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## HIV and AIDS in Zimbabwe

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### Introduction to HIV and AIDS in Zimbabwe



With around one in seven adults living with HIV<sup>1</sup> Zimbabwe is experiencing one of the harshest AIDS epidemics in the world. In a country with such a tense political and social climate, it has been difficult to respond to the crisis. President Robert Mugabe and his government have been widely criticised by the international community, and Zimbabwe has become increasingly isolated, both politically and economically. The country has had to confront a number of severe crises in the past few years, including an unprecedented rise in inflation (in January 2008 it reached 100,000%<sup>2</sup>), a severe cholera epidemic, high rates of unemployment, political violence, and a near-total collapse of the health system.<sup>3</sup>

The situation in Zimbabwe is now so bad that:

- Between 2002 and 2006, the population is estimated to have decreased by four million people.<sup>4</sup>
- Infant mortality has doubled since 1990.<sup>5</sup>
- Average life expectancy for women, who are particularly affected by Zimbabwe's AIDS epidemic, is 34 - the lowest anywhere in the world.<sup>6</sup> Officials from the World Health Organisation have admitted that since this figure is based on data collected a few years ago, the real number may be as low as 30.<sup>7</sup>

- Zimbabwe has a higher number of orphans, in proportion to its population, than any other country in the world, according to UNICEF. Most of these cases are a result of parents dying from AIDS.<sup>8</sup>

In 2006 a Zimbabwean doctor explained to reporters:

*“Put simply, people are dying of AIDS before they can starve to death” - 9*

### Pattern of the HIV/AIDS epidemic so far



A video of Professor Mhlovi talking about the AIDS situation in Zimbabwe in 1993.

The first reported case of AIDS in Zimbabwe occurred in 1985. By the end of the 1980s, around 10% of the adult population were thought to be infected with HIV.<sup>10</sup> This figure rose dramatically in the first half of the 1990s, peaking and stabilising at 29% between 1995 and 1997. But since this point the HIV prevalence is thought to have declined, making Zimbabwe one of the first African nations to witness such a trend. According to government figures, the adult prevalence was 24.6% in 2003,<sup>11</sup> and fell to 15.3% in 2007.<sup>12</sup>

Yet although survey results indicate a fall in Zimbabwe's adult HIV prevalence, caution should be taken when interpreting the data available; it is not yet known whether the trend is a sign of long-term change or merely a temporary movement. Given the large number of homeless and displaced people living in Zimbabwe who are not likely to have been surveyed, the results cannot be taken as wholly representative of the situation. A rise in the number of people dying from AIDS is thought to have played a role in the decline, as well as an increase in the number of people (HIV positive or otherwise) who have migrated to other countries.

Brian Nyathi, a Zimbabwean health practitioner in [South Africa](#), is among those questioning the official statistics:

*“Many people have left Zimbabwe and the ones that are left are so struck down by poverty and the collapse of the health delivery system such that they can not access hospitals. We wonder if these figures can be trusted.” - 13*

Nonetheless there is evidence of positive changes in sexual behaviour.<sup>14</sup> Condom use has increased, a higher number of young people are delaying first sex and many people have reduced their number of sexual partners. The Zimbabwe Demographic and Health Survey showed that around 76 percent of women and 81 percent of men know that condoms can reduce the risk of HIV infection.<sup>15</sup>

It is thought that an increased awareness of HIV and AIDS has influenced these changes. In many cases, people may have changed their behaviour after witnessing the effects of the epidemic first hand, through the deaths of friends or relatives. One young Zimbabwean told reporters:

*“I'm not sure if sexual attitudes are changing altogether, but I tell you around the streets of Harare you will see lots of used condoms on the ground”. - 16*

While it is encouraging that sexual behaviour change has helped to reduce HIV prevalence, there is a long way to go. As the WHO country representative, Dr Custoda Mandlhate, has pointed out:

*“a sero-prevalence rate of 15,6 percent remains high and this is not the moment for relaxing”. - 17*

## The government's response

When AIDS first emerged in Zimbabwe, the government was slow to acknowledge the problem and take appropriate action. Discussion of HIV and AIDS was minimal and President Mugabe rarely addressed the subject in speeches. When he did, it was considered newsworthy.

