

New fallacies about HIV-AIDS in Zimbabwe

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Accepted 27 May, 2013

ABSTRACT

Since 1990, the Zimbabwe government has struggled with the devastating effects of HIV-Aids pandemic. By cooperating with the US government and world non-governmental organizations (NGOs), such as the United States AID (USAID), United Nations Aids Fund (UNAIDS), United Nations Children's Fund (Unicef), Families with Aids Care Trust (Fact) and faith based organizations, such as the Salvation Army, the prevalence rate has declined from 32% in 1990 to 15.3% in 2010. Based on this obvious success, and the fear that foreign NGOs interfere in the internal politics of the country, the Zimbabwe government has asked these organizations to close and hand over their operations and resources to the government controlled National Aids Council. The paper argues that when NGOs are forced to close operations, they do not hand over their resources to a foreign government. They dismiss workers and migrate to a neighboring country. Secondly, the new prevalence figure of 15.3% is the fifth highest in the world. When taking into account high HIV-AIDS related deaths between 2004 and 2010, and the huge migration from Zimbabwe of 3.5 million people during that same period, the lower HIV-AIDS prevalence is due to these factors rather than an improvement in prevention. Consolidating NGOs work under the government umbrella actually dissipates resources rather than consolidates them. Resources falling under government control are subject to looting and political mismanagement. An additional fallacy is a government program that gives the impression that circumcision is a cure.

Keywords: HIV-AIDS, fallacies, non-governmental organizations, Zimbabwe, government, prevalence, National Aids Council.

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INTRODUCTION

In 1996, this author directed a three person team to make a comparative study of the causes related to HIV-AIDS prevalence in Zimbabwe and to make policy recommendations usable by political authorities in Southern African countries, including Zimbabwe. The six year research, based on Clemson University School of Nursing Professor Shirley Timmons' doctoral dissertation, was entitled: "Knowledge Efficacy as a Preventive Paradigm for Addressing HIV-Aids Pandemic." In this study, published in AFRICA INSIGHT under the same name, the conclusion was inescapable that knowledge alone was insufficient as a deterrent to risky behavior. Whether the subjects were African Americans in South Carolina or Africans in Malawi-Zimbabwe-South African labor migrant corridor, knowledge efficacy did not overcome resistance to behavior change; "in terms of how HIV is transmitted and what risk prevention

behaviors exist, such as condom use. Many individuals, however, have failed to heed this information or to change their at risk sexual behavior." This behavior is referred to in both the United Nations and the Center for Disease Control to suggest a need for the study of new preventive measures in view of the failure of knowledge efficacy as a preventative measure (Mufuka et al., 2006).

Data related to Central Africa labor migration to the gold mines, gleaned over from Scottish missionaries, and dating back to between 1905 and 1932, revealed that as early as 1932, the prevalence of venereal diseases and the destruction of family cohesion were part of a three headed monster. Missionaries became aware that sexual diseases spread largely through labor migration from Malawi through Rhodesia (Zimbabwe) into the South African gold mines and vice versa. Migration of young men from Malawi to the gold mines of South Africa was

considered the most singular cause in the transmission of this venereal disease epidemic. A United Missionary Conference Report for 1935 said that: "Very few Europeans... acknowledge the degree of wretchedness when a wife is abandoned by her husband and is left in the village." (Colonial Office Report, 193525/166/4 40531).

The most damaging conclusion was that of the 400,000 men employed in the gold mines, as many as 90% were at one time or other infected by venereal disease.

"Home life will cease to exist; all belief in the sanctity of marriage will disappear. In consequence, venereal disease will affect one hundred percent of the population. The birth rate will fall... and resident chiefly in other lands, the (Malawi) born natives will have acquired mistrust and loathing for administration by white people which made a wilderness and called it peace." (Mufuka, 1977).

The contributory nature of labor migration as a singular most important cause has already been referred to earlier. Secondly, one issue regarded as problematic was the ineffective treatment of the disease. The men, who worked for two years at a time, returned home to their wives, perhaps partially treated or in the early stages of incubation. Wives were innocent receptors of the disease. Other causes might be polygamy and blood rituals related to circumcision and puberty ceremonies (James, 1996).

