The Southern African Liaison Office

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THE IMPACT OF THE ZIMBABWE CRISIS ON PUBLIC HEALTH IN ZIMBABWE, SOUTH AFRICA AND SADC

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Note: This is an updated version of a SALO paper first published in 2007 by the Conflict and Governance Facility of the EU and the National Treasury of South Africa (CAGE)

Executive Summary

1) The primary threats to public health in Southern Africa are what the World Health Organisation (WHO) calls "diseases of poverty": infectious diseases for which poverty, malnutrition and poor living conditions are the major risk factors.

Malaria, tuberculosis (TB) and HIV/AIDS are the three biggest threats to public health in the SADC region. The other infectious diseases most strongly associated with poverty are measles, pneumonia, and diarrheal diseases (such as cholera and dysentery).

These diseases feed into a vicious cycle that worsens and perpetuates poverty. They are not only a threat to human security; unchecked, they can eventually become threats to national and regional security.

Mental illness, which has become increasingly widespread in Zimbabwe, will tend to further exacerbate the impact of these diseases.

2) Interlinked factors which promote the spread of infectious diseases and mental illnesses include:

- Poverty and unemployment
- Malnutrition
- Poor living conditions: overcrowding, lack of sanitation and clean water
- Inadequate and increasingly inaccessible healthcare
- Uncontrolled migration in search of means of survival.

3) The actions of the government of Zimbabwe have been exacerbating all these factors which promote the spread of infectious diseases in Zimbabwe and the region, as well as mental illness.

- Sharp increase in poverty and unemployment
- Rising malnutrition due to poverty, food shortages and politically directed food aid distribution
- Deteriorating living conditions which have been exacerbated by the inability of local government to provide basic services, and by Operation Murambatsvina
- Increasingly inadequate health care and/or exclusion from health care due to a lack of drugs and essential equipment, high consultation fees, failing infrastructure, loss of skilled personnel, and strikes by doctors.

Results of these trends:

- a steep increase in poverty-related infectious diseases among Zimbabweans: malaria, TB, HIV/AIDS, cholera
- extremely high prevalence of mental illness among Zimbabweans in Zimbabwe
- a sharp increase in uncontrolled migration into neighbouring states in search of means of survival
- growth in the sex trade.

4) Factors in SA and the region that further promote the spread and impact of infectious poverty-related diseases

- Refusal to acknowledge the extent of the crisis in Zimbabwe for political reasons, and extreme reluctance to grant refugee status to asylum seekers
- The tendency to exclude illegal migrants and even registered refugees from health care.

5) Effects on South Africa and the region

There are four main areas of concern:

- the spread of infectious diseases into the populations of neighbouring states via illegal migrants and asylum seekers from Zimbabwe, who are generally marginalised and denied protection
- the promotion of drug-resistant strains of TB, malaria and HIV/Aids due to disrupted or inadequate treatment in Zimbabwe, and exclusion from treatment in neighbouring states
- increasing strain on the budgets, infrastructure and personnel of public health services and other government departments in neighbouring states
- the loss of regional expertise and research capacity into diseases which may affect everyone in the region.

6) Conclusions and comments

The information presented shows conclusively that the actions of the government of Zimbabwe pose a serious threat to the health of its own citizens, and that this threat is being exported to other countries in the region as well.

It would obviously be highly dangerous to lobby in a manner which could in any way be misinterpreted – deliberately or not - as blaming illegal migrants from Zimbabwe for spreading deadly diseases in the region.

It seems it might be better to focus on the fact that the *exclusion of illegal migrants and refugees from health care* poses a serious potential threat to

public health in the region, rather than the migrants and refugees themselves.

Perhaps it could be argued that unless policies are adopted by all institutions concerned to ensure that everyone has access to basic health care, including illegal migrants and refugees, the threat to public health in the region that is currently being generated by the Zimbabwean government will only increase.

A note on research methodology

This paper was intended to serve as a catalyst for discussion within a group of experts in the field of public health in the SADC region. As such, it is based on a review and analysis of secondary sources. Dr Peter Barron, Specialist Technical Advisor to the Health Systems Trust, who has 25 years of experience working in and alongside the public health sector with a focus on primary health care, commented in detail on the first draft of the paper, and his comments were incorporated into the final draft in preparation for presentation to the wider discussion group.

The impact of the Zimbabwe crisis on public health in Zimbabwe, South Africa and SADC

The primary threats to public health in Southern Africa

The primary threats to public health in Southern Africa are what the World Health Organisation (WHO) calls "diseases of poverty": infectious diseases for which poverty, malnutrition and poor living conditions are the major risk factors. Mental illnesses tend to exacerbate the impact of these factors.

Malaria, tuberculosis (TB) and HIV/AIDS are the three biggest threats to public health in the SADC region. The other infectious diseases most strongly associated with poverty are measles, pneumonia, and diarrhoeal diseases (such as cholera and dystentery). There has also been a sharp increase in the incidence of mental illnesses among Zimbabweans, particularly since Operation Murambatsvina in 2005.

Poverty-related infectious diseases feed into a vicious cycle that worsens and perpetuates poverty. They are not only a threat to human security; unchecked, they can eventually become threats to national and regional security.

Mental illness will tend to further exacerbate the impact of these diseases and social problems; by 2006, according to a World Health Organisation (WHO) consultant based in Harare, around 40% of Zimbabweans surveyed in high-density areas and at HIV clinics were suffering from mental illnesses.

Interlinked factors which promote the spread of infectious diseases include:

- Poverty and unemployment
- Malnutrition
- Poor living conditions: overcrowding, lack of sanitation and clean water
- Inadequate and increasingly inaccessible healthcare
- Uncontrolled migration in search of means of survival.

Impact of the Zimbabwe crisis

The political and economic crisis that has prevailed in Zimbabwe over the last decade has exacerbated all these factors which promote the spread of infectious diseases in Zimbabwe and the region. But many would argue that the roots of the crisis lie not merely in the repressive and destructive policies and practices followed by the ruling party in that country since the challenge to its hold on power by the Movement for Democratic Change, but in the Economic Structural Adjustment Policy of the late 80's.