Although the National AIDS Co-ordination Programme (NACP) was set up in 1987 and several short term and medium term AIDS plans were carried out over the following years, it was not until 1999 that the country's first HIV and AIDS policy was announced. This policy was implemented the following year by the newly formed National AIDS Council (NAC), which took over from the NACP. At the same time, the government introduced an AIDS levy on all taxpayers to fund the work of the NAC.

While these measures have had a positive impact, the government's response to HIV and AIDS has ultimately been compromised by numerous other political and social crises that have dominated political attention and overshadowed the implementation of the national AIDS policy. The NAC has also been constrained by poor organisation and a lack of resources.

The government should not be presented as innocent victims of inevitable problems, though; many of the struggles facing the country stem from their mistakes and failures. While political commitment towards fighting AIDS is apparent in Zimbabwe, the decisions made by Mugabe in dealing with other issues have led to a situation where the government is unable to adequately address the crisis.

## Political issues in Zimbabwe

The government of Zimbabwe, led by President Mugabe since 1980, has attracted intense international criticism in recent years. Mugabe's rule has been marked by corruption, human rights abuses and media repression, all of which have had an impact on the AIDS epidemic.

### Land reforms

Although Zimbabwe gained political independence from British rule in 1980, the majority of the country's land remained in the hands of non-indigenous white farmers, despite the fact that they made up just 1% of the population. This was a source of tension in the years that followed, and in 1999 the government began to forcibly evict white farmers from their land.

The land redistribution campaign that followed is thought to have contributed to the AIDS epidemic in several ways. As farming communities were disrupted, the economy deteriorated, leading to increased poverty and reduced access to education and healthcare. Many farm workers were forced to move to different areas and in some cases families were separated: both factors that are likely to have widened sexual networks and increased the risk of HIV transmission. Violence against farmers was practically encouraged, a climate of lawlessness ensued in many areas and rape became increasingly common, making women more vulnerable to HIV infection.

### Operation Murambatsvina

Operation Murambatsvina, which translates to 'operation drive out trash', was initiated in May 2005 with the aim of redistributing people from urban to rural areas. Large numbers of homes and businesses were demolished and their tenants forcibly removed, leaving thousands homeless, unemployed and starving. The government claims that this was a response to increases in illegal housing, crime, and the spread of sexually transmitted diseases in urban areas, while critics (such as the UN) have claimed that the campaign was a direct attack on the poorer sections of society that represent the main opposition to President Mugabe. Mugabe himself labelled it an 'urban beautification' programme.



Before the destruction of Porta Farm, Zimbabwe (22nd June 2002)



After the destruction of Porta Farm, Zimbabwe (6th April 2006), trees have replaced houses (photos courtesy of Amnesty International)

By July 2005, it was estimated that Operation Murambatsvina had displaced some 700,000 people, including over 79,500 adults living with HIV.<sup>18</sup> A number of these people had previously been receiving antiretroviral drugs (ARVs) to delay the onset of AIDS, but now had no access to them as treatment centres and clinics had been demolished. The interruption of ARV treatment can lead to drug resistance, declining health, and in some cases death.

Other HIV and AIDS-related services such as home based care and prevention programmes were also disrupted. Several home-based care programmes for people living with HIV indicated a 15-25% reduction in the number of patients accessing their services.<sup>19</sup>

One year after Operation Murambatsvina, Lynde Francis – co-ordinator of The Centre, an HIV and AIDS non-governmental organisation (NGO) with 4,500 clients that was disturbed by the campaign – described the difficulties her organisation was facing in re-establishing connections with people living with HIV:

*“We still haven't traced some clients ... they've vanished as far as we're concerned. Others disappeared for weeks and were homeless and incomeless, which means they were not eating, and that's a problem when taking [ARVs]” - <sup>20</sup>*

