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Zimbabwe, Factor 12: Human Diseases

Zimbabwe: Renovating Clinics and Improving Condom Education to Reduce HIV/AIDS of Hopeful Zimbabweans

Imagine a beautiful southern African country with tropical eastern mountains, and Victoria, the massive waterfall which forms the world's largest curtain of falling water. The climate supports crop growth, with a small temperature range between 56-69 degrees Fahrenheit from January to July, and an average rainfall of 33 inches. This country contains several precious natural resources, including gold, iron ore, and coal. Now, picture the same magnificent country overrun with air, water, and heavy metal pollution due to toxic waste produced by poor mining practices. For the people of Zimbabwe, this imaginary nightmare is their reality. Over 11.5 million people populate 400,000 square kilometers. Their population is regularly growing at about 2 percent each year (CIA World Factbook). However, the polluted and limited water supply already is unable to support the current population. What additional catastrophes could occur in the upcoming years?

In 1980, Zimbabwe gained independence from the United Kingdom. President Robert Mugabe has acted as a dictator - a sole ruler who has dominated the political culture (Country Watch). He enacted his land reconstruction plan, which seized white-owned farms and allowed native Zimbabweans to settle the land. Since the reform policy, farm production dropped nearly 70 percent, ruining the agricultural economy. This collapse had a ripple effect, resulting in total economic turmoil. Hyperinflation rapidly climbed, and it eventually reached an all-time high of 500 billion percent in 2008. Local currency virtually disappeared, and was replaced by foreign money such as the United States' (Country Watch). Unemployment peaked around 80 percent, leaving Zimbabweans in the misery of extreme poverty. Mugabe is blamed for the destruction of Zimbabwe's once lively economy, the spike in crime and violence, the reduced human rights, and the decrease in democracy (Country Watch). While international governments worry about Zimbabwe's political shambles and demolished economy, the people starve.

The disastrous political and economic crisis caused poverty among Zimbabwean families to skyrocket; between 1990 and 2003, the poverty rate rose from 25 percent to 63 percent (Rural Poverty Portal). Poverty strikes the country's total population despite socioeconomic class, gender, or age. From the declining number of 11 million Zimbabweans, 43.9 percent are 0 to 14 years of age, 52.2 percent are 15 to 64 years of age, and only 3.9 percent are over the age of 65. Overall, females have a slightly larger population than males. The average age for a Zimbabwean woman to birth her first child is 20.5. Steadily declining fertility rates show an average of 3.69 children per woman. Still, 32.31 out of 1,000 live births will result in death. Infants who survive are expected to live slightly over 45 years. Surprisingly, this number is annually growing despite current conditions. These boys and girls will usually attend school for nine years, and 90.7 percent of the population is literate due to the common schooling. As of 2000, education expenditures are 2.5 percent of the GDP (CIA World Factbook). Despite the rising life expectancy and excellent education opportunities, hunger remains a growing problem for the Zimbabwean children.

Farm families do not receive an adequate income, nor do they produce enough edible crops. More rural households turn to emergency aid from international governments every year (Rural Poverty Portal). These Zimbabweans rely on food staples, mainly maize, to feed their families. Mealie meal - or cornmeal - is used as a primary ingredient in several native dishes including Bota and Sadza. Bota is a mixture of cornmeal and water which forms a diluted porridge, and it is typically seasoned with milk or peanut butter. This simple meal is consumed for breakfast. Sadza is made by adding extra cornmeal to Bota to

create a chunky porridge. Accompanying Sadza are leafy vegetables such as spinach, or collard greens. Usually, Sadza is eaten for lunch and dinner (Maps of World). However, these meals lack sufficient nutrition for children's growing bodies. A conducted study showed both boys and girls between 8 and 15 are considered underweight. Their height and weight scored below the tenth percentile, meaning they are severely malnourished (US National Library of Medicine and National Institute of Health). The food and water the emaciated children consume also carries diseases. These illnesses include bacterial and protozoa diarrhea, hepatitis A, and typhoid fever (CIA World Factbook). Due to limited medical access, the food and waterborne diseases are extremely painful and fatal.

