are taken, the Government has to provide an objective and rational explanation.¹⁷ These retrogressive acts can occur through acts of omission as well as acts of commission.¹⁸

The right to health also imposes obligations of immediate effect.¹⁹ These core obligations require, at the very least, access to health facilities on a non-discriminatory basis, the provision of a minimum essential package of health-related services and facilities, including essential food, basic sanitation and adequate water, essential medicines, sexual and reproductive health services including prenatal and post-natal services, emergency obstetric care, and the development and adoption of a comprehensive national health plan.²⁰ Even in the presence of limited resources, the government is required to give first priority to the most basic health needs of the population and to pay particular attention to protecting the most vulnerable sections of the population.²¹

To monitor progressive realization and to provide health information, the right to health requires indicators and benchmarks.²² These indicators and benchmarks should be disaggregated, at a minimum, on the basis of sex, socioeconomic status, rural-urban divide, and age, so that a government can monitor whether or

not its health programs for disadvantaged individuals and communities are working.²³ The right to health imposes a legal obligation. Accordingly, accountability on the part of the government for implementation of the right to health is essential.²⁴ The accountability process requires a government to show, explain, and justify how it has discharged its obligations regarding the right to the highest attainable standard of health. The process also provides individuals and communities with an opportunity to understand how government has discharged its right to health obligations. If it is revealed that there has been a failure on the part of government to fulfill the obligations contained in the right to health, rights-holders are entitled to effective remedies to redress this failure.²⁵

» **Right to life and the prohibition against torture or cruel, inhuman or degrading treatment or punishment**

Zimbabwe is also state party to the International Covenant on Civil and Political Rights (ICCPR). The Constitution of Zimbabwe²⁶ incorporates some civil and political rights, such as protection of the right to life (section 12), protection from inhuman treatment (section 15), as well as freedom of expression (section 20), assembly and association (section 21), and protection from discrimination on the grounds of race, etc. (section 23). Zimbabwe's accession to the ICCPR and its incorporation of some of these rights into the Constitution is particularly relevant to this report in view of the U.N. Human Rights Committee's interpretation of the right to life.

The Human Rights Committee (HRC) has consistently opined that the right to life cannot be interpreted in a narrow sense.²⁷ In General Comment No. 6 the HRC noted that the right to life requires the adoption of

13 Id. para. 19. See also Backman, et al, supra note 5.

14 Id. para. 30.

15 Hunt and Backman, supra note 10.

16 General Comment No. 14, supra note 3, para. 32.

17 Backman et al, supra note 5.

18 General Comment No. 14, supra note 11, paras. 48 and 49.

19 Id. para. 43.

20 Id. See also Backman et al, supra note 5.

21 Committee on Economic, Social and Cultural Rights, The nature of States parties obligations (Art. 2, para. 1), 14/12/90. CESCR General Comment 3, 5th Session 1990, para. 12. <http://www2.ohchr.org/english/bodies/cescr/comments.htm> [accessed 6 Jan. 2009].

22 General Comment No. 14, supra note 3, paras. 57 and 58.

23 Potts H. Accountability and the right to the highest attainable standard of health (Human Rights Centre, University of Essex, 2008). Monitoring can also be conducted by civil society either in collaboration with government or on its own initiative. http://www2.essex.ac.uk/human_rights_centre/rth/docs/HRC_Accountability_Mar08.pdf [accessed 8 Jan. 2009].

24 Id.

25 Id.

26 Constitution of Zimbabwe as amended at 30th October, 2007, up to and including amendments made by Constitution of Zimbabwe (Amendment) No. 18 Act, 2007. (Act No. 11 of 2007) <http://aceproject.org/ero-en/regions/africa/ZW/zimbabwe-constitution-of-zimbabwe-2008/view> [accessed 7 Jan. 2009].

27 Magdalena Sepúlveda, The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights, (Intersentia, Antwerpen, 2003), at 149.

positive measures on the part of the State. Significantly, the examples provided include the adoption of measures to eliminate malnutrition and epidemics and the reduction of infant mortality:

“Moreover, the Committee has noted that the right to life has been too often narrowly interpreted. The expression *inherent right to life* cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.”²⁸

In a later General Comment²⁹ the HRC again established that the right to life required positive acts on the part of the State including the provision of data on pregnancy and childbirth-related deaths of women, the provision of information on the impact of deprivation and poverty on women, and the provision of sexual and reproductive health services, including access to safe abortions among other services.³⁰ Sepúlveda notes that the HRC maintains the same line of argument when examining State Party reports.³¹

The HRC has confirmed that, as with the right to life, the prohibition against torture is non-derogable even during declared public emergencies.³² It is insufficient simply to prohibit this conduct; States must ensure effective protection. Complaints are to be effectively investigated, those found guilty held accountable, and the alleged victims must have effective remedies.³³

28 Human Rights Committee, General Comment No. 6: The right to life (art. 6), para. 5. <http://www2.ohchr.org/english/bodies/hrc/comments.htm>.

29 Human Rights Committee, General Comment No. 28: Equality of rights between men and women (Art. 3), U.N. Doc CCPR/C/21/Rev.1/Add.10. <http://www2.ohchr.org/english/bodies/hrc/comments.htm> (accessed 6 Jan. 2009).

30 *Id.* para. 10.

31 Sepúlveda, *supra* note 27, at 150. State party reports are periodic reports to the U.N. treaty monitoring committee by states that have ratified the relevant treaty.

32 Human Rights Committee, General Comment No. 7: torture or cruel, inhuman or degrading treatment or punishment (Art. 7, 30/05/82, paragraph 1. <http://www2.ohchr.org/english/bodies/hrc/comments.htm> (accessed 7 Jan. 2009). Torture is a clear example of how human rights violations impact health. Reciprocally, damaged health furthers the destruction of human rights – by destroying human capital and by consuming scarce financial and material resources; hence, the interaction between health and human rights contributes importantly to the downward spiral of an entire society.

33 *Id.*

Torture or cruel, inhuman or degrading treatment or punishment is understood in a broad sense as it may extend to persons kept in solitary confinement, especially when the person is kept incommunicado.³⁴ Additionally, when people are deprived of their liberty, the prohibition against torture or cruel, inhuman or degrading treatment or punishment is augmented by the positive requirements of article 10 (1) of the ICCPR:

*All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human persons.*³⁵

METHODS

This report is based on the findings of a health and human rights assessment conducted in Zimbabwe by a PHR team, comprising four human rights investigators, including two physicians with expertise in public health and epidemiology. The team conducted a series of key informant interviews and several focus group discussions, and interviewed a wide range of stakeholders. The qualitative domains of the interview instrument were developed by adapting health and rights instruments used by PHR, the Center for Public Health and Human Rights at Johns Hopkins University, and the School of Public Health at the University of the Western Cape, South Africa in similar settings where violations of the right to health occurred. An Expert Review Board convened by PHR reviewed the instruments, which the team adapted to the field while in Zimbabwe. For protection of key informants, all interviews were anonymous by removing identifying information from the interview record. PHR investigators asked participants for their verbal informed consent after hearing an explanation of PHR, the investigation, and the intent to conduct advocacy based on the assessment findings. All participants were adults aged 18 or older, and all interviews were conducted in English, which is commonly spoken in Zimbabwe.

During the seven-day investigation to Zimbabwe (13-20 December 2008), PHR interviewed and met with 92 participants, including healthcare workers in private and public hospitals and clinics, medical students from both of the medical schools in Zimbabwe, representatives from local and international NGOs, representatives from U.N. agencies, Zimbabwean

34 *Id.* para. 2.

35 *Id.* para. 3.

government health officials, members of Parliament, water and sanitation engineers, farmers, and school teachers. The assessment team visited four of the ten provinces in Zimbabwe, in both urban and rural areas, and in some of the affected border areas. Provinces visited included Harare, Mashonaland Central, Mashonaland West, and Mashonaland East.

Interview data were analyzed using qualitative methods and were augmented with a literature and lay media review. The security conditions in the country precluded doing a quantitative study.

LIMITATIONS

PHR conducted an emergency investigation, which, by its nature, is subject to limitations in duration, scope, and access. The field investigation took place during a short time frame of seven days in country. The scope of the current investigation did not permit a full analysis of the health system. Restricted access to health facilities, participants, and regions precluded

a complete account of all human rights violations occurring. This investigative study should be construed as a snapshot in time, partial rather than complete accounts or prevalence reports of human rights violations. Notwithstanding these limitations, the study has produced sufficient firm data to make informed recommendations.

BACKGROUND

When Robert Mugabe came to power in 1980 he implemented several policies that benefited the majority of the people such as extending education and health care to the black majority and increasing minimum wages. The lives of most Zimbabweans improved dramatically in the first years of independence. Dramatic improvements were seen in key health indicators such as life expectancy, maternal mortality and infant mortality.

We're going to kill you

PHR investigators interviewed three Zimbabweans as they lay in separate hospital beds.¹ On 13 December 2008, 15 police and military personnel stopped a car carrying a 32-year-old MDC counselor from Chitungwiza, his 29-year-old wife, and their friend, a 26-year-old male, who was driving the vehicle. The three were traveling to attend a funeral service for a young relative who had died from cholera.

After a group of 15 armed police and military stopped them at a makeshift roadblock outside Rusape in eastern Zimbabwe, they searched the vehicle and found work-related documents showing that the husband was an MDC city councilor. One of the police yelled at them: "You're coming here to mobilize MDC support against Mugabe, so we're going to kill you!"

The group of police and AK-47-toting military drove them to a nearby vacant elementary school building that served as their barracks. There, several of the 15 police and military took turns beating each of the three individually while the other two were forced to watch. After taking \$25 USD out of her bra, the attackers forcibly ripped the wife's clothes off and lashed her back and arms with a leather whip. They then pummeled her buttocks with a wooden baton stick. The police and military beat the two men similarly and forced them to spread ash and water all over their bodies. The police then made them roll on the ground back and forth as fast as possible. Two of the police took turns jumping on the stomachs of the two men, forcing them to vomit. When the husband began to have diarrhea, the police and military left them alone in apparent fear of cholera.

Before leaving, one of the military officers threatened the MDC councilor: "We're coming to your house to finish the job." On examination, both the husband and wife had visible signs of having been whipped and beaten, with lacerations on their backs and shoulders and severe intramuscular hematomas of the buttocks.

¹ PHR investigators also interviewed staff from the local NGO that arranged and paid for their medical treatment at a private clinic.

Tragically these early improvements have all been eroded by Mugabe's policies. In the nearly 29 years that Mugabe and his ruling party, the Zimbabwe African National Union-Patriotic Front (ZANU-PF), have been in power, the Government has established a record of gross human rights abuses that is well documented.³⁶ Human rights organizations have shown that the Mugabe government has carried out policies designed and calculated to cause suffering and loss of life to specific groups of people, specifically the Ndebele ethnic minority concentrated in the Matabeleland North and South provinces as well as urban and rural groups who support the opposition Movement for Democratic Change (MDC).

» **Matabeleland massacres**³⁷

Mugabe is from the Shona ethnic group, which makes up more than 70% of Zimbabwe's population of 12 million, and throughout his rule he has consistently disadvantaged the minority Ndebele, who constitute 20% of the population and whom he saw as supporters of opposition parties. In February 1982, Mugabe accused opposition leader Joshua Nkomo, who was Ndebele, of plotting to overthrow the government. Nkomo was fired from cabinet, and several of his supporters in the army were jailed. Violent anti-Mugabe protests erupted across Matabeleland, where Nkomo's Ndebele supporters were concentrated.

The largest number of human rights atrocities occurred between 1983 and 1987, when Mugabe ordered a brutal campaign in which the army killed an estimated 20,000 rural Ndebele people in Zimbabwe's two southern provinces, Matabeleland North and Matabeleland South. These killings highlighted Mugabe's ongoing abuse of Zimbabwe's ethnic minority, the Ndebele people.

Mugabe ordered a special army brigade into Matabeleland to stamp out the anti-government

violence. The Fifth Brigade was made up of virtually all Shona troops, and it had received special training from North Korean advisers. The Fifth Brigade swept across Matabeleland throughout 1983 and 1984 carrying out a series of mass beatings, torture, and killings, according to numerous witnesses. The army also set up road blocks, which prevented food supplies from going into the Matabeleland region where there was drought and where widespread hunger was reported. In 1987, Mugabe succeeded in getting Nkomo to merge his smaller party, PF-ZAPU, into Mugabe's ZANU-PF. The army's violence in Matabeleland halted; but the government continued to restrict spending on health, education and infrastructure in the region.

» **Operation Murambatsvina**³⁸

In June 2005, Mugabe's government destroyed the homes and businesses of urban populations suspected of supporting the opposition MDC. The urban townships in Harare, Bulawayo and other major cities had voted overwhelmingly against Mugabe and for the MDC. In retaliation, Mugabe launched Operation Murambatsvina – Shona for “clean out the filth” – in which the army and police destroyed thousands of MDC-supporter homes in the urban townships. The destruction was on such a massive scale that the United Nations sent a delegation to Zimbabwe to investigate. The U.N. Special Envoy reported that 700,000 homes and small businesses were destroyed, affecting an estimated 2.4 million people.

Thousands of these newly homeless people were trucked into rural areas by the Government and told to settle there, without benefit of food or supplies. Once again large groups of people huddled alongside roads. Public health experts expressed concern that the newly homeless population suffered high levels of malnutrition, disease and, as a result, lower life expectancy.

» **Election violence**

Mugabe's ruling political party, ZANU-PF, lost power in the House of Assembly on 29 March 2008 for the first time since the country's independence in 1980. On that date, Morgan Tsvangirai's opposition party, MDC, won a majority of seats in the Assembly. During

36 See e.g., Redress. Torture in Zimbabwe, Past and Present: Prevention, Punishment, Reparation? A Survey of Law and Practice. June 2005. <http://www.redress.org/publications/Amani2005.pdf> (accessed 6 Jan. 2009); see also reports from human rights organizations including: Amnesty International: www.amnesty.org (accessed 7 Jan. 2009); Zimbabwe Human Rights NGO Forum. <http://www.hrforumzim.com> (accessed 7 Jan. 2009); Zimbabwe Association of Doctors for Human Rights. <http://www.kubatana.net/html/sectors/zim065.asp?like=Z&details=Tel&orgcode=zim065> (accessed 7 Jan. 2009).

37 See generally, Catholic Commission for Justice and Peace in Zimbabwe. Report on the 1980s Disturbances in Matabeleland and the Midlands, (March 1997). <http://www.newzimbabwe.com/pages/gukurahundi.html> (accessed 7 Jan. 2009).

38 See generally, United Nations. Report of the Fact-Finding Mission to Zimbabwe to assess the Scope and Impact of Operation Murambatsvina, U.N. Special Envoy on Human Settlements Issues in Zimbabwe. Anna Kajumulo Tibaijuka. http://www.un.org/News/dh/infocus/zimbabwe/zimbabwe_rpt.pdf (accessed 7 Jan. 2009).

the first round of presidential elections that took place on the same day, Tsvangirai won out over Mugabe, but since neither won a simple majority, run-off elections were scheduled for June 2008. Citing massive and targeted violence against MDC supporters throughout the country,³⁹ Tsvangirai withdrew from the second round. The election proceeded with Mugabe standing unopposed – despite widespread international criticism – leading to Mugabe’s victory.⁴⁰

To address the political impasse, negotiations between the two parties began in July 2008; former South African President Thabo Mbeki has mediated these talks on behalf of the Southern African Development Community (SADC). All parties signed a power-sharing Memorandum of Understanding in September 2008 allowing Mugabe to remain as president while Tsvangirai would become prime minister.⁴¹ Negotiations have since faltered over the composition and political control of key ministerial posts. During these ongoing negotiations, widespread human rights violations continue within a culture of impunity.⁴²

» Ongoing human rights violations

A political environment marked by partisan violence, arbitrary arrest, incommunicado detention, torture, and extrajudicial killings have continued unabated since the March 2008 parliamentary and presidential elections.

The Zimbabwe Peace Project, a human rights coalition of local NGOs and faith-based organizations, recorded 20,143 incidents of human rights violations between January and September 2008 including: 202 murders, 13 attempted murders, 41 rapes, 21 attempted rapes, 411 cases of torture, 463 kidnappings



Zimbabwean President Robert Mugabe

and abductions, 3,942 assaults, 444 cases of unlawful detention, 10,795 cases of harassment or intimidation, 2,290 forced displacements, 195 cases of discrimination (e.g., being denied access to government-subsidized food), 419 cases of looting or theft, and 907 cases of malicious damage to property.⁴³ The majority of these human rights violations were politically motivated: 73% of victims are said to be supporters of the opposition MDC, and 80% of the perpetrators of violence are alleged to be ZANU-PF supporters.⁴⁴

› Torture

Human rights groups have documented a pattern of torture inflicted by state agents on those suspected of supporting the opposition.⁴⁵ Army, police, the Central Intelligence Organization (CIO), the war veterans and youth militia have all perpetrated torture, according to testimony from survivors.⁴⁶ Cases of falanga, where the soles of feet are beaten until they are swollen, have been widespread. Another common torture is the beating of a person’s buttocks until the flesh comes off. Electric shock, often with electrodes applied to the genitals, has been inflicted to provoke convulsions and unconsciousness and has been carried out in police stations. Doctors have documented thousands of cases of injuries consistent with victims’ claims of torture.⁴⁷

39 Human Rights Watch. Bullets for each of you. Election violence. <http://www.hrw.org/en/reports/2008/06/09/bullets-each-you> (accessed 7 Jan. 2009).