Increased poverty and unemployment

By mid-2006, the economy of Zimbabwe had shrunk by 40%. A decade ago, three Zimbabwean dollars were worth one U.S. dollar. The government now puts the rate at more than 100,000 Zimbabwean dollars to the U.S. dollar, and the blackmarket rate is roughly double that.

Inflation is at 1 043%. There are severe shortages of food, petrol, and imports of every description due to a lack of foreign currency. Unemployment is estimated at 80 %. In mid 2006, salary increases for teachers and soldiers still left them below the country's official poverty line.

Hunger, malnutrition and extreme poverty has become commonplace in many areas. The UN is distributing emergency food aid to about a quarter of the population, and states that many people across the country were trying to survive on one meal or less a day.

Operation Murambatsvina, carried out in mid-2005, was described by the Zimbabwe government as an "urban renewal programme" aimed at clearing slums which had become health hazards. It was condemned by the UN as a "nationwide demolition and eviction campaign" which resulted in the destruction of the homes and small businesses of hundreds of thousands of very poor people. UN envoy Anna Tibaijuka said the action violated human rights and may also have been in breach of international law. She said at least 700 000 people were left homeless and without a means of earning a living, while another 2.4 million were also affected. The Harare administration estimated that it would need Z$3 trillion to rebuild houses, but later estimates by government civil engineers put the costs at $5.5 trillion.

In August 2005, a survey of just under 82 000 people affected by Murambatsvina in 26 wards of Harare's high-density suburbs was conducted by Action Aid International together with Combined Harare Residents' Association (CHRA). More than 90% of the people living in these suburbs were adversely affected. No less than 79% of interviewed households reported that they had lost their sources of income; about 73% had been engaged in informal trading prior to the operations. The main sources of livelihood that were destroyed were tuck shop business (98%), flea market (11 %), fruit and vegetable vending (17 %), offering accommodation (18 %), cross-border trading (6 %) and petty trade such as sale of firewood (5

%).

The survey found that the education of children had been severely affected, with many children no longer attending school. About 60 % of households said they had become food insecure as a consequence of the operation, and 75% reported losing shelter. The survey noted that 37 % of the interviewed homesteads acknowledged that women and children had become more vulnerable to abuse as a consequence of the operation.

By December 2005, many of those affected by Murambatsvina in Bulawayo were still living in informal settlements and had no prospects of ever obtaining alternative housing because government requires a deposit of Z$600,000 to Z$7 million (depending on the size of the house) as well as proof of formal employment and a specified salary. A Human Rights Watch report, *Evicted and Forsaken*, said the vast majority of the internally displaced would not meet the criteria for ownership of the new houses, and noted that the number being built was negligible compared to the hundreds of thousands of people rendered homeless by the evictions.

In late 2005, ZimOnline was told by a senior health official who did not want to be named that government has diverted Z$250 billion from the country's already deeply indebted public health sector to finance a programme to construct houses to replace those destroyed during Murambatsvina.

Malnutrition due to food shortages and politically directed food aid distribution

By March 2006, Zimbabwe had been experiencing severe food shortages for around four years. The government blames drought for the food shortages , but Michael Huggins, the UN's World Food Programme spokesperson for Southern Africa, believes these shortages of food are the result of the failure by the economy to attract investment in infrastructure as well as the disruption of the agricultural sector through the government's land reform programme. This resulted in a drastic reduction in food production, and many of the beneficiaries of land reform have received no support in terms of loans or training and have not been able to make the land productive.

By June 2006, according to John Makumbe, a senior political science lecturer at the University of Zimbabwe, most food had become unaffordable to Zimbabweans. On 22/07/2006 it was reported that the price of bread had gone up by more than 30%, sending it way beyond the reach of nearly everyone. A loaf now costs Z$200,000 or more. A pint of milk now costs the same.

It is difficult to obtain information on crop production in Zimbabwe as government treats this information as secret. Early in 2006, Agriculture Minister Joseph Made warned foreign organizations against doing crop assessments, calling this "illegal". In July 2006, the World Food Program reported that Zimbabwe was the only country among 10 Southern African nations that did not present data on food security at an assessment conference in Johannesburg in June.

Government recently insisted that the country will soon no longer need food aid this year because it would harvest about 1.8 million tonnes of the staple maize, enough for national annual consumption. But Huggins has stated that at least 4,3-million people would continue to need food aid until the next harvests in May 2007, and that many people across the country were surviving on one meal or less a day.

In June 2006, the chair of the Public Service, Labour and Social Welfare parliamentary portfolio committee tabled a report into the drought relief distribution programme in the House of Assembly. Mabel Mawere, a Zanu-PF MP, said distribution delays had left some people on the brink of starvation, especially in what she called "the hardest-hit areas of Masvingo and Matabeleland South", but she told the UN's IRIN[1] that it was her understanding that the entire country was similarly affected. She said maize was procured by the government from national production or from South Africa, but that it could take *four to six months* for it to be transported to those in need because of a lack of fuel.

In late July 2006, the Consortium for Southern Africa Food Security Emergency (C-SAFE) produced a report compiled from data collated in April when most households would have finished harvesting. The consortium consists of a number of NGOs involved in relief work including World Vision, CARE, Catholic Relief Services and the Adventist Development and Relief Agency. This was the first independent survey on Zimbabwe's harvests, and aimed to assess the food situation in eight rural districts across the country.

The report describes the food situation in Zimbabwe's countryside as "grave". Because of extremely high unemployment levels in rural areas many households were resorting to brewing illicit beer which they sell to raise money to buy food. The report reads in part:

> "Most of the households reported cereal stocks below 51 kg. Households usually require an average of 78.7 kg of cereals per month. The worst districts are Kadoma, Murehwa, Matobo and Chirumhanzu where all the respondents reported stocks below 51kg. This comes soon after harvests and shows that harvests for

[1] Integrated Regional Information Networks, commonly known as IRIN, is a project of the United Nations Office for the Coordination of Humanitarian Affairs.