Access to medical doctors in Zimbabwe is chronically limited. According to the World Health Organization, "fewer than 2.3 health workers per 1,000 people would be insufficient to achieve coverage of primary health care needs" (CIA World Factbook). Currently, Zimbabwe's physician density is 0.06 per 1,000 people, a shocking statistic miles behind the recommended number and utterly heartbreaking. Thankfully, sanitation facility access has increased 40 percent across rural and urban communities (CIA World Factbook). Higher access to sanitation improves the quality of life for Zimbabweans, as well as their health. Although there are significant improvements, health expenditures are only 0.7 percent of the GDP, which is astonishingly less than surrounding African countries and other governments around the world. Lack of nutritious food and clean water result in health problems, which are left unattended because of the rarity of medical doctors. This tragedy causes the deaths of thousands of Zimbabweans.

Farming is an absolute necessity in order to provide food for the hungry Zimbabweans. The average small-scale farms are 125 hectometers (Country Pasture Profiles). Only 10.5 percent of the country is arable, but, only .31 percent is used (CIA World Factbook). Maize is Zimbabwe's major food staple. It is the most harvested and most exported crop. This prominent product is steadily in decline; Zimbabwe farmers produced less than one million tons of maize in 2013, compared to two million tons in 2000 (Fox News). Agriculture contributes to 18.1 percent of the GDP. (CIA World Factbook). Roughly 70 percent of the Zimbabwean population participates in farming (F.A.O. of the U.N.). This number is rather large compared to other countries, so why do they struggle from a hunger epidemic?

Most families who claim to participate in farming actually do not. Exuberant inflation has led Zimbabweans to pan for gold rather than plant food. They must dig and search for gold in rivers and dry land in order to buy a loaf of bread. Children do not attend school in order to pan for the precious metal. Parents are too focused on finding gold to pay for food, so they leave their farm fields barren. The elderly and disabled are too weak or unable to pan gold, which leaves them with empty pockets and empty stomachs. If the family cannot find an adequate amount of gold to buy food, parents will feed the children rats. If there are no rats, parents will abandon children to have one less mouth to feed (The Guardian). In the end, no one is satisfied and everyone is starving.

The extirpated economy has not helped Zimbabwe's food crisis. Economic growth decelerated in 2012, which reflected the political turmoil and economic uncertainties, an immensely high debt, and the deteriorating infrastructure. In 2013, the economy continued its downfall because of the decline in agriculture output, and the political tensions caused by President Mugabe's re-election (Country Watch). The GDP's "growth rate" is not growth at all - it's -6.2 percent. Per capita, the GDP is a measly \$200. Industry accounts for 22.6 percent, and agriculture only 18.1 percent. Zimbabweans who fall below the poverty line - 68 percent - directly mirror the destroyed economy (CIA World Factbook). Between 1990 and 2003, the poverty rate rose from 25 percent to 63 percent. Rural households, the farmers and food producers, account for most of this percentage because farm incomes and production are scarce, meaning poverty and food shortages are rising (Rural Poverty Portal). National infrastructure is a catastrophe. According to Rural Poverty Portal, "about 40 per cent of the road network is in poor condition, water and sanitation coverage is very poor, and railway freight traffic has declined by more than half since 1990, effectively isolating rural communities from markets." Every economic aspect of Zimbabwe creates

barriers. These barriers contribute to the ripple effect, which cumulates in a wave of depression, starvation, and failure.

Disease is a common killer in Zimbabwe. However, one deadly incurable disease has caused permanent damages to Zimbabwean families - HIV/AIDS. HIV has a long incubation period which is mostly unnoticeable. First, an infected person passes through the “acute infection” stage, and experiences a horrible flu while large quantities of the virus are being produced in the body. The second incubation stage is “clinical latency”, which lasts ten years without symptoms. After these stages, the infection progresses to AIDS. Without treatment, the victim will live for about three years. Transmission occurs through sexual contact, pregnancy, breastfeeding, needles, occupational exposure, and rarely organ transplants. One in five adults is living with HIV in Zimbabwe, and it is constantly spreading (Case Studies in Food Policy for Developing Countries). With 15.3 percent of the adult population infected, Zimbabwe has one of the most severe epidemics in the world. When conducting a census, the government lowers the total population number to take into account excess mortality due to AIDS. Not only is the life expectancy lowered, but AIDS also largely contributes to higher infant mortalities and higher maternal death rates (CIA World Factbook). Many of these tragic fatalities occur in rural communities, meaning the victims are farmers. As they die, so do their crops. Their children become orphans, and their customers starve.

