Vital Threats to Human Security in Southern Africa: The Regional Ramifications of the Public Health Crisis in Zimbabwe

by

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To

Him in whom all things hold together

Abstract

The southern African region is beset with numerous security concerns: pervasive poverty, deepening inequality, starvation, contamination of essential natural resources, violent crime and state oppression. However, the most vital of the region‟s security concerns in the 21st century is the spread of infectious disease. The region shoulders a disproportionate amount of the continent‟s infectious disease burden, with diseases such as HIV/AIDS, tuberculosis and malaria claiming more lives every year than any other factor. The nature of these diseases and their propensity to spread, coupled with inadequate regional public health structures pose a significant threat to regional security and stability.

The study asserts that southern Africa‟s security concerns are most appropriately characterised under the paradigm of Human Security. It further asserts that if such vital threats to human security are not adequately managed they have the ability to permeate across state borders, spelling numerous negative ramifications for the region. To this end, the study details the public health crisis in Zimbabwe and its effects on regional security and stability in southern Africa. An enduring political and economic collapse in Zimbabwe led to the dramatic deterioration of its public health sector, the concomitant mass migration of Zimbabwean nationals across the region presented a unique and complex challenge to the Southern African Development Community (SADC) and its member states. As the premier regional governance institution, SADC has failed to adequately mobilise its structures and member states to respond to the challenges resulting from the public health crisis in Zimbabwe. The study explores the factors accounting for this regional inertia, and asserts that while infectious diseases are at present the most vital of the human security threats, similar threats to human security have the potential to affect the region if SADC fails to recognise and prioritise threats to human security as legitimate regional security concerns.

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
AU	African Union
CIA	Central Intelligence Association
DRC	Democratic Republic of Congo
ESAP	Economic Structural Adjustment Programme
EU	European Union
FMSP	The Forced Migration Studies Programme
GNU	Government of National Unity
GPA	Global Political Agreement
GRA	General Resources Account
HIV	Human Immunodeficiency Virus
ICC	International Criminal Court
IMF	International Monetary Fund
IR	International Relations
LRA	Lord‟s Resistance Army
MDC	Movement for Democratic Change
MDR-TB	Multi Drug Resistant Tuberculosis
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
PRGT	Poverty Reduction and Growth Trust
RISDP	Regional Indicative Strategic Development Plan
SADC	Southern African Development Community
SAMP	Southern African Migration Programme
SIPO	Strategic Indicative Plan for the Organ on Politics, Defence and Security Co-operation
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Organisation for AIDS
UNICEF	United Nations Children‟s Fund
UNU	United Nations University
US	United States
WHO	World Health Organisation
WWII	World War II
ZANU	Zimbabwe African National Union

ZANU-PF	Zimbabwe African National Union – Patriotic Front
ZAPU	Zimbabwe African People‟s Union
ZCTU	Zimbabwe Congress of Trade Unions
ZNLWVA	Zimbabwe National Liberation War Veterans Association

Chapter One – Introduction

The concept of security goes beyond military considerations. (It) must be constructed in terms of the security of the individual citizen to live in peace with access to basic necessities of life while fully participating in the affairs of his/her society in freedom and enjoying all fundamental human rights

African Leadership Forum 1991

The concept of security must change – from an exclusive stress on national security to a much greater stress on people's security, from security through armaments to security through human development, from territorial to food, employment and environment

UNDP 1993

Traditionally „security" has been perceived as the security of the state (Mutimer, 2008, p. 34). This gave rise to the assumption that threats to security arose from outside the state and that these threats were primarily if not always military in nature (Ayoob, 1991, p. 261). This state-centred view has dominated security narratives for decades (Buzan, 1991, 1997; Krause, 1996; Booth, 2005). The seminal 1994 Human Development Report (UNDP, 1994) was therefore a distinct departure from this narrative, as it spoke to the heart of the security needs of the time. It asserted that rather than fear of external military attack, people had more pressing security concerns such as the source of their next meal or protection from natural disasters such as floods. It called for a more introspective conception of security that addressed the real concerns of humanity, coined as „human security". Numerous statesmen, authors and scholars came to the fore supporting this notion of human security asserting that "the international community urgently needs a new paradigm of security...The state remains the fundamental purveyor of security yet it often fails to fulfil its security obligations and at times has even become a source of threat to its own people" (Sen, 2003).