> households were poor. This coupled with cereal shortages gives a grave picture of the food security situation in the surveyed districts."

With regard to government-administered food aid, there have been persistent allegations that communities considered to be in opposition to Zanu-PF are starved of aid, and that people who cannot produce Zanu-PF membership cards have been denied food aid. In August 2002, when commenting on the food shortages, senior ZANU PF politician Didymus Mutasa said:

> "We would be better off with only six million people, with our own people who supported the liberation struggle."

Food shortages have continued to plague Zimbabwe, and the country currently faces a severe famine. It is estimated that 2, 8 million Zimbabweans are in need of food aid because of the severe drought that has affected the country[2]. The forecast for the 2010 maize harvest in Zimbabwe has been set at 435 000 tonnes which falls way short of the annual consumption of 1, 6 million tonnes[3]. Peter Chitambara of the Labor and Economic Research Development Institute of Zimbabwe notes that the fact that in the urban areas incomes are below the poverty line of US $ 524, 00 a month means that adequate nutrition is therefore unavailable for many[4]. Thus both rural and urban families are in need of food aid[5].

Deteriorating living conditions

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[2] Hurd, E. 2010. "Millions in Zimbabwe Face Hunger Crisis". **Sky News.** http://news.sky.com/skynews/Home/World-News/Zimbabwe-Millions-Face-New-Hunger-Crisis-And-International-Red-Cross-Launches-Appeal-For Funding/Article/201003215571296?lpos=World_News_Top_Stories_Header_2&lid=ARTICLE_1 (Accessed 14/3/10)

[3] **CBC News**. 2010. "Failed harvest deepens Zimbabwe food crisis". http://www.cbc.ca/world/story/2010/03/11/zimbabwe-food-crisis.html (Accessed 14/3/10)

[4] Nyaira,S., Moyo, B. and Rusere, P. 2010. "Red Cross Says 2,2 Million Zimbabweans Need Food Aid as Poor Harvest Looms". **VOA News**.http://www1.voanews.com/zimbabwe/news/food-agriculture/Experts-Paint-Grim-Picture-Of-Zimbabwe-Food-Situation-11Mar10-87366907.html (Accessed 14/3/10)

[5] *Ibid*

Local governments are starved of funds and fuel and have difficulty in providing services. At the end of 2005, IRIN reported that the residents of many towns and cities were living with uncollected rubbish, broken sewer pipes, electricity cuts, and water shortages. Local governments are not able to raise funds on their own.

> "In Harare uncollected rubbish has begun to pile up in the central business district. Environmentalists and health experts have warned that the city may be sitting on a disease time bomb, as raw sewerage continues to spill into Lake Chivero, the capital's main source of water.
>
> "Bulawayo, Zimbabwe's second city, has been facing acute water shortages due to successive droughts, but mayor Japhet Ndabeni-Ncube's council does not have the authority to borrow funds, making it difficult to maintain minimal services. Francis Dhlakama, the mayor of Chegutu, 140 km southwest of Harare, said his town was "as good as dead". "While we need 30,000 megalitres of water a day, we are able to purify only 12,000 megalitres a day ... [and] some of it is lost through leakages," he explained. In smaller urban centres like Bindura and Shamva, north of Harare, ongoing fuel shortages have forced councils to collect refuse using ox-drawn carts hired from nearby farmers."

According to the WHO, clean water is fundamental to public health:

> "Prevention of the health effects of water contamination is vital to a society's well being due to the fact that access to clean and safe water is a cornerstone of public health and increases life expectancy if sanitation methods are improved."

In early 2006, ZimOnline reported that Mabvuku, along with other poor suburbs in Harare, has been experiencing serious water shortages for months because of frequent breakdowns of the city's ageing water supply system and mismanagement by the city council which results in water cuts. Residents have had to rely increasingly on unprotected and therefore easily contaminated wells for their water, and have adopted measures such as harvesting rainwater from roofs.

Apart from being erratic, Harare's water has been condemned as unfit for human consumption in a WHO report published in 2005. The state-appointed commission running the affairs of Harare blamed the Zimbabwe National Water Authority (ZINWA), alleging that it had failed to treat water to acceptable standards. ZINWA has repeatedly and publicly denied these accusations, and insists that the failure of the Harare commission to pay for water on time has resulted in difficulties in obtaining sufficient water treatment chemicals.

The aftermath of Operation Murambatsvina

Hundreds of thousands of people who were already poor lost their homes and livelihoods, and became even more impoverished. According to IRIN, in May 2006, New Hope Zimbabwe (NHZ), a local NGO providing community assistance, said it recorded 500 cases of severe malnutrition every week in Epworth, one of the capital's poorest suburbs. This was one of the areas worst affected by Operation Murambatsvina.

In March 2006, Mark Heywood of the Treatment Action Campaign noted that this dispersal of people due to Operation Murambatsvina had disrupted Aids treatment efforts. There is no doubt that this applies to TB treatment as well.

A sharp increase in the incidence of mental illness

In August 2007, Dickson Chibanda, a consultant with the World Health Organisation and Ministry of Health in Harare, stated that the latest data indicated that about 40 percent of Zimbabweans suffer from mental disorders. In part he ascribed this exceptionally high rate to worsening economic hardship and the effects of Operation Murambatsvina, "which caused a lot of mental disorders to those who were forced out of their homes." According to Chibanda, a survey of Harare's low-income suburbs in 2006 showed a 36% prevalence of mental illness, while a similar survey of HIV patients attending the opportunistic infection clinic at Harare Central Hospital indicated that 44% were suffering from mental illnesses.[6]

Inadequate and increasingly inaccessible health care

Zimbabwe's spectacular success in improving health care and education in the early 1980s was widely admired. Life expectancy at birth rose by nearly a decade from 54.9 years in 1980 to 63 years in 1988. Childhood immunisation for diphtheria, pertussis and tetanus (DPT) increased to 75% coverage in 1986, 80% in 1994 and 81% in 1999, compared to an average of 32%, 51% and 48% respectively for Sub-Saharan Africa as a whole. The improvements in primary healthcare ensured that between 1980 and 1998 infant mortality rates fell by **80%** to 49 deaths per thousand by 1988.