By 2020, experts estimate the size of the labor force in Sub-Saharan Africa will be 10 to 30 percent smaller due to AIDS. This means the epidemic will only worsen. Zimbabwe is stuck in a vicious cycle that causes these catastrophes, including food insecurity. Victims of AIDS are the working members of the family so, “this decline in the working-age population has led to a decrease in area being cultivated, [and] less labor-intensive cropping patterns and animal production” (Case Studies in Food Policy for Developing Countries). One in nine children in the Sub-Saharan region are orphans. One in two orphans drop out of school, and thus remain ignorant of their surroundings, including deadly diseases such as AIDS. These uneducated adolescents cannot provide food for themselves or younger siblings, which leads to malnourishment. Prevention, care, and treatment rely on food security because malnourishment raises HIV exposure and susceptibility (Case Studies in Food Policy for Developing Countries). If the infected orphans survive childhood, they will pass the disease to sexual partners and their own children. The cycle repeats without an end in sight.

Women play a major role in the continuous cycle. A large gender inequality exists in Zimbabwe, because men hold the power over land and sexual relations. Land equals money, so essentially women are bound to their husbands. If a woman is not married, she will be driven into prostitution in order to make money to feed herself. By having multiple partners, HIV spreads like wildfire, and so does death. Often the male chooses not to wear a condom, and the woman does not object due to her low status and lack of education. Safe sex practices would significantly reduce the spread of AIDS, but women do not have access to information due to their low socioeconomic standing, and the men keep it a secret. Some African cultures encourage female genitalia mutilation to scare off sexual partners, thus preventing sexually transmitted diseases. But, the practice actually increases infection rates. Vertical transmission of HIV is rising along with the number infected. Pregnant mothers can pass HIV to the fetus in utero, or to a child during delivery or breastfeeding. Most Zimbabwean mothers breastfeed longer than average due to limited food supply, thus increasing chances of transmission (Case Studies in Food Policy for Developing Countries).

“The prevalence of HIV/AIDS in Zimbabwe has declined, but the rate [of 15.3 percent] remains one of the highest in the world” (Rural Poverty Portal). It is fifth in the world for HIV prevalence, and falls shortly behind four other Sub-Saharan countries including its neighbor South Africa who holds the top slot (CIA World Factbook). Counting deaths caused by AIDS in Zimbabwe is difficult due to the unorganized government and widespread chaos. However, groups such as the United Nations believe the

situation is slowly improving. “Only in Zimbabwe did both HIV prevalence and incidence fall” (Case Studies in Food Policy for Developing Countries). Few organizations have ventured to Zimbabwe to build clinics or spread AIDS/HIV prevention information. The programs currently in place are not large-scale, which restrains the majority of the agrarian population in reaching the care sites. Installed clinics are not common, and the rare few are called “expensive boutiques.” The three pillars to the AIDS policy are prevention, mitigation, and care (Case Studies in Food Policy for Developing Countries). However, none of these strategies are being implemented in Zimbabwe. If easily accessible clinics were to be constructed throughout rural and urban Zimbabwe, numerous aspects of everyday life would change for the better. Gender inequality gaps would be decreased by an increase in female sex education, and improved knowledge and treatment options for AIDS. Orphans would decrease due to lower maternal death rates, and the children could have the opportunity to stay in school. Mothers and fathers could return to the fields without suffering from AIDS symptoms. Food output would be increased because of the heightened labor force. Zimbabweans would no longer be hungry.

Several other major issues present in Zimbabwe contribute to the AIDS epidemic, including lack of education, government turmoil, and water scarcity. Agrarian families have limited or no access to public school systems. One in nine children become orphans due to parental deaths related to AIDS, and half of these orphans decide to drop out of school to cater to their basic needs (Case Studies in Food Policy for Developing Countries). Without a basic education, these children are unaware of AIDS, and follow their parent’s footsteps (Interagency Coalition on AIDS and Development). However, the group who suffers the most from a lack of education is women. Females have minimal access to clinics with HIV/AIDS information, thus putting themselves at risk. If Zimbabwean women knew how to prevent and treat AIDS, the rate of infection would decrease while the quality of life would skyrocket. In order to install these educational facilities for children and women, the government must deduct money from its budget to fund construction and employment. As of 2000, education expenditures only account for a measly 2.5 percent of the GDP (CIA World Factbook). If Zimbabwe’s education is going to improve, then the government must improve, too.

Zimbabwe is currently enduring one of the worst political upheavals in the world. The economy and government collapsed in 2008, which disrupted every aspect of life from agriculture to public services (Country Watch). In September of that year, inflation reached almost 500 billion percent. However, the stubborn dictator-like Mugabe refuses to pass reforms to stabilize the crumbling economy (CIA World Factbook). Robert Mugabe has ignored human rights activists, and as a result, Zimbabwe has one of the worst human rights records in the world (Country Watch). Native citizens describe Mugabe as “the destroyer of their lives” and they have fear for their country’s future (The Guardian).