40 Ploch L. Congressional Research Service (CRS). CRS Report to Congress - Zimbabwe: 2008 Elections and Implications for U.S. Policy. 26 Sept. 2008. <http://fas.org/sgp/crs/row/RL34509.pdf> (accessed 6 Jan. 2009).

41 Agreement between the Zimbabwe African National Union-Patriotic Front (ZANU-PF) and the two Movement for Democratic Change (MDC) formations, on resolving the challenges facing Zimbabwe, (Art. 20.1.6), at 12. http://www.kubatana.net/docs/demgg/mdc_zpf_agreement_080915.pdf (accessed 6 Jan. 2009).

42 Zimbabwe Human Rights NGO Forum. Political Violence Report. Nov. 2008. http://www.hrforumzim.com/frames/inside_frame_monthly.htm (accessed 30 Dec. 2008). See also Peace Watch, detailing the recent abductions of MDC and human rights activities. 28 Dec. 2008; U.S. Department of State. Fact Sheet. In Zimbabwe, No End to Suffering. 23 Dec. 2008. <http://www.state.gov/g/drl/rls/104399.htm> (accessed 6 Jan. 2009).

43 Zimbabwe Peace Project (ZPP). ZPP Human Rights Violations Report, at 11-12. Sept. 2008. http://www.kubatana.net/docs/hr/zpp_hrviol_report_0809.pdf (accessed 30 Dec. 2008).

44 Id. at 15.

45 Amani Trust. Organized Violence and Torture in the June 2000 General Election in Zimbabwe (28 Feb. 2002); Amani Trust. Beating your opposition. Torture during the 2002 Presidential campaign in Zimbabwe (25 Jun. 2002); Torture in Zimbabwe Past and Present: Prevention, Punishment and Repatriation. Redress: June 2005. <http://www.redress.org/publications/Amani2005.pdf> (accessed 7 Jan. 2009).

46 The Solidarity Peace Trust. Shaping youths in a truly Zimbabwean manner: An overview of youth militia training and activities in Zimbabwe, October 2000 - August 2003 (5 Sep. 2003).

47 Amnesty International, Human Rights Watch, Redress and other human rights groups have written extensively about torture by

The erosion of civil and political rights under the Mugabe regime parallels an equally severe economic collapse in Zimbabwe.

» **Economic collapse**

A causal chain runs from Mugabe's disastrous economic policies, to Zimbabwe's economic collapse, to food insecurity and malnutrition, to the destruction of public healthcare, and finally to the current outbreaks of infectious diseases. These policies include the land seizure of 2000,⁴⁸ a failed monetary policy and currency devaluations, and a cap on bank withdrawals. These policies have led to displaced farmers, low salaries and unemployment, hyperinflation, dollarization⁴⁹ of the economy – all of which have led to food insecurity and malnutrition that have aggravated the recent outbreaks in disease and drastic declines in leading health indicators.

› **Failed monetary policy and currency devaluations**

The significant loss in foreign exchange revenue from agricultural exports in tandem with failed monetary policies in turn undermined all economic activity. In May 2008, the state-controlled Reserve Bank of Zimbabwe (RBZ) allowed the dollar to float, but did not maintain its commitment in the face of the currency's continuous fall.⁵⁰ The RBZ next carried out a second redenomination scheme in August 2008 by removing ten zeros from the currency; this monetary policy failed to rein in hyperinflation.⁵¹

› **Cap on bank withdrawals**

In addition, the RBZ capped the monthly amount that an account holder can withdraw from one's bank in December 2008 to 10 billion Zimbabwean dollars per month,⁵² which would purchase one loaf of bread or two bus fares at December prices. Zimbabwe's hyperinflationary environment, moreover, renders any withdrawal limit irrelevant within days as prices soar.

state officials, especially by police in police stations. See supra, note 37.

48 See infra, Nutrition and food security.

49 Dollarization refers to the (official or unofficial) replacement of a country's system of currency with U.S. dollars.

50 Economist Intelligence Unit. Zimbabwe Country Report, at 5 [Dec. 2008].

51 Id. at 7. The first redenomination effort occurred in August 2007 when three zeros were removed.

52 ZLHR. RBZ must remove cash withdrawal limits. 31 Oct. 2008. http://www.kubatana.net/html/archive/hr/081031zlhr.asp?sector=HIVAID&year=0&range_start=1 [accessed 4 Jan. 2008].

› **Displacement of farm workers**

During the land seizures which began in March, 2000, more than 4,000 white-owned farms were taken over by Mugabe's supporters. Twelve white farmers were killed during the land seizures. The workers on those farms were also targeted for abuse because they were identified as supporting the opposition. There were more than 300,000 farm laborers on the white-owned farms, comprising the largest group of employees in the country. With their families the farm-workers were more than one million people. The vast majority of these farm-workers were thrown out of their homes and off the farms. Many suffered violence and loss of property. For months large groups of these displaced workers were seen camping alongside roads. Public health experts estimated that this large group of people suffered serious health problems.

› **Low salaries and unemployment**

More significantly, salary levels have not kept pace with inflation. A government physician in Harare showed PHR investigators her official pay stub; her monthly gross income amounted to the equivalent of 32 U.S. cents (\$0.32 USD). The Zimbabwean currency is literally not worth the paper on which it is printed and is commonly seen strewn on the pavement. Moreover, Zimbabwe's unemployment rate is estimated to be over 80%.⁵³ Low-income households have been most adversely affected forcing them to reduce the quantity and quality of purchased food.

› **Hyperinflation**

Inflation has sky-rocketed from 231 million percent in July 2008 to an unfathomable 79.6 billion percent each month, according to the Cato Institute, equating to an annual inflation rate of 89.7 sextillion (1021) percent as of November 2008.⁵⁴ RBZ Governor Dr. Gideon Gono continues to issue new higher denomination notes while the Mugabe regime fails to address the fundamental problem of the lack of foreign revenues, investment inflows, and domestic production.⁵⁵

53 Index Mundi. Zimbabwe unemployment rate. http://www.indexmundi.com/zimbabwe/unemployment_rate.html [accessed 6 Jan. 2009].

54 Cato Institute. New Hyperinflation Index (HHIZ) Puts Zimbabwe Inflation at 89.7 Sextillion Percent. 14 Nov. 2008. <http://www.cato.org/zimbabwe> [accessed 5 Jan. 2009].

55 Economist Intelligence Unit. Zimbabwe Country Report, at 5 [Dec. 2008].

› **Dollarization**

Hyperinflation has led in part to the unofficial dollarization of the Zimbabwean economy as residents there have extensively begun to use foreign currency alongside (and often in place of) the Zimbabwean dollar. The U.S. dollar has become the de facto currency along with the South African rand, and most goods are only available in foreign currency stores.⁵⁶ Until late 2008 it was illegal to buy or sell goods or services in any currency other than the Zimbabwean dollar; however, the government gradually loosened these restrictions, and in November 2008, dollarization became legal when the RBZ licensed selected businesses to sell goods in foreign currency.⁵⁷ Today nearly every business accepts (if not prefers) foreign currency for payment, whether licensed or not.

Dollarization has led to two main adverse effects. Switching to foreign currency has caused the domestic currency to depreciate further, fueling the inflationary spiral. Although prices of goods and services in foreign exchange remain relatively stable, the dollarized economy in Zimbabwe discriminates against those who do not have access to foreign currency – specifically, vulnerable populations, the rural poor, and those without relatives abroad.

Those Zimbabweans who have access to foreign currency include relatives of the growing diaspora (currently numbering more than three million) who have largely emigrated to neighboring countries, the United States, Australia, and the United Kingdom. Zimbabweans began sending remittances to their relatives back home on a large scale as the collapse of the economy escalated in the early 2000s.⁵⁸ The Global Poverty Research Group estimates that in 2006, 50% of all households surveyed in Harare and Bulawayo were regular recipients of money, food, and other goods from relatives who had fled Zimbabwe – an exceptionally high density of receipt.⁵⁹ Several key informants told PHR investigators how they receive such remittances through text messaging (SMS). Entrepreneurial expatriates living in the United

Kingdom launched Mukuru in 2007 – an SMS-based coupon remittance program that allows Zimbabweans living in the UK to remit value to friends or relatives in Zimbabwe through their mobile phone.⁶⁰ Coupons are sent via text message, which people in Zimbabwe can redeem for actual goods across an expanding network of local stores, banks, and gas stations. A University of Zimbabwe professor of political science estimates, however, that 80% of Zimbabweans do not have access to foreign currency or remittance payments.⁶¹

Zimbabwe's shortage of foreign exchange and domestic currency has even led to what may become known as petrolization: the bartering of goods and services for fuel coupons. Although exchanging such fuel coupons is legal, the coupons themselves are not legal tender⁶² and are only redeemable at gasoline stations. Some businesses and even public institutions are now demanding fuel coupons as a means of payment. In a 31 December 2008 statement, the Mugabe-appointed RBZ Governor warned Zimbabweans of counterfeit coupons and urged members of the public to resort to the official currency for day-to-day payments and to use foreign currency for special cases covered by the RBZ dispensations (e.g., Foreign Exchange Licensed Warehouses and Retail Shops, Foreign Exchange Licensed Oil Companies, and Foreign Exchange Licensed Outlets for Petrol and Diesel).⁶³

Showing that he too has lost confidence in the Zimbabwean dollar, RBZ Governor Gono established these government-sanctioned foreign currency shops and businesses in September 2008 as a means of capturing some of the foreign currency circulating in the country.⁶⁴ The creation of Foreign Exchange Licensed Warehouses and Retail Shops (FOLIWARS), however, negatively impacts not only Zimbabwe's economy, but also the rural poor and vulnerable populations who have no access to foreign currency. Goods purchased at FOLIWARS are imported from South Africa and

56 Economist Intelligence Unit. Zimbabwe Country Report, at 12 (Dec. 2008).

57 Nkiwane N. The Standard. Zimbabwe: Gono's Foliwars – Evaluating the Benefits. 20 Dec. 2008. <http://allafrica.com/stories/200812221258.html> [accessed 1 Jan. 2009].

58 IRIN. Zimbabwe: Remittances slow the slide into ruin. 4 July 2006. <http://allafrica.com/stories/200812221258.html> [accessed 31 Dec. 2008].

59 http://www.queensu.ca/samp/migrationresources/Documents/GPRG_Zim_June2006.pdf [accessed 31 Dec. 2008].

60 See <https://www.mukuru.com/whatis.php> [accessed 31 Dec. 2008].

61 Allen K. BBC News. Dollar is key to Zimbabwe survival. 19 Dec. 2008. <http://news.bbc.co.uk/2/hi/africa/7791404.stm> [accessed 31 Dec. 2008].

62 Reserve Bank of Zimbabwe Act [22:15]. <http://www.rbz.co.zw/inc/publications/legaldept/rbzpdfs/RESERVE%20BANK%20OF%20ZIMBABWE%20ACT.pdf> [accessed 31 Dec. 2008].

63 The Herald. Zimbabwe: Fuel Coupons Warning. 1 Jan. 2009. <http://allafrica.com/stories/200901010011.html> [accessed 3 Jan. 2009].

64 Nkiwane K. The Standard. Zimbabwe: Gono's Foliwars – Evaluating the Benefits. 20 Dec. 2008. <http://allafrica.com/stories/200812221258.html> [accessed 1 Jan. 2009].

Botswana, thus accelerating neighboring countries' economies and suppressing local industry.⁶⁵ FOLIWARS also fuels inflation by creating demand for foreign currency and further devaluing the Zimbabwean dollar. The foreign currency shops also allow the wealthy elite, including ZANU-PF ministers and government officials, to circumvent shortages of commodities in the local economy by frequenting FOLIWARS and loading up on food stocks and luxury goods available in these stores. The vast majority of Zimbabweans who barely survive on less than \$1 USD per day has no access to these stores.

In sum, the Mugabe ZANU-PF government must be held accountable for the violation of the fundamental right to be free from hunger for its citizens, not only for those with access to hard currency. More specifically, as a result of Mugabe's farm seizure and failed monetary and fiscal policies, Zimbabwe has experienced severe shortage of foreign exchange, hyperinflation, a paucity of basic commodities, and a sharp rise in unemployment – all of which result in the inability of Zimbabweans to purchase food, hence the occurrence of widespread malnutrition, and a population rendered extremely vulnerable to the current outbreaks in disease that are now occurring. This causal chain is an economic indictment of the ZANU-PF government, which has employed macro-economic strategies that have demonstrably and disastrously failed and have undermined people's health and well-being.

PUBLIC HEALTH SYSTEM COLLAPSE

The Government of Zimbabwe has abrogated the most basic state functions in protecting the health of the population – including the maintenance of public hospitals and clinics and the support for the health workers required to maintain the public health system.⁶⁶ The result is that people whose health has been undermined by the collapse of public services, who lack access to clean drinking water, adequate nutrition, and primary prevention services have become unable to obtain care in the public sector when they fall sick. These services have been in sharp decline since

⁶⁵ Id.

⁶⁶ For an historical overview of Zimbabwe's public health system prior to its collapse, see, e.g., Todd C and Sanders D. What is the future for Zimbabwe's health system? *BMJ* (2009) forthcoming.



Discarded Zimbabwean 500,000,000 dollar bills.

2006, but the deterioration of both public health and clinical care has dramatically accelerated since August 2008.

PHR examines the collapse of Zimbabwe's public health system by assessing access to healthcare and healthcare delivery (affordability, transportation, closing of hospitals, health workforce, access to medicine and medical supplies, public versus private healthcare, private-sector user fees, the role of NGOs in healthcare delivery, and access to health information) as well as several key determinants of health (water, sanitation, nutrition and food security).

HEALTHCARE AND HEALTHCARE DELIVERY

The current status of healthcare in Zimbabwe is best understood as an overall health system collapse: both public health functions, including water and sanitation services, and the clinical care delivery system, from hospital-based care to community clinic primary healthcare, have markedly decreased in both amount and quality or ceased to function altogether in 2008. A senior Ministry of Health official whom PHR interviewed stated: *The healthcare system has*

virtually stopped despite the fact that in the 1990s, Zimbabwe's healthcare system was so good that 85% of the population lived within 10 kilometers of a health facility, according to another health official.

Nowhere has the collapse of healthcare in Zimbabwe been more striking than in critical care. As of December 2008, there were no functioning critical care beds in the public sector in Zimbabwe. Patients needing intensive care who do not have the \$500 USD (in cash) for an admission are literally dying. For instance, in obstetrical critical care, the director of a still functioning but markedly over-burdened mission hospital told PHR:

"A major problem is the loss of life and fetal wastage we are seeing with obstetric patients. They come so late the fetuses are already dead. We see women with eclampsia who have been seizing for 12 hours. There is no intensive care unit here, and now there is no intensive care in Harare. If we had intensive care, we know it would be immediately full of critically ill patients. As it is, they just die."

The collapse of Zimbabwe's healthcare and healthcare delivery is reflected in the country's deteriorating health indicators in such a short timeframe:

- The Human Development Index (HDI) for Zimbabwe has fallen from a rank of 130th in 1999 to 151st out of 177 countries in 2007.⁶⁷ (HDI offers a broad measure of well-being by examining a country's life expectancy, adult literacy, educational enrollment, and purchasing power parity.)
- The maternal mortality ratio has increased at an alarming rate from 283 per 100,000 in 1994 to 1,100 per 100,000 in 2005.⁶⁸
- The infant mortality rate (the probability of a child born in a specific year or period dying before reaching the age of one) rose from 52 per 1,000 live births in 1990 to 68 per 1,000 in 2006.⁶⁹
- The adult mortality rate (the probability that

a 15-year-old person will die before reaching her 60th birthday) in Zimbabwe sky-rocketed from 286 per 1,000 in 1990 to 751 per 1,000 in 2006.⁷⁰

- Most distressing is that life expectancy at birth fell dramatically from 62 years for both sexes in 1990 to 36 years in 2006 – 34 years for males and 37 years for females.⁷¹

This drastic fall in vital health statistics results in part from diminished access to care, public hospital closings, and inadequate or unaffordable medical supplies, which this report discusses below.

» Access to healthcare

There are two components relevant to access to healthcare: first, financial access or the affordability of healthcare and second, physical access or transportation, both detailed below.

➤ Affordability

The dollarization of the economy since November 2008 has led to an economic apartheid in healthcare access.⁷² Since then, only a tiny elite with substantial foreign currency holdings can be said to have any real access to healthcare. This amounts to marked discrimination against the poor generally – but also more specifically against those working in the public sector, including healthcare staff at clinics and hospitals, who are still being paid in Zimbabwe dollars. Only those with access to foreign currency can purchase life-saving medical treatment.