Pervasive poverty, deepening inequality, starvation and disease are the most prominent security concerns in Africa. This is especially true for southern Africa which is beset with the highest infectious disease burden on the continent (Cooke, 2009, p. 3). The most recent United Nations (UN) statistics show that 11.3 million people are living with HIV/AIDS in the region, an increase of nearly one-third (31 percent) compared to the 8.6 million present in the region between 2000 and 2005. Of

the 23.3 million people living with HIV in Africa, southern Africa accounts for 49 percent of these cases (USAID, 2011, p. 1). In addition other infectious diseases such as Tuberculosis (TB) are widespread, with South Africa reporting 981 cases per 100,000 people and Swaziland at 1,287 per 100,000 people, the highest in the continent (WHO, 2011a, p. 1). Malawi, Mozambique and the Democratic Republic of Congo (DRC) rank among the highest in the worlds lists of infant mortality rates, with as many as 192 deaths per 1,000 births being recorded in the DRC. The five lowest life expectancies in the world are southern African states: Swaziland, Angola, Zambia, Lesotho and Mozambique (UN, 2011).

Caroline Thomas correctly points out that human insecurity is not some inevitable consequence: although natural disasters such as floods undermine human security, at the core human insecurity is a direct result of the existing structures of power which determine security agendas (Thomas, 2001, p. 160). This is true at national, regional and even international levels. In southern Africa these negative indicators are symptomatic of state dysfunction. Southern African states have failed to ensure adequate supplies of food, shelter, health care, water and sanitation to all their citizens, and so the populations of the southern African region are chronically insecure. It is established that insecurities such as these have an adverse effect on development and social cohesion (Jenson & Saint-Martin, 2003). In addition, such insecurities have the potential to destabilise the region, affecting order and security at the regional level. Such is the case with the political and economic crisis in Zimbabwe. The once prosperous state suffered a massive economic collapse, with hyperinflation reaching a record high of 89.7 sextillion percent in November 2008 (Hanke, 2008, p. 1). Central to the economic collapse was the political rule of the leading party, the Zimbabwe African National Union – Patriotic Front (ZANU – PF). Political oppression, the violent suppression of political opposition, rigged elections, human rights abuses, corruption and mismanagement led the country into a state of political dysfunction. The resultant economic instability led to capital flight, acute declines in foreign direct investment, the suspension of international aid and multilateral credit, and the eventual collapse of the entire banking sector. At present the Gross Domestic Product per capita of Zimbabwe is one of the lowest in the world at US$487 and unemployment stands at 95 percent (IMF, 2011). The economic and political crisis in the country devastated the government departments, most notably those tasked with providing social services. As a result the country struggles to provide its citizens with basic amenities such as clean water, sanitation, food, electricity and health care.

The Zimbabwean situation has dominated the political agenda of the Southern African Development Community (SADC)[1] since 2000. Efforts led by Thabo Mbeki led to the formation of a Government

[1] SADC was formed in 1992, as a successor of the Southern African Development Co-ordination Conference (SADCC) which was formed in 1981. The members of SADC are: Angola, Botswana, The Democratic Republic of Congo (DRC),

of National Unity (GNU), between President Mugabe and his political opponent Morgan Tsvangirai, after a violent and contentious 2008 election. However, new and re-emerging tensions between the two parties have caused a political deadlock within the country, which has inevitably been felt throughout the region. The political impasse in Zimbabwe translates into insecurity at the individual level. A cholera outbreak in 2008 demonstrated just how deeply the political collapse had penetrated into the functions of the government. The public health structures of Zimbabwe failed to provide the necessary health care and medication to thousands of infected individuals across the country, which led to the migration of individuals out of the country, and the spread of cholera throughout the region. The enduring crisis in Zimbabwe has raised issues of regional security and stability for southern Africa as it is estimated that up to 3.5 million Zimbabweans have migrated throughout the region (Monson & Kiwanuka, 2009).

1.1The Study of Security

The discipline of International Relations is concerned with the study of the political interactions amongst international actors (Hough, 2004, p. 2). Since its inception, this discipline has been dominated by Realism. Classic Realists believe that states are the most significant actors in the international arena, and that their behaviour is always premised on self- interest and the pursuit of power. This approach permeates all other branches of the study of International Relations, including that of Security Studies, which is concerned with those international interactions that are particular to the maintenance of the security of the actors involved (Hough, 2004, p. 2). The academic study of security and its application to the study of *real politik* is predominantly focused on the state, military defence and strategic alliances. Consequently, issues such as the availability of food or the health of the public did not feature within traditional Security Studies.