Victoria Falls is located on the Zambezi River which divides Zambia and Zimbabwe. The strikingly beautiful waterfall forms the world’s largest curtain of falling water (CIA World Factbook). While tourists and fortunate citizens visit this beautiful wonder, local villagers pan for gold specks in muddy rivers. Children desperately search in the filth-ridden rivers for a few grams of gold to pay for basic necessities for their families (The Guardian). However, gold is not the only substance running through the grotesque rivers. These rivers are contaminated with diseases, such as schistosomiasis (CIA World Factbook). Schistosomiasis is caused by a parasitic worm which causes both severe abdominal pain and lasting physical damage. Untreated, the disease will persist and lead to an increased risk of cancer (Centers for Disease Control and Prevention). Another hazardous aspect of Zimbabwean water sources is pollution (Country Watch). Poor Zimbabwean mining practices have led to toxic waste and heavy metal pollution (CIA World Factbook). The people have no other option except to rely on the infected water for money and hydration; recurring droughts have riddled the country with disaster. Water scarcity is especially an issue for farmers. Crop production has decreased as a result of these droughts. By investing in irrigation systems and water harvesting, productivity and food output will improve (Rural Poverty Portal). But, these changes have not been implemented in Zimbabwe. Therefore, droughts cause the dependency on

foreign aid (International Business Times). Many rural families have limited accessibility to outside food aid, and the families are left malnourished. When the families become malnourished, susceptibility to AIDS increases. The numerous water problems have a direct impact on AIDS: the more water pollution and droughts, the increase in AIDS cases.

Combating HIV/AIDS is the sixth Millennium Development goal of the United Nations. Currently, the United Nations Country Team (UNCT) in Zimbabwe is implementing the Zimbabwe United Nations Development Assistance Framework (ZUNDAF) and the Common Humanitarian Action Plan (The United Nations). Zimbabwe's three goals to reverse HIV/AIDS are to "improve access (and uptake of) to HIV prevention services, improve access to (and uptake of) HIV treatment, care, and support services, and improved leadership, coordination and management of the multi-sectoral HIV response" (United Nations Zimbabwe). To reach these goals by 2015, assistance from the United Nations will derive from financial funding of an estimated \$219.6 million U.S. dollars (United Nations Zimbabwe). However, previous relief efforts have been cut short due to limited budgets. The World Food Programme was forced to reduce rations in half because of a \$60 million shortfall in February of 2014. As of March 2014, WFP and their affiliate programs will further reduce aid. The 1.2 million rural Zimbabweans the administration helps could suddenly lose the crucial assistance due to money shortages (World Food Programme). One pressing question faces all relief programs: how should organizations efficiently spend relief money to achieve the most success?

First, programs must invest in the distribution of antiretroviral therapy (ART). ART is the combination of several antiretroviral (ARV) drugs which work together to "maximally suppress the HIV virus and stop the progression of HIV disease" (World Health Organization). In 2013, the World Health Organization also recommended the use of ARV to prevent HIV infection. ARV has already reduced death rates and suffering when used in the early stages of the virus (World Health Organization). In Zimbabwe's neighboring country Zambia, the Ministry of Health has built 68 new ART treatment sites where 400,000 Zambians have access to free HIV/AIDS care (The United Nations). Similar progress could be achieved in Zimbabwe with ART sites, too.

Second, education about HIV transmission and condom usage needs to increase. Zimbabweans do not use condoms for two reasons: they are unaware of the consequences of unprotected sex, and they have no access to condoms. An estimated 13 billion condoms are needed to end the spread of HIV. But, many developing countries do not have enough donor support to import condoms, and to distribute them to citizens for free. The national government cannot purchase condoms, because the funds are vitally needed for food (United Nations Fund for Population Activities). With education about HIV/AIDS and accessibility to condoms, the spread of HIV could quickly decline.

Currently, Zimbabwe has 131 HIV-care facilities with trained medical personnel. Only 16 percent of the clinics are funded by nongovernment organizations, including private, faith-based, and charity groups. Clinics tend to centralize around the two major cities, Harare and Bulawayo. Western Zimbabwe has far fewer clinics, and they have poor communication (World Health Organization). Better equipped clinics must be built in remote areas to allow accessibility to rural families. These existing clinics provide ART to registered patients, but the limited space to store ARV and treat patients severely limits the quality and quantity of health care (United Nations Development Programme). By 2015, existing clinics should be renovated to repair relevant issues. Beyond the one-year time frame, more clinics should be built in isolated areas to more easily reach rural families.