As well as affecting people who were already living with HIV, the campaign may also have contributed to the spread of infection. Factors such as increased population mobility, the separation of couples and an increased number of women turning to sex work in order to survive are likely to have increased the frequency of unsafe sex in many areas. Access to education and information about HIV decreased, and nationwide sales of condoms fell: between May and June 2005, sales of male and female condoms dropped by over 20% and 40% respectively.<sup>21</sup>

## International aid

While campaigns to prevent and treat HIV in other African nations benefit from international aid, the political situation in Zimbabwe has caused some foreign donors to either decrease aid for the country or halt it altogether. The government has been increasingly hostile towards foreign non-governmental organisations (NGOs), to the extent where they threatened to pass a law that would prohibit organisations from working on human rights, and would give the government the power to interfere with how NGOs are run.<sup>22</sup>

Despite this hostility, Zimbabwe is still receiving international aid, and the main donors are the UK and the US departments for international development (DFID and USAID), and the European Commission (EC). Since 2002, DFID has provided Zimbabwe with over £35 million to help tackle HIV/AIDS and health priorities.<sup>23</sup> At the beginning of 2008 USAID donated US\$12.5 million to increase women and children's access to HIV prevention services.<sup>24</sup>

However, these donations are not as much as other sub-Saharan African countries are receiving. Put into context, the neighbouring nation of Zambia, which has a similar HIV prevalence rate, was reported in 2005 to receive around US\$187 per HIV positive person annually from foreign donors; in Zimbabwe, the figure was estimated to be just US\$4.<sup>25</sup>

## HIV prevention in Zimbabwe

Efforts to prevent the spread of HIV in Zimbabwe have been spearheaded by the NAC, NGOs and religious and academic organisations. Although HIV prevalence has probably fallen, indicating a change in sexual behaviour, it is difficult to say how significant the role of prevention programmes has been in achieving this trend. Prevention schemes have been significantly expanded since the turn of the millennium, but remain critically under-funded.

There has also been conflict between the messages promoted by different programmes; for instance, some religious or traditional campaigns discourage the use of condoms and place emphasis on abstinence, contrasting with the strategies of some other organisations. This has led to confusion about how it is best to prevent HIV infection, particularly amongst young people.

## Education

Children in Zimbabwe are currently taught about HIV and AIDS in schools. In 2006 the Ministry of Education, Sport and Culture, and UNICEF initiated an in-service training scheme of primary and secondary school teachers in HIV and AIDS life-skills and counselling. By the end of 2007 around 2753 primary and secondary schools had been reached by the scheme.<sup>26</sup> Outside of school, efforts to educate and inform people about HIV and AIDS (which are often organised by NGOs) have used a number of different means to convey prevention messages, including television and radio, drama, and community groups.

With around half of the people living with HIV in Zimbabwe becoming infected during adolescence or young adulthood, education campaigns have primarily targeted young people. As a result, knowledge about HIV and AIDS is higher than the average for sub-Saharan Africa.<sup>27</sup> A greater understanding and awareness of HIV and AIDS is thought to lead to changes in sexual behaviour, which has been shown to reduce the number of new HIV infections. A study carried out in 2006 suggested that the adoption of safer sexual behaviours was one of the reasons why HIV prevalence in Zimbabwe has declined.<sup>28</sup>

## Voluntary counselling and testing

The government emphasised the importance of voluntary counselling and testing for HIV (VCT) in its National AIDS Policy in 1999. Between 2005 and 2007 the total number of VCT sites increased from 395 to 649.<sup>29</sup> A target has now been set to increase the number of people who know their status from 20 percent in 2007 to 85 percent by 2010.<sup>30</sup>

However, there is still a strong reluctance to access testing amongst much of the population. People living with HIV face a particularly high level of discrimination in Zimbabwe, and many people fear that if they are found to be HIV-positive they will be victimised. In places where there is little access to ARVs, some see testing as pointless, as one HIV-positive woman described to reporters:

*"I said [to the doctor]: "Why have you tested me - you have just put me on a death sentence because I'm scared now because I know I am HIV positive. If you test me, it was to give me tablets." Here in Zimbabwe we don't have something like that. We don't have tablets" - 31*

In 2007, the government shifted focus from voluntary testing to provider-initiated testing, meaning that whenever a person visits a healthcare facility, they will be offered HIV testing as part of the hospital service. Dr

