ZADHR

Zimbabwe Association of Doctors for Human Rights

Cholera in a time of Health System Collapse:

Violations of Health Rights and the Cholera Outbreak

26 February 2009

Executive Summary

Although Zimbabwe has experienced cholera outbreaks since 1992, the outbreak which began in August 2008 is the worst ever in this country and is set to become the worst outbreak on the African continent. Violations of the rights to safe and potable water, adequate sanitation and a collapsed health system were the cause of the outbreak. The course of the outbreak has been difficult to predict and to control.

To date, the Government of Zimbabwe has fallen far short of its responsibility to ensure the availability of appropriate health services. Despite the epidemic continuing for more than six months, sanitation remains poor and lack of access to safe drinking water persists against the backdrop of a collapsed health system with degraded infrastructure and very few health workers.

Health is a fundamental human right indispensable for the exercise of other human rights. Despite this, the right to health is becoming an increasingly remote privilege, out of the reach of most Zimbabweans. Health in Zimbabwe is presently largely unavailable, unacceptable, inaccessible and of poor quality.

This report concludes that Zimbabwe will require long term commitment of the humanitarian and donor agencies working in the country with large scale, multi-faceted assistance to address the situation. The Government of Zimbabwe must also take responsibility for the restoration of the basic social services that fulfil basic human rights.

ZADHR makes the following recommendations:

On the public health system:

An emergency health response plan to restore function to the public health system must be produced and implemented. This plan should begin by focusing on making primary and secondary care services (clinics and district hospitals) affordable and accessible to all. The Government must also ensure that health workers concerns are addressed to ensure that conditions in which these workers return to work and their skills can be retained are put in place (including adequate remuneration and safe working conditions).

On access to safe water

If the outbreak is to be brought under control, and ultimately to an end, there is an urgent need to restore safe potable water to communities. Where infrastructure for piping water exists this needs to be rehabilitated.

On adequate sanitation

Ensuring that communities make use of sanitary facilities for defecation is vital. Everyone should have access to a toilet connected to a septic tank or working public sewer system or a ventilated improved pit latrine.

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1. Overview

Methodology and rationale

This report is based on a review of the documentation from various sources of Zimbabwe's cholera outbreak including the Epidemiological Bulletins and Daily Cholera Updates produced by the Ministry of Health and Child Welfare (MoHCW) and the World Health Organisation (WHO), Situation Reports on Cholera in Zimbabwe produced by the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), media reviews, and interviews conducted with those involved in managing, and those affected by the cholera outbreak.

The objective of the report is to elucidate the health rights violations that were the root cause of the outbreak, and the further violations that have resulted from it, and the reasons that efforts to manage the outbreak are faltering, resulting in further rights violations.

Cholera in Zimbabwe

Cholera is a diarrhoeal disease caused by infection of the intestine with a bacterium named *vibrio cholerae*. It is transmitted through consumption of faecally contaminated food or water and outbreaks are most common in areas with poor sanitation and safe water supply. Major outbreaks occur when access to safe water and sanitation is very poor. Zimbabwe has intermittently experienced cholera outbreaks since 1992 and some cases every year since 1998. However the outbreak which began in August 2008 is Zimbabwe's worst ever. The outbreak is also set to become the worst on the African continent.[1]

Cholera has a short incubation period of between 2 and 5 days. Not all people that are infected will develop severe symptoms. Approximately 20% of persons infected go on to develop acute, watery, rice coloured diarrhoea and 10 – 20% o these will also experience vomiting.[2] The main method of treatment is rehydration. Patients require prompt and adequate treatment as the loss of fluid and salts due to the severe diarrhoea can lead to severe dehydration and subsequently death if treatment is not prompt.

