

# An Analysis of Zimbabwean Health Crises Since Independence

**By James McClure**

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In 2007, the lowest average female life expectancy in the world was Zimbabwe, at just thirty-four years of age.<sup>1</sup> However, over the span of the last decade the estimated female life expectancy has risen to sixty-four years.<sup>2</sup> From these measures, we can assume that the quality of life for Zimbabweans has significantly improved in the last decade, yet quantitative data does not paint the entire picture. Today Zimbabwe remains the eighth highest Human Immunodeficiency Virus (HIV)-prevalent nation in the world, despite a drop from twenty-nine to fifteen percent in the infection rate since its peak in 1997.<sup>3</sup> A full understanding of the seriousness of Zimbabwe's health crisis requires examination of the history of Zimbabwe, changes in its political leadership, and governmental response to various disease outbreaks. While Zimbabwean life expectancy and health outcomes have improved since the 2007 lows,

high rates of infectious disease and malnutrition remain due to gross incompetence by former president Robert Mugabe, as well as continuing economic hyperinflation and instability. Recurring authoritarian tendencies of current president Emerson Mnangagwa suggest that he is likely to repeat the same mistakes as Mugabe.

Historically, the nation of Zimbabwe has experienced detrimental setbacks since the creation of a state with adequate health resources. First colonized by the British empire as the colony of Rhodesia, Zimbabwe became an independent nation after a 1965 revolution led by the whittsettler class and their prime minister, Ian Smith. Under Smith's rule, Black Zimbabweans suffered from "nutritional deficiencies, communicable diseases and problems associated with pregnancy."<sup>4</sup> "Structures of racial domination", which primarily consisted of government health spending in-

equality between Black-majority and White-majority areas of Zimbabwe, reinforced racially-stratified patterns of disease.<sup>5</sup> Private medical services, used primarily by White Zimbabweans, received nearly five times as much funding than public medical services in urban areas and roughly thirty-six times more funding than public medical services in rural areas.<sup>6</sup> White minority rule occurred in international isolation and continued until Robert Mugabe led the Black Zimbabwean majority in a civil war against the ruling government in 1975. In 1983, Mugabe was successful over Smith's regime and declared official independence for Zimbabwe from the White Rhodesians.<sup>7</sup>

In the 1980s, Mugabe and his government were able to construct a healthcare system in Zimbabwe that was considered a "model for Africa."<sup>8</sup> According to a 1990 report on health post-independence in Zimbabwe, the setting of a national

minimum wage was the most important reform made under Mugabe to positively influence health.<sup>9</sup> Other important policy changes included subsidies on basic food, expansion of public schools, free health care provided for those making below the minimum wage, the creation of more rural health facilities, increased commitment to the vaccination of major childhood diseases, and the formation of specified national departments to address malnutrition and diarrheal diseases.<sup>10</sup> The report concluded that these health improvements “removed the worst nutritional and communicable disease effects of a settler colonial state”, and that this new health system showed “national commitment towards destroying the old order of racist and undemocratic health care institutions.”<sup>11</sup> While trends of health funding disparities between rural and urban areas during the 1980s remain ingrained in government health policy, Mugabe’s reforms saw significant improvement to healthcare under former ruler Ian Smith. Proper maintenance of the national healthcare system continued into the 1990s, until political instability and economic failure in the late 1990s and early 2000s led to the system’s downturn.

In 2000, Mugabe began encouraging land invasions of White farms in order to scapegoat the remaining White population for economic problems in Zimbabwe and consolidate a majority within his party.<sup>12</sup>

The invasions created instability and rendered farming impossible, which in turn triggered “a humanitarian crisis in which more than half of the population needed food aid.”<sup>13</sup> Government land redistribution programs under Mugabe failed to provide land invaders with the proper tools and materials needed to farm, resulting in a ninety percent decrease in the production of corn and wheat. The collapse of productivity in these farms, as well as gross corruption within the Mugabe regime, caused sustained hyperinflation, which plagues the Zimbabwean economy to this day.<sup>14</sup> As Zimbabwe’s economy contracted, Mugabe began to experience more feelings of political vulnerability and lashed out at any group he viewed as his opposition. Attacks by Mugabe’s “Youth Militias” against doctors providing treatment for political opposition members caused thousands of doctors to flee Zimbabwe. In 2008, only twenty-five percent of positions for doctors were filled in the state health system due to fear of political oppression. Inflation also made conditions for doctors who remained in Zimbabwe more dangerous, as most hospitals were no longer able to provide healthcare professionals with adequate amounts of gloves or sanitized equipment, putting them at higher risk of contracting blood-borne diseases such as HIV.<sup>15</sup>