The debate about HIV-AIDS epidemic should therefore be placed in the context of long standing economic and health problems associated with the movement of labor to and from the rural areas into urban areas. The failure of colonial governments to control, treat and to take preventative measures also date back to 1935.

CURRENT FALLACIES

The statistics relating to HIV-AIDS prevalence in Zimbabwe between 2003 and 2010 have shown a remarkable decline in new cases. This has led the authorities to believe that their education programs and health packages designed by the United Nations AIDS (UNIAIDS) and the USAID programs have been successful.

As a reaction to this, the Zimbabwe government has been quietly expelling donor related organizations, or compelling them to work through government organs, or simply hand over their resources and money to a government body, the National Aids Council.

If we include long established missionary societies as well as proto Christian groups coming from the United States, there are, according to government statistics, more than 2000 donor related organizations. Obviously,

some kind of co-ordination is necessary. However, the real reason behind government hostility is the assumption that during and before an election, these societies, on the whole, tend to favor the opposition Movement for Democratic Change. As such, resources garnered from these societies, if channeled through government, will be neutralized, or at best channeled towards government sympathizers. Assuming that foreign organizations continue to fund the program, government workers can use donor funded monies to augment their salaries as well as donor funded transport vehicles, such as all-terrain vehicles. This is the case with the National Aids Council, whose transport vehicles and office management systems were donated from UNIADS organization (Chimhuru, 2011).

Thesis

The proposition by the Government of Zimbabwe (GOZ) that the spread of HIV-AIDS has been arrested due to its educational and treatment programs, is premature. Data used for years between 2006 and 2011 showing that HIV-AIDS prevalence for adults has declined from 18% by three percentage points is, in our opinion, inconclusive. These figures are collected largely from pregnant women who must, by government regulation, undergo HIV-AIDS tests before giving birth. This information excludes a large proportion of sexually active adults who do not wish to have children.

The improved prevalence rates were probably due to massive emigration from Zimbabwe as well as cumulative deaths recorded between 2000 and 2010.

The second proposition by GOZ that consolidating resources into the National AIDS Council will avoid duplication and increase the efficiency of the national effort is theoretically correct but wrong in practice. In practice, when foreign organizations lose financial control of operations and personnel, they tend to close shop and migrate to neighboring countries.

METHODOLOGY

The field research took five years and covered Saunyama Tribal Trust Lands and the Nyanga- Selbourne plantations. The area was chosen because it lies along the Malawi-Mozambique-Johannesburg labor migratory route. The plantations are almost entirely populated by migrant labor. Howard Hospital is in Mashonaland North while Masvingo Province is in Southern Zimbabwe. These two were used for comparative purposes. As is common in such researches, many informants prefer to remain anonymous.

THE DEBATE

Pursuing this line of argument, the governor of Masvingo Province discontinued 29 NGOs in one month alone

(June 2011) on the grounds that their work can best be done through his office. At the national level, United States AID (USAID), the largest donor for HIV-AIDS related diseases, discontinued its operations in Zimbabwe and transferred them to the United Nations Development Program. In the transfer of responsibilities, USAID donated \$26.4 million to the project, a tenth of what they had done previously. A larger sum of \$300 million went to Zambia and \$130 million to Namibia where the organization was not subjected to restrictions. Similarly, the Global Fund discontinued its financial support for the GOZ National Aids Council, instead donating \$37.9 million to the UNDP. Two years earlier (2009), donor organizations had funded 76% of all HIV-AIDS projects in Zimbabwe. Without this donor support in 2012, the GOZ funding for these projects suffered a \$227 million deficit (AVERT-Global HIV-AIDS Fund Report, 2012).

A case study of Howard Hospital, run by the Salvation Army, revealed that government interference in the personnel and financial management of the institution, far from yielding positive results, led to a boycott by Canadian donor organizations and the subsequent degradation of the hospital. Details will be provided later.