The private healthcare sector, much like the rest of Zimbabwe's economy, has been increasingly dollarized since the last currency devaluations in the third and fourth quarter of 2008. Virtually all economic activity is in U.S. dollars. PHR was told repeatedly by patients and providers of the very alarming and increasing high cost of healthcare.

➤ Transportation

The cost of transportation has become prohibitive for both providers and would-be patients. Providers cannot afford to get to work. Patients can no longer afford to travel to healthcare facilities.

67 UNDP. Human Development Reports. UNDP, New York, 2008. http://hdrstats.undp.org/countries/data_sheets/cty_ds_ZWE.html [accessed 5 Jan. 2008].

68 DFID. Reducing maternal deaths in Africa. [2008]. <http://www.dfid.gov.uk/countries/africa/zimbabwe-reducing-maternal-deaths.asp> [accessed 7 Jan. 2009].

69 WHO. WHO Statistical Information System (WHOSIS). WHO, Geneva, 2008. <http://www.who.int/whosis/data/Search.jsp> [accessed 29 December 2008]. See also UNICEF. Zimbabwe Background. http://www.unicef.org/infobycountry/zimbabwe_1403.html [accessed 7 Jan. 2009].

70 WHO. WHO Statistical Information System (WHOSIS). WHO, Geneva, 2008. <http://www.who.int/whosis/data/Search.jsp> [accessed 29 Dec. 2008].

71 WHO. Zimbabwe Mortality Country Fact Sheet. [2006]. http://www.who.int/whosis/mort/profiles/mort_afro_zwe_zimbabwe.pdf [accessed 6 Jan. 2009].

72 See supra, Economic collapse.

Transport costs, even within Harare proper, have made the simple act of getting to work impossible for many healthcare employees. The Director of a national healthcare NGO reported to PHR that the public clinics are staffed by government salaried nurses, pharmacists, aides and other staff. These staff are no longer reporting to work because they cannot afford the transport costs, many have not been paid in months, and their pay is no longer a living wage. Several nurses interviewed by PHR reported that their monthly wages for the past month (November 2008) were less than their daily round-trip transportation costs to work. Hence, nursing staff are currently losing money by reporting to work. A rural clinic staff nurse reported that since he lived at the clinic, he had no difficulties in getting to work; however, since bus fare to get to the nearest town to collect his monthly salary cost more than the entire salary, it made no sense to collect it. He had not done so since April 2008. A senior government official put it this way:

“Government salaries are simply rotting in the bank.”

When asked about how the absence of healthcare workers was affecting HIV treatment, the official stated that:

“This is not a strike. The problem is the staff and the patients cannot come due to travel costs.”

Transport costs have also made accessing healthcare facilities an enormous challenge for would-be patients. One of the few hospitals open to the public near Harare is a mission hospital with three physicians, an hour’s drive from the capital. On the day PHR visited the hospital all the beds were full, patients were sleeping on the floors of the wards between the beds, and the corridors too, were lined with patients. PHR physicians asked the director if the hospital was always so crowded, and he reported that it was actually less busy and less over-crowded than in previous weeks when Harare patients were less numerous and most patients came from the surrounding communal area. The reason, he stated, was transport costs. People simply could not afford the cost of getting to the hospital. This facility was some 80 kilometers outside Harare, the last 12 kilometers requiring travel over a rough dirt track. Buses and other transport dropped off patients at the road head—and those too poor to hire a taxi were using ox-drawn carts for the long ride to the hospital. For those unable to afford even the ox carts,

some local people were willing to transport patients in wheelbarrows.

» **Closing of public hospitals and medical school**

Between September and November 2008 most wards in the large public hospitals gradually closed. The most abrupt halt in healthcare access occurred on 17 November 2008, when the premier teaching and public referral hospital in Harare, Parirenyatwa Hospital, closed its doors along with the medical school. Parirenyatwa Hospital and Harare Central Hospital (also closed in November 2008) are Harare’s largest. The Hospital had no running water since August of 2008. Toilets were overflowing, and patients and staff had nowhere to void—soon making the hospital uninhabitable. Parirenyatwa Hospital was closed four months into the cholera epidemic—arguably the worst of all possible times to have shut down public hospital access. Successful cholera care, treatment, and control are impossible, however, in a facility without clean water and functioning toilets.

Parirenyatwa Hospital’s surgical suites were closed in September 2008. Pediatric surgeries also ceased in the same month. A surgeon PHR interviewed reported having children in his care who he knew would die without needed surgeries, but said:

“I have no pain medication, some antibiotics, but no nurses If I don’t operate the patient will die, but if I do the surgery the child will die also.”

The closure of hospitals has led to the deterioration of clinical instruction for medical students. Following these closings, the Vice-Chancellor of the University of Zimbabwe declared the medical school closed for *an early vacation*. PHR interviewed members of the Zimbabwe Health Students Network on the closure of the hospital and the medical school. The students reported that lectures had been canceled from two to three months before the official closure on 17 November 2008, since the teaching faculty had gradually stopped coming to work. Lecturers told the students they could no longer afford the transport to come to work. A fourth-year medical student in Harare told PHR that

“...school exams were cancelled because there was no paper and no ink to print them.”

Students did not go on their required rural clinical rotations since there was now no teaching or mentoring available in the rural areas. One faculty member told

them he had ceased trying to teach his course since he *did not want to take part in a charade*. One medical student stated:

“Truth be told, the closing of the medical school was just collateral damage of the collapse of the health system.”

PHR investigators also visited the medical school library. A handful of students were studying near windows in order to have enough light to read, given there was no electricity. Although the textbook collection appeared adequate – albeit most titles are relatively old – most journals on display were significantly out-of-date.

➤ **Health workforce**

The exponential and continuing drop in the value of Zimbabwe’s currency has resulted in a spiraling decline in working conditions and remuneration for public sector health personnel.⁷³ The near collapse of public sector healthcare provision is dated by most as having commenced in mid-November 2008. Although certain categories of health workers (e.g., junior physicians

and nurses) have in the past withdrawn their labor for limited periods, on this occasion, a broad spectrum of personnel – professionals and support staff – either ceased coming to work or began working minimal hours per week due to insufficient wages.

The response has been a continuing and large migration out of the public health service and into the private sector, and, increasingly, to other countries. Precise numbers are difficult to obtain since many health professionals maintain their registration (licensure) with their respective medical boards. Many have increased their time in the private sector or entered it for the first time. Those health professionals interviewed by PHR indicated that their main reason for taking such action was their insufficient and declining salaries. Indeed, a group of senior medical students told PHR investigators that some of their colleagues are undertaking private medical work. One example given was of fourth- and fifth-year medical students performing illegal and unsupervised abortions in exchange for payment in foreign currency.

73 See supra, Economic collapse.



Oxcart used to bring a patient to a clinic.

› **Access to medications and medical supplies**

The decline of the public health sector dating back to the late 1990s frames the current collapse. Long-standing under-investment in infrastructure by the Mugabe regime and recurrent under-expenditure, including in medicines, supplies, equipment and, most importantly, human resources, underlies the healthcare crisis. Lack of access to essential medications was raised as a concern by nearly all providers interviewed. In addition to drug shortages, medical supplies (including the most basic clinical supplies such as cleaning agents, soap, surgical gloves, and bandages) were also in critically short supply—or absent altogether. A rural clinic nurse reported:

“Right now I have no anti-hypertensives, no anti-asthmatics, no analgesics, nothing for pain. The worst is I have patients with epilepsy and no anti-epileptics. I have a woman in labor right now, and I have no way to monitor blood pressure, no oxytocin for post-partum hemorrhage, and I have no suture material to do a repair if she tears.”

This same nurse, when asked if he had sufficient supplies reported that he had a few pairs of latex gloves, but that he stored these at his home, not at the clinic, to save them for emergencies.

Another nurse in a public sector clinic, which had been heavily burdened with cholera cases, reported that:

“Our situation is really bad. We have no running water in the clinic. The toilets are not functioning and we

have no proper chemicals to clean them, so the smell is very bad. It is demoralizing to the cleaners to have no proper chemicals to clean the toilets. We nurses have no protection, no gloves, to protect ourselves. The clinic is not clean. We have no way to get rid of our trash. Now that the cholera has started the Red Cross has given us some gloves and some disinfectants, but it is not enough.”

This nurse reported her fear of treating cholera patients without proper materials for precautions like gloves and protective garments.

These financial problems for those working in the government health sector are the direct result of the marked under-funding of health by the Mugabe regime. One senior official reported to PHR that:

“The Ministry of Health budget was approved in January 2008. It is supposed to last the year, but was spent in the first month. This has been true for the past five years—it [the annual health budget] only lasts about a month.”⁷⁴

Health officials also cited the deteriorating working conditions, with care being compromised by lack of essential supplies and equipment. In addition, the breakdown of physical infrastructure, such as water and sewerage systems and blockage of patient and staff toilets, has made it increasingly impossible for health personnel to render a service. One informant indicated that some personnel working at Harare Central Hospital would even travel to their homes to use the toilet.

Doctors treated like dogs at peaceful protest

According to several key informants who were participants, a group of local physicians, nurses, pharmacists, medical and dental students organized a non-violent demonstration on 18 November 2008 to protest poor working conditions and wages.

The group, numbering several hundred, intended to march peacefully from Parirenyatwa Hospital in Harare to the office of Zimbabwe’s Minister of Health to deliver a petition. Soon after the march began, approximately 50 police exited armored personnel carriers and prevented the healthcare professionals, many of whom were wearing white coats, from marching. Many in the march then continued protesting within the confines of the hospital itself. Two truck-loads of armed police arrived on hospital grounds and began beating them using wooden baton sticks.

One medical student interviewed reported not being able to walk for a week. He stated: “Doctors with high esteem were treated like dogs.” As many protesters were wearing their white coats, once the marchers began to flee, they were readily identifiable in the crowds by the police who were chasing them.



Police chasing health professionals at a non-violent demonstration.

» **Public versus private healthcare**

There are marked urban-rural disparities in healthcare access in Zimbabwe, and these have worsened in the healthcare crisis. Most of the private-sector healthcare is urban, and primarily in Harare and Bulawayo. In rural areas healthcare is provided through both the public and private sectors.⁷⁵ According to the head of a local health NGO, private mission hospitals account for 68% of healthcare delivery in rural areas. There are 126 mission hospitals and clinics throughout Zimbabwe's ten provinces.⁷⁶ Some mission hospital staff are paid by grants from the national health budget; mission hospitals supplement staff salaries with funds raised from the faith-based and donor community. As the Harare hospitals have closed down since November 2008, the proportion of patients from Harare presenting at rural mission hospitals has increased. A mission hospital director reported:

"We are now getting 50-60% of our admissions from Harare, and this is an increase since the Harare hospitals have closed. In the past, about 25% of our admissions were from Harare 80 kilometers

⁷⁵ Some of the private, non-profit mission hospitals also officially serve as district- and provincial-level hospitals in the public healthcare system.

⁷⁶ Mission hospitals in Zimbabwe are supported mainly by the Catholic and Anglican churches as well as the Salvation Army.

away. A health administrator at the same mission hospital noted that the steep recent increase in (predominantly middle-class) patients coming from outside the district has been counterbalanced by a decrease in utilization by patients from within the district – particularly those living far from the hospital for whom transport costs are unaffordable."

› **Private-sector user fees**

Exorbitant user-fees preclude access to private-sector healthcare for most people in Zimbabwe. According to several physicians working in urban private hospitals whom PHR interviewed, user fees for medical services are far beyond what is affordable for the vast majority of Zimbabweans:

- › \$200 USD in cash for an initial medical consultation
- › \$500 USD to secure an in-patient bed
- › \$3,000 USD for a Cesarean section

Such user fees are within reach of only very few wealthy Zimbabweans. Consequently, the vast majority of the population is effectively denied access to medical care. A member of Parliament reported to PHR investigators that even the Minister of Health is not immune to the high cost of medical care, relating how he was recently unable to produce the \$3,000 USD

cash required by Avenues private hospital in Harare in order for his wife to be admitted for emergency care. Referring to physicians who are not treating patients due to their inability to pay, a rural mission hospital physician reported:

“It’s a healthcare delivery war. ... The ethical underpinnings of healthcare in Zimbabwe have broken down.”

› **Ambulance fees**

The severe shortage of ambulances in Zimbabwe and the high cost for this emergency service are barriers to accessing affordable healthcare throughout the country. According to a senior Ministry of Health official whom PHR interviewed, there are almost no ambulances in the rural districts. Patients are put in an oxcart and loaded onto the nearest bus. Private ambulances currently accept only U.S. dollars, starting at \$100 USD even for short trips. Furthermore, ambulances have little relevance in Harare for those without the dollars for private care as the public sector hospitals have been closed since November 2008. There is nowhere in the city for an ambulance to take a patient unless he or she has a \$200 USD in cash for a medical consultation.

» **Role of NGOs in healthcare delivery**

The above serious under-provision of services has had a demonstrable major negative impact on the health and well-being of many Zimbabweans, especially the poor majority. The energetic and focused efforts of a number of local non-governmental organizations (NGOs), international NGOs, bilateral organizations, and donors have played a critical role, however, in providing healthcare to Zimbabweans, bolstering the country’s healthcare system, and addressing the current humanitarian crisis.⁷⁷ For example, UNICEF has coordinated a number of critical interventions and sourced key inputs. International donors by mid-December had contributed over \$8 million USD for the cholera response.⁷⁸ This has included the trucking of over 500,000 liters of water per day to Budiriro high-density suburb, the sourcing of borehole drilling equipment and technical personnel, the importation of intravenous and oral rehydration supplies, and the provision of over 70% of Zimbabwe’s vital medicines. Médecins Sans Frontières (MSF) is largely responsible

77 For an overview of Zimbabwe’s current humanitarian crisis, see, e.g., Ncayiyana D, London L, Sanders D, et al. Zimbabwe’s humanitarian crisis. *BMJ* 2008;337.

78 See *infra*, Cholera.

for staffing the major cholera treatment centers (including Beatrice Road Infectious Diseases Hospital, Chegutu Hospital, and Beitbridge Hospital) as well as coordinating antiretroviral treatment for more than 30,000 HIV/AIDS patients. The World Food Program and the Consortium for Southern African Famine Emergency (C-SAFE) are coordinating the supply of relief food aid, which is being distributed mainly by local NGOs. Finally, the largest contribution to health service provision continues to be made by mission health facilities. In short, the government’s withdrawal from healthcare delivery has been counter-balanced by increasing involvement of the donor and voluntary sector.

It is widely acknowledged, however, that these efforts, while crucial, cannot replace a functioning public sector. So for example, when PHR visited urban and rural clinics to assess cholera preparedness, several clinics did have oral rehydration supplies, intravenous fluids, and IV infusion sets that staff felt were adequate to their cholera case burdens. These commodities were virtually all supplied by UNICEF, with funding reportedly from the British Government through the Department for International Development (DFID), the European Commission Humanitarian Aid Office (ECHO), the Canadian International Development Agency (CIDA), and other members of the donor community. These same clinics however, lack running water and functioning toilets, adequate (and paid) staff to provide cholera care, and other essential medicines.

PHR found a similar situation with regard to U.S. bilateral assistance for Zimbabwe’s HIV/AIDS program. The U.S. Embassy in Harare supports the large President’s Emergency Plan for AIDS Relief (PEPFAR) program in Zimbabwe, which is currently providing antiretroviral (ARV) medication for some 40,000 patients across the country – about 20% of all patients in the country receiving these AIDS drugs. But the PEPFAR program is dependent on the overall healthcare system to function. Since the closure of the public hospitals in November 2008, access to free HIV testing and counseling services has declined. Members of an HIV/AIDS support group told PHR that the cost for an HIV test at the private clinics now offering the service was \$200 USD (in December 2008). Hence access to testing for the majority of Zimbabweans, the first step in seeking HIV treatment, has declined. Hospitalization for AIDS patients who require it has also dramatically declined—so even those patients on PEPFAR supported ARVs may be unable to access in-

patient care if they need it and do not have U.S. dollars to pay the \$500 USD admission charges that PHR was told are being demanded by the private hospitals.

» Access to health information

Actions and omissions by the ZANU-PF government have markedly worsened the healthcare system collapse. PHR identified a number of instances, including the cholera epidemic and the reporting of malnutrition, where government denial and suppression of health data have contributed to this collapse.

The Mugabe regime intentionally suppressed initial reports of the cholera epidemic⁷⁹ and has since denied or underplayed the gravity of the epidemic with fatal consequences.⁸⁰ The Minister of Information and Publicity, Sikhanyiso Ndlovu, reportedly ordered government-controlled media to downplay the cholera epidemic, which he said had given

“... the country’s enemies a chance to exert more pressure on President Robert Mugabe to leave office. The Minister instructed the media to turn a blind eye to the number of people who have died or [have become] infected with cholera, and instead focus on what the Government and NGOs are doing to contain the epidemic.”⁸¹

Zimbabwe Association of Doctors for Human Rights (ZADHR) informed PHR that when their physicians had offered to the Harare City Council to volunteer to respond to the cholera epidemic in October 2008, the Council declined their offer and responded:

“We have the situation under control.”