HIV remains one of the most pressing and harmful medical crises in Zimbabwe. As of 2017, HIV/

AIDS is the leading cause of death and disability in Zimbabwe, with a prevalence rate of 12.7 percent among adults.<sup>16</sup> While Zimbabwe has the ninth highest HIV death rate on the planet, significant improvements have been made in decreasing infection counts in the last decade. In 2008, Zimbabwe experienced the peak of its HIV/AIDS crisis, with a total national adult prevalence of 33 percent. Death rates were worsened by a lack of access to antiretroviral drugs, as the government was not able to consistently produce these medications. The limited drugs available were oftentimes distributed to Mugabe regime loyalists and army officers of the ruling Zimbabwe African National Union- Patriotic Front (ZANU-PF) Party, which forced hundreds of HIV-positive Zimbabweans to travel to Mozambique to receive antiretrovirals. Mugabe’s dictatorial governing style also reduced the amount of international aid received in Zimbabwe to combat the crisis.<sup>17</sup> While many Southern African countries received loans totaling upwards of \$150 million from the World Bank in 2004 to finance HIV treatment, Zimbabwe received only \$4 million. The Global Fund to fight AIDS also rejected the majority of Zimbabwe’s funding proposals of the same year.<sup>18</sup>

Social stigma is another factor that worsens the burden of HIV in Zimbabwe, particularly for the LGBTQ+ population. Beginning in the late 1990s, during Mugabe’s

period of political fragility, he continually condemned homosexuality as a “repugnant offense.”<sup>19</sup> Mugabe’s statements contributed to the existing taboos surrounding homosexuality in Zimbabwean society, which created more barriers to HIV care for LGBTQ+ populations in Zimbabwe. A 2017 study by Jennifer Hunt found that LGBTQ+ Zimbabweans and sex workers in Zimbabwe are adversely impacted by doctors’ inaccurate perceptions of their sexual and gender identity, where “equal access to care” is “dependent on conforming to ‘sexual norms.’”<sup>20</sup> One lesbian woman even described that doctors were “afraid to touch” her when giving care.<sup>21</sup> While HIV is a significant challenge for people of all walks of life in Zimbabwe, cultural prejudices against LGBTQ+ gender and sexual identities by healthcare providers remain a significant challenge to this marginalized population.

Reduction in HIV prevalence rates since 2007 is mainly unassociated with government intervention. Experts claim that community-based behavior change primarily accounts for the reduction of HIV infection, as many adults between the ages of twenty and twenty-five delay sexual activity in response to the high death and infection rates.<sup>22</sup> One government policy success came from an initiative known as the “National Prevention of Mother to Child Transmission Program.” In 2004, the government expanded the

production of antiretroviral drugs, specifically for HIV-positive mothers. This intervention proved to be successful, as infant mortality decreased from 102 deaths per 1000 births to 82 deaths per 1000 births by 2006.<sup>23</sup> Recent estimates show a continued positive trend in infant mortality from lowering of mother-to-child HIV transmission rates, with a predicted infant mortality of 56 deaths per 1000 births in 2017.<sup>24</sup>

Tuberculosis (TB) persists as another significant factor in the causation of negative health outcomes in Zimbabwe. TB is the third highest cause of death and the second highest cause of premature death in the nation.<sup>25</sup> Compared to the rest of the world, Zimbabwe has the highest TB infection rate per capita. HIV infection is a risk factor in the contraction of TB, as nearly seventy-five percent of people with TB in Zimbabwe are also infected with HIV. The increase in the prevalence of multidrug-resistant tuberculosis (MDR TB) in Zimbabwe has made the persistence of this disease more difficult to combat. Government inattention to MDR TB surveillance is correlated with the decline of the national healthcare infrastructure, as oversight of MDR TB infection was last performed by the Zimbabwean government in 1995. In a 2012 study on TB cases in hospitals in the capital of Harare, nearly one-fourth of TB patients were infected with MDR TB. While the study only analyzed a small sample of eighty-

four patients, the researchers stated the urgency of “a comprehensive response” to MDR TB by the Zimbabwean government, as the prevalence of MDR TB nationally could be even higher than in this sample.<sup>26</sup>

