

## Two new reports conclude that the health costs of war are unaffordable

A war on Iraq could cause half a million deaths and devastate the lives, health and environment of the combatants, Iraqi civilians, and people in neighbouring countries and beyond. The details are examined in an independent report entitled *Collateral damage: the health and environmental costs of war on Iraq*, prepared by health researchers under the aegis of Medact, a British nongovernmental organization.

The report's estimates of the total possible deaths on all sides during the conflict and the following three months range from 48 000 to over 260 000. Civil war could kill another 20 000 people, while deaths occurring later caused by adverse health effects could reach 200 000. The number of wounded could range from 120 000 to 650 000. In all scenarios the majority of casualties are civilians.

The research team is from the London School of Hygiene and Tropical Medicine, the Albert Einstein College of Medicine in New York, and other institutions. They based their calculations on the 74 most reliable sources available, consisting of reports from UN agencies, aid agencies active in Iraq, and government and academic publications. They studied the health status of Iraqis before and after the Gulf War of 1990–91, the environmental impact of that war, strategic and military war scenarios available in the public domain, and morbidity and mortality data from comparable conflict areas.

The author of the report, Jane Salvage, told the *Bulletin*: "I concluded that even a contained, short war could trigger famine and epidemics, displacement of millions of people, catastrophic effects on children's health and development, and economic collapse. Any new conflict will probably be much more intense and destructive than the 1990–91 Gulf War, involve more deadly weapons developed in the interim, and be likely to take place in densely populated urban areas."

The report also points out that the mental and physical health of ordinary

Iraqis is far worse than it was in 1991. This makes them more vulnerable than before, and less able to muster the resources needed for recovery and reconstruction. Iraq before 1991 had become a middle-income country with a modern social infrastructure and public services. It now occupies 126th place out of 174 countries on the UN Human Development Index.

The second report, *Our common responsibility: the impact of a new war on Iraqi children*, concludes that the vast majority of Iraq's 13 million children would be adversely affected if the war went ahead. It was released on 30 January by a Canadian-led team of health experts, and is based on data they gathered on a humanitarian fact-finding mission to Iraq earlier in January, visiting more than 100 families (parents and children) in their homes in Baghdad, Basra, and Kerbela.

They found that the health and nutritional status of Iraqi children were still in a significantly worse state than they had been before the Gulf War in 1991. Most of them are still dependent on food distributed by the Government of Iraq. War would disrupt that system and expose them in large numbers to severe malnutrition.

The researchers, two of whom are leading child psychiatrists, also found that children suffer significant psychological harm from the ambient fear of war. "The first and foremost message from the children was about their fear", the report states. "Except for some boys who denied any fear at all and 14-year-old Ahkmed who in a breaking voice stated 'Right now I think more about my exams', they all report strong daily fear. A majority specify this fear to be thoughts about the death of family members and the fear for their own lives."

Other facts and findings in *Our common responsibility*: 16 million Iraqi civilians are entirely dependent for food on government-distributed rations; there is only an estimated one-month supply of food in Iraq; 500 000 Iraqi children are acutely malnourished and underweight; only 60% of Iraqis have access to clean drinking-water; the UN estimates that hospitals and clinics

will run out of medicines within three to four weeks of a conflict.

*Collateral damage: the health and environmental costs of war on Iraq* can be found at [www.medact.org](http://www.medact.org). *Our common responsibility: the impact of a new war on Iraqi children* is available at <http://warchild.ca> ■

Desmond Avery, *Bulletin*

## Brazil mobilizes for a war to save lives



Luís Inácio Lula da Silva, President of Brazil.

In January, the new Brazilian President, Luís Inácio Lula da Silva, announced his top priority with details of his Zero Hunger initiative. In his own words: "We need to defeat hunger, poverty and social exclusion. Our war objective is not to kill anyone but to save lives."

So far the response both of Brazilians and of representatives of major national and international organizations has been mainly enthusiastic. A united mission of the Inter-American Development Bank (IDB), the World Bank and the Food and Agriculture Organization of the United Nations (FAO) visited Brazil last December to discuss the project and define modes of collaboration. The President of the IDB, Enrique Iglesias, had pledged, last November, in Washington, a contribution of about US\$ 6 billion for social programmes, in addition to the US\$ 5.8 billion in low-interest loans approved earlier.