A nurse felt strongly that the Government’s denial of the cholera epidemic was part of the problem:

“What the Government is saying about cholera is lies, lies, lies.”

79 Zimbabwe Independent. Cholera Deaths Masked in Official Figures. 13 Nov. 2008. <http://www.thezimbabweindependent.com/local/21529-cholera-deaths-masked-in-official-figures.html> [accessed 24 Dec. 2008].

80 Dugger CW. New York Times. Cholera Is Raging, Despite Denial by Mugabe. 11 Dec. 2008. http://www.nytimes.com/2008/12/12/world/africa/12cholera.html?_r=1&bl&ex=1229230800&en=c8a2cd67405bac74&ei=5087%0A [accessed 29 Dec. 2008]; see also CBC News. Zimbabwe accuses West of starting cholera epidemic. 13 Dec. 2008. <http://www.cbc.ca/world/story/2008/12/13/zimbabwe-cholera.html> [accessed 29 Dec. 2008].

81 Radio Voice of the People. State Media Ordered to Down Play Cholera Epidemic. 14 Dec. 2008. http://www.radiovop.com/index.php?option=com_content&task=view&id=4702&Itemid=171 [accessed 29 Dec. 2008].

We asked her to explain this statement and she replied:

“We have had many cases of gastro[enteritis] and cholera cases since August. The Government says that cholera is under control – I saw this yesterday on the TV. But how can this be true when people are still dying?”

PHR also received reports from several sources in Zimbabwe that the Government has intentionally tried to suppress information regarding a burgeoning caseload of malnutrition. PHR asked a nurse staffing a public-sector clinic in a rural district outside Harare if there had been cases of malnutrition and diseases like kwashiorkor presenting in children. The nurse became visibly anxious and then replied:

“Malnutrition is very political. We are not supposed to have hunger in Zimbabwe. So even though we do see it, we cannot report it.”

DETERMINANTS OF HEALTH

The health of Zimbabweans and of all people requires a great deal more than medical care. PHR assessed key underlying determinants of health that have contributed to the collapse of healthcare and healthcare delivery in Zimbabwe. As part of its emergency assessment mission, PHR examined access to safe water, adequate sanitation, sewerage, and food security.

» Water and sanitation

The basic infrastructure for the maintenance of public health, particularly water and sanitation services, has deteriorated in the worsening political and economic climate. According to several public health specialists whom PHR investigators interviewed, water treatment and delivery systems were better managed before the ZANU-PF government nationalized municipal water authorities in 2006-2007. The Mugabe regime, however, politicized water for political gain and profit,⁸² policies that proved disastrous for sanitation and water delivery systems, and which have clearly contributed to the ongoing cholera epidemic.⁸³

The government established the Zimbabwe National Water Authority (ZINWA) with the promulgation of the

82 See generally, Human Rights Watch. Not Eligible: The Politicization of Food in Zimbabwe. (2003). <http://www.hrw.org/en/reports/2003/10/23/not-eligible> [accessed 2 Jan. 2009].

83 See *infra*, Cholera.

Water Act in 1997. The functions of ZINWA include advising the government on policy, standards, and conservation of national water supplies as well as promot[ing] an equitable, efficient, and sustainable allocation and distribution of water resources while assist[ing] local authorities in the discharge of their functions . . . with regard to the development and management of water resources under their jurisdiction and in particular, the provision of potable water.⁸⁴ A government official reported to PHR that the ZANU-PF government nationalized well-functioning municipal water authorities to provide additional revenue streams for the cash-strapped government. Usurping this function also deprived MDC-backed municipal councils of an important source of revenue. A health professional from Bulawayo informed PHR investigators that ZINWA suspended plans to take over Bulawayo's city water council in 2008 believing that residents there would vote against ZANU-PF during the parliamentary elections as backlash to the unpopular move.⁸⁵ Bulawayo, Zimbabwe's second largest city, has not experienced the same water shortages as in Harare and has a markedly lower incidence of cholera⁸⁶ with most cases being imported into Bulawayo, according to a government epidemiologist.

ZINWA has presided over the collapse of water sanitation and delivery across Zimbabwe. According to two members of parliament whom PHR interviewed, the ZANU-PF government has since willfully allowed outdated and damaged water systems to go unrepaired and water supplies to go untreated. A water systems engineer in Harare stated that ZINWA had not improved water service delivery; instead the parastatal agency had caused its ruin. Residents in Harare informed PHR that on 29 November 2008, without warning, ZINWA cut off water to the capital for several days. Zimbabwe's own government-controlled press later reported that ZINWA had failed to procure enough aluminum sulfate – one of four chemicals used to treat

the water supply – so it stopped pumping water from the Morton Jaffray Water Treatment Plant in Norton outside Harare.⁸⁷ According to several sources, instead of ensuring an adequate stockpile of water treatment chemicals or quickly importing them from South Africa, the ZANU-PF Minister of Health, David Parirenyatwa, flippantly responded by urging the population to stop shaking hands.⁸⁸ The November cut-off was not the first instance of water shortage in Harare; numerous Harare residents informed PHR that water delivery has been sporadic for years – sometimes absent for more than six months.

› **Failed Sewerage and Sanitation Systems**

Surface water, which seeps into porous ground and into shallow wells, has become contaminated with fecal waste because of leaking sewerage pipes. A key informant with an NGO that provides technical assistance to the Government on reticulated water systems informed PHR that Zimbabwe has one of the highest levels of unaccounted for water (UFW) at 45%.⁸⁹ (Reticulated water systems are piped water networks as opposed to well water.) In other words, the country loses nearly half its water supply through leakage from broken water pipes. These leakages and the intermittent supply of water lead to inadequate pressure in the reticulated system. When water is not pumped through the pipes at a continuous rate, the pipes do not completely fill with water, leading to negative pressure. This pressure draws in the effluent from parallel-running sewerage pipes.

The economic collapse occasioned under Mugabe's government has had further indirect but important negative effects on water and sanitation: clogged sewerage pipes leading to inoperative toilets in households and the cessation of public trash collection. City council public works department employees usually unclog pipes and sewerages, but because they are not working (due to insufficient wages), this crucial task is not performed. PHR received reports that these

84 Zimbabwe Ministry of Rural Resources and Water Development. Zimbabwe National Water Authority Bill, 1997, 5.1.a, 5.1.c, 5.1.d. <http://www.africanwater.org/zinbill2.htm> [accessed 24 Dec. 2008].

85 See also, Kholwani N. Zimbabwe: ZINWA Shelves Bulawayo Takeover. *The Standard*. [3 Feb. 2008]. <http://allafrica.com/stories/200802041053.html> [accessed 2 Jan. 2009].

86 See e.g., U.N. figures reporting Bulawayo (Zimbabwe's second largest city after Harare) with only 377 cumulative cases, compared to Harare with 11,500 cumulative cases. U.N. OCHA. Situation Report on Cholera in Zimbabwe, Issue No. 9, (6 Jan. 2009). <http://ochaonline.un.org/Default.aspx?alias=ochaonline.un.org/zimbabwe> [accessed 8 Jan. 2009].

87 *The Herald*. Zimbabwe: Most Harare Suburbs Go Without Water, 1 Dec. 2008). <http://allafrica.com/stories/200812010204.html> [accessed 25 Dec. 2008].

88 For quotes made by the Health Minister, see, e.g., Shumba T. Don't shake hands, Zimbabwe advises citizens. *The Harare Tribune* (8 Dec. 2008). <http://www.hararetribune.com/harare-city-zimbabwe/harare-news/953-dont-not-shake-hands-zimbabwe-advises-citizens.html> [accessed 2 Jan. 2009].

89 Cf. WHO. Water Supply and Sanitation Sector Assessment (2000) showing how the UFW rate has increased from 30% in 2000. <http://www.afro.who.int/wsh/countryprofiles/zimbabwe.pdf> [accessed 8 Jan. 2009].

municipal employees are moonlighting in the private sector. To augment their meager salaries, some are using available municipal supplies, such as sewerage rods, and offering their services to the public for cash payment. Another cause of contaminated surface water is broken sewerage pipes. Effluent with human waste leaks from burst pipes allowing seepage into the reticulated water system. The clogged pipes have also led to inoperative household toilets. People are then forced to urinate and defecate outside their homes. All Harare residents PHR interviewed spoke of the city's sanitation system collapsing during the past several years.

All Harare residents PHR interviewed reported that trash collection has effectively ceased. Throughout Harare, and especially in the poor high-density areas outside the capital, PHR investigators saw detritus littering streets and clogging intersections. Steady streams of raw sewage flow through the refuse and merge with septic waste. A current Ministry of Health official reported to PHR:

"There is no decontamination of waste in the country."

ZINWA mismanagement coupled with the economic collapse has led to the current cholera epidemic. A water systems engineer informed the PHR team that a severe shortage of potable water has forced people to dig shallow wells (10-12 meters), which are not deep enough to extend below the protective bedrock. Bedrock, which may lie more than 20 meters below the surface, is a natural barrier that protects the water below it from contaminants. Boreholes, which are mechanically dug to a depth of 30-40 meters, usually ensure a source of uncontaminated drinking water. The engineer explained that when shallow wells are dug, seepage from run-off water enters these wells from which the residents are drinking. Much of this run-off water, however, has recently been contaminated with fecal waste containing the cholera bacteria. Further, these shallow wells are essentially linked because they are not protectively lined with cement. He warned that the rainy season commencing in December is going to exacerbate the crisis because when the ground and soil becomes saturated with water, it is easier and faster for the (contaminated) run-off water to travel from well to well. Residents of the high-density areas near Harare, Budiriro and Chitungwiza, where incidence of cholera is highest, filed a class-action lawsuit against ZINWA in November 2008 for failing to provide safe and clean

drinking water,⁹⁰ thus leading to more than 300 deaths from cholera in their districts alone.⁹¹

» Nutrition and food security

Another key determinant of health concerns nutrition and access to an adequate supply of safe food (i.e., food security). Until 2000, Zimbabwe was one of Africa's leading agricultural breadbaskets. As recently as 2000, agriculture constituted the base of Zimbabwe's economy contributing to 45% of export earnings and providing livelihood to more than 70% of the population.⁹² Today, more than two million Zimbabweans rely on food assistance.⁹³ The U.N. Food and Agricultural Organization (FAO) predicts that this figure will rise to 5.1 million (45% of the population) who will require food aid by early 2009 in order to survive.⁹⁴

Many sources suggest that these stark figures result from the policies of the ZANU-PF regime, which has rendered nearly half its population vulnerable to food insecurity.⁹⁵ These policies include the land seizure

90 Zimbabwe Times. Residents sue ZINWA over cholera deaths. <http://www.thezimbabwetimes.com/?p=7837> (accessed 2 Jan. 2009).

91 OCHA. Cholera Daily Update, 3 Jan. 2009. <http://ochaonline.un.org/Default.aspx?alias=ochaonline.un.org/zimbabwe> (accessed 5 Jan. 2009).

92 FAO. Country Paper Proposed by Zimbabwe. <http://www.fao.org/docrep/meeting/004/ab438e.htm> (accessed 30 Dec. 2008).

93 WFP. Major food appeal for Zimbabwe as WFP relief distributions begin. 9 Oct. 2008. <http://www.wfp.org/ENGLISH/?ModuleID=137&Key=2955> (accessed 30 December 2008).

94 In 2008, WFP provided food aid to 1.8 million beneficiaries in Zimbabwe and plans to scale up to 3.98 million in the first quarter of 2009. WFP. Major food appeal for Zimbabwe as WFP relief distributions begin. 9 Oct. 2008. <http://www.wfp.org/ENGLISH/?ModuleID=137&Key=2955> (accessed 30 December 2008). Also, a consortium of US-sponsored NGOs known as C-SAFE plans to cover more than one million additional Zimbabweans in regions not covered by WFP. ReliefWeb. Zimbabwe: WFP feeds 2 million in October but forced to cut rations in November. 11 Nov. 2008.

<http://www.reliefweb.int/rw/rwb.nsf/db900SID/SHIG-7LAHVK?OpenDocument> (accessed 5 Jan. 2009).

These two food pipelines should reach roughly five million people – nearly half of Zimbabwe's 11.9 million population – at the height of the expected food crisis from December 2008 to March 2009. These alarmingly high statistics show that without the vital support of donor governments and the humanitarian work of nongovernmental organizations, hundreds of thousands of Zimbabweans might very well die from starvation.

95 See, e.g., United Nations. U.N. emergency coordinator says Zimbabwe's humanitarian situation is worsening. 8 Dec. 2005. <http://www.un.org/apps/news/story.asp?NewsID=16867&Cr=zimbabwe&Cr1=> (accessed 4 Jan. 2009); IPS. Zimbabwe: Food Crisis Worsens. 16 Oct. 2008. <http://ipsnews.net/news.asp?idnews=44290> (accessed 5 Jan. 2009); Forum for Food Security in Southern Africa. Zimbabwe Food Security Issues Paper at 33. <http://www.odi.org.uk/projects/03-food-security-forum/docs/ZimbabweCIPfinal.pdf> (accessed 1 Jan. 2009).



The broad flat band in this photograph is plant life thriving on biological matter (sewage and human waste) in a river that feeds into Lake Chivero - Harare's main water source.

and the blockage and politicization of food. Drought has further exacerbated food insecurity. PHR investigators examined the impact of this insecurity in the HIV/AIDS population and in children.

› **Land seizure**

In April 2000, the ZANU-PF-controlled parliament approved amending the Zimbabwe Constitution to establish the legal framework for land acquisition.⁹⁶ Mugabe quickly mobilized some 35,000 war veterans and unemployed youth militia and ordered them to begin expropriating white-owned farms while brutally assaulting and sometimes murdering the commercial farmers and farm workers.⁹⁷ Under the guise of land redistribution to benefit landless black Zimbabweans, Mugabe instead awarded many of these once productive farms to government ministers and other ZANU-PF supporters for their patronage.⁹⁸ Many of these farmlands now remain fallow and serve as nothing more than second homes to these non-farming government officials. Indeed, agricultural output has dropped 50-70% over the past seven years.⁹⁹ The land

96 Government of Zimbabwe. The Constitution of Zimbabwe, as amended to No. 16 of 20 April 2000. http://www.kubatana.net/docs/legisl/constitution_zim_000420.pdf [accessed 5 Jan. 2009].

97 Human Rights Watch. Fast Track Land Reform in Zimbabwe. Mar. 2002. <http://www.hrw.org/legacy/reports/2002/zimbabwe/index.htm#TopOfPage> [accessed 3 Jan. 2009].

98 Hill G. What Happens After Mugabe? Can Zimbabwe Rise from the Ashes? Zebra Press, Cape Town, 2005, at 16-18.

99 New Agriculturist. Zimbabwe agriculture on its knees. <http://www.new-ag.info/08/03/develop/dev1.php> [accessed 30 Dec. 2008]. See also, Hawkins T. Still Standing: The economic, political and security situation in Zimbabwe 2006 and implications for the SADC region. <http://www.swradioafrica.com/Documents/ProfHawkins.pdf> [accessed 6 Jan. 2009].

seizure led to sharp falls in agricultural production, precipitated the collapse of the economy in turn impacting negatively on small-scale farmers unable to afford agricultural inputs such as small grain seeds, top-dressing fertilizer, pesticides, and fuel, and increased food insecurity for millions.¹⁰⁰

› **Government politicization and obstruction of food aid**

The Mugabe regime has also been accused of using donor food aid as a tool to manipulate elections by providing food to communities that supported his ZANU-PF political party and denying food aid to communities that did not.

After the Matabeleland massacres, the Mugabe government established a pattern of restricting the transport of food into that region during election periods so that only supporters of Mugabe's ZANU-PF party would receive food.¹⁰¹ This policy became severe around the parliamentary elections in June 2000 and again around the presidential election in March 2002. The Army prevented supplies of maize meal, the staple food, from being delivered to many Matabeleland and other rural areas, such as Binga and other parts of the Midlands, that had voted against Mugabe. It also restricted the operations of aid organizations, such as Save the Children and Oxfam, and prevented large quantities of food from being distributed. In one incident, in June 2002, Mugabe's supporters in Binga prevented the distribution of nutrition packs to schoolchildren.¹⁰² The state-owned Grain Marketing Board (GMB) sold inexpensive maize, but officials would sell the grain only to card-carrying members of Mugabe's ZANU-PF party. People suspected of supporting the opposition were refused food.¹⁰³

This policy of restricting food aid to areas that support the opposition party, the Movement for Democratic Change (MDC) has persisted and was used during the recent 2008 elections. In addition, the Government restricted seed and fertilizer in areas which voted for

100 See e.g., Human Rights Watch. Fast Track Land Reform in Zimbabwe. Mar. 2002. <http://www.hrw.org/legacy/reports/2002/zimbabwe/index.htm#TopOfPage> [accessed 3 Jan. 2009]; Economist Intelligence Unit. Zimbabwe Country Report, at 5 (Dec. 2008).