Cholera was first recorded in Zimbabwe in 1992/1993 with 2048 and 5385 cases recorded respectively in these years.[3] Since then it has been reported every year with 5637 cases recorded in an outbreak in 1999 including 385 deaths, a case fatality rate of 6.8%. Other major outbreaks included one in 2002 with 3125 cases and 192 deaths recorded. *"Cholera outbreaks in Zimbabwe are characterised by relatively low morbidity, but high case fatality (greater than the WHO acceptable CFR of 1%) mainly due to late presentation of cases at health facilities and poor case management."*[4]

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[1] With cases currently at 80,250 and expected to rise to 92,000 cases Zimbabwe's outbreak will have registered more cases than any previously recorded outbreak: Angola's 2007 outbreak registered 82,204 cases with 3092 deaths (a CFR of 3,75%), Nigeria registered 59,478 cases with 7,654 deaths (CFR 12,9%) in 1991; Mozambique recorded 42,672 cases and 1353 deaths (CFR 3,2%) in 1998; Tanzania recorded 40,249 cases and 2,231 deaths (CFR 5.54%) in 1997; Senegal registered 31,719 cases in 2005 with 458 deaths (CFR 1.44%). See http://www.who.int/cholera/countries/en/ accessed 18 February 2009

[2] *Cholera Outbreak: Assessing the Outbreak Response and Improving Preparedness*, Global Taskforce on Cholera Control, World Health Organisation 2004

[3] Cholera Country Profile: Zimbabwe, World Health Organisation Global Taskforce on Cholera see http://www.who.int/cholera/countries/ZimbabweCountryProfile2008.pdf accessed 18 February 2009, last updated 19 January 2009

[4] Zimbabwe 2009 Consolidated Appeal, United Nations Office for the Coordination of Humanitarian Affairs See http://ochadms.unog.ch/quickplace/cap/main.nsf/h_Index/CAP_2009_Zimbabwe/$FILE/CAP_2009_Zimbabwe_VOL1_SCREEN.pdf?OpenElement accessed 18 February 2009

Whether or not the cholera outbreak might have been prevented, there should have been a clear strategy in place to contain it, to prevent further spread of the disease and to focus on early detection and effective response to cases. Warnings over the past few years of an impending major cholera outbreak went unheeded.[5] When the outbreak finally did occur there was a haphazard response and at times a denial of the severity of the outbreak. It was only four months into the outbreak that the Ministry of Health and Child Welfare finally declared a national emergency.[6]

Nature of the recent outbreak

As a country in the middle of a complex emergency,[7] Zimbabwe was vulnerable territory for a major cholera outbreak. Years if neglect arising from the economic and political crisis has led to the breakdown of water and sanitation infrastructure. There has been inadequate provision of safe water and sanitation services in most parts of the country for years. Most suburbs in Harare rely on an irregular supply of piped water while others such as Mabvuku, Tafara, Greendale have been without any piped water for between 6 months and 2 years.

The current cholera outbreak started in August 2008.[8] The first cases were recorded in Chitungwiza on 27 August, Harare (Mbare) on 31 August, Kariba (21 September) and Chinhoyi (3 October). The outbreak eventually spread throughout all 10 provinces in Zimbabwe. 90% of all districts are now affected (58 of 62 districts)

Table 1: Cholera cases and Deaths between December 2008 and February 2009[9]

Date	Cumulative Cases	Cumulative Deaths	Cumulative Case Fatality Rate (CFR%)	Community Deaths (Percentage of total)
1 December 2008	11,735	484	4.1%	20.5%
1 January 2009	32,615	1,591	4.9%	45.3%
1 February 2009	62,909	3,229	5.1%	60.5%
25 February 2009	83,631	3,879	4.6%	61.3%

The cholera outbreak has been ongoing now for 6 months, the Case Fatality Rate (CFR: the number of deaths due to cholera divided by the number of cases of cholera) remains high and the number of cases and the number of deaths continue to rise. There have been 3879 deaths and over 83,631 cases countrywide as at 25 February. The World Health Organisation considers a Case Fatality Rate of <1% to

[5] Hansard, Parliament of Zimbabwe, Wednesday 8 February 2006: **"**we have reports of cholera, we have health warnings being given out by the City of Harare workers themselves that there is a danger of cholera in Harare. We have the Association of Zimbabwe Doctors for Human Rights releasing statements about two weeks ago, highlighting the outbreak of cholera and highlighting the danger of further outbreaks of disease in Harare and elsewhere, if we do not do something about our service provision, which is what we are supposed to do."