While government gave a positive view of the overall HIV-AIDS scenario, research generated by the University of Zimbabwe women's study division was not encouraging. A University of Zimbabwe study gives a breakdown of HIV-AIDS prevalence by age groups. The concentration of HIV-AIDS prevalence among certain at risk groups indicates that the problem is far from being contained. While HIV-AIDS prevalence is 18% among adult women and 12% among men, it reaches the 29% mark among men in the 30 to 34 age groups and gets slightly higher among the 45 to 49 age groups. In that age group, it goes up by one percentage point. These statistics correlate with social factors. Men in the 45 to 49 age groups have reached their highest earning capacity and because of their enhanced social status are able to command the attention of more than one partner (Tauya, 2012).

When the University of Zimbabwe HIV-AIDS research group examined HIV-AIDS related figures over a period of five years, prior to 2011, it uncovered new fallacies among the respondents. Among these new fallacies, was that circumcision among men was equivalent to inoculation. As such, the use of condoms was no longer necessary. In addition, there was a widespread belief that since women infected with HIV-AIDS could bear children, a cure had been found for the disease. However, the report states, "the HIV-AIDS prevalence rate among circumcised males between the ages of 15 and 49 in Zimbabwe is higher than that of uncircumcised males owing to the misconception that circumcision completely shields men from infection. According to the latest Health Demographic Survey, the prevalence rate among the circumcised is 14% while that of the uncircumcised is

12%" (Tauya, 2012).

The Zimbabwe government rightly prides itself in taking the right measures in combating HIV-AIDS infections. While some measures have been discussed above, special preventative measures aimed at those who had not yet been exposed, or if exposed, could be prevented from exposing others were laudable. Despite cultural barriers that prohibit explicit exposure to sexual conversations in schools, Zimbabwe schools approached the issue of HIV-AIDS in a direct and explicit manner following western European examples. FACT, a non-governmental organization supported by USAID and other foreign funds set up village cells and leadership committees to teach, give away pamphlets, encourage testing and give early advice to those showing signs of infection.

The Zimbabwe Family Planning Association, in tandem with village health workers, also spread the word. The Zimbabwe government can therefore boast that there is no village in Zimbabwe that was not exposed to HIV-AIDS information between 2000 and 2010.

The Global HIV-AIDS Fund, also known as AVERT, in its annual report for July 2012 shows a remarkable decline in HIV-AIDS related deaths between 2001 and 2010. Based on this report and its own statistics, the National Aids Council estimated that the mean prevalence between 2003 and 2010 had dropped from 28.1 to 15.3. The success rate can be measured as shown in Table 1.

As shown in Table 1, the mean prevalence figures used are in the last column. These reveal that HIV-AIDS prevalence has dropped from 1.9 million in 2003 to 1.3 million in 2010. The mean figure is even more impressive at 15.3% of the population, a reduction of almost 50% in seven years. The conclusion is that Zimbabwe is now able to manage its health affairs and that foreign organizations should hand over their tasks and resources to local management through the National Aids Council.

Brian Nyathi, a health practitioner, suggested that the success rate has been over blown in order to underscore Zimbabwe's ability to takeover foreign assistance resources. The number of Zimbabweans who have migrated between 2000 and 2010 is estimated to be 3.5 million. "The ones that are left are so struck by poverty and the collapse of the health system that they cannot access the hospitals" due to user fees and distances. Many of those who left the country did so in order to receive treatment, either for themselves, or for their loved ones (AVERT-Global HIV-AIDS Global Fund Report, 2012).

University of Zimbabwe HIV-AIDS research unit documents indicate that the Zimbabwe government, despite all the help it has received from world organizations, has only been able to reach 80% of those affected by HIV-AIDS. The latest report from the National Aids Council itself supports this view. During the last few years, the number of people requiring HIV-AIDS treat-

Table 1. Decline in HIV-AIDS prevalence 2003 to 2010.