In addition to ongoing tuberculosis outbreaks, the persistence of cholera reveals the ineptitude of Zimbabwean political leaders in addressing health crises. In 2008, an outbreak of cholera in Zimbabwe resulted in nearly 100,000 cases and more than 4,000 deaths over a period of ten months.<sup>27</sup> The epidemic was worsened by the politicization of sanitation infrastructure by the ZANU-PF party. After the opposition Movement for Democratic Change (MDC) party won numerous majorities in the 2005 parliamentary elections, ruling ZANU-PF politicians nationalized municipal water supply in areas of MDC support. Consequently, the price of accessing water rose and sanitation infrastructure was neglected in these areas, particularly in Harare. As sanitation systems deteriorated, cholera-inducing bacteria grew in the water supply. The neglect of water supply continued even after the onset of the 2008 epidemic, and Harare’s water supply was cut off in November 2008. Zimbabwe’s health system was also under strain during the outbreak, due to Mugabe’s failure to acknowledge the severity of the crisis. Rather than making a call for international donations to address cholera when cases were con-

firmed in Harare, Mugabe waited for four months, claiming publicly that there was “no cholera in Zimbabwe” even after his health minister had declared a crisis.<sup>28</sup> Despite an official end to the epidemic in 2009, doctors in Harare report that the city still experiences regular outbreaks of cholera due to lack of maintenance of sewage and water infrastructure.<sup>29</sup>

Since the 2008 epidemic, mass vaccination campaigns have been the Zimbabwean government’s primary policy solution to the recurring threat of cholera. Zimbabwe’s Ministry of Health declared another cholera outbreak in 2018 in Harare, totaling 8535 total cases and fifty deaths. While the severity of the crisis was significantly less than the 2008 epidemic, poor management of water infrastructure by the municipal government remained the primary causal factor. A vaccination campaign began in Harare and the surrounding region soon after the declaration of the outbreak, where over 2.7 million vaccines were produced for two rounds of the campaign. With support from the World Health Organization, the United Nations Children’s Fund, Oxfam, and other non-governmental organizations, the government was able to construct four cholera treatment centers in Harare and distribute sanitation and other non-food items to impacted areas.<sup>30</sup> Government response was more rapid and efficient than during the 2008 epidemic. The mass vaccination campaign

in 2018 occurred less than a month after the first cases were discovered, while in 2008, Mugabe did not even acknowledge there was an epidemic after his own health minister stated so. Timely acknowledgement of the crisis also allowed the government to quickly appeal for international aid, which likely mitigated the negative health consequences of the outbreak in comparison to 2008.

Environmental disasters have only worsened Zimbabwe’s public health crisis response. In March 2019, Cyclone Idai ravaged Southern Africa and displaced thousands of people in the region. A consequence of cyclone-induced flooding was the possibility of the return of cholera after the outbreak just a year earlier, as well as other infectious diseases prevalent in Zimbabwe such as typhoid fever and malaria.<sup>31</sup> The government began another mass vaccination campaign for cholera in April 2019 primarily targeting the most severely affected districts of Chimanimani and Chipinge. International aid was utilized once again, as United Nations Children’s Fund (UNICEF), the World Health Organization (WHO), Doctors Without Borders, and the Red Cross were instrumental in the creation of nearly one million doses of the oral vaccine, which were administered in two rounds to grant full immunity to recipients of the vaccine.<sup>32</sup> One difficulty in vaccine administration was that rural road networks that connected the districts of Chi-

manimani and Chipinge to the rest of Zimbabwe were decimated from flooding after the cyclone. In order to deliver the vaccines to the districts, public health officials had to use helicopters, and were limited to only thirty minutes on the ground for each of the target areas.<sup>33</sup> These challenges highlight the continuing urban-rural disparity that exists regarding access to healthcare services.

At the onset of independence, the Mugabe regime prioritized maternal and child healthcare improvement. During Zimbabwe’s colonial era, maternal malnutrition was extremely prevalent, as it contributed to “low birth weight in ten to twenty percent of all births”, causing newborns to be more vulnerable to “more severe and often fatal infections.”<sup>34</sup> After the creation of the national primary care program in 1980, the maternal mortality rate fell by twenty-eight percent by 1983.<sup>35</sup> While post-independence maternal health gains were significant during the 1980s, they quickly eroded as economic hyperinflation and ruthless authoritarian leadership plagued Zimbabwe from the late 1990s onwards. According to a 2010 demographic survey in Zimbabwe, “maternal and child health has stagnated in recent years”, with stalling or downturn of the child mortality rate since the mid-2000s.<sup>36</sup> High rates of malaria and HIV are significant burdens on the health of mothers in Zimbabwe. A 2003 report on maternal health



in Northern Zimbabwe implicated malaria and HIV in the high rates of “preterm delivery, low birth weight, stillbirth, or neonatal mortality.”<sup>37</sup> While the researchers recommended the use of antimalarial and antiretroviral treatments to address the possibility of mother-to-child transmission of these diseases, the Zimbabwean government has not been able to produce these medications on a consistent basis, mainly due to the costs of production in a state of economic hyperinflation.<sup>38</sup>