"The IDB has every interest in supporting the projects of Lula's Government to reduce poverty and promote human development in Brazil," said Waldemar Wirsing, who represents the IDB mission here."

The project is aimed in particular at poor populations in the south, the



C. Jurberg

A garbage dump outside Rio, where families can sometimes make a dollar a day.

About 14% of the population of Rio de Janeiro — nearly two million people — live in extreme poverty. A group of 70 scavengers living on the 12 truckloads of garbage dumped in the Embankment of Bongaba in the outer suburbs exemplifies their situation. One of them is Vilméia Gomes, 35 years old, a mother of five children, only two of whom survive. The others died of complications from malnutrition. Vilméia has been working there since 1996.

"Some days, I can raise about a dollar from sorting garbage and reselling cans, plastic bottles and glass," she says. "When I don't find anything to sell, I get food out of the garbage. It's a dangerous way to live but I keep dreaming that one day I'll somehow be able to leave and live somewhere clean."

Claudia Jurberg, *Rio de Janeiro*

north and the north-east of the country. In parts of the north and north-east, up to 50% of the population lives in poverty. The proposals outlined in the project will benefit 9.3 million families or 44 million Brazilians out of a total of 170 million.

The plan includes short-term and long-term strategies for food security, estimating the costs, target populations and sources of funding. Its 20 objectives include measures in the areas of land reform, social security, food stocks for homeless people, programmes to combat maternal and child malnutrition, expansion of the popular restaurants where meals cost a symbolic US 30 cents, and distribution of meal tickets.

José Graziano da Silva, the project's coordinator and Minister for Food Security says: "The intention is for the Zero Hunger initiatives to have a multiplier effect on local production. It is not one of those projects which invite people to sit and wait for help. We want to transform the fight against poverty into a force for productive economic engagement and social inclusion." For this first year, da Silva says,

the plan is to invest about US\$ 2 billion in implementing these strategies.

The Centre of Social Politics of the Getúlio Vargas Foundation has drawn up a "Map of the End of Hunger in Brazil" to focus the project's activities. It summarizes living conditions from town to town, locating the estimated 50 million people, or 29% of the total population, who are living in poverty. Poverty is defined as living in a situation of food insecurity, which means having no assurance that one will obtain the average of 2288 kilocalories (9.6 megajoules) a day the body needs, according to Marcelo Néri, the head of the Centre.

This means Brazil has a high prevalence of malnutrition. While the average proportion of undernourished children is estimated to be about 10% for the country as a whole, in slums and other poor areas in the interior of north-eastern Brazil it is between 40% and 60%. Malnutrition goes with social exclusion, poverty, unhealthy living conditions, lack of access to health services, and broken families. In Brazil this is also seen in low height-for-age, caused by chronic malnutrition of long duration.

Among the health problems caused or made more severe by malnutrition are anaemia, diarrhoeal diseases, respiratory infections, parasitic diseases, and vitamin deficiencies. Gisela Soly-mos, director of projects at the Centre of Nutritional Recovery of São Paulo, points out that lack of appropriate treatment can also lead in adulthood to chronic degenerative diseases such as obesity, diabetes and hypertension, which are risk factors for cardiovascular diseases.

The Ministry of Health rates malnutrition a major public health problem which has been getting worse from year to year. Deaths from malnutrition rose from 6872 in 2000 to 7195 in 2001. Hospitalizations rose from 64 390 in 2000 to 67 534 in 2001, and by September 2002 there had been over 55 000 hospitalizations for malnutrition, with a mortality rate of 11%. The cost of hospitalizing and treating those patients was over US\$ 4 million, resources that would have been far better spent on reducing hunger.

The Zero Hunger project has critics, however, especially in relation to the meal tickets. The main objection is that this and several of the other measures will foster dependence. Even more fundamental to a human being than the need for food, they say, is the need for self-fulfilment. Any social programme that fails to take this into account will fail. Unawareness of this is the greatest cause of failure in anti-poverty initiatives: hungry families are excluded from the knowledge and opportunities available to others, and food hand-outs reinforce their exclusion, because it reinforces their dependence. In the critics' view, a programme to combat malnutrition must promote responsibility and autonomy if it is to have any hope of success.