[6] The Herald, 4 December 2008

[7] A complex emergency is defined as "a humanitarian crisis in a country ... where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/ or the ongoing United Nations country program." See http://www.reliefweb.int/library/documents/ocha_orientation_handbook_on_.htm accessed 11 February 2009

[8] *Situation report on Cholera and Anthrax in Zimbabwe,* Issue Number 1, 14 October 2008, United Nations Office for the Coordination of Humanitarian Affairs

[9] This information has been taken from Daily Cholera Updates issued by WHO and the Ministry of Health and Child Welfare

be an acceptable level during a cholera epidemic. Zimbabwe's CFR currently stands at 4.6%. All 10 provinces in Zimbabwe are affected with cases and deaths having been reported in 56 of the country's 62 districts

. The focus of interventions by the Ministry of Health and Child Welfare and donor agencies has been on equipping and running Cholera Treatment Centres (CTCs) and Units (CTUs), trucking of water, and distribution of water purification tablets, Oral Rehydration Solution (ORS) and soap. It is clear that these interventions are not working as intended. Public education was initially weak and did not adequately target rural communities.

Difficult to predict, hard to control

The course of the outbreak has been both difficult to predict and to control. In October 2008 the Consolidated Appeal predicted a most likely scenario of 2000 cholera cases from a cholera outbreak.[10] This had been surpassed by early November 2008. On 8 December the United Nations Office for the Coordination of Humanitarian Affairs estimated that total cholera cases would reach 60,000 before the outbreak was brought under control.[11] 60,000 cases had already been recorded by 30 January 2009.

The Cholera Command and Control Centre (C4) estimated as at 5 February 2009, when 67,945 cases had already been recorded, that an additional 21000 to 55000 cases could occur with the most likely scenario being 32000 cases.[12] This adds up to 99,945 cases by the end of the outbreak although 92000 cases were cited as the most likely number. The worst case scenario (55,000 + 67,945) is 122,945. They also predicted that the outbreak would continue until April or May of 2009.

As at 20 February 2008 the total number of cases had risen to 80250. The worst case scenario seems likely to occur if drastic improvements in access to safe water and sanitation are not made immediately. Zimbabwe is set to exceed the number of cases recorded in the worst ever cholera outbreak in Africa.

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[10] Zimbabwe 2009 Consolidated Appeal, United Nations see http://ochadms.unog.ch/quickplace/cap/main.nsf/h_Index/CAP_2009_Zimbabwe/$FILE/CAP_2009_Zimbabwe_VOL1_SCREEN.pdf?OpenElement accessed 18 February 2009

[11] See ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docId=1100452 accessed 10 February 2009

[12] *Situation Report on Cholera in Zimbabwe,* Issue Number 12, 6 February 2009, United Nations Office for the Coordination of Humanitarian Affairs in Zimbabwe

2. Access to Health Care

The lack of functioning public health facilities has rendered health care unavailable. In many health centres staff are already strained as a result of low staffing levels - some clinics are operating with skeleton staff but some have no health workers at all. ***"There is a shortage of staff to maintain even a skeleton staff at most clinics."***[13] With no functioning equipment and an inadequate supply of drugs and other commodities, when cases of cholera start to present at a clinic they are ill equipped and too overstretched to cope and manage cases properly. Since transport is now charged in foreign currency most rural people cannot afford to travel to health centres. These people are dying at home with no help. Zimbabwe is currently violating health rights by failing to ensure equitable access to health facilities for its population.

The cholera outbreak stretches further an already collapsed health system. Resources have been diverted to managing the outbreak at the expense of management of other illnesses. Public hospitals remain barely functional. Health workers are yet to return to work. The Ministry of Health and Child Welfare (MoHCW) currently operates 50% of the CTCs and CTUs but have been unable to staff them adequately as they are unable to pay workers in foreign currency on a weekly basis as is the case in CTCs and CTUs co-managed by donor agencies.

Community deaths have accounted for 61% of cholera fatalities. It is clear that in spite of all the effort being made by donor agencies in conjunction with the Ministry of Health and Child Welfare there is still inadequate coverage by cholera treatment centres and units. According to the World Health Organisation the target for cholera deaths occurring outside of cholera treatment centres should be 0%. This unacceptably high number of community deaths reflects that lack of access to health care that Zimbabweans have faced in the last two years, and especially since the last half of 2008.