Mugurungi, Head of the AIDS and TB Unit in the Ministry of Health and Welfare, believes that the new testing regulation will mean that a greater number of people will know their status, which will help "both the service provider and the infected person to plan effectively on either living positively or maintaining a negative status."<sup>32</sup>

### **Mother to child transmission**

*In 2006 UNAIDS estimated that only 4.4 percent of pregnant women were receiving treatment to reduce mother-to-child transmission.*

In Zimbabwe, more than 17,000 children are infected with HIV every year,<sup>33</sup> the majority through mother to child transmission. As with VCT, the provision of services to prevent the transmission of HIV between mothers and their children during pregnancy is gradually being scaled up. The prevention of mother-to-child transmission (PMTCT) pilot programme was launched at four sites in 1999 and today the programme is nationwide. It aims to provide pregnant women with free VCT and give them access to nevirapine, a drug that significantly reduces the chances of transmission occurring.

The provision of drugs to prevent MTCT rose from 4% in 2006 to 29% in 2007. Although this is an encouraging scale-up, the provision of PMTCT services remains severely limited by a lack of funding, and access to nevirapine remains low.<sup>34</sup> Around 120,000 children are living with HIV in Zimbabwe, most of whom became infected through mother-to-child transmission. AVERT is calling for rapid improvements in PMTCT in our Stop AIDS in Children campaign.

Read more about Mother to child transmission of HIV world wide.

### **Condom use**



"What smart guys are wearing" condom poster in Zimbabwe

Increased condom use has been recognised as a major factor in the recent decline in Zimbabwe's HIV prevalence. The number of free condoms distributed by the government, NGOs and social marketing campaigns tripled during the 1990s, and further increased in subsequent years. The number of condoms sold through the private sector has also increased dramatically, and most condoms are now purchased rather than acquired for free, suggesting that condom use has become more accepted in Zimbabwean society.<sup>35</sup> It has also been reported that female condom sales are high in Zimbabwe.<sup>36</sup>

### **HIV and AIDS treatment in Zimbabwe**

Largely as a result of Zimbabwe's declining economy, there has been a shortage of antiretroviral drugs (ARVs). In 2002 the government declared the treatment shortage as a national emergency, allowing Zimbabwe to produce and purchase generic AIDS drugs locally under international law, and thereby reducing their cost.

However, in October 2005 it was reported that the cost of antiretroviral drugs had quadrupled in the previous three months.<sup>37</sup> The increasing cost of antiretrovirals has led to a number of problems, such as the selling of fake drugs at flea markets.<sup>38</sup> An article published in 2006 even reported that government officials who were HIV positive had been given priority access to the drugs. While doing so, they had intercepted drugs for their own use that were actually meant for public hospitals.<sup>39</sup> More recently there has also been the severe threat brought about by interruptions of regular supplies of ARVs. Reports of breakdowns in drug delivery and theft of drugs by government officials, as well as physicians switching patients on established regimens due to lack of

drug availability could all lead to drug resistant HIV strains developing.<sup>40</sup>

Women who live in rural areas are reported to find it very difficult to obtain ARVs. As the income for rural households tends to be low, and rural women often rely upon husbands working in urban areas for financial support, the women cannot afford the cost of the drugs.<sup>41</sup> They also have to travel long distances to health centres in order to receive ARVs, which is another financial burden. Even at sites where treatment has been made accessible, a severe national shortage of healthcare workers has led to long waiting lists and administration problems.

Other reports have revealed that people living with HIV/AIDS in Zimbabwe have crossed the border into Mozambique in order to receive ARVs, which Mozambique provides for free.<sup>42</sup>

In 2007 the government aimed to increase treatment provision through public health sector facilities, with the aim of reaching at least 140,000 people in need of ARVs by the end of the year. In October 2007, the government claimed that they were on track with the target, and had reached close to 90,000 people already.<sup>43</sup> WHO figures for the end of 2007, however, put treatment figures at an estimated 98,000, somewhat short of the target. The government estimate that 102,566 people are still in need of antiretroviral therapy,<sup>44</sup> although the World Health Organisation estimate is much higher at 570,000.<sup>45</sup>

## Other major issues

### Stigmatisation

Despite a high level of awareness, HIV and AIDS remain highly stigmatised in Zimbabwe. People living with HIV are often perceived as having done something wrong, and discrimination is frequently directed at both them and their families. Many people are afraid to get tested for HIV for fear of being socially alienated, losing their partner or losing their job. Those who do know their status rarely make it publicly known, which often means that they do not have access to sufficient care and support.