Year	AIDS Prevalence	Deaths	Mean prevalence
2003	1.9 million	1.6	28.1
2004	80,000 children	56,000	
	440,000 women	800,000	
	380,000 men	544,000	
2010	1.3 million (total)	6581 children	15.3 (NAC)
	152,189 children	15% (combined)	
	300,000 adults		

ment packages has been rising. Those requiring treatment packages in “Zimbabwe is 503,678 adults over 15 years and 89,490 children under age 15. The number of patients in need of ART has also increased over the years from 350,000 in 2009 to 503,000 in 2010.” (10)

Further, the actual accessibility to treatment is 78% for adults and 45% for children; both figures are far below the standards set by the World Health Organization.

HIV-AIDS curable

In the early versions of HIV-AIDS syndrome, a common denominator among patients in East Africa was the severe loss of weight so that a formerly bouncy person became but a shadow of former self. In Malawi and Zimbabwe, then, it was simply known as the “thinning disease.” However, with time, it was realized that HIV-AIDS was not itself a disease but a condition on which other parasitic diseases used as a bandwagon.

Thus, Dr. Leon Sullivan, US Secretary of Health, 1988 to 1992, was himself confused. Being aware of the complicated interaction between malnutrition, poverty, hunger and a plethora of diseases that had not been completely wiped off the map of Africa, he was not certain what to recommend to the George W. Bush administration of which he was an emissary. Should the eradication of poverty take precedence over the treatment of HIV-AIDS related sicknesses, knowing full well that the base cause of these diseases was poverty itself? He prevaricated and dodged the issue. In his famous Sullivan Report, 1991, he wrote:

“The disease AIDS in Africa is only one of many diseases. They have not yet brought this disease to heel, though it adds to an already complicated situation. They estimate that malnutrition (affects) 30% of African children twelve to twenty three months old. Other vaccine preventable diseases that cause substantial sickness and death in African children include neonatal tetanus, whooping cough, polio, and diphtheria. In

Zimbabwe, half the pediatric hospital admissions in the capital city were for HIV associated diseases.” (Sullivan, 1991).

Sullivan, writing in 1991, could not have imagined an easy solution to malnutrition, especially in children because he had a US regiment of food requirements, inaccessible and unaffordable for African children.

In 1996, two Frenchmen, Andre Briend, a pediatrician and Michael Lescame, a food specialist produced a food paste based on the peanut paste, but fortified with fats, carbohydrates and proteins as well as vitamins and minerals. In the past, infant malnutrition required an amount of hospitalization. The attraction of this new Plumpy Nut (as it was called) was that it was easy to store, transport and mothers could administer the paste within their homes. A United Nations Report recognized the significance of this ready to use food paste in 2007, thus giving it its official blessing. “New evidence suggests that large numbers of children with severe acute malnutrition can be treated in their communities without being admitted to a health facility or a feeding center”. (Abate and Bowman, 2012)

In Zimbabwe, village health workers, working with HIV-AIDS support workers were able to include this new food nutrient in their arsenal. The more popular one was a Swiss food package called Nutella. Plumpy Nut was, however, out of reach. The cost was U\$60 per package, a man’s wage per month. Arrangements and compromises about patents were made through the United Nations Children’s Fund (UNICEF) to make these new discoveries available to the Zimbabwe government workers.

Researchers from the University of Maryland, Dr. C.G. Abate and Dr. D. Bowman who wrote a guide for use by HIV-AIDS Health Workers state that throughout Africa, these three factors are always intertwined. Use of fees for children showing signs of infection causes delays. The cost of medicine even when available is usually beyond reach. Malnutrition is always an accessory to the fact and requires supervised feeding. In their experience, in order to save lives and avoid delays in treatment and feeding,

they often waived user fees. This makes the presence of foreign aid groups even more necessary as African countries are unable to bear the costs. Abate and Bowman's report mentions a unique feature of African conditions, very common in Zimbabwe as well as in West Africa, where their research was based. Even under good conditions, governments willing to cooperate, lines of communications always break down and the supply of medicines and food are interrupted (UN Food Agency, 2012).

Abate and Bowman expressed a kindly view of the relationship between African authorities. As the experience of Dr. Thistle of the Salvation Army, discussed in some detail below, the interruption of foreign aid and supplies by authorities is very often intentional.