Not only "*our central hospitals are literally not functioning*,[14]" but clinics, district and provincial hospitals are no better. A disproportionate burden has been placed on mission hospitals which in many areas are now the only source of health care. Urban dwellers that can afford the transport costs are flocking to rural mission hospitals for treatment.

The collapse of the health system is the result of years of decreasing real spending on personnel and infrastructure. This will take years to rebuild and it is key that Government establishes clear priorities to avoid spending in areas that do not translate into any immediate benefit for Zimbabwe's population.

3. Safe Water and Adequate Sanitation

> ***"Access to safe water is a fundamental human need and, therefore, a basic human right. Contaminated water jeopardizes both the physical and social health of all people. It is an affront to human dignity."***
> *Kofi Annan, former United Nations Secretary-General.*

The cholera outbreak in Zimbabwe is the result of an inadequate supply of safe drinking water and broken down sanitation systems that often leave residents without safe water and surrounded by flowing

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[13] *Situation Report on Cholera in Zimbabwe*, Issue Number 10, 21 January 2009, United Nations Office for the Coordination of Humanitarian Affairs

[14] Former Minister of Health and Child Welfare, Dr David Parirenyatwa quoted during a meeting in which he declared the cholera outbreak a national emergency; The Herald, 4 December 2008

raw sewage. It is the Government of Zimbabwe's obligation to ensure that all Zimbabweans have access to safe water and adequate sewage disposal systems. General Comment Number 14 on the Rights to Health[15] cites an adequate supply of safe and potable water and sanitation as minimum essentials for fulfilment of the right to health. The government continues to be in violation of these rights by failing to ensure that these minimum obligations to Zimbabwe's population have been met.

Raw sewage from burst sewer pipes flows outside homes in Mkoba and Athlone, Gweru
Photos courtesy of Zimbabwe Lawyers for Human Rights

Burst sewer pipes with raw sewage running in the streets are common in high density areas. Blocked toilets in residential blocks (including Harare Central Hospital) are not attended to for extended periods of time forcing residents to defecate in the open. No water with which to flush toilets has the same effect.

In the absence of piped water urban residents have resorted to digging shallow wells (10-12 metres deep). These wells, which are above bedrock, are highly susceptible to contamination by faecal coliforms (bacteria passed out of the intestine) as they are fed by surface runoff water. They may be contaminated by faeces on the surface and by seepage from cracked sewer pipes underground. Cholera has found easy access to these wells which have in turn served as infection points. Faecal coliforms should be completely absent in water meant for domestic consumption. In February 2009 a team of

[15] General Comment 14 on The Right to the Highest Attainable Standard of Health; Committee on Economic, Social and Cultural

health experts from Bangladesh working with the World Health Organisation tested all water sources in Budiriro including taps, boreholes, dug out wells and drain water and found them to be *"heavily contaminated with total coliforms and some of them also contaminated with faecal coliforms."*[16]Water tests done on wells in Chitungwiza in September 2008 also showed a *"high level of faecal contamination in all of the tested wells."*[17]

In December 2008, four months into a major cholera outbreak, the Zimbabwe National Water Authority (ZINWA) ran out of aluminium sulphate supplies resulting in the Morton Jaffray Water Works stopping pumping of water to Harare.[18] In November the Minister of Local Government, Public Works and Urban Development, Ignatius Chombo, had insisted that ZINWA would remain in charge of water supply although it had failed to supply safe water to most residents. Mr Chombo was quoted as saying, ***"We have made a policy decision to get water under the Government. It is not the mandate of the new (Harare) mayor and his team to say we will get water back. Government has done a lot. Council should be grateful that government is assisting in a significant way."***[19]

Aid agencies have attempted to relieve the shortage of safe water by trucking water into the communities most at risk and rehabilitating boreholes in those areas. It has however been difficult to meet demand. In December 2008 German Agro Action (GAA), Action Contre La Faim (ACF), UNICEF, Population Services International (PSI) and Oxfam were trucking 360,000 litres water to residents of Budiriro on a daily basis. Estimated demand in Budiriro is 645,000 litres a day.[20]

Children Queuing for water in Budiriro

Restoration of piped water to areas where such infrastructure is in place must be given priority together with rehabilitation and sinking of new boreholes in areas where it is absent. "Unaccounted for water"[21] is currently estimated at 45% (up from 30% in 2000[22]). Reduction of this extraordinary proportion in Harare and other cities would be best achieved by prompt repair of leaks above and underground.