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[6] 40 Percent of Zimbabweans Mentally Ill. ZimOnline, 27/08/07. Prince Nyathi. http://www.reliefweb.int/rw/RWB.NSF/db900SID/SHES-76GRYJ?OpenDocument (Accessed 28/08/2007)

By mid-2006, all these gains had been wiped out, and health care had become increasingly inaccessible to all but the most wealthy. As a result of extremely low pay and impossible working conditions, many nurses and doctors and other workers in the health sector such as ambulance drivers had left the country to work elsewhere. There is a lack of equipment of every description, from drips to spare parts for ambulances. Many hospitals and clinics have almost no drugs.

In June 2006 *The Herald* reported that there was a danger that non-sterile implements were being used in at least three hospitals because a coal shortage meant that autoclaving machines were not functioning. *The Herald* said that the city health department needed at least Z$22-billion Zimbabwe every month to purchase drugs and maintain its clinics and hospitals, but treasury is not releasing the money "despite requests to prioritise health."

Despite an HIV positive rate of at least 20%, only 20 000 people were receiving government-administered anti-retrovirals (ARVs) in 2006. In May 2006*, The Herald* newspaper reported that the parastatal, National Pharmaceutical Company (Natpharm), which supplies drugs to all state-run hospitals and clinics, had less than a month's supply of ARVs in stock because of the lack of foreign currency to purchase them. The MD of Natpharm told a Parliamentary portfolio committee on health and child welfare that the Reserve Bank of Zimbabwe had allocated just $106 000 to the company between January and March; Natpharm had requested $7,4-million.

In April 2006 *The Herald* reported that the Zimbabwean government had announced its new health fee structure: general practitioners' consultation fees rose by 100% to Z$5.8m, from $2.9m. Fees at public hospitals were increased by more than 2 700%. Consultation fees in the casualty departments in central hospitals had jumped from Z$300 to Z$1m while provincial and general hospitals would charge Z$800 000. District and mission hospitals would now charge Z$400 000. *The* Herald said people suffering from tuberculosis, leprosy, Aids, and those aged 65 and above would be exempted from paying.

These increases came shortly after a 100% fee hike by private doctors, clinics and hospitals.

In May 2006 *The Washington Post* published an article on health care in Zimbabwe.

> "Elopy Sibanda, a physician, says that nearly every day he receives test results labeled "withheld until payment is made." Most of his poor patients have stopped coming for appointments. For those who do come, Sibanda said he must ask bluntly about their means before embarking on long-term treatments. The result, he said, is a two-tiered medical system reminiscent of the days of white rule before Zimbabwe's independence in 1980.

> "They're creating a health care apartheid," Sibanda said. "We're no longer looking at the colour of the people. We're looking at the fatness of the wallets." Combined with rampant HIV, the failing health system has contributed to a falling life expectancy that has become the shortest in the world. The World Health Organization reported in April that the average Zimbabwean man will die by 37 and the average woman by 34."

A few months later, in July 2006, medical aid tariffs had gone up by 85 and there was a further round of increases at clinics: consultation fees rose to Z$800 000, while maternity fees had shot up to about Z$11m from Z$7m.

In mid-2006 Zimbabwean intern doctors went on strike again at the four biggest hospitals in Zimbabwe, demanding better pay and an improvement in the supply of essential medicines and equipment in public hospitals. They stated that they were tired of watching patients die of otherwise treatable diseases simply because there are no medicines. Patients needing urgent treatment for HIV/Aids related symptoms were being turned away by nurses.

Chimbari *et al* (2008)[7] observe that a large number of health professionals have left Zimbabwe in search of better opportunities in terms of greater remuneration and improved working conditions. Chimbari *et al* argue that this mass exodus of health professionals has drastically weakened the public health sector in Zimbabwe. It is noted that: "[w]ithin the SADC region, South Africa was most often mentioned as the country most preferred by staff intending to emigrate, followed by Botswana and Namibia."[8] The most pressing reasons for leaving Zimbabwe given by the health service workers were: "Zimbabwe's poor economic performance, poverty level wages, unsupportive management and insufficient social recognition of their work."[9]

The most adverse effect of the migration of health service workers is that movement is not only limited to that " from lower to higher levels of the public sector or from public to private institutions within the country, or of high skills personnel outside the country" - even the low-level staff are

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[7] Chimbari MJ, Madhina D, Nyamangara F, Mtandwa H, Damba V . 2008. 'Retention incentives for health workers in Zimbabwe,' *EQUINET Discussion Paper Series 65*. NUST/ UNAM, U Limpopo, ECSA-HC, EQUINET: Harare:

[8] Chimbari *et al* . 2008. 'Retention incentives for health workers in Zimbabwe,', p.24

[9] *Ibid*, p.10

[10] *Ibid,* p.31

[11] SADC. http://www.sadc.int/index/browse/page/453

leaving for other countries within and beyond the region[10]. This has crippled the public health system in Zimbabwe and is one of the major reasons behind the failure to contain 2008-9 cholera epidemic.

The dire state of Zimbabwe's health system is without a doubt a matter for regional concern. This led to SADC initiating the Zimbabwe Humanitarian & Development Assistance Framework (ZHDAF) in "recognition of the challenges facing Zimbabwe especially in meeting the country's food, water, health and other social needs, SADC Member States have responded by mobilising resources to address these challenges."[11]

The results of these trends

These trends have resulted in a resurgence of infectious diseases in Zimbabwe, a sharp increase in uncontrolled migration into neighbouring states, and a growth in the sex trade.

In May 2006, Blessing Chebundo, chair of the parliamentary portfolio committee on health and child welfare, told IRIN that the failure of disease control mirrored the rot in the entire public healthcare system.