101 Rotberg R, Who will have the courage to save Zimbabwe? Boston Globe (25 Jun. 2008), at A15. For background to the Government's pervasive use of food for political ends, see generally, Human Rights Watch. Not Eligible: The Politicization of Food in Zimbabwe. (2003). <http://www.hrw.org/en/reports/2003/10/23/not-eligible> [accessed 2 Jan. 2009].

102 Id. Human Rights Watch (2003).

103 Id.

the opposition. This restriction of food became most blatant in June through August 2008, when the Mugabe government banned all charitable organizations from distributing food or from operating in Zimbabwe's rural areas.¹⁰⁴

This politicization of food aid has continued. On 31 December 2008, a government official in Chivhu prevented WFP from distributing food aid:

"The villagers accused the chief of being corrupt and diverting donor aid and distributing it along party lines. They indicated that ... the chief and his ZANU-PF supporters used to source maize from the nearby Grain Marketing Board and then sell it to the poor villagers."¹⁰⁵

Hunger is a special problem in institutional settings as well. A leader of a health NGO reported that:

"There is no food in many of the hospitals and there is starvation in the prisons."

PHR did not visit any of Zimbabwe's prisons or detention facilities, but is deeply concerned that violations of the rights of prisoners to adequate food, water, sanitation, and healthcare may be occurring. A senior Ministry of Health official confirmed that

"...malnutrition is pronounced in prisons."

The ZANU-PF government has exacerbated food insecurity for Zimbabweans in 2008 by blocking international humanitarian organizations from delivering food aid and other succor to populations in the worst-affected rural areas.¹⁰⁶ Since the start of the March 2008 election period, government officials increasingly constrained the humanitarian community's access to vulnerable populations, according to several international NGO staff in Zimbabwe whom PHR interviewed. On 4 June 2008, the ZANU-PF government formally requested full cessation of field operations for humanitarian organizations providing relief in Zimbabwe.¹⁰⁷ The Mugabe regime prevented the U.N. World Food Program (WFP) and other U.N.

partner organizations from delivering food assistance to the rural poor.¹⁰⁸ It is difficult to assess how many thousands have died as a result. Only in October 2008 were these humanitarian organizations allowed to resume distribution of monthly emergency food rations.¹⁰⁹ Almost certainly this resumption of life-saving food aid is mitigating nutritional decline.

› Drought

Poor harvests during the past three years due to droughts and erratic rainfall – especially in marginal agro-ecological zones – exacerbate the government-induced unavailability of basic agricultural inputs (or farmers unable to afford such inputs).¹¹⁰ PHR investigators interviewed several rural subsistence farmers who reported that over the past three years they have experienced severe food shortages. On random inspection of a few grain silos in one area that is prone to food insecurity in times of drought, PHR confirmed that they had exhausted their meager stocks of maize, which would normally supply them during the lean months of the growing season (December through March) before the next 2009 spring harvest. Most families whom PHR interviewed survive on less than one meal per day,¹¹¹ and a senior Ministry of Health official confirmed this deplorable statistic adding that the food situation is very pathetic and quite bad in Zimbabwe. In fact the United Nations estimates that two-thirds of Zimbabweans currently subsist on one meal a day and that 56% of all Zimbabweans live on less than \$1 USD per day.¹¹² The World Food Program additionally warns:

"The crisis is going to get much worse in the coming months"

108 IPS. RIGHTS-ZIMBABWE: Government Blocks Aid for Six Million in Need. 18 June 2008. <http://ipsnews.net/news.asp?idnews=42859> [accessed 3 Jan. 2009].

109 Friends of WFP. Major Food Appeal for Zimbabwe as WFP Relief Distribution Begins. 9 Oct. 2008. <http://www.friendsofwfp.org/atf/cf/%7B90E7E160-957C-41E4-9FAB-87E2B662894B%7D/10.09.08-MAJOR%20FOOD%20APPEAL%20FOR%20ZIMBABWE%20AS%20WFP%20RELIEF%20DISTRIBUTIONS%20BEGIN.htm> [accessed 5 June 2009].

110 FAO and Emergencies: Zimbabwe. http://www.fao.org/emergencies/country_information/list/africa/zimbabwe/en/ [accessed 30 Dec. 2008].

111 Per capita daily caloric consumption has steadily decreased among Zimbabweans from 2260 kcal in 1979 to 2010 kcal in 2003. Current figures are unavailable. FAO. FAO Statistical Yearbook Zimbabwe Country Profile. (2006). http://www.fao.org/ES/ESS/yearbook/vol_1_2/pdf/Zimbabwe.pdf [accessed 8 Jan. 2009].

112 UNDP. Human Development Report, 2007. <http://hdr.undp.org/en/reports/global/hdr2007-2008/> [accessed 31 Dec. 2008].

104 Id.

105 Radio Voice of the People. Hungry Villagers Overturn Chief's Car. 6 Jan. 2009. http://www.radiovop.com/index.php?option=com_content&task=view&id=4893&Itemid=171 [accessed 6 Jan. 2009].

106 UNICEF. Ban on humanitarian aid threatens Zimbabwe's most vulnerable children. 12 June 2008. http://www.unicef.org/infobycountry/index_44442.html [accessed 31 Dec. 2008].

107 World Vision. Work in Zimbabwe remains suspended after government order last month. 11 July 2008. <http://www.worldvision.org/news.nsf/news/zimbabwe-update-20080711?OpenDocument> [accessed 3 Jan. 2009].

due to this extreme lack of food stocks following an especially poor 2008 harvest;¹¹³ thus, food insecurity and extreme nutritional vulnerability are likely to persist.

› **Impact of food insecurity on HIV/AIDS**

PHR also conducted a focus group of 15 HIV-positive urban women who all reported experiencing food insecurity. In addition to drug therapy, food and nutrition are essential for treatment. More than half the women interviewed reported having no food to eat that day. They said they lived each day, and for that day alone. More than half of the women ate a small amount of the lunch provided by the hosting NGO (or none at all) because they wanted to take the food home to feed their children. One woman broke down crying when she was offered an extra sandwich; she noted that she would take it home to her young son who is also HIV-positive and who had not had food in two days.

The head of a local AIDS organization reported that the current economic crisis has led to a sharp increase in commercial sex, which is helping fuel the spread of HIV. PHR was told that many sex workers are now

requesting payment in kind (sugar, soap, maize meal), and have increased the number of clients per day to 10 to 15. More than 6,000 Zimbabweans per day cross into South Africa at the border town of Beitbridge. An increasing number of these economic migrants are women who make the journey and engage in commercial sex in order to buy food to bring back home for their families.

A former Ministry of Health official and current mission hospital administrator reported that some HIV/AIDS patients are selling their ARV medications to receive money to buy food. She also reported that many AIDS patients in Harare travel to their rural homes to die; thus rural mission hospitals are seeing an increase in the HIV/AIDS caseload. This has abruptly accelerated since the closure of the public hospitals in Harare.

Patients living with HIV/AIDS are especially vulnerable as a result of food insecurity. They are prone to both diarrheal diseases and wasting, which can be exacerbated by poor nutrition. For those fortunate enough to be on ARVs, adequate nutrition is essential for the drugs to work. Lack of essential micronutrients is itself immunocompromising, especially for pediatric HIV/AIDS patients. Having to choose between medication or food is especially deadly for patients with AIDS and tuberculosis, since treatment interruptions can lead to drug-resistant organisms – a grave complication.

› **Impact of food insecurity on children**

Save the Children reports that child malnutrition has risen to 50% in some regions and has found that acute malnutrition in children aged six months to five years has nearly doubled since 2007 in one of the two districts in which it has been working in Zimbabwe.¹¹⁴ The humanitarian organization also reports that in some localities wasting rates are now over seven percent.¹¹⁵ PHR anticipates these rates will rise during the next several months as already low food stocks become depleted. According to one senior physician interviewed:

“An unprecedented famine in Zimbabwe’s history awaits us next year.”

113 WFP. Major food appeal for Zimbabwe as WFP relief distributions begin. 9 Oct. 2008. <http://www.wfp.org/ENGLISH/?ModuleID=137&Key=2955> [accessed 30 Dec. 2008].



Man showing signs of Pellagra including dark, cracking skin in sun-exposed areas, and wasting. Photograph taken 5 January 2009 inside Harare Central Prison.

114 Save the Children. Child malnutrition in Zimbabwe increasing as emergency aid pipeline falters. <http://www.savethechildren.net/alliance/media/newsdesk/2008-12-27.html> [accessed 31 Dec. 2008].

115 Id.

CURRENT HEALTH CRISIS

The collapse of the public health system and corresponding key determinants of health described above have resulted in a cholera epidemic, an anthrax outbreak, worsening HIV/AIDS, tuberculosis (TB), maternal mortality and morbidity, and malnutrition and vitamin deficiency in Zimbabwe.

» Cholera

Cholera is an acute diarrheal disease, caused by the bacteria *Vibrio cholerae*, which, if untreated or is treated too late, can result in severe dehydration and death within hours. Cholera is water-borne and food-borne: it spreads through fecal contamination, and ingestion of water or food contaminated by human feces. Cholera is easily treated with oral rehydration, if it is treated in time, and with intravenous rehydration in severe cases.

The current cholera epidemic in Zimbabwe appears to have begun in August 2008.¹¹⁶ As of this writing, more than 1,900 Zimbabweans have died from the disease and another 37,000 people have been infected.¹¹⁷ A recent U.N. report states that the cholera epidemic has spread to all of Zimbabwe's ten provinces, and 55 of the 62 districts (89%) are affected.¹¹⁸ The U.N. reports that the cumulative case fatality rate (CFR) across the country has risen to 5.0% - five times greater than what is normal in large cholera outbreaks.¹¹⁹ A closer inspection of these statistics reveals that 42% of all districts have cumulative death rates greater than 10%. As of 6 January 2009, the highest case loads have been in Harare, Beitbridge, Makonde, Chegutu, and Mudzi districts; a recent surge in reported cases has occurred in Manicaland province.¹²⁰

These statistics are thought to be underestimates. One government health official whom PHR interviewed estimated that the current Ministry of Health figures (distributed through the U.N. Office for the Coordination of Humanitarian Affairs (OCHA) and WHO) represent

80% of the true cholera caseload. According to staff at the U.S. Centers for Disease Control and Prevention (CDC) in Harare whom PHR interviewed, this under-reporting is due in part to failed public health reporting systems. OCHA also acknowledges in its daily updates that it does not receive new cholera statistics from some districts for up to seven days. PHR physicians spoke with a government nurse at a small rural public clinic who reported that he sees cholera patients every day. He related:

"Cholera is killing a lot of people. There must be a minimum of 50 deaths from cholera every day, so there must be more [cases] than are being reported."

In addition, PHR is concerned that unknown numbers of cholera deaths likely go unreported because people are forced to die at home: public hospitals are now closed, and those mission hospitals that are functioning are financially inaccessible to many of the rural poor.¹²¹ This is likely to be particularly true in more remote rural areas and among the many child-headed households in Zimbabwe, which has more than a million orphaned children, largely as a consequence of the ongoing HIV/AIDS epidemic.¹²²

The available data suggest that the epidemic is worsening. Cholera is normally seen sporadically in Zimbabwe in the rainy season. The current epidemic began in August, in the dry season, an unusual situation almost certainly due to the government's disastrous failure to treat water and sewage and decision to turn off municipal water supplies. The epidemic progressed through the dry season. A current Ministry of Health official whom PHR interviewed warned that we have not seen the last of the [cholera] outbreak and expected to see the number of cases increase in the coming months as the rainy season begins because resultant floods will further spread contaminated water. In support of this prediction, there has been a doubling of both cases and deaths during the last three weeks in December.¹²³

116 See e.g., U.N. OCHA. Cholera in Zimbabwe. 6 Jan. 2009. <http://ochaonline.un.org/Default.aspx?alias=ochaonline.un.org/zimbabwe> (accessed 6 Jan. 2009). There are reported cases, however, of cholera as early as February 2008. See generally, OCHA. Situation Report on Cholera and Anthrax in Zimbabwe (Issue No 1); 14 Oct. 2008.

117 U.N. OCHA. Daily Cholera Update. 9 Jan. 2009. <http://ochaonline.un.org/Default.aspx?alias=ochaonline.un.org/zimbabwe> (accessed 10 Jan. 2009).

118 Id.

119 Id.

120 Id.

121 High case fatality rates - over 25% in some districts - are indicative of deaths taking place at home away from clinical care.

122 Donnelly J. Boston Globe. Number of orphans spikes as Zimbabwe crises deepen. 18 Jul. 2007. http://www.boston.com/news/world/africa/articles/2007/07/18/number_of_orphans_spikes_as_zimbabwe_crises_deepen/ (accessed 31 Dec. 2008); see also, UNICEF. Children and AIDS: A stocktaking report (2007) at 40. http://www.unicef.org/publications/files/ChildrenandAIDSStocktakingLoResPDF_EN_USLetter_15012007.pdf (accessed 9 Jan. 2009).

123 WHO. Cholera in Zimbabwe: Epidemiological Bulletin No 3. 30 Dec. 2008. http://www.who.int/hac/crises/zwe/zimbabwe_cholera_

The Zimbabwe Health Cluster (comprising a number of NGOs in Zimbabwe working on the cholera epidemic, including the World Health Organization, the International Committee of the Red Cross, and the International Organization for Migration) conducted a rapid assessment and developed an operational plan for the coming year.¹²⁴ The Health Cluster estimates an annual case load of 60,000 – a figure that the Health Cluster itself believes to be an underestimate because of using a conservative attack rate of 1%.¹²⁵

› *Infectivity*

The origin of the current cholera epidemic appears to stem from the failure of the Mugabe regime to maintain water purification measures and manage sewerage systems. *Vibrio cholerae* usually reside in tidal waters and bays and proliferate mostly in summer months (when water temperatures exceed 20°C). Humans become infected incidentally, but then can act as vehicles of spread. Research has shown that passage through the human gastrointestinal tract imparts a hyperinfective state to cholera that plays an important role in dissemination of the disease.¹²⁶ Human cholera epidemics are largely preventable. If the water supply is kept safe and sanitary disposal of feces operates, the risk of spread of the disease is virtually nil. If, however, the public sector fails to maintain water and sanitation, the risk of disease escalates dramatically.

A further challenge to cholera control in Zimbabwe is the large proportion of the general population who are immunocompromised. With more than 15% of all adults living with HIV infection,¹²⁷ and widespread micronutrient deficiency and malnutrition also contributing to poor immunity,¹²⁸ Zimbabwe's population is markedly more

vulnerable to severe clinical cholera and to cholera spread. Since the closure of the General Hospitals in November, 2008, and the interruption of HIV/AIDS drug supplies, delivery systems, and clinical care over the past 18 months, the ability of the healthcare system to provide the added care needed to address cholera among the immunocompromised is severely limited.

› *Epidemiology*

Cholera has been threatening Zimbabwe for several years. In 2004, an outbreak killed 40 people and infected 900 others.¹²⁹ In 2005, 14 recorded deaths and 203 cases of cholera occurred – and these during the low-risk months from May to June.¹³⁰ In 2006, a cholera epidemic resulted in 27 deaths.¹³¹ Civic organizations in Harare warned of a cholera time-bomb in 2006, but the Mugabe regime ignored the warning signs.¹³² In February 2007, three deaths and 19 cases were reported.¹³³ Beginning in August 2007, there were reports that ZINWA had dumped raw sewage into Lake Chivero, Harare's main water supply source;¹³⁴ public clinics reported treating some 900 cases of diarrhea daily some of which may have represented cases of cholera.¹³⁵ These outbreaks suggest that the preconditions for a major outbreak of water-borne disease were present and worsening for at least the past three years. Despite the repeated warnings from civil society groups, healthcare providers, and donors, the Mugabe regime failed to take decisive action over these years.

Not until 4 December 2008 did Zimbabwe's Ministry of Health and Child Welfare finally request aid to respond to the cholera outbreak by declaring a national emergency. This negligence represents a four-month delay since the beginning of the current cholera outbreak, but at least a three-year delay in responding to the water and sanitation breakdowns, which have allowed cholera to flourish.¹³⁶

epi_bulletin3_30dec2008.pdf [accessed 6 Jan. 2009].

124 WHO Zimbabwe Health Cluster. Cholera Outbreaks, Coordinated Preparedness and Response Operational Plan, at 7. Harare. Nov. 2008. http://www.who.int/hac/crises/zwe/zimbabwe_cholera_resp_plan_nov08.pdf [accessed 6 Jan. 2009].

125 The Zimbabwe Health Cluster assumed a population of 12 million with 50% of the population being at risk of acquiring cholera, and an attack rate of 1%, totaling 60,000. *Id.* at 7. The attack rate is defined as the number of exposed persons infected with the disease divided by the total number of exposed persons.