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[16] *"Water Sources Condemned";* The Herald Monday 16 February 2009

[17] Zimbabwe Humanitarian Situation report on cholera Outbreak, 12 September 2008, United Nations Office for the Coordination of Humanitarian Affairs

[18] *"Most Harare Suburbs Go Without Water",* The Herald, Thursday 1 December 2008

[19] The Herald, Tuesday 4 November 2008

[20] Regional Update 1, Cholera Outbreaks in Southern Africa, 8 December 2008, United Nations Office for the Coordination of Humanitarian Affairs

[21] Unaccounted-for water is the difference between the amount of water produced and the amount of water sold to all customers. Unaccounted-for water includes underground leakage; unauthorized use; unavoidable leakage, inaccurate meters; and unusual causes. Leakage is usually the largest part of unaccounted for water.

[22] See http://www.afro.who.int/wsh/countryprofiles/zimbabwe.pdf accessed 18 February 2009

4. Nutrition

The World Food Program (WFP) estimates that 7 million Zimbabweans will be in need of food aid between February and March 2009.[23] WFP has subsequently been forced to reduce the cereal ration to 5kg per person per month to ensure that food reaches a greater proportion of those in need. While these reduced rations will help millions more hungry people to survive, they will be more vulnerable and more susceptible to cholera and other disease because of less than adequate nutrition.

5. Management of Information/ Access to Information

Following the onset of the outbreak, the Government maintained a farce that a response to the outbreak was being well coordinated and that they had the outbreak under control. In early November following reports of 9 deaths from cholera in Budiriro, Minister of Health and Child Welfare, Dr David Parirenyatwa said the authorities had witnessed a reduction of cholera in cases in Budiriro.[24] Budiriro has since gone on to record over 8,000 cases of cholera and 195 fatalities. The World Health Organisation set the record straight in the WHO Epidemiological Bulletin Number 3 of December 2008 when they stated that the cholera outbreak was "*not yet under control*". On 4 December 2008 the then Minister of Health and Child Welfare Dr David Parirenyatwa held a meeting in which he finally declared the cholera outbreak a national emergency. However, President Robert Mugabe went on to claim on 11 December that cholera *was* under control. He was quoted as having said *"I am happy to say our doctors have been assisted by others, and WHO [the World Health Organisation] and they have now* ***arrested cholera****."*[25] Nothing could have been further from the truth.

Information subsequently became more readily available through United Nations Office for the Coordination of Humanitarian Affairs and WHO. However Zimbabwe's communication and reporting systems are currently very poor and this has impacted negatively on disease surveillance. Districts have often gone for long lengths of time without reporting. It is rare that more than 50% of districts affected will report on any given day and at times as few as 29% of districts have reported. There are also long delays before a district is heard from. For example as at 19 February Centenary had not reported for 9 days while Rushinga, Makumbe (Goromonzi), Murehwa, Mutoko and Lupane had not been heard from for 6 days.[26] ***"It is paramount to be able to reily on accurate surveillance data to monitor the evolution of the outbreak and put in place adequate intervention measures."***[27]

Under-reporting has affected interpretation of the data collected and made it difficult for those working on management of the outbreak to draw conclusions from the bits of information gathered. Under-reporting continued to be significant in the week of 8-14 February 2009.[28] The inability to communicate information on outbreaks quickly also impacts on the management of outbreaks. Timely reaction to outbreaks is paramount in reducing avoidable deaths. ***"If supporting agencies arrive on site with >1-2***

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[23] See http://www.wfp.org/node/3586 accessed 18 February 2009
[24] *"Cholera: CPU Steps In";* The Herald Tuesday 4 November 2008
[25] See http://www.reuters.com/article/worldNews/idUSTRE4BA1T320081211
[26] Daily Cholera Update, 22 February 2009, Ministry of Health and Child Welfare and World Health Organisation
[27] Prevention and Control of Cholera Outbreaks: WHO Policy and Recommendations, November 2008, World Health Organisation
[28] Cholera in Zimbabwe: Epidemiological Bulletin Number 10, 15 February 2009, World Health Organisation

***days of delay with respect to when the main outbreak wave starts, it is difficult to avert most avoidable deaths.*"**[29] In other words, a day or two's delay in response means many more people dead.