The E.F. Watson Medical Clinic in Bulawayo, Zimbabwe is suffering from a shortage of space. Two-hundred patients arrive daily for HIV testing and treatment but, with the limited space, nurse Ivy Chiyani says, "this is a big challenge" (United Nations Development Programme). An opportunistic infections clinic recently opened alongside the E.F. Watson clinic, but the new addition requires more storage to house antiretroviral drugs. To accommodate their needs, the Global Fund gave a grant to construct a

standard pharmaceutical storage room (United Nations Development Programme). Nurse Chiyani believes the renovation will “greatly improve patient welfare and our challenging working environment” (United Nations Development Programme). Other clinics should be repaired to fix significant problems. Updates should occur in each clinic too. These updates would include the addition of better technology to improve communication, educational products such as pamphlets to teach patients about HIV/AIDS, and civilian accessibility to condoms. If other organizations donated money to repair and update clinics, more Zimbabweans could be treated and protected against HIV.

Local communities, the national government, and nongovernment organizations will all need to cooperate and contribute to implement the recommendations listed above. Zimbabwe civilians will play a large role in making these recommendations a reality. The planning, construction, and upkeep of the revamped facilities must be done by Zimbabweans. Employees responsible for managing the supply and distribution of antiretroviral drugs will be local citizens. They will be paid, thus improving their lives.

The national government’s role would not be major compared to the Zimbabwean citizens. But, their cooperation and support will be needed to put the recommendations into action. The government should actively seek international aid, rather than hoping a charity will help the country without invitation. It is unlikely the government would agree to expand the budget to include HIV/AIDS clinic repair. Maintaining the current Zimbabwe National AIDS Trust Fund would be sufficient. This fund has continued to gain money each year, and as of 2010 it collected 25 million dollars (National AIDS Council). Local governments could raise education benchmarks to include sexual education for adolescents. If the governments agreed, the money would serve a good cause.

Nongovernment organizations and charities are absolutely vital to the execution of the recommendations. Funding will largely derive from grants given by large operations such as the Global Fund, the Ministry of Health and Child Care, or the United Nations Office for Project Services. All three of these life-saving groups coordinate, fund, and manage humanitarian projects. With their resources, these organizations could renovate Zimbabwean clinics. The Centers for Disease Control and Prevention have condom distribution programs, and these programs could be implemented in Zimbabwe to provide free, widely accessible condoms (Centers for Disease Control and Prevention). Members from these groups could train locals to spread HIV/AIDS knowledge to new generations after their departure. If these associations could collaborate, the recommendations could be quickly and efficiently implemented due to their expertise, funds, and resources.

Currently, Zimbabwe is burdened with numerous crushing problems which prevent the developing country from growing into a democratic paradise. An economic crisis recently struck with unprecedented consequences. President Mugabe failed to initiate a recovery plan to combat the catastrophe. A poverty rate of 68 percent reflects the economic shambles and political turmoil. These financially troubled families cannot afford to feed their children. More rural families are forced to receive emergency aid each year. Malnourished people are more susceptible to infections which are common throughout the disease ridden Zimbabwe. Early fatalities happen every day due to limited medical access. The deadliest disease in Zimbabwe is AIDS. This virus has infiltrated almost one fifth of the entire Zimbabwean population (CIA World Factbook). Poor sexual education, gender inequality, and limited access to treatment all contribute to the monstrous stampede of HIV/AIDS. If communities, the national government, and outside organizations joined arms, the movement would be invincible. With the combined funds, existing HIV/AIDS clinics could be repaired and renovated to better serve the suffering people. New storage facilities could be added to expand space for patients, and technology for communications could be improved. The distribution of the lifesaving antiretroviral drugs and education of protective condoms could be increased. However, amidst the severe devastation, Zimbabweans hold the most powerful weapon against HIV/AIDS - hope. Every Zimbabwean is a survivor, whether they have survived the economic fiasco, the horrific starvation, or the pain of HIV/AIDS. Eventually, HIV/AIDS can be

eliminated from Zimbabwe. Hope is visible in the mother's arms. Hope is visible in the farmer's fields. Hope is visible in the doctors' persistence. Hope is visible in the eyes of the survivors.

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