126 Hartley D, Morris J, Smith D. Hyperinfectivity: A critical element in the ability of *V. cholerae* to cause epidemics? *PLoS Med.* 2006;3:e7.

127 UNAIDS / WHO. Zimbabwe Epidemiological Country Profile on HIV and AIDS (2008). http://www.who.int/globalatlas/predefinedReports/EFS2008/short/EFSCountryProfiles2008_ZW.pdf [accessed 2 Jan. 2008].

128 WHO. World Health Organization Statistical Information System (WHOSIS). WHO, Geneva, 2008. <http://www.who.int/whosis/>

[data/Search.jsp?indicators=\[Indicator\].Members](http://www.who.int/whosis/data/Search.jsp?indicators=[Indicator].Members) [accessed 5 Jan. 2009].

129 IRIN. Zimbabwe: Cholera timeline. 5 Dec. 2008. <http://www.irinnews.org/report.aspx?ReportId=81845> [accessed 9 Dec. 2008].

130 *Id.*

131 *Id.*

132 *Id.*

133 *Id.*

134 Zimbabwe Independent. Residents Give ZINWA Ultimatum. 27 Nov. 2008. <http://www.thezimbabweindependent.com/local/21608-residents-give-zinwa-ultimatum.html> [accessed 3 Jan. 2009].

135 IRIN. Zimbabwe: Cholera timeline. 5 Dec. 2008. <http://www.irinnews.org/report.aspx?ReportId=81845> [accessed 9 Dec. 2008].

136 *Id.*

According to the CDC, the Zimbabwe outbreak has spread as of December 2008 to all its neighboring countries; there are confirmed cholera cases in Botswana, Mozambique, Zambia, and South Africa.¹³⁷ This spread has been accelerated by the increased movement of Zimbabweans across international borders. In the face of the current economic crisis and political repression, Zimbabweans are traveling more to seek food, supplies, healthcare, and refuge in neighboring countries and carrying the disease with them.

The striking feature of Zimbabwe's cholera epidemic is that it occurred during peacetime. The recent historic trend is that cholera epidemics are associated with large-scale humanitarian disasters resulting from war. *V. Cholerae* has been responsible for at least seven global pandemics since 1817 (e.g., following the 1994 Rwandan genocide).¹³⁸ These cholera outbreaks were precipitated by war or natural disaster that led to a breakdown in public the health system. The implication for Zimbabwe is that the current breakdown of public health services and the collapsed economy is tantamount to a failed state.

› **Treatment**

Cholera is a temporally self-limiting disease; it usually runs its course in a matter of days. Untreated, this short disease course can be lethal. When recognized and treated early, cholera is easily managed with oral or intravenous rehydration. It suffices to match diarrheal losses with fluids and electrolytes during the several-day course of the disease and if done, many symptoms are avoided, and patients typically make full recovery. Although specially formulated, pre-packaged oral rehydration salts (ORS) are ideally required for rehydration in mild and moderately severe cases, oral rehydration therapy (ORT) in the form of any sugar-salt solution or other liquids containing salt and a source of energy (carbohydrate or protein) are also efficacious. Antibiotics diminish the duration and volume of fluid loss and hasten clearance of organisms from the stool, but are not necessary for curing cholera.

Death rates from cholera are generally around one percent of clinical cases.¹³⁹ PHR asked a senior government official responsible for cholera surveillance

¹³⁷ CDC. Outbreak Notice. Cholera in Zimbabwe and Neighboring Countries. (19 Dec. 2008). <http://www.cdc.gov/travel/content/CholeraZimbabwe.aspx> (accessed 6 Jan. 2009).

¹³⁸ Harrison's Principles of Internal Medicine, 17th Ed. (2008): 968-72.

¹³⁹ Id.

why Zimbabwe's case fatality rate was more than five times greater than this norm. She attributed the high cumulative rate to three causes:

First, in the initial phase of the response there simply were no supplies, such as ORS and IV fluids, to treat the many cases.

Second, few clinic or hospital staff were sufficiently experienced or trained to respond to cholera, and many patients died even in facilities that did have adequate supplies.

Finally, the issue of transport costs for patients and staff, exacerbated by the closure of the public hospitals, meant that many patients either could not reach care, or reached care in very advanced stages of dehydration, and could not be saved.

The last point was corroborated by the director of a functioning mission hospital at some distance from Harare, who reported that since the rise in transport costs and the dollarization of private healthcare, he was seeing more and more patients presenting too late for clinical care. Referring to the malignancy created by government neglect and overt action, he further stated:

"Cholera is one of the symptoms of the cancer."

He reported that his cholera patients were all overflow from Harare because of the severe lack of free treatment available in the city. He said:

"For every cholera patient here, there are a hundred more who are not receiving treatment."

Cholera treatment measures have impacted the treatment access to patients with other diseases. The government-run Beatrice Road Infectious Diseases Hospital (BRIDH) in Harare is the city's main infectious diseases hospital. BRIDH is now only admitting cholera patients, and is under tight government security. PHR spoke with a Zimbabwean physician who was volunteering at BRIDH and treating these patients. This physician reported being hidden by the nursing staff during intrusive visits by the Zimbabwean Army – armed soldiers apparently limiting access to the hospital in an attempt to conceal the extent of the epidemic. PHR spoke with a government official about the other patients who had been at BRIDH. She stated that once Beatrice was designated as a cholera hospital all other patients, including those with TB, HIV/AIDS, and other infectious diseases, were forcibly discharged. She put it this way:

“If you don’t have cholera, too bad.”

Additionally, a number of key informants explicitly warned PHR not to attempt to visit Beatrice Hospital because government authorities there would most probably not allow PHR physicians to witness the severity of the problem, or worse would compromise or shut down the investigation. This warning attests to how the ZANU-PF government has politicized the cholera epidemic by trying to suppress knowledge of the extent of the disease.

› **Prevention**

The Minister of Health announced on 5 January 2009 plans to initiate an awareness campaign focusing on good hygiene;¹⁴⁰ not only is this measure insufficient to address the serious needs of the public, but the Government waited a full five months following the initial cholera outbreak to launch it. In addition to ensuring access to safe water, the Government needs to implement a robust public health campaign to educate people about fecal-oral transmission (basically that vigilant hand-washing is key), about home water purification (such as boiling, chlorination, or filtration), and about sterilization (for example, bleaching) of any fecally contaminated items (clothing and bedding) with which the cholera patient has been in contact.

The Mugabe regime has also compromised the communication and educational steps crucial to combating the disease. In Chinhoyi, for example, the capital of Mashonaland West and provincial rural home of Mugabe, a cholera outbreak occurred in late September 2008.¹⁴¹ Although a key informant told PHR that local authorities initially used a megaphone to alert people of cholera deaths and that people should wash hands, they failed to report the outbreak to higher authorities until three weeks later. Although notification of a cholera outbreak is required by law, this breakdown in communication, critical for an emergency response, was compromised by a failed communications system. A senior Ministry of Health official reported that they relied on a failed public health reporting system that required district and provincial medical staff to place

telephone calls to the Ministry of Health. She opined that:

“Because these physicians were no longer showing up to work because their salaries were so small and the cost of transportation to work was too high, these phone calls were no longer being made.”

Communication was thus compromised by the economic collapse: workers could not pay for public transportation because their salary was less than the cost of transportation to work.

The onus of prevention of cholera lies with the public sector. Individuals depend on government authorities and institutions to supply clean water, to dispose of sewage, and to warn and educate when a crisis occurs. The culpability of the Mugabe regime lies at the very origin of this epidemic, which has caused more than 1,900 gratuitous deaths from this preventable and treatable disease. Access to potable water and medical care are fundamental rights that the Mugabe regime has abrogated with lethal effect on its own people.

» **Anthrax**

Zimbabwe has long been an endemic country for the anthrax bacillus, *bacillus anthracis*. Primarily a disease of grazing animals, who become infected from ingestion of long-lived spore forms in the soil, anthrax can cause several forms of disease in humans including cutaneous, and the more lethal and rare gastrointestinal form, an outcome of eating anthrax contaminated meat—usually from carcasses. Zimbabwe has had several outbreaks of cutaneous anthrax, including one with over 6,000 cases during the independence struggles between October 1979 and March 1980.¹⁴² But the most recent outbreak has not been of this endemic form, but rather of gastrointestinal anthrax. WHO has recently reported some 200 human cases of anthrax since November 2008 with eight confirmed deaths.¹⁴³ These cases were attributed to the ingestion of animals (cattle and goats) that had died of anthrax. Zimbabwean custom is to avoid eating animals that have died of disease – but these cases appear to have been in starving rural people willing to risk disease themselves in order to eat. PHR interviewed one senior pediatrician who had just diagnosed a child suffering

140 APA News, reproduced in Zimbabwe Situation (6 Jan. 2009). Zimbabwe launches cholera awareness campaign. http://www.zimbabwesituation.com/jan6a_2009.html#Z10 [accessed 8 Jan. 2009].

141 IRIN. Zimbabwe: Cholera outbreak threatens to become endemic. 20 Oct. 2008. <http://www.irinnews.org/report.aspx?ReportID=81009> [accessed 10 Dec. 2008].

142 Davies J. A major epidemic of anthrax in Zimbabwe. *Cent Afr J Med* 1982;28:291–8.

143 WHO. Zimbabwe Health Cluster Bulletin No 2. 12 Dec. 2008. http://www.who.int/hac/crises/zmb/sitreps/health_cluster_bulletin_12dec2008/en/ [accessed 6 Jan. 2009].

from anthrax with lesions in the mouth on the day of the interview; the family reported having recently eaten meat from a dead cow. The physician suspects this was the mode of transmission – an outcome of resorting to eating rotting meat, which people would otherwise not do.

PHR was also told that veterinary anthrax control programs in Zimbabwe, which had included regular monthly dipping programs for cattle, have been dramatically curtailed in the economic collapse. The results in the veterinary sector are that dipping and vaccination of livestock have largely ceased and the surviving herds are much more vulnerable to infectious diseases.

» **Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS)**

Zimbabwe has had severe HIV/AIDS and tuberculosis epidemics for more than two decades. In 1999, UNAIDS considered Zimbabwe to be the highest prevalence country for HIV infection worldwide, with some 25% of all adults HIV positive.¹⁴⁴ HIV/AIDS treatment was largely unavailable until 2004, when the U.S. funded PEPFAR program began providing support for anti-retroviral therapy. Since that time both the PEPFAR program and the Global Fund to Fight AIDS, Tuberculosis and Malaria have been providing programmatic support. Since 2006 however, the programs have been affected by the same systemic issues which have affected every aspect of healthcare in Zimbabwe: loss of professional staff, hyper-inflation, a collapsing health infrastructure, food insecurity, and breakdowns in commodity supply, distribution and end-user delivery systems. Access to HIV/AIDS care and treatment is threatened by the current collapse, but in addition, the HIV program is currently capped: some 205,000 people are thought to be on ARVs, but no major program is currently able to enroll new patients. Some 800,000 Zimbabweans are thought to require therapy, or will require it in the coming months-years, and access is now closed to these individuals.¹⁴⁵

144 UNAIDS 2000. Report on the global AIDS epidemic (UNAIDS, Geneva, 2000).

145 UNAIDS 2008. Report on the global AIDS epidemic (UNAIDS, Geneva, 2008). http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp (accessed 27 Dec. 2008); PEPFAR 2008 Country Profile: Zimbabwe. <http://www.pepfar.gov/pepfar/press/81902.htm> (accessed 27 Dec. 2008).

» **Epidemiology**

The most current epidemiological data available on HIV for Zimbabwe are the estimates from the UNAIDS program, which are cited by both in-country professionals and donor agencies. The UNAIDS figures show that Zimbabwe has a severe generalized epidemic of HIV-1, with an overall adult (ages 15-49) HIV prevalence rate of 15.3%. An estimated 1.3 million adults and children in Zimbabwe are living with HIV infection in 2008. Of these some 680,000 were women of childbearing age.¹⁴⁶

In 2007, some 140,000 Zimbabweans died of AIDS, and the current toll is estimated at 400 AIDS deaths per day.¹⁴⁷ More people die of AIDS each week than have died of cholera over the past five months.

Zimbabwe has an enormous number of AIDS orphans—children who have lost one or both parents to AIDS – which UNICEF reports was 1.1 million children in 2005, or roughly one child in four.¹⁴⁸ The Clinton Foundation has focused on provision of ARVs for pediatric AIDS care.

The surveillance system and reporting systems have markedly declined in Zimbabwe since 2006, and had almost entirely ceased by mid-2008. The HIV programs have been somewhat spared since they are donor supported, but the TB program has essentially shut down, making current TB estimates extremely unreliable. There is no drug sensitivity testing capacity in the National TB program, and there is only one staff member in the national lab, who has no training in TB culture methods. If multi-drug resistant TB (MDR-TB) were spreading in Zimbabwe, or extremely drug resistant TB (XDR-TB), there would be no capacity to evaluate these problems or address them. It is unknown to what extent resistant strains of TB are spreading in Zimbabwe.

» **Antiretroviral drug access**

The U.S. PEPFAR program currently supports ARVs for some 40,000 Zimbabwean AIDS patients. In 2007, the program provided ARVs to 70,900 pregnant women for prevention of mother to child transmission, and provided testing to some 403,000 women. The PEPFAR program has detailed a number of challenges in

146 Id.

147 Id.

148 UNICEF. Children and AIDS: A stocktaking report (2007) at 40. http://www.unicef.org/publications/files/ChildrenandAIDSAStocktakingLoResPDF_EN_USLetter_15012007.pdf (accessed 9 Jan. 2009).

2008 that reinforce PHR's findings described above: Zimbabwe continues to suffer a severe socioeconomic and political crisis, including unprecedented rates of inflation and a severe brain drain of Zimbabwe's health professionals. Elements of a previously well-maintained healthcare infrastructure are crumbling. Zimbabwe's HIV crisis is exacerbated by chronic food insecurity. Sub-optimal nutrition increases the vulnerability of individuals with compromised immune systems to life-threatening opportunistic infections, such as tuberculosis.¹⁴⁹

We asked a nurse staffing a rural public sector clinic about ARV supplies:

"We are doing quite well with ARVs and we usually have these in stock. The problem is many of the patients have no food, nothing to eat, so the drugs don't work so well. We have no ability to provide them with more nutrition."

Male and female condoms were available at this clinic, and the nurse reported that condom supplies (largely supported by the United States Agency for International Development - USAID) were adequate and that demand was considerable. In other regions, however, Zimbabweans report inaccessibility to ARVs.¹⁵⁰

Waiting times for HIV testing and immunologic monitoring with CD4 counts are also a barrier. One HIV/AIDS patient interviewed in peri-urban Harare reported being on a waiting list for over a year to get a CD4 count. After the blood draw, he waited another six months to get the results. His CD4 count at that time was 270, and he had a history of clinically active TB and HIV co-infection, but had not yet qualified for starting ARVs. With such a low CD4 count and an opportunistic infection (TB), this patient should have been on ARVs.

The representative of an international humanitarian NGO operating in Zimbabwe reported that the National AIDS Council in Zimbabwe – a coordinating body including government and NGO representatives – had told him and other heads of humanitarian relief organizations at the end of 2007 not to scale up with ARV enrollment. PHR spoke with a Zimbabwean Government official who confirmed that the HIV

program has virtually stopped enrolling new patients. He added:

"And now there is a black market in ARVs."

A donor country official corroborated the report of a black market in ARVs. A key informant informed PHR of reports that ZANU-PF officials had loaded up their trucks with ARV medicines from the national pharmacy and then sold them on the black market. A local medical NGO also confirmed these abuses were happening, but the medical staff were not certain of its extent. A local NGO that works with HIV/AIDS patients also reported that nurses and other healthcare professionals were selling ARVs and other drugs obtained from public hospitals and selling them on the black market to supplement their incomes.

PHR investigators received corroborating reports from donors and HIV/AIDS patients in Zimbabwe that ZANU-PF government officials had plundered \$7.3 million USD in humanitarian aid for ARV drugs – part of \$12.3 million USD from the Global Fund. Following public outrage over the scandal months later in November 2008, the ZANU-PF-controlled reserve bank returned the stolen funds to the Global Fund.¹⁵¹ The representative of a humanitarian NGO operating in Zimbabwe also informed PHR that the Government had frozen some of his organizations funds intended for HIV/AIDS.

These reports underscore the importance of accountability and quality treatment in the public sector and make the collapse of that sector all the more life-threatening for patients with HIV/AIDS in Zimbabwe. Finally, we asked the women's focus group to prioritize the solutions they saw to the HIV/AIDS problems they were facing. Their priority solutions in order were: Governance, healthcare, food.

› **Impact on HIV/AIDS**

Zimbabwe's severe HIV/AIDS epidemic is the focus of multiple donor programs including the U.S. PEPFAR program, the CDC, and the Global Fund to Fight AIDS, TB and Malaria (GFATM). PHR found that the collapse of the healthcare system has profoundly impacted HIV/AIDS programs and drug-delivery systems in Zimbabwe. The prioritization of cholera treatment over other infectious diseases in the health care system has also been a new, acute threat to inpatient AIDS care.