The report of the World Food Program for Zimbabwe (June 2012) makes a direct connection between HIV-Aids prevalence and the shortage of food in Zimbabwe for the rainy season, October to March 2012-2013. While estimating that 1.6 million Zimbabweans are on the verge of starvation at the beginning of the rainy season, the report says:

“Food production has been devastated by a combination of economic and political instability and natural disasters. Recurrent droughts, a series of very poor harvests, high unemployment (estimated at more than 60%) a restructuring of the agricultural sector and a high HIV-AIDS prevalence rate at 13.7%, the fifth largest in the world, have all contributed to increasing levels of vulnerability and acute food insecurity since 2001. This situation necessitates large scale humanitarian food assistance operations in the country.” (UN Food Agency, 2012).

The presence of foreign aid organizations, especially in the provision of HIV-AIDS medicines and nutritional supplements has enabled patients to overcome the visible signs of HIV-AIDS syndrome, in particular the thinning apparition factor so dreaded by patients themselves and by relatives of the patients. The Provincial Medical officer for Manicaland, Dr. Edward Chimhuru, also chief National Aids Council Officer, reported that the new feeding program for children begins bearing results within two weeks of its inception. Similarly, adults placed on some weight enhancement drugs have fully recovered from weight loss and in many cases became almost obese. These successes have given the impression that HIV-AIDS can be cured and that patients can live a normal life after treatment. What is missing is the seriousness of missing or skipping treatment regiment during such times of euphoric relief from the previous suffering. Subjects exposed to HIV-AIDS, who have undergone the treatment regiment, have gone on to marry and have children further strengthening the belief that HIV-AIDS syndrome can be cured

(National Aids Council, 2011).

The figures amount to 600,000 children and adults in need of some “packages” from the Health Ministry. The US NGOs have been withdrawing their ground agents since the beginning of 2012. Family Aids Caring Trust, a US supported NGO has withdrawn its troops from the ground. Director Elijah Nyamavuvu's letter was dated 19 March stated that the agents had left the field by January 1 (Nyamavuvu, 2012).

The work of FACT and other organizations were being consolidated into the National Aid Council. Also, downgraded was the work by the United Nations Population Fund.

POLITICAL PROBLEMS

Missionaries are quasi foreign agencies, and since they are associated with former imperialist home countries and outlook, they have unique problems with the Zimbabwe government.

The Zimbabwe government accuses aid givers of a colonial and superior attitude towards black authorities, whom they regard as responsible for the grueling poverty in a country that is rich in minerals. Dr. Paul Thistle, a radical Salvation Army Canadian missionary, who headed Howard Hospital, illustrates a typical love hate relationship between donors and recipients of aid.

With support from Scarborough Salvation Army Corps in Toronto and Canadian friends, Thistle's fame at Howard mirrored that of Dr. David Livingstone, whom he admired. It became apparent that as the number of HIV-AIDS orphans reached 1500, the daily feeding program of Bida (nutritional porridge) rations was a temporary measure. Without educational opportunities, the orphans were condemned to a life of poverty. With friends in Canada, an Adopt a Hospital Foundation was set up in Calgary, Canada. Mrs Barbara Mushayandebvu, R.N. a former student at Howard Institute and her husband Professor Martin Mushayandebvu, PhD, a Zimbabwean geologist, were founding members of the twelve member board of directors. With the help of a Canadian doctor and the Rotary Club in their province, they began to source for funds to help Howard Hospital. The statistics reveal that Zimbabwe government contributed \$7000 towards the running of the hospital in the year 2011. The Canadian Foundation reported revenues of \$500,000 that same year (Table 2). In the year 2012, the Foundation collected by mid-year \$300,000 and bought an ambulance valued at \$114,000. Thus, the Foundation contributed 51% of all revenues while government contributed less than 8% (Hospital Zimbabwe Foundation Report for Howard Hospital, 2011).

The relationship between Howard Hospital and GOZ is complicated. In brief, there are three areas of conflict. Since 2000, the year of land invasions, and the subsequent disruption of the foreign exchange

Table 2. Financial Commitments 2011: NGO versus GOZ.