> *"The problem at disease control has been growing with the crisis since 2000. Every year we remind the government about the need to replenish the health sector, but the usual excuses are budgetary constraints, and promises of reforms that never work out or pay. The problem is with government, not the ministry or an isolated department."*

Malaria

The malaria season begins with the onset of the rains in October and ends in May. The major malaria problem areas are in the southeastern Lowveld, including Chiredzi and Beitbridge, the Midlands, and areas along the Zambezi Valley in the north. The prevalence of bodies of water make Hwange, Binga, the Victoria Falls, Gokwe, Sanyati, Kariba and Bindura some of the highest risk areas.

In late 2003, Stanley Midzi, director of the Directorate of Disease Prevention and Control told IRIN that there had been a "disturbing increase" in deaths

due to malaria after nearly 790 people had died. He believed the situation warranted a massive anti-malaria spraying exercise, but expressed concern about the lack of funds and fuel to carry out operations of this kind. It was hoped that UN funds made available to Zimbabwe would be sufficient to deal with the developing emergency.

Dr Andrew Jamieson, the medical director of SAA-Netcare Travel Clinics stated that this situation posed "a direct threat" to South Africa because many of the major malaria areas in Zimbabwe are very close to South Africa's northern borders. He warned that in the absence of effective and timeous treatment increasing numbers of Zimbabweans would become infected with the malaria parasite and it would spread across the border.

By 2004, the Ministry of Health and Child Welfare estimated that malaria had become the primary reason for hospital admission and the second most frequently treated disease for outpatients. Africa Fighting Malaria, a health NGO, found that because the malaria control program has been starved of funds it had not been able to carry out even the most basic malaria control activities:

> "(I)n 2004 only 3.4% of the structures that were targeted for spraying were actually sprayed. The malaria control teams not only lacked insecticides, but also couldn't obtain the fuel that they required to drive into the malarial areas. The result of this lack of control has been a sharp rise in malaria cases, possibly in excess of 2 million cases in 2004, five times higher than the low of 400 000 cases in 1992 . (…)
>
> "(M)any of the experienced and qualified malaria control staff have abandoned the government's malaria control program in recent years, leaving a vacuum where there once was a highly competent and organised team. Replacing that expertise has not been easy and has undoubtedly compromised malaria control. The long-term prospects for malaria control in the country are also unfavourable, even if peace, stability and democracy return. "

Tuberculosis (TB)

TB is curable, but this infection remains a major cause of death in poor communities because of poor nutrition and sanitation, a lack of information and insufficient access to care and drugs. In Southern Africa and elsewhere it has become the most common opportunistic infection in people living with HIV/AIDS. High HIV prevalence rates along with increasing poverty means that TB is becoming an ever more serious health concern.

In early 2002 the WHO stated that Zimbabwe had six times more cases of tuberculosis than it did 20 years ago: the incidence of the disease had shot up from 60 per 100 000 people in 1981 to 384 per 100 000.

In late 2004, the WHO found that there were 462 new cases for every 100 000 people per year, a seven-fold increase since 1982.

The southern province of Matabeleland South has been particularly severely affected; the Ministry of Health and Child Welfare's Nicholas Sizaba reported in 2004 that the number of cases had risen to 3,000 from 2,000 in previous years.

In mid-2006, *The Herald* reported that acting director of health services Stanley Mungofa said anti-TB drugs had run out at public clinics and hospitals in Harare. Requests for money to purchase the medicine were not being heeded by the Treasury.

Disruptions to treatment programmes encourage the development of drug-resistant strains of tuberculosis, which have reportedly been detected in Zimbabwe.

HIV/AIDS

In 2002, the Zimbabwe government declared AIDS a national emergency, which allowed it to import cheaper, generic versions of AIDS medicines and improve access to treatment. There was rare good news provided by a UN-commissioned survey released in late 2005: over two years, the percentage of those infected between the ages of 15 and 49 fell by almost 5% to 20.1%.

Despite this, Zimbabwe remains severely affected by the disease, and very few people receive ARVs.

In late 2005, the WHO found that only 15 000 Zimbabweans were receiving ARVs, and that in a four-month period the cost of a monthly course of the drugs rose from Z$200 000 (US$3) to Z$1.2m (US$20). Although the government licensed local firms to manufacture generic Aids drugs, acute shortages of hard currency have stopped imports of raw materials and held back a government programme to treat 55 000 patients through public health services.

In October 2005, *The Herald* reported that an emergency meeting had been called by the government to discuss the fact that ARV stocks at about 48 public health centres across the country were not expected to last until December. Angeline Chiwatani, spokesperson for Network for HIV-positive Women in Zimbabwe, told AFP that many people were "just waiting to die because they can't get ARVs,".

> "Because of lack of foreign currency most hospitals have run out of ARVs and it's a dangerous situation. We are advising people not to start taking ARVs because there is a risk of drug resistance if they take the drugs and later stop because the drugs are no longer available."

In May 2006, Zimbabwe officials again announced that they had only a few weeks' supply of ARVs left for the AIDS patients who receive them as part of a government health program.

According to the *Washington Post*, health workers said that many AIDS patients had already stopped taking the medication because of high costs, causing risks not only for those patients but creating ideal conditions for the emergence of drug-resistant strains of HIV.

Cholera

Cholera, a highly infectious disease which causes violent diarrhoea and vomiting, spreads quickly in the rainy season especially in places where public sanitation systems are poor. Babies and anyone who is very weak can succumb to this disease if they do not receive appropriate treatment.

At the end of 2005, IRIN reported that there had been at least 250 reported cases of cholera during that rainy season alone. A few months later (in February 2006), *The Herald* reported that there had been a serious increase in cases of the disease with at least 14 fatalities. Health Minister David Parirenyatwa advised Zimbabweans not to shake hands and to "be careful when buying fruit and fish": it was believed that three of the dead had become ill after eating fish confiscated from illegal vendors and then sold by the police.

In May 2006, IRIN reported that another outbreak of cholera had claimed 15 lives and infected at least 45 people in the northeastern town of Guruve, 150km from Harare. A senior disease control officer told IRIN the numbers affected could be much higher, as health teams have been unable to cover the more remote parts of the district.