149 PEPFAR 2008 Country Profile: Zimbabwe. <http://www.pepfar.gov/pepfar/press/81902.htm> [accessed 27 Dec. 2008].

150 Radio Voice of the People, reproduced in, Zimbabwe Situation. Manicaland HIV/AIDS Patients Fail to Access Drugs (4 Jan. 2009). http://www.zimbabwesituation.com/jan5_2009.html#Z9 [accessed 9 Jan. 2009].

151 Zimbabwe Times. Plunder of HIV drug funds spark outrage. 7 Nov. 2008. <http://www.thezimbabwetimes.com/?p=6949> [accessed 8 Jan. 2009].

For HIV/AIDS the most severe threat has been the interruption of regular supplies of antiretroviral drugs. Multiple key informants, patients, and providers told PHR that ARV supplies had become irregular due to breakdowns in drug delivery, distribution, provision, and theft of ARV drugs by ZANU-PF operatives. Most troubling were reports that some physicians were switching patients on established ARV regimens to other regimens based not on clinical need, but on drug availability. These changes occurred, in some reported cases, on a monthly basis – since supplies were too low to give patients the usual three-month supplies. Such changes in ARV regimens can be life-threatening for individual patients by markedly increasing the likelihood of multi-drug resistant variants of the HIV virus, and thus of treatment failure and death. Changing regimens on a monthly basis increases not only the risk of HIV-drug resistance, but also of drug complications and side-effects further endangering AIDS patients and undermining patient adherence.

These dangerous practices constitute a significant threat to public health since the development and transmission of multi-drug resistant variants of HIV in Zimbabwe could undermine not only Zimbabwe's HIV/AIDS program, but regional programs as well. This is particularly true since the predominant HIV strain in Zimbabwe, subtype C of HIV-1, is known to have distinctive genetic pathways of ARV drug resistance development.¹⁵² Subtype C is the dominant strain of HIV in South Africa, Botswana, Mozambique, Zambia, and Malawi – all countries where resistant variants of HIV-1 C viruses could have devastating impacts. Given that some three to four million Zimbabweans have already fled their homeland, and that the HIV prevalence among Zimbabwean adults is over 15%, neighboring countries may have already acquired several hundred

152 Martínez-Cajas J, Pant-Pai N, et al. Role of Genetic Diversity amongst HIV-1 Non-B Subtypes in Drug Resistance: A Systematic Review of Virologic and Biochemical Evidence. *AIDS Rev.* 2008 Oct-Dec;10(4):212-23.

No treatment without the money first

PHR spoke with a support group of 15 HIV positive women who detailed some of their recent problems with ARV supplies. All of the women present were receiving free ARVs on a fairly regular basis. The drugs are distributed monthly at government clinics for free.

However, about once every three months the supply is not adequate. When this happens patients are given a two-week supply. More troublesome is the fact that when they return for treatment a different drug may be available from the regime they were on the previous month. So patients are changed across regimes due to unavailability. Patients reported getting Trimune one month and Stelanave or Combivir pack the following month. These practices have been going on for one year or more.

Two women reported that on occasion they have gone to buy their own drugs when they were not available, and that the cost is approximately \$100 USD per month. Second-line drugs are more expensive and more often not available than first line.

Discussants also shared that private doctors often don't really know about HIV. Two women reported presenting themselves to private practice doctors with symptoms for two years, being treated for a variety of illnesses, and having been sent for expensive medicines at pharmacies owned by the same doctors for cash.

"After two years of deteriorating health, I went to Harare hospital and wanted to get an HIV test. I knew the doctors there were more prepared to treat people like me and I could not afford it [private care] anymore."

This woman confirmed that her private physician had never suggested she get an HIV test. Many women also reported feeling that many private doctors knew nothing about AIDS treatment and often gave ARV without proper dosing and instructions.

"And if you are diagnosed [HIV] positive, you get no treatment without the money first."

thousand additional cases of HIV/AIDS. Unless quality ARV services can be quickly restored for Zimbabweans at home, and for these large numbers of refugees, increased HIV-drug resistance in the region is virtually assured resulting in increased treatment costs, treatment complexity, and poorer clinical outcomes – and, possibly, an HIV epidemic that ultimately gets completely out of control.

The collapse of public-sector HIV testing and counseling also undermines access to treatment for HIV-positive Zimbabweans and prevention services for those at risk of infection. HIV testing is a cornerstone of prevention and treatment. The gains Zimbabwe has made in HIV prevention could be swiftly reversed if free public HIV testing is not made immediately accessible.

» Tuberculosis

The public-sector TB program in Zimbabwe has been in sharp decline since 2006. The national laboratory is down to one technician and no longer has the capacity to test for TB drug resistance. TB treatment interruptions are occurring for similar reasons as with the ARV program: loss of staff, supply chain interruptions (from central stores to clinical pharmacies, shortages of TB antibiotics), and loss of diagnostic capacity. PHR asked an expert working with the national program to describe the status of the program in December 2008:

“There is no politically correct way to say this – the TB program in Zimbabwe is a joke. The national TB lab has one staff person. There is no one left trained in drug sensitivity testing. The TB reference lab is just not functioning. This is a brain drain problem. The lab was working well until 2006 and has since fallen apart. The DOTS program in 2000 was highly effective, but that has broken down now too. There is no real data collection system for TB. That stopped in 2006 as well.”

The major concern with TB treatment interruptions is the likelihood of TB drug (in this case antibiotic) resistance, which can lead to MDR-TB and the most severe form, XDR-TB. Extensively drug-resistant TB has emerged as an almost incurable form of TB with very high case fatality rates – over 90% in some South African settings.¹⁵³

One physician at a rural mission hospital reported

153 Andrews J, Sarita N, Moll T, et al. Extensively Drug-Resistant Tuberculosis: Implications for the HIV Epidemic and Antiretroviral Therapy Rollout in South Africa. *Journal of Infectious Diseases* 2007;196:S482–S490.

that he currently had one probable case of MDR-TB, but was awaiting lab results. He acknowledged that the results might never return because of the lack of lab facilities. He stated that TB is a significant co-morbidity in the HIV/AIDS population, but that the symptoms of TB are often masked by the symptoms of HIV/AIDS. He also acknowledged that XDR-TB could be an emergent problem in Zimbabwe, but that the diagnostic capacity in the country was probably insufficient to identify this virulent form, should it be present.

Multiple-drug-resistant and drug-resistant TB variants (especially XDR-TB) are most commonly seen among patients who have co-morbid HIV infection. These drug-resistant strains are more likely to spread in populations, like Zimbabwe, where high proportions of the population are immunocompromised. Both MDR-TB and possible XDR-TB have emerged in Zimbabwe, but the critical capacity to diagnose and manage these infections has collapsed. That Zimbabwe has a failing TB program in the context of HIV and TB epidemics is a threat to the health of its own people, and a regional threat since the further generation and spread of MDR-TB and XDR-TB would be a lasting public health catastrophe.

Drug-resistant variants of TB and HIV are arguably more of a threat to southern Africa than the spread of cholera from Zimbabwe. Cholera is an acute illness that remains both treatable and curable with basic medical services. Drug-resistant HIV and TB will pervade in the region for years and will greatly increase the cost and complexity of treatment and care, while decreasing the clinical benefits of treatment.

» Maternal morbidity and mortality

It is generally agreed that indicators of maternal health in Zimbabwe have deteriorated greatly over the past decade and now are among the world's worst. The maternal mortality ratio has increased at an alarming rate from 283 per 100,000 in 1994 to 1,100 per 100,000 in 2005.¹⁵⁴ The major contributors are HIV/AIDS and, particularly in the recent period, a significant decline in availability and quality of maternal health services. This situation has been dramatically worsened in the period since November 2008 by withdrawal of maternity services throughout the public health sector, and especially in the major conurbations. The flight of professional health workers

154 DFID. Reducing maternal deaths in Africa. [2008]. <http://www.dfid.gov.uk/countries/africa/zimbabwe-reducing-maternal-deaths.asp> [accessed 7 Jan. 2009].

and recent withdrawal of labor (strikes) by doctors, nurses, and midwives combined with the widespread unavailability of key items of equipment and medicines (e.g., suture materials, swabs, protective clothing and gloves, oxytocin, etc.) have resulted in closure of most delivery units. Several informants told U.S. that, as a consequence, large and increasing numbers of pregnant women expecting normal deliveries are being forced to deliver at home, with many traveling from urban areas to their rural homes.

Additionally, women requiring assisted deliveries are compelled to utilize private sector or mission facilities. PHR received reports of women booked for elective Cesarean section at public-sector maternity units being referred to private, non-mission facilities. Since the current (mid-December) charges for Cesarean section at private facilities (e.g., Avenues Clinic) total approximately \$3,700 USD, many women travel to rural mission hospitals for such care. (Given that two-thirds of the population earns less than \$1 USD per day, this cost is prohibitive).

Given a birth rate 31.62 births per 1,000 and a current estimated population of 11.35 million in Zimbabwe,¹⁵⁵ there are approximately 360,000 births per year. The World Health Organization reports that 5% of all women in Zimbabwe gave birth by Cesarean section in 2005,¹⁵⁶ thus roughly 18,000 women require this obstetric surgical procedure each year. Because Zimbabwean hospitals are now closed, and it is no longer possible to receive this critical emergency care in the public sector, thousands of women are at risk of dying.

“Nearly 66% of maternal deaths in Zimbabwe are directly caused by just five common obstetric complications. These are bleeding, infection, complications of abortion; high blood pressure associated with pregnancy and prolonged or obstructed labor.”¹⁵⁷

Staff from mission hospitals reported to PHR investigators that other maternal health conditions requiring emergency hospital care are also presenting at their facilities. Moreover, delays are often incurred

as a result of difficulties in securing or paying for transport. We were told of a woman who had had an incomplete abortion (miscarriage) in a distant part of the district, and who had to secure the requisite funds to travel to All Souls’ Mission Hospital, incurring a three-day delay in having her potentially life-threatening condition treated.

PHR did find evidence that the declines in maternal healthcare had been suppressed by the Government. A former government physician reported:

[The Ministry of Health] “suppressed the maternal mortality rate for the past two years.”

» Protein-calorie malnutrition

The same emergency physician stated that Parirenyatwa hospital was filled with malnourished kids (before its closure) and that like maternal mortality rates, the incidence of child malnutrition has been suppressed. Malnutrition is not new to Zimbabwe;¹⁵⁸ however, PHR received a number of reports that suggest that this preventable disease is increasing dramatically. Several informants, including pediatricians, stated that cases of severe protein-energy malnutrition (PEM) have become more common in hospitals over the past several months. They attributed this to the combined impact of HIV/AIDS and food insecurity. On a visit to a rural mission hospital, PHR was shown several young children with severe PEM (marasmic Kwashiorkor and marasmus). While some of these children were HIV-positive, others were not, and inquiry revealed that their households were extremely food insecure.

A senior Ministry of Health official confirmed that one would definitely find wasting and stunting in rural areas. A senior physician at a mission hospital stated that the lack of transportation prevents most children with malnutrition from coming to his rural hospital, where there were 15 such children in the pediatric ward when PHR visited. In his district, the number of children with malnutrition was so high he can’t even count. He also reported that in his rural district an increasing number of relatively healthy people in their twenties and thirties are coming to hospital and dying because of starvation. He stated that most people in his rural district survive on one meal a day or less and that most people only eat meat twice a year at most. He stated:

158 Sokwanele. The silent cries of the little ones: Zimbabwe’s under-fives cry out for justice. 10 Apr. 2006. <http://www.sokwanele.com/print/41> [accessed 8 Jan. 2009].

155 CIA. CIA World Factbook. CIA, Washington, DC, 2008. <https://www.cia.gov/library/publications/the-world-factbook/print/zi.html> [accessed 5 Jan. 2009].

156 WHO. World Health Organization Statistical Information System (WHOSIS). WHO, Geneva, 2008. [http://www.who.int/whosis/data/Search.jsp?indicators=\[Indicator\].Members](http://www.who.int/whosis/data/Search.jsp?indicators=[Indicator].Members) [accessed 5 Jan 2008].

157 DFID. Reducing maternal deaths in Africa. (2008). <http://www.dfid.gov.uk/countries/africa/zimbabwe-reducing-maternal-deaths.asp> [accessed 7 Jan. 2009].

“Kwashiorkor is also present, but hidden in the community.”

The head of an international humanitarian NGO reported that he anticipates a sharp increase in malaria and malnutrition in March – April 2009.

» **Vitamin deficiency**

Several informants, including local NGO personnel, mission hospital staff, and physicians reported having each seen several cases of pellagra (in Mudzi and Tjolutjo districts), which is caused by severe deficiency of nicotinic acid, one of the B vitamins. In fact, a senior physician at a mission hospital reported seeing pellagra, which had disappeared in the previous ten years, every day now. Pellagra, as a problem of public health significance, is characteristically seen during famines or times of nutritional stress, particularly when diets consist predominantly of maize. This nutritional disorder is characterized by diarrhea, dermatitis (cracking and peeling skin), and dementia. Although PHR investigators did not see any overt cases of pellagra, they encountered an elderly widow, who had lost all her children to illness, foraging for firewood who had early signs of pellagra-like dermatitis. She reported having no food stocks and being totally reliant on neighbors and charity. Inspection of the grain

storage structures of her immediate neighbor revealed a very small amount, enough for only a few weeks.

CONCLUSION

Physicians for Human Rights conducted an emergency assessment of the collapse of Zimbabwe’s public health system in December 2008. Viewed through a human rights lens, the health and healthcare crisis in Zimbabwe is a direct outcome of the malfeasance of the Mugabe regime and violations of human rights.

The civil and political rights referenced in the introduction of this report are non-derogable, meaning that they cannot be abrogated or limited in any way, not even in times of public emergency or war. Any failure on the part of the Government of Zimbabwe to implement and protect these rights amounts to a violation. The economic, social, and cultural rights mentioned in this report are subject to progressive realization. Accordingly, the Government is required to provide an objective and rational explanation for any deliberately retrogressive measures taken in respect of these rights. To date, this has not occurred. Additionally, each of these rights also contains core obligations, which

Emergency Cesarean section

A primary school teacher aged 30 who lives near Warren Park in Harare was interviewed at Howard Mission Hospital on 16 December. She is a primary school teacher who has taken permanent leave since August because the pay is so poor.

Because her first pregnancy had required a Cesarean section, she had been scheduled to deliver her second child at Mbuya Nehanda Government Maternity Hospital by Cesarean section on 14 November 2008. She went to the hospital on that day and was told that the operation could not be performed because there were no nurses, doctors, or anesthesiologists at work. She was advised to go to a private obstetrician who demanded \$200 USD for registering under his care and \$500 USD for delivery. (This excludes the payment required for hospital accommodation, use of the OR, supplies and medicines.)

Since these costs were unaffordable, she proceeded to the Avenues Clinic where she was quoted the same charges. She then learned through a relative of the service available at Howard Mission Hospital and was driven there from Harare on 15 November 2008, admitted and placed on a waiting list for operation.

The arrival of successive emergencies resulted in her receiving her operation only on 11 December 2008 when she was already in labor. There were no complications, and a healthy baby was delivered. She expressed gratitude for her excellent care at Howard Hospital, but stated that “it was painful that the nurses at Mbuya Nehanda hospital would not assist [her]”.

Traveling far for obstetric care

PHR interviewed a woman from Harare who had traveled to a distant Mission hospital for a Cesarean section. She stated: "I wanted to have my baby in Harare but Parirenyatwa hospital was closed. I was having my prenatal care with my own doctor at the Avenue Clinic [a private clinic and hospital in Harare.] But they wanted so much money. They wanted only U.S. dollars, in cash. \$3,000 dollars for the surgeon, \$140 dollars for the nurse, and \$700 dollars for the doctor who puts you to sleep. We could not afford that, so four days ago we came here. This was the only hospital helping people in Harare."

Reporting on her entire bill for the delivery and post-surgical care at the Mission hospital, she said: "Altogether I think it will be about 1 billion Zimbabwe dollars [about \$10 USD at the current exchange] and this my husband and I can afford."

require immediate implementation and are not subject to resource constraint. Any failure on the part of the Government, among others, to implement these rights amounts to a violation of the respective right.

» Violations of the right to life

The Zimbabwean government is required to adopt positive measures to reduce infant mortality, increase life expectancy (especially in adopting measures to eliminate malnutrition and epidemics). The following activities and omissions of the Government have resulted in deaths or have the potential to result in deaths:

- Uncontrolled cholera epidemic;
- Cessation and obstruction of humanitarian aid;
- Lack of access to emergency obstetric care;
- Changes in ARV regimens due to depletion of stocks, increasing the likelihood of multi-drug resistant variants of the HIV virus, and so of treatment failure and death;
- Theft and black-marketing of ARV drugs.

These deaths and potential deaths would appear to be a clear violation of the right to life.

» Violations of the prohibition against torture, inhuman or degrading treatment or punishment

- The government policy of torture, intimidation, kidnappings and other inhuman and degrading treatment or punishment, for the past several years is a clear violation of the prohibition against torture, inhuman or degrading treatment or punishment.