Compared to the rest of sub-Saharan and northern Africa, Zimbabwe is an outlier in negative health outcomes due to its high HIV death and prevalence rates, as well as the continuing pervasiveness of vaccinatable diseases such as TB and cholera. Within Africa, only the nations of South Africa, Mozambique, Nigeria, Zambia, and Kenya surpass or compare to Zimbabwe in the infection count and death rate of HIV, according to 2018 estimates.<sup>39</sup> Even in comparison with the handful of nations that are on par with Zimbabwe in HIV counts, Zimbabwe leads the world in TB deaths and TB-induced disability. While Zimbabwe was viewed as a progressive African state in the 1980s due to its healthcare model and improvements in disease and maternal health outcomes, rapid decline of medical infrastructure places Zimbabwe far above world averages in infection and death count for highly preventable and treatable diseases.

After close inspection of Zimbabwe’s major health problems mentioned in this paper, several trends emerge to cause these difficulties. The main explanation for Zimbabwe’s health woes is continued inattention and strain placed upon the once-advanced national health program, primarily by former president Robert Mugabe. During his peak of political fragility in the early to mid-2000s, inducing attacks on doctors by youth militias, the lack of doctors in Zimbabwe was so significant that there were “only 800 registered doctors in the country.”<sup>40</sup> A lack of doctors impacts all areas of health, and legacies of this problem exist in all sectors of healthcare in Zimbabwe today. Mugabe’s pattern of politicizing and downplaying disease emergencies, such as the 2008 cholera epidemic and the 2007 HIV crisis, worsened the effects of these incidents and reduced the potential for receiving significant aid donations from international organizations. Economic mismanagement and corruption occurring under the watch of Mugabe also exacerbated the intense downturn of healthcare. Continuing hyperinflation has led to difficulties in government production of medications for HIV and malaria. Financial distress also contributes to the decline of the national education system, which has in turn limited the training of doctors in Zimbabwe to address shortages. Only time will tell if future leaders can overcome the disastrous health

legacy that Mugabe created.

Moving forward, it will be up to the political leadership of recently elected president Emmerson Mnangagwa to determine if Zimbabwe will see improvements in health outcomes. Upon election, Mnangagwa’s promise to the Zimbabwean people was that he would take the country in “a new direction.”<sup>41</sup> In his first three years of president, Mnangagwa has only accomplished this objective to a limited degree. Since promising to change the autocratic nature of the presidency in Zimbabwe, Mnangagwa “continues to prevent and violently suppress political protests” and keep the media “heavily biased in favor of the ruling party.”<sup>42</sup> Many Zimbabweans even view Mnangagwa’s governing style as even more repressive than Mugabe, as more than twenty citizens have been killed and over 1,000 arrested since the beginning of Mnangagwa’s rule. These killings are especially concerning because Mnangagwa already resembles Mugabe at the end of his rule, despite being just barely three years into his first term. Economic reforms have also been few and far between, with “a brief government surplus” and “the introduction of a new currency aimed at curbing inflation” serving as the only significant changes made since Mnangagwa took power.<sup>43</sup> Currently the Zimbabwean economy is close to entering a total state of disrepair, with shortages and basic resources that resemble the economic

crisis in the early 2000s, according to political scientist Andrew Noyes.<sup>44</sup> The COVID-19 pandemic is also likely to place pressure on the continually strained healthcare system in Zimbabwe, especially with

the high population of HIV-positive, immunosuppressed people in the country. Without any promise of commitment to improving the national healthcare infrastructure, it seems that president Mnangag-

wa will continue the same trend of complete disregard for healthcare as Mugabe, at the expense of the Zimbabwean people.

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*This photo portrays the view from a cafe in Baščaršija—the oldest part of Sarajevo, Bosnia and Herzegovina. While living in Sarajevo during her gap year, Emma Holmes loved Baščaršija and the Ottoman-styled buildings with the specific roofing style as seen here. And Baščaršija Mosque, like many other religious buildings, is a defining feature in Sarajevo’s landscape.*

*Photo by Emma Holmes, Class of 2024, Global Studies and Asian Studies*