6. Health Education

The control of a cholera epidemic is most efficient when there is adequate education of communities on how the disease spreads and ways in which that spread can be prevented. There has not been enough awareness building in Zimbabwean communities, of cholera and how to prevent and manage it, and what there has been was late. The government finally launched a public education campaign on 5 January 2009, five months after the outbreak began.

61.3 % of cholera deaths occurring in the community deaths may also be a reflection of inadequate public education.[30].

7. Mortality

The cholera case fatality rate (CFR) is the percentage of patients that contract cholera that die as a result of it. CFRs should be below 1% if the disease is managed properly. The World Health Organisation cites 3 reasons that CFR's may be higher than 1%:

i. Poor case management due to insufficient numbers of health workers and inadequate training of those health workers that are present and insufficient supplies when the outbreak occurs;

ii. Lateness in seeking treatment by cholera patients and lack of early use of ORS and

iii. Bias of surveillance – that the deaths are being better recorded than the actual number of cases.[31]

Zimbabwe's CFR for the outbreak was 4.6% as at 25 February.[32] This was down from a high of 5.7% as at 21 January 2009.[33] This is unacceptably high. Even more unacceptable is the high percentage of deaths occurring outside of health facilities, 61.3% as at 25 February. The target for deaths outside of health facilities is 0%. In the week between 11 and 17 January 2009, 69% of cholera deaths occurred outside of treatment centres. As long as there are inadequate health facilities and staff and a limited amount of active case finding[34] this is unlikely to decrease significantly.

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[29] Cholera in Zimbabwe: Epidemiological Bulletin Number 1, 15 December 2008, World Health Organisation
[30] Community deaths constituted 61.3% of cholera fatalities as at 25 February 2009 - Daily Cholera Update, 25 February 2009, Ministry of Health and Child Welfare and World Health Organisation
[31] Prevention and Control of Cholera Outbreaks: WHO Policy and Recommendations, November 2008, World Health Organisation
[32] Daily Cholera Update, 25 February 2009, Ministry of Health and Child Welfare and World Health Organisation
[33] *Situation Report on Cholera in Zimbabwe*, Issue Number 10, 21 January 2009, United Nations Office for the Coordination of Humanitarian Affairs
[34] Active Case Finding consists of efforts to detect cholera patients in the community at early stages of the disease, educate the patient and their family and surrounding community and provide an appropriate clinical response.

The high CFR may not reflect quality of care in CTCs and CTUs. Now that there is a disaggregated CFR being calculated for community and institutional deaths[35] it is clear that much is being done to increase quality of case management in institutions and thereby to lower mortality rates. However the extraordinarily high CFR in the community reflects that there is an immense problem in ensuring that cholera patients are able to access health facilities and able to access them in time.

Zimbabwe's high CFR is also undoubtedly affected by the high prevalence rates of co-morbid conditions, namely malnutrition and HIV/AIDS. These are factors which place a cholera patient at greater risk of death. Seven million Zimbabweans are estimated to be in need of food aid and therefore more vulnerable to severe clinical cholera than in times when nutrition was more adequate.

With 15.1% of Zimbabwe's population infected with HIV, "***HIV infection can plausibly be assumed to increase the risk of infection, the risk of progression to symptomatic disease, and case-fatality from cholera, due to immune suppression. These increased risks, taken together, could mean a higher prevalence of HIV positive persons among cholera cases and cholera deaths especially, i.e. a self-selection of HIV-positives among cholera victims."***[36]

8. The response to the outbreak

There are several factors that have limited communities' ability to respond successfully, eg. lack of resources such as soap for hand washing, lack of sugar and salt to enable them to make Salt Sugar Solution (SSS)[37] at home for consumption until they can reach a health facility, and inability to afford transport to a health facility.