Health Minister Dr David Parirenyatwa admitted that foreign currency shortages, fuel and transport problems, and an exodus of specialist staff meant his ministry faced huge challenges in running an effective disease control unit.

> "The rate at which the diseases have been recurring is proof that we are failing in total epidemic control. A lot of work needs to done in rebuilding the unit, but we are not sure if we are going to be able to attract and retain highly qualified staff."

In July 2006, contradicting government claims that cholera was no longer an issue, Douglas Gwatihdzo, chairperson of the Zimbabwean Association for Doctors for Human Rights, said the country was far from seeing the end of the outbreak due to filthy living conditions: "The city has numerous heaps of garbage which gets washed into the water when it rains." IRIN reported that the Harare city council was still not managing to collect heaps of garbage and provide clean drinking water, forcing some residents to dig wells

and get water from open streams, exposing them to water-borne diseases. The city currently has 14 refuse collection trucks as opposed to the 90 required.

The situation in Zimbabwe eventually culminated in the 2008-9 cholera outbreak. The World Health Organization (WHO) termed the cholera outbreak in Zimbabwe "one of the world's largest ever recorded"[12]. The cholera outbreak resulted in over 3 100 deaths and over 60 000 infections[13]. Dr Heymann the WHO's Assistant Director - General for Health Security and Enviroment Cluster stated at the time of the outbreak that:

> "The challenge is not just in Harare, but in remote, hard-to-access parts of the country where the effective implementation of control measures to contain Zimbabwe's cholera epidemic is very difficult."[14]

Dr Heymann went on to say:

> "In addition to the issue of staff shortages, there is a need for increased awareness about how to treat cholera, filling the gaps in medical supplies, providing reliable logistics support and capacity to deliver supplies, and increasing access to health services and safe water supply in remote areas where nongovernmental organizations are not operating. Combined, these factors present a major challenge to bringing this outbreak quickly under control."[15]

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[12] **WHO.** 2010. "Global, national efforts must be urgently intensified to control Zimbabwe cholera outbreak".http://www.who.int/mediacentre/news/releases/2009/cholera_zim_20090130/en/index.html (Accessed 14/3/10)

[13] *Ibid*

[14] *Ibid*

[15] **WHO.** 2010. "Global, national efforts must be urgently intensified to control Zimbabwe choleraoutbreak".http://www.who.int/mediacentre/news/releases/2009/cholera_zim_20090130/en/index.html (Accessed 14/3/10)

The cholera outbreak was also adversely affected by the inconsistent United Nations' (UN) response to the crisis[16]. The director of the UN's Office for the Coordination of Humanitarian Affairs (OCHA) in Zimbabwe was unable to reach mutual consensus on the issue of the cholera outbreak with the office of UN country director of Zimbabwe. The two institutions could not agree on whether the cholera outbreak was an epidemic or not. The head of the OCHA initially warned of a 'catastrophic outbreak' if measures were not implemented to counter the disease but his warning was 'stifled' by the country director[17]. The UN country director was viewed as sympathetic to the ZANU government and allegedly decided to be diplomatic in the matter by not declaring a cholera crisis which would have discredited the ZANU government[18]. The logic behind this is articulated by a UN official in *Foreign Policy* (2010):

> "The U.N. has to work with the government. Clearly, we work in a lot of countries where the government can make it very challenging. But should we say forget it? Or stay and try to help?...To be the resident coordinator in some of these countries is not an easy task; you have to deal with the consequences of the actions of those regimes, but in a way that those regimes don't take for granted that you'll be there to clean up."

The lack of consensus and co-operation between the OCHA and UN country director's office adversely affected attempts to deal with the

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[16] Dickinson, E. 2010. "Case Raises Questions About U.N.'s Role in Zimbabwe". **Foreign Policy**. http://www.foreignpolicy.com/articles/2010/02/22/did_the_un_cover_up_a_cholera_outbreak_for_robert_mugabe?page=0,0 (Accessed 14/3/10)

[17] *Ibid*

[18] *Ibid*

cholera outbreak and initiate measures that would prevent it. Dickinson writes:

> "Cholera epidemics in Africa have been known to edge up on 2 to 3 percent mortality rates at their worst. But in Zimbabwe, rates rose well over 5 percent -- five times the rate cholera epidemics should yield if they are tackled with simple, readily available treatments, according to international guidelines. Meanwhile, the Mugabe government denied there was even a cholera outbreak until December 2008."[19]

The silence of the UN was fatal and lead to a high number of deaths. In essence the cholera outbreak in Zimbabwe had been preventable but UN internal bureaucracy and government denial of an impending epidemic led to high infection and death rates.

Sharp increase in illegal migration from Zimbabwe

There has been a sharp increase in the number of illegal migrants and asylum seekers from Zimbabwe arriving in neighbouring countries, particularly Botswana and South Africa. Very few have attempted to apply for asylum, and of those who do a very small number are granted

[19] Dickinson, E. 2010. "Case Raises Questions About U.N.'s Role in Zimbabwe". **Foreign Policy**. http://www.foreignpolicy.com/articles/2010/02/22/did_the_un_cover_up_a_cholera_outbreak_for_robert_mugabe?page=0,0

refugee status.

In late July 2006 it was reported that South Africa had deported more than 51 000 illegal Zimbabwean migrants between January and June. The Department of Home Affairs said it was now deporting 265 Zimbabweans a day.

In 2005, 97 433 Zimbabweans were deported compared with 72 112 in 2004. Consideration is being given to building a second detention centre in Limpopo to cope with the increase in illegal immigration from Zimbabwe. Information on the estimated costs of such a centre were not available.

It is not known how many illegal migrants evade arrest. Various analysts and government officials have estimated the number of illegal Zimbabwean migrants in the country at between two and five million.