The idea, though, according to da Silva, is that the campaign will involve everyone in the struggle for both a livelihood and autonomy. ■

## Health standards plummet on occupied farms in Zimbabwe



PANAPRESS

Workers at Mbare Musika in Harare sort out the few maize cobs that have arrived at the marketplace from communal farmers.

About 900 000 people, consisting mainly of farm workers and their families, have been displaced by the recent take-over of white-owned commercial farms in Zimbabwe. The occupation of the farms by veteran independence fighters and “land-hungry” villagers is supported politically by the government as part of a land redistribution plan.

According to the Farm Community Trust of Zimbabwe (FCTZ) essential services at most of these farms are grinding to a halt. The farms no longer have fresh water as pipes are in disrepair and the pumps are not working. In addition, water purification chemicals are not affordable for most of the settlers. For lack of boreholes and protected wells, the villagers are using dirty water from dams and streams.

In the first week of December last year, 51 cases of cholera were reported in Bikita district. Eight people died of cholera at Angus Farm, Dewure Extension and Village 26, UNICEF reported on 1 January 2003. UNICEF responded by sending 42 000 water purification tablets and three water tankers to the affected areas, and supporting the Ministry of Health in developing a community health and hygiene education programme and a cholera awareness campaign. WHO has contributed 35 motorcycles for use by Environmental Health Technicians on disease control. The main causes of cholera, however — contaminated food and water — continue to accumulate.

“The situation is deplorable; we know the risks of waterborne diseases such as bilharzia, cholera and dysentery that we could catch, but there is really no choice,” said Saviour Sibamba, a liberation war veteran resettled at a farm in Odzi, about 30 km outside Mutare, Zimbabwe’s fourth largest city. He said that most settlers hoped the government would quickly move to provide basic sanitary facilities on the farms, now that the land acquisition process was said to be complete.

“The bush toilets, abandoned during the first decade of independence, have made a popular return as we await government and donor assistance in the construction of pit latrines,” Sibamba added. Most of the settlers cannot afford the six bags of cement required to construct a Blair toilet, as the pit latrines are commonly called. During this rainy season (November through March), raw sewage from the surrounding bushes is finding its way into the reservoirs from which the farmers draw their water for domestic consumption.

Even prior to the land reform programme, government policy had been contributing to the lack of health facilities on the farms, by discouraging the development of public infrastructure on private properties. Research conducted by FCTZ has shown that 65–89% of farm workers have to walk over 20 km to get to the nearest health facility, contrary to the government policy that no one should have to go further than 8 km to reach one.

For the majority of farm worker communities, the only contact with health services was through the Farm Health Workers (FHWs), an initiative that began as a national programme in 1990, with support from Save the Children Fund (UK). These are mainly farm community members trained in the provision of basic health care and first aid. The disruption of the farming communities has resulted in the discontinuation of this programme on most resettled farms, since it was the white commercial farmers who paid the salaries of the FHWs. Previously, each FHW covered two or more villages, consisting of about 400 people.

Four nongovernmental organizations running home-based care projects for HIV/AIDS patients on farms in Mashonaland West and Central provinces had to abandon this work in the face of the farm invasions and the violence that accompanied them. They are the Batsirai AIDS Group, the Red Cross Society of Zimbabwe, Silveira House and the FCTZ. They had been engaged in training trainers of personnel for the home-based projects. UNAIDS estimates that 33.7% of adults in Zimbabwe are infected with HIV, and that there are over 100 000 AIDS orphans on farms in the country.

The farm workers are one of the communities worst hit by the HIV/AIDS pandemic in the country, and with their displacement, prevention-oriented programmes have been largely discontinued.

The WHO country office recently reported that Zimbabwe is suffering a severe shortage of vaccines owing to chronic foreign currency shortages.

In addition, over 7 million people countrywide have no daily assurance of obtaining enough to eat. A Food Security Network survey carried out in November 2002, covering 53 districts in Zimbabwe, found a sharp rise in insecurity. Districts reporting ‘everyone’ to be facing shortages rose from 0% in September to 40% in October and 51% in November 2002.

According to the Director of Social Services in the Ministry of Public Service and Social Welfare, the World Food Programme is carrying out food relief schemes on both the resettled farms and in farm worker communities, through its 12 implementing NGO partners. ■

Innocent Sithole, *Harare*