Contributions 2011	Amount (US\$)
Zimbabwe Government	7,000
Canadian Foundation (ambulance)	114,000
Estimated Canadian Revenues	500,000
Zimbabwe Govt. exp. per person per year	0.38
Human Output	Number
Population covered	270,000
Sick patients seen in 2011	7,813
Babies delivered in 2011 (estimate)	200

mechanism managed by the Reserve Bank of Zimbabwe (RBZ) foreign funds denominated in US dollars were subject to multiple exchange regimes. For instance the exchange rate for politicians was Z33 dollars to US1. The second rate was that applied by Customs and Exercise regime, starting at Z\$250 per US1. The black market regime was Z\$2000 to US1. NGOs, sending their money through the RBZ felt cheated. Quite often the money never reached the local organizations for which it was intended. The second problem that faced NGOs was that in consolidating services, GOZ wanted some say or control of the finances of each organization. In that case, Dr. Thistle reported that medical supplies worth US\$17000, intended for Howard Hospital from Canada, had been redirected elsewhere. The third problem was that during and after elections (2002, 2008) opposition workers who were beaten up by GOZ thugs were treated at Howard Hospital. GOZ demanded information and that those treated at the hospital be handed over to the authorities (Oral sources in Zimbabwe, 2012).

While Thistle was indifferent to the political affiliation of patients at the church hospital, government was not. Government interference led to Thistle's dismissal. Six months after Thistle's dismissal, the hospital was no longer able to fulfill its obligations. "Howard depends largely on donors, mostly from Canada, but since Thistle's departure, they have been withholding funds because they are afraid that they will be misused." The report adds that "the hospital is short of drugs and other health consumables. The wards are dirty, lacked fresh air and were mostly empty." (Shoko, 2013)

K-International

This outfit has moved away from HIV-AIDS related aid programs to hunger relief. The UN estimated that 1.6 million people were affected in Masvingo Province. The Zimbabwe government nominated families to be served.

K-International enumerators, working as auditors found serious discrepancies in some listed victims. One family had twenty head of cattle, a "bunch of goats" and

chickens. While enumerators worked in communal areas, they were forbidden entry into resettlements. Enumerators believed that the need was greater in resettlements than in communal areas. Government preferred to distribute supplies through its own organs.

K-International felt that government organizations were corrupt, that it favored ZANU members in its distribution of aid.

Then K-International itself suffered from an internal anti-racist protest by workers against an Australian official who used inappropriate words in interaction with blacks. The Central Intelligence Organization which works from the Zimbabwe Presidium blew everything out of proportion, taking the incident as an affront to the sovereignty of the country. The Australian female thus regarded, fearing incarceration, fled to her native Australia before she was apprehended.

No win situation

The HIV-AIDS funding is in a crisis. Zimbabwe's national bill for HIV-AIDS treatment packages for 2012, supported by the USAID was US\$39 million. An estimated shortfall of US\$10.9 million was expected for the supplies already ordered for that year. Whether USAID continued to foot the whole bill depended on whether President Barack Obama was re-elected in the US election of November 2012.

If USAID (including that which comes from NGOs) is withdrawn, the hope of defeating the HIV-AIDS crisis by 2015 is lost. At the same time, Zimbabwe wants all help channeled through the government for the simple reason that all AID agencies are suspect as political meddlers, an unfair charge.

Even assuming that the Zimbabwe government's fear of meddling is correct, government's monetary outlay in the HIV-AIDS programs is virtually non-existent. The GOZ makes such a minuscule contribution to Howard Hospital that the amount cannot be used as a basis for controlling the administration of the hospital or influencing policy and hiring of staff. K-International is wholly funded

by Canadian and US charities.

CONCLUSION

Without financial resources of its own, the GOZ, through the NAC, can best achieve the eradication of HIV-AIDS by facilitating the work of foreign NGOs. The aim should be to influence the NGOs without seeking to take over their work.

ACKNOWLEDGEMENT

Thanks goes to Dr. Edward Chimhuru, Director of Manicaland National Aids Council, who allowed us access to the National Aids Council library in Mutare, which was in its infancy.

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