Human Rights Watch[20] (2009) states that from the 3rd of April 2009 the then – Minister of Home Affairs Nosiviwe Mapisa-Nqakula "announced a positive shift in migrant policy toward Zimbabweans, which included visa-free entry and "special dispensation permits" to legalize Zimbabweans' stay and give them work rights and access to basic healthcare and education." The reaction to this by South African citizens is important in light of the recent Xenophobic Attacks that took place in 2008. The result of the government's new approach to migration will be an increase in the number of Zimbabweans within the country and the use of resources to cater for them in terms of healthcare and education. This will anger poor South African citizens who feel that their government has not provided adequate service delivery in relation to healthcare and other social services; as was evidenced by the intense service delivery protests that occurred in 2009.

Growth in the sex trade

It seems that reliable data on the sex trade as it affects illegal migrants and asylum seekers is not available, but there have been several press reports from South African and Botswana in which reference is made to increasing numbers of Zimbabwean women turning to sex work for survival.

The Poverty Reduction Forum (PRF) of Zimbabwe .published a report in late 2004 titled *Redirecting our response to HIV/AIDS: the war for survival.* Their researchers found that the exchange of sex for transportation had become a common practice among cross-border traders moving from Zimbabwe into neighbouring states. They found that people were "quite aware of HIV/AIDS,

[20] http://www.hrw.org/en/node/87452

yet they are being forced by circumstances to engage in risky behaviour." In Beitbridge, some women offer sex to truck drivers in exchange for a lift to South Africa and also for assistance in paying import duty and other levies. When one driver drops them off, they offer sex to the next driver. The probability that this will encourage the spread of HIV via major transport routes in the region is clear.

In early 2005 Dr Bernard Uzabakirilo, who was practicing at the Ekurhuleni hospital near Pretoria and also lobbying for the Coordinating Body of Refugee Organisations, said his experience as a doctor had shown him that HIV prevalence among refugees and illegal migrants in the country "is higher than the local prevalence because the young women refugees can't work and are thus almost always forced into prostitution."

Factors in SA and the region that further promote the spread and

Neighbouring countries have shown a reluctance, at times refusal, to extend any form of protection to asylum seekers. Illegal migrants and asylum seekers alike have to try to survive on their own in urban areas; there are no refugee camps.

While there is no reliable data on the HIV prevalence among illegal migrants and refugees in South Africa, Sunjie noted that all refugees and illegal migrants are at increased risk of contacting the virus during and after displacement.

An increasing number of women are forced into prostitution as they attempt to survive and/or provide for families back home.

In both South Africa and Botswana, xenophobic attitudes are very common. According to Melita Sunjie, a researcher at the Pretoria office of the United Nations High Commissioner for Refugees:

> "Refugees are regarded with suspicion in South Africa and are as a result discriminated against and barely integrated into society, let alone into HIV and Aids initiatives."

Once given asylum status, refugees in South Africa have the right to seek treatment from the country's health-care system and are issued with identification cards to be shown at hospitals. *A* 2003 study conducted by the Community Agency for Social Enquiry (CASE), the *National Refugee Baseline Survey,* found that of the 1 500 migrants interviewed only 11% had been issued with identification cards; the remaining 89% had been waiting for more than three years for asylum status. CASE found that about 20% who had tried to access emergency health care were refused help, mainly by hospital administrative staff.

The situation did not seem to have improved by early 2005. Dr Uzabakirilo said that officials at registration points of hospitals were still refusing to

recognise the legitimacy of refugee identification cards. As a result, patients would be registered as illegal migrants and asked to pay an upfront consultation fee before receiving treatment. These fees were usually completely unaffordable and the patient could not see a doctor. Without a doctor's reference, an HIV-positive patient cannot receive treatment from a clinic. The only available option is to buy ARVs privately, at a cost then of about R300 a month - a price few could afford.

As South Africa's Refugees Act of 1998 places restrictions on asylum seekers by prohibiting their employment while their applications are being processed – and given the backlog in the Department of Home Affairs, this can take years - HIV-positive migrants find themselves unable to use state health facilities, or to take on formal employment to earn the money that may cover the costs of private health care.

In November 2005 Human Rights Watch (HRW) published a detailed report titled *Living On the Margins: Inadequate Protection for Refugees and Asylum Seekers In South Africa*. HRW noted that while South Africa has excellent refugee laws on paper, in practice asylum seekers are generally marginalised and have no protection. Georgette Gagnon, HRW deputy director for Africa, called on the South African government to commit itself to protecting and respecting the rights of refugees. HRW expressed criticism of the Lindela Repatriation Centre for ill-treating refugees and running a poor healthcare system.

In April 2007, the HIV Clinicians Society launched a publication on the ARV treatment of refugees. Francois Venter, president of the Society, described the treatment of HIV-positive foreigners in South Africa as a "huge problem". The Society found that they were being discriminated against by xenophobic medical staff and health professionals, who restricted refugees' and asylum-seekers' access to ARVs. He noted that government was paying inadequate attention to the welfare of refugees and was not budgeting accordingly.

He argued that specific guidelines for the treatment of HIV-positive refugees should be developed, and that attention should be paid to educating health professionals, some of whom believed that HIV positive refugees had come to the country in order to obtain ARVs. .

The senior regional HIV/AIDS coordinator for the UNHCR, Laurie Campbell Bruns, urged that access to antiretroviral drugs be extended to everyone in SA. Celicia Serenata, a specialist at the US-based Centres for Disease Control and Prevention, stated that the South African government had not adequately addressed the treatment of refugees, and called for the wide distribution of the Society's guidelines.

Effects of the situation in Zimbabwe on public health in SA and the region

There appear to be four main areas which are cause for concern:

- the spread of HIV/Aids, TB, malaria and other infectious diseases of poverty into the populations of neighbouring states via illegal migrants and asylum seekers who are left to fend for themselves
- the promotion of drug-resistant strains of TB, malaria and HIV/Aids due to disrupted or inadequate treatment, or by exclusion from health care
- financial strain on the public health services and other government departments of neighbouring states
- the loss of regional research capacity into diseases which affect everyone in the region.

The spread of diseases by illegal migrants among host populations

It stands to reason that an increased uncontrolled influx of people who may be carriers of HIV, TB and malaria into any area could pose a threat to the residents of that area. This is particularly the case if they are carriers of drug resistant forms of these diseases.