The World Health Organisation recommends rehydration through the administration of oral rehydration salts as the primary method of treating cholera. "Up to 80% of patients can be treated through the administration of ORS."[38] Intravenous fluids are used to hydrate patients in more severe cases. However, Zimbabwe seems to have initially adopted an approach of rehydrating all patients intravenously which not only constituted improper management of cases but also wastes resources. Rehydration through ORS is more cost effective than intravenous rehydration. The former Minister of Health and Child Welfare, Dr David Parirenyatwa, was quoted as having said *"hospital staff would receive all patients,* ***immediately put them on drips*** *and tests are carried out to ascertain whether the patient is infected with cholera."* [39] This is not only improper case management but also a waste and misdirection of resources such as infusion fluids and 'giving sets'.

There have also been undue beaurocratic restrictions placed on operations by humanitarian organisations by a government that is ill-equipped to afford its citizens their right to access health care. Médecins Sans Frontières (MSF), reported that in December when the number of cholera patients in Harare had reached a peak with close to 2000 admissions a week, it took them *"weeks to get permission to open a second empty ward"* at Beatrice Road Infectious Diseases Hospital.[40] Similar restrictions are said to have been faced when cholera broke out in Chegutu in December 2008. When MSF arrived in Chegutu ***"patients,***

[35] As at 25 February institutional CFR stood at 1.85% while crude CRF (combining institutional and community deaths) stood at 4.6%
[36] Cholera in Zimbabwe: Epidemiological Bulletin Number 1, 15 December 2008; World Health Organisation
[37] SSS is the home-made oral rehydration solution which Zimbabwe adopted very successfully as the cornerstone of its Diarrhoeal Disease Programme.
[38] Prevention and Control of Cholera Outbreaks: WHO Policy and Recommendations, November 2008, World Health Organisation
[39] The Herald, Monday 3 November 2008
[40] Beyond Cholera: Zimbabwe's Worsening Crisis, Médecins Sans Frontières, February 2009

dead and alive, were lying on the floor, sanitation services were non-existent and there was no water or food to be found."[41]

Conclusions and Recommendations

1. **The outbreak is the result of violations of the right to health and the right to access safe water and adequate sanitation. It has been compounded by the continued violation of these rights. The government has a responsibility to respect, protect and fulfil its obligations to the people of Zimbabwe in terms of these human rights and must take tangible steps to do so.**
2. **An emergency health response plan to restore function to the public health system must be produced and implemented. This plan should begin by focusing on making primary and secondary care services (clinics and district hospitals) affordable and accessible to all rather than placing excessive emphasis on tertiary and quaternary facilities (provincial and central hospitals).**
3. **The Government must ensure that health workers' concerns are addressed to ensure that conditions in which these workers return to work and their skills can be retained are put in place (including adequate remuneration and safe working conditions).**
4. **If the outbreak is to be brought under control and ultimately to an end there is an urgent need to restore safe potable water to the communities. Where infrastructure for piping water exists this needs to be rehabilitated.**
5. **Ensuring that communities make use of sanitary facilities for defaecation is vital. Efforts need to be put into improving sanitation – ensuring that everyone has access to a toilet connected to a septic tank or working public sewer system or a ventilated improved pit latrine.**
6. **Collapsed health information systems must receive urgent attention so as to improve disease surveillance and early warning systems**
7. **Health care must be affordable, accessible, acceptable and of good quality**
8. **Active case finding for cholera patients must continue and be scaled up in rural communities in tandem with health education.**
9. **The budget allocation to health must be increased to at least 15% of the budget (as agreed in the Abuja Declaration of 2001). The allocation for 2009 is just 8.3% although the government spoke of prioritising health in this year's budget.**
10. **There must be public accountability for all funds received for management of the cholera outbreak.**

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[41] See http://www.msf.org.uk/chaos_in_new_cholera_outbreak_20081218.news?fId=chaos_in_new_cholera_outbreak_20081218