» Violations of core obligations of the rights to health, water, food, and work

- Denial of equal access to health services on a non-discriminatory basis, especially for the most vulnerable: *de facto* discrimination, directly following from the dollarization of the health sector is the inability of people, with severely restricted access to foreign currency, to purchase life-saving medical treatment; the costs of transportation to health facilities resulting in these facilities being inaccessible.
- Denial of access to medicines: insufficient recurrent expenditure to ensure an adequate supply of medications (e.g., oxytocin for post-partum hemorrhage, depletion of ARVs resulting in the interruption of regular supplies; and depletion of TB drugs leading to multiple-drug-resistant strains of tuberculosis).
- Denial of access to safe water and adequate sanitation: cessation of water supply; willfully allowing outdated and damaged water supplies to go untreated; depletion of water treatment chemicals such as aluminum sulfate; failure to maintain the reticulated water systems; failure to repair or replace inoperable sewerage pipes.
- Denial of minimum essential food that is nutritionally adequate and safe: State activity resulting in prevention of access to food, such as the land seizures in 2000, which has led to sharp falls in agricultural production and food insecurity for millions; ZANU-PF blockage of humanitarian food aid resulting in needless deaths.

Severely underweight boy

A boy aged 16 months was admitted on 12 December 2008 with pneumonia. After antibiotic treatment, his chest infection had greatly improved, but he remains severely underweight. Inspection of his weight-for-age card revealed (the typical pattern of) growth faltering from eight months of age. Although he continues to be breast-fed, his mother described a diet inadequate in both quantity and quality. She reported giving him three meals a day, consisting largely of dilute porridge with little added protein or oil.

When asked about household food stocks she reported that the household of ten, with five children under the age of five, relies almost wholly on humanitarian food aid (bulgur wheat) as well as maize grain (three 50-kg sacks for most of this year) received from neighbors in exchange for one cow.

On further inquiry, PHR established that this household previously possessed three cattle, with only two now remaining for essential draft power (plowing). Sale of such precious assets reflects extreme household food insecurity.

- Failure to adopt and implement a national health workforce plan, which addresses issues such as: health information systems; health worker salaries; health worker human rights of association, assembly and expression; health worker occupational health and safety; and the skills drain.
- » **Violations of the obligation to respect the right to health, water, food, and work**
 - Government actions that contravene the standards set out in the rights to health, water,

food, and work: failure to ensure maintenance of the water and sanitation system leading to the outbreak of cholera; failure to ensure supply of water, electricity, sanitation, medical supplies, to hospitals, leading to shuttering of hospitals and lack of access to health care; the deliberate misrepresentation of information vital to health protection or treatment (e.g., the statistics of the cholera epidemic and the levels of malnutrition).



People wait in line to receive food aid.



An elderly villager searches for firewood.

» **Violations of the obligation to protect the rights to health, water, food, and work**

- › Follow from State failure to take all necessary measures to safeguard persons within the jurisdiction from infringements of the right to health by third parties:
 - › Exorbitant fees in the private health sector denying access to the services
 - › Failure to ensure that private medical practitioners have sufficient skill to treat HIV/AIDS patients.

» **Violations of the obligation to fulfill the rights to health, water, food, and work**

- › Follow from State failure to take all necessary steps to ensure the realization of the rights contained in articles 6, 11 and 12 of the ICESCR:

- › Insufficient expenditure or misallocation of public resources;
- › Failure to provide health care, including sexual and reproductive health services;
- › Failure to ensure non-discriminatory access to the underlying determinants of health, such as nutritiously safe food and safe drinking water, and basic sanitation;
- › Failure to reduce maternal mortality rates;
- › Failure to provide *directly* food in a quantity and quality that is sufficient to satisfy the dietary needs of people;
- › Failure to ensure safe working conditions for health workers;
- › Failure to protect the rights of association, movement and expression of health workers;
- › Failure to provide health workers with domestically competitive salaries;

- › Failure to ensure the appropriate training of health workers.

» Crimes against humanity

Crimes against humanity have been considered part of international customary law for over half a century.¹⁵⁹ The term originated in the 1907 Hague Convention preamble, which articulated the customary law of armed conflict. Between 1907 and the 1945 Nuremberg Charter,¹⁶⁰ the notion that international law encompassed humanitarian principles that existed beyond conventional law,¹⁶¹ gained widespread consensus.¹⁶² The 1945 Nuremberg Charter, article 6 (c) articulated the first definition of crimes against humanity. Article 6 (c) provides:

“Crimes against humanity: murder, extermination, enslavement, deportation, and other inhumane acts committed against civilian populations, before or during the war; or persecutions on political, racial or religious grounds in execution of or in connection with any crime within the jurisdiction of the Tribunal, whether or not in violation of the domestic law of the country where perpetrated.”

The International Military Tribunal for the Far East, followed upon the Nuremberg Charter, in article 5 (c) of its Charter. The statutes of the International Criminal Tribunal for the former Yugoslavia and the International Criminal Tribunal for Rwanda, include this category of crimes and contribute to developing and broadening the notion of crimes against humanity.¹⁶³ It is now a settled rule of international customary law that crimes against humanity do not need to be connected to international armed conflict and may not need to be connected to conflict at all.¹⁶⁴ The definitions contained

¹⁵⁹ Cherif Bassiouni M, Crimes Against Humanity, in Gutman R, Reiff D, and Dworking A (eds), Crimes of War: What the public should know, Crimes of War Project. <http://www.crimesofwar.org/> (accessed 10 Jan. 2009). Customary international law results from states following certain practices generally and consistently out of a sense of legal obligation.

¹⁶⁰ Charter of the International Military Tribunal for the Far East, 19 Jan. 1946, art. 5(c). <http://www.icwc.de/index.php?id=42&L=5> (accessed 9 Jan. 2009).

¹⁶¹ Conventional international law derives from international agreements and may take any form that the contracting parties agree upon http://topics.law.cornell.edu/wex/international_law (accessed 10 Jan. 2009).

¹⁶² Badar M, From the Nuremberg Charter to the Rome Statute: Defining the Elements of Crimes Against Humanity (2004) San Diego International Law Journal 5: 73-144.

¹⁶³ Id.

¹⁶⁴ Id.

in the statutes of both ad hoc tribunals influenced the definition of crimes against humanity contained in the statute of the International Criminal Court (ICC).

The ICC was established by the Rome Statute of the International Criminal Court (The Rome Treaty).¹⁶⁵ The Rome Treaty is an international treaty, binding only on those States which formally express their consent to be bound by its provisions. Although Zimbabwe is not currently a State party to the Rome Treaty, the U.N. Security Council has the authority to address international threats to peace and security and refer such matters to the ICC. It should be made clear that under customary international law, individuals in the Mugabe regime may be found guilty of crimes against humanity.

Article 7 of the Rome Treaty provides:

1. For the purpose of this Statute, *crime against humanity* means any of the following acts when committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack:

- e. Murder;
- f. Extermination;
- g. Enslavement;
- h. Deportation or forcible transfer of population;
- i. Imprisonment or other severe deprivation of physical liberty in violation of fundamental rules of international law;
- j. Torture;
- k. Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity;
- l. Persecution against any identifiable group or collectivity on political, racial, national, ethnic, cultural, religious, gender as defined in paragraph 3, or other grounds that are universally recognized as impermissible under international law, in connection with any act referred to in this paragraph or any crime within the jurisdiction of the Court;
- m. Enforced disappearance of persons;
- n. The crime of apartheid;

¹⁶⁵ Rome Statute of the International Criminal Court, adopted in Rome, Italy on 17 July 1998, [entered into force 1 Jul. 2002],

- o. Other inhumane acts of a similar character intentionally causing great suffering, or serious injury to body or to mental or physical health.

For the purposes of paragraph 1 of Article 7, an attack directed against any civilian population,¹⁶⁶ means a course of conduct involving the multiple commission of acts referred to in paragraph 1 against any civilian population, pursuant to or in furtherance of a State or organizational policy to commit such attack. Widespread refers to the number of victims. Systematic refers to thoroughly organized acts following a regular pattern on the basis of a common policy involving substantial public or private resources.

The findings of this report indicate that to establish a crime against humanity on the part of Robert Mugabe and other member of his government, one needs to rely on article 7(1)(k) of the Rome Treaty. The Elements of Crimes, one of the basic legal texts of the ICC, sets out the following five prerequisites:

1. The perpetrator inflicted great suffering, or serious injury to body or to mental or physical health, by means of an inhumane act.
2. Such act was of a character similar to any other act referred to in article 7, paragraph 1, of the Statute.
3. The perpetrator was aware of the factual circumstances that established the character of the act.
4. The conduct was committed as part of a widespread or systematic attack directed against a civilian population.
5. The perpetrator knew that the conduct was part of or intended the conduct to be part of a widespread or systematic attack directed against a civilian population.

The findings in this report provide prima facie evidence that may satisfy most, if not all, elements of crimes against humanity. Robert Mugabe and his regime have conducted several acts: willful disregard to an ongoing and geographically extensive cholera epidemic; systematic obstruction of humanitarian aid at all points of entry and in-country distribution; obstruction of access to emergency obstetric care;

degradation of all aspects of health systems leading to widespread collapse of health care capacity and closure of hospitals; sweeping and repeated campaigns of land seizures leading to economic collapse and population-wide nutritional diseases and malnutrition; and comprehensive disruption in supplies of medications leading to significant levels of human death.

Each of these acts has been inhumane in nature and character and has caused great suffering or serious injury to body or to mental or to physical health. Data regarding the collapse of the health system, the cholera epidemic, and the regression in vital health metrics have been collected by various U.N. agencies and are in the public domain. It is undeniable that Robert Mugabe and members of his government have actual and abundant knowledge of the broader context of these acts. And finally, the majority of the Zimbabwean population has been the focus of the acts.

The findings contained in this report show, at a minimum, violations of the rights to life, health, food, water, and work. When examined in the context of 28 years of massive and egregious human rights violations against the people of Zimbabwe under the rule of Robert Mugabe, they constitute added proof of the commission by the Mugabe regime of crimes against humanity.

¹⁶⁶ The term attack can in peacetime refer to state campaigns of aggression or assaults against civilian population.

RECOMMENDATIONS

» **Resolve the Political Impasse**

As PHR's report clearly reveals, there can be no adequate solution to the health crisis in Zimbabwe without a solution to the political crisis.

- The United Nations Security Council must ensure that the current political impasse in Zimbabwe is resolved expeditiously by calling on the Mugabe regime to accept the result of the 29 March election where MDC T gained a majority.
- Accordingly, and in the spirit of the Southern African Development Community agreement, the MDC should be allowed to assume its place in a government whose composition and ministerial allocations reflect the democratic will of the people of Zimbabwe as expressed in the March elections.
- The South African Government should facilitate this process.
- The US and other governments should press the Southern African Development Community member nations and other regional actors to end their support of Mugabe's regime and to call for a democratic political transition.
- The U.S. and other governments should maintain all targeted bilateral sanctions in place for Zimbabwe until Mugabe cedes power and a stable government is established.

» **Launch an Emergency Health Response**

The UN General Assembly, at its 2005 World Summit, has affirmed the principle of the Responsibility to Protect. At this summit, attended by over 170 member states, the member states acknowledged the necessity of intervening against the sovereignty of a State (under the UN Charter Chapter VII: Action with respect to threats to the peace, breaches of the peace, and acts of aggression) in order to protect the population of that State from state-sanctioned or state-permitted atrocities, including crimes against humanity.¹⁶⁷ It is relevant to note that the UN Security Council has already stated that, unchecked, the HIV/AIDS pandemic may pose a risk to international stability and security.

¹⁶⁷ 2005 World Summit, Sept. 14-16, 2005, 2005 World Summit Outcome, ¶ 139, U.N. Doc. A 60/L.1 (Sept. 20, 2005).

¹⁶⁸ The epidemics of HIV/AIDS, cholera and TB currently raging in Zimbabwe pose threats to international peace and security in the region and beyond.

Health services and essential aspects of public health infrastructure in Zimbabwe are now in a state of complete collapse. The policies and practices of the Mugabe regime precipitated the crisis, and the regime lacks the capacity, let alone the intent, to reverse it even with the support of the international agencies now providing emergency assistance. The Government has failed to engage in political and economic reforms necessary to enable health systems to recover. It has also obstructed the distribution of humanitarian aid. Only through the intervention of the international community can hospitals and clinics be reopened, supplies and drugs obtained, staff paid, and public health infrastructure be restored, so that the acute health care needs of the people of Zimbabwe can be met.

Accordingly, the government of Zimbabwe should yield control of its health services, water supply, sanitation, disease surveillance, Ministry of Health operations and other public health functions to a United Nations-designated agency or consortium. Such a mechanism would be equivalent to putting the health system into a receivership pursuant to the existence of a circumstance that meets the criteria for the Responsibility to Protect. This entity, taking full advantage of the human resources for health available in Zimbabwe (including administrative resources at the Ministry of Health), and generously supported by international donors, should assume all administrative responsibility for the operation of health services, water supply, sanitation and other public health functions until such time as a government capable of providing these services is in place. The entity would exercise all functions and powers of the Ministry of Health, regulatory agencies responsible for health functions, and agencies responsible for water supply, power and sanitation.

- The U.N. should convene an urgent conference of donors and relevant U.N. agencies to secure the resources needed to restore health

¹⁶⁸ UN Security Council's Resolution 1308: Stressing that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security and [f]urther recognizing that the HIV/AIDS pandemic is also exacerbated by conditions of violence and instability, which increase the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care.

services and public health infrastructure in Zimbabwe.

- › If the government of Zimbabwe refuses to yield such control, the U.N. Security Council, acting pursuant to its authority under Article 39 of the Charter, should enact a resolution compelling the Government of Zimbabwe to do so.
- › The incoming Obama Administration, for its part, should prepare a comprehensive package of humanitarian and reconstruction relief to be implemented as soon as political stability is restored.

» **Refer the situation in Zimbabwe to the International Criminal Court for Crimes Against Humanity**

There is no doubt that egregious, widespread, and systematic violations of human rights have occurred under the Mugabe-led ZANU-PF regime and that death and serious injury to the physical and mental health of Zimbabweans continue unabated. To date, international criminal prosecution has not addressed crimes against humanity in the context of willful and state-sponsored actions that lead to massive loss of life resulting from, for example, failures to respond to epidemics, active obstruction of humanitarian aid, or the deliberate destruction of health systems.

Although Zimbabwe is not a party to the Rome Statute of the International Criminal Court, Article 13(b) of the Statute enables the ICC to exercise its jurisdiction with respect to crimes against humanity where the matter is referred to the Prosecutor by the UN Security Council acting under Chapter VII of the UN Charter.

The U.N. Security Council, acting pursuant to its authority under Article 41 of the Charter, should enact a resolution referring the crisis in Zimbabwe to the International Criminal Court for investigation and to begin the process of compiling documentary and other evidence that would support the charge of crimes against humanity.

» **Convene an Emergency summit on HIV/AIDS, Tuberculosis and other infectious disease**

Zimbabwe's severe HIV/AIDS epidemic is the focus of multiple donor programs including the U.S. PEPFAR program, the US Centers for Disease Control, and the Global Fund to Fight AIDS, TB and Malaria. PHR found that the collapse of the healthcare system has profoundly impacted HIV/AIDS programs and drug-delivery systems in Zimbabwe. The acute need to prioritize cholera treatment over other infectious diseases in the health care system has also been a new, acute threat to inpatient AIDS care.

For HIV/AIDS the most severe threat has been the interruption of regular supplies of antiretroviral drugs. Given the grave risk to the infected populations, and the urgent need to prevent the generation of multi-drug resistant strains of the virus, the Obama Administration should consider this crisis as a first test-case of the collapse of a health system in a country that is a recipient of emergency AIDS and TB prevention and treatment programs.

The Obama Administration, together with the GFATM and other donors, should convene an emergency summit to coordinate action by PEPFAR and the Global Fund to fight AIDS, Malaria, and Tuberculosis to address the current acute shortfalls in AIDS and Tuberculosis treatment and care.

» **Prevent further nutritional deterioration and ensure household food security**

To prevent further deterioration of nutritional status, especially among the most vulnerable (young children, mothers, HIV/AIDS, and TB sufferers), the international community needs urgently to strengthen ongoing humanitarian efforts in Zimbabwe. Specifically, donor governments should fully fund the 2009 Consolidated Appeal (CAP) for Zimbabwe of \$550 million USD. Importantly, donor governments must ensure non-interference by the current governing regime in obstructing, diverting, politicizing, or looting such humanitarian aid. The United States as well as other donor governments and private voluntary organizations should increase donations of appropriate foods to the responsible multilateral agencies, such as WFP, to meet the impending shortfall in the coming three to six months.



Physicians for Human Rights (PHR)
2 Arrow St. Suite 301
Cambridge MA 02138
T: 617.301.4200
F: 617.301.4250
physiciansforhumanrights.org