There does not appear to be any reliable data that is readily available to the public on the extent to which illegal migrants can be directly linked to cases of increased incidence in SA of the diseases under discussion. The report prepared by Africa Fighting Malaria (*Despotism and Disease: A report into the health situation of Zimbabwe and its probable impact on the region's health)* makes alarming assertions but offers no hard data. This is not surprising: gathering information of this kind is probably almost impossible.

Drug resistance

The WHO has repeatedly voiced its concern about the global rise of drug-resistant strains of diseases. According to the WHO, microbes (bacteria, fungi, parasites and viruses) cause infectious diseases, and antimicrobial agents (such as antibiotics, anti-malarial drugs and ARV's) have been developed to combat these diseases. Under favourable conditions, nearly all the infecting organisms will be killed and the body's immune system will deal with the rest. But if there are a few particularly robust organisms infecting a patient, and that patient's treatment is inadequate or interrupted, these extra-strong mutants will grow even stronger. Those with weakened immune systems are particularly vulnerable.

The result is longer illnesses and greater strain on the family of the patient and the health care system, and a greater risk of death. Patients remain infective for longer, so there is a greater chance for the resistant strain of the microbe to be passed on to other people.

The diseases of most concern in the development of drug resistance are identified as follows by the WHO:

> "The bacterial infections which contribute most to human disease are also those in which emerging resistance is of most concern: diarrhoeal diseases such as dysentery, respiratory tract infections, including multi-resistant tuberculosis, sexually transmitted infections such as gonorrhoea, and hospital-acquired infections. Among the other major infectious diseases, the development of resistance to drugs commonly used to treat malaria is of particular concern, as is the emerging resistance to anti-HIV drugs."

The WHO warns that the global rise of resistance to certain antimicrobial agents is a serious threat:

> "(W)hen a resistant strain emerges, there is not necessarily a new "wonder drug" ready on the shelf. Most alarming of all are microbes that have "accumulated" resistance genes to virtually all currently available drugs and have the potential to cause untreatable infections, thus raising the spectre of a post-antibiotic era. Even if the pharmaceutical industry were to step up efforts to develop new drugs immediately, current trends suggest that some diseases will have no effective therapies within the next ten years."

The WHO also warns that in very recent times, the development and spread of resistant microbes has been "greatly accelerated" by a number of interlinked trends which have resulted in an increased number of infections.

The most important of these is identified as the inappropriate use of antimicrobials: in developing nation this most often occurs when such drugs are taken for too short a time or irregularly, at too low a dose, at inadequate potency, or for the wrong disease. The high cost of medicines can result in people stopping treatments as soon as feel better, which may occur before the microbe has been eliminated.

Other trends which encourage the development and spread of resistant microbes are identified as the growth of global trade and travel, overcrowding and poor sanitation; the AIDS epidemic, which has greatly enlarged the population of patients with weakened immune systems who are therefore vulnerable to opportunistic infections; and the resurgence of malaria and tuberculosis.

As the above information has shown, every one of these factors which encourage the development of drug-resistant diseases of poverty are being promoted by the ongoing crisis in Zimbabwe.

The WHO warns that when infections become resistant to "first-line" drugs, treatment has to other drugs which are usually far more expensive and difficult to obtain. The drugs needed to treat multidrug-resistant forms of TB are over 100 times more expensive than the first-line drugs used to treat

non-resistant forms. The result is that some diseases can no longer be treated in areas where resistance to first-line drugs is widespread. [21]

The impact on SA's public health system

It seems there is no detailed, reliable information currently available on which to base an overall assessment of the extent to which the influx of illegal migrants is affecting SA's health system.

However, if reports about the frequent exclusion of illegal migrants and refugees from public health care are generally accurate, and taking account of concerns expressed by the WHO regarding the development of drug-resistant forms of the major diseases affecting poor people, it seems that the exclusion of illegal migrants and refugees from the health system is a far greater potential threat to the country than any strain the system might be taking from assisting those who receive do help.

In July 2006, Phuti Seloba, the Limpopo health spokesperson told the SA Broadcasting Corporation that his department could not deny illegal migrants health care, and around 800 patients, most them illegal migrants, had been treated at Musina Hospital near the Beitbridge border over the past three months. Of the 20 who had passed away, only 8 were claimed by relatives, which forced the hospitals to conduct 12 pauper funerals. He complained that the growing influx of people from Zimbabwe was affecting budget planning and the number of beds occupied in the hospitals.

The SA government's Department of Home Affairs spent a total of R218-million on immigration control in 2005, more than double the amount it spent in 2004. Lindela detention centre was reportedly struggling to cope with the numbers of illegal migrants; the cost of detaining illegal migrants had gone from R21.95 a day per detainee in 2001 to R75 a day in mid-2006. As noted earlier, the construction of another detention centre in the north of the country is being considered.

Loss of regional research capacity

According to the NGO Africa Fighting Malaria, the Blair Research Institute in Harare had long been a "dynamic and cutting edge malaria research facility", but most of its staff has left and the "essential, ongoing research needed to strengthen malaria control has fallen away."

It is not known whether other institutes in the SADC region are making up for this loss of research capacity; if they are not, this could also be considered a potential threat to public health in the region.

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[21] http://www.who.int/drugresistance/amr_q&a.pdf. Accessed 25/07/2006

Conclusions and comments

The information presented shows conclusively that the Zimbabwe crisis has posed a serious threat to the physical and mental health of its own citizens over the past decade, and that this threat has been exported to other countries in the region as well. Although there has been some improvement with the advent of the inclusive government just over a year ago it would obviously be highly dangerous to lobby in a manner which could in any way be misinterpreted – deliberately or not - as blaming illegal migrants from Zimbabwe for spreading deadly diseases in the region.

It seems it might be better to focus on the fact that the *exclusion of illegal migrants and refugees from health care* poses a serious potential threat to public health in the region, rather than the migrants and refugees themselves.

In addition lobbying and advocacy should highlight the need for an end to the ongoing political and economic crisis in Zimbabwe thereby dealing with the threat to the region at source.

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