There is a feeling in Zimbabwe that the stigma surrounding HIV is gradually diminishing, although it remains a significant problem. Various attempts have been made to improve the situation, such as the 2005 "Don't be negative about being positive" campaign. Organised by PSI-Zimbabwe, this campaign encouraged people to reveal their HIV-positive status and to share their stories. The organisers won the 2005 Global Media Award for their work.<sup>46</sup>

### Gender inequalities

There are large social and economic gaps between women and men in Zimbabwe, and these inequalities have played a central role in the spread of HIV. Constrictive attitudes towards female sexuality contrast with lenient ones towards the sexual activity of men, resulting in a situation where men often have multiple sexual partners and women have little authority to instigate condom use. Sexual abuse, rape and coerced sex are all common, and as the economy deteriorates more women are turning to sex work as a means of survival.

Prevention campaigns that emphasise safe sex and abstinence often fail to take into account these realities, and are more applicable to the lives of men than those of women. Women are likely to be poorer and less educated than men, predisposing them to HIV infection and making it harder for them to access treatment, care and information.

According to UNAIDS estimates, almost 60% of Zimbabwean adults living with HIV at the end of 2006 were female. This gender gap is even wider amongst young people – women make up around 77% of people between the ages of 15 and 24 living with HIV.<sup>47</sup>

Read more about [Women and HIV](#).

### Human resources

With an unemployment rate of over 80%, Zimbabwe is suffering from a severe lack of human resources. In many cases this problem is a direct result of the HIV epidemic, as workers are either caring for family members with AIDS or suffering from it themselves.

In the healthcare sector, the deficiency of workers has hindered efforts to treat and care for people living with HIV. Estimates suggest there is only one doctor for every 12,000 people,<sup>48</sup> and in the public sector there are no functioning critical care beds.<sup>49</sup>

Additionally, large numbers of health personnel migrate to other countries once they are trained, and many of



those who remain in the country are affected by HIV themselves.

### **Famine and malnutrition**



Queues for food outside a supermarket in Zimbabwe

As the economy deteriorates and farming communities struggle to recover from Mugabe's land reforms, food shortages have escalated. Sickness and death from AIDS has caused a reduction in agricultural output, especially since women (who form the bulk of agricultural labour in Zimbabwe) are so vulnerable to HIV infection. Women are also expected to care for relatives who have AIDS, forcing many to abandon their agricultural work.

As Zimbabwe's workforce has deteriorated, the resulting food shortages have increased the number of deaths from AIDS. Malnutrition has caused people living with HIV to develop AIDS faster, and is likely to have decreased the effectiveness of ARVs for those who are receiving treatment.

While it is essential that those on ARVs are receiving adequate nutrition for the drugs to work effectively, there are reports of HIV positive patients in such desperation that they are actually selling their ARV medication in order to buy food.<sup>50</sup>

### **Conclusion**

Most people feel that the Zimbabwean government's response to the AIDS crisis has been relatively good in comparison with their performance in other areas. Prevention and treatment initiatives have been scaled up and the national HIV prevalence seems to have declined.

Yet in the context of such a fragmented political and economic background, the fight against AIDS has been unable to make substantial progress. HIV prevalence is still one of the highest in the world and the majority of those in need of antiretroviral treatment are not receiving it.

HIV/AIDS is just one of many crises in Zimbabwe and, despite optimism following the establishment of a Government of National Unity in late 2008, each day thousands of Zimbabweans are still crossing the borders to neighbouring countries, as a matter of survival.<sup>51</sup>

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*This page was written by Graham Pembrey and updated by Gemma Spink*

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