This overemphasis on state security dominated the 20th century, neglecting less privileged concerns, such as the protection of human rights. The conduct of the United States and the Soviet Union during the Cold War is indicative of this: chiefly concerned with increasing and strengthening their spheres of influence, the US and the Soviet Union largely ignored principles of peace and the protection of human rights (Cingranelli & Richards, 1999, p. 511). The US government tolerated and supported many authoritarian, repressive regimes simply because the leaders of those regimes were willing to oppose the Soviet Union (Cingranelli & Richards, 1999, p. 513). For its part, the Soviet Union was silent about defects in allied non-communist dictatorships as long as those regimes were opposed to the US. It was only after two World Wars, the collapse of Fascism, Nazism and Colonialism and the end of the Cold War, that the international system began to re-orientate the focus of international

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Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

politics towards the pursuit of peace, and to recognise the need to reaffirm the pledge to ensure the safety and welfare of all citizens across the globe (Cingranelli & Richards, 1999, p. 520). Even though substantial institutional[2] and legislative[3] provisions had been established before the onset of the Cold War to ensure the safety of individuals, the lack of political will among states during the Cold War had resulted in widespread oppression and significant loss of human life.

The end of the Cold War was welcomed by academics such as Matthews, who saw it as an opportunity to „re-define security" (Matthews, 1989, p. 162).

There was a universal call for the broadening of Security Studies. Scholars and statesmen alike acknowledged that concerns of „high politics" such as nuclear attack had long dominated the terrain of international security agendas, and as such threats had subsided it was time for less recognised though equally significant security concerns to come to the fore. State-centred considerations of security that focused solely on military capabilities had to be broadened. The overemphasis on military threats negated the reality that states could be weakened by circumstances other than military conflict and that weapons were not the only threats to human life.

In response to the inadequacies of traditional Security Studies, theorists such as Booth, Krause, Vale and Williams have submitted an essential critique of state-focused security perceptions (Booth, 1991, 2005, 2007; Krause, 1996, 1998; Krause & Williams, 1997; Vale & Booth, 1995, 1997; Vale & Swatuk, 1999; Vale, 2003; Booth & Wheeler, 2008). This conception contends that the study of security should focus on the individual and individual emancipation rather than on the state. Critical Security Studies, the result of their work, asserts that individuals, not states should be the referent objects of security analyses, that political realism fails to offer either a satisfactory theory or practice of security, and that systems of security based on the insecurity of others are unsustainable (Zamarcozy, 2007, p. 1).

A central component of Critical Security Studies is a contestation of the supremacy of the state. Traditional Security Studies focuses on the state, that is, the state is the chief referent in security agendas and the sole guarantor of security at all levels. As such, the safety of the individual is assigned to the state. It was therefore tacitly assumed that if the state was secure, its citizens were also secure. However a cursory analysis of international politics will show this assumption to be unjust. Firstly, the state itself has become a source of insecurity to individuals. Approximately six million

[2] The establishment of the United Nations, and its key organs with regard to security: the United Nations Security Council and the United Nations Human Rights Commission.
[3] The ratification of International Laws and Treaties, most notably: The UN Charter – 1945, The Universal Declaration of Human Rights – 1948, The Convention on the Prevention and Punishment of the Crime of Genocide – 1949 and the Geneva Conventions – 1949.

European Jews were killed under the Nazi government of Germany during WW II (Niewyk, 2000, p. 45). In 1994 800,000 members of the Tutsi ethnic group were massacred in a state endorsed genocide in Rwanda (Holzgrefe, 2003, p. 17). And on March 4, 2009 Sudanese President Omar al Bashir became the first sitting president to be indicted for war crimes, for directing a campaign of mass killing, rape, and pillaging against civilians in Darfur: the UN estimates that this conflict has claimed 400,000 lives and displaced up to 2 million people (United Nations, 2010). This condition presents an inherent contradiction within traditional Security Studies: how can the state function both as the sole referent and beneficiary of international security objectives, while it also periodically functions as a source of insecurity to the international system and individuals? Critical Security Studies seeks to address this contradiction.

Secondly, placing the state as the only referent in security agendas makes the incorrect assumption that only the state can be affected by threats to security. However, the non-military threats mentioned above target the state and individuals. Infectious diseases and their effects affect the state as well as individuals; as do the effects of climate change, natural disasters and poverty. In some instances even the most equipped state structures become overwhelmed and are unable to secure its citizens against such dangers. For example, the inability of the US to protect its citizens against Hurricane Katrina in 2009 claimed 1,836 lives (Knabb, 2005, p. 5). The coastal regions of Mozambique are prone to flooding; in 2000 floods killed 700 people and displaced more than half a million, and a further 3 million in 2001 (BBC, 2011). Drought in Mozambique in 2002 affected 587,000 people, some in the previously flood-stricken regions (SADOCC, 2002). Projections in 2012 predicted continued flooding, and by January of 2012 4,000 people had already been displaced (BBC, 2012). In this context Critical Security Studies makes an appeal to deepen the study of security, asserting that non-state actors such as societies and individuals should also be considered as security referents, separate from and or in addition to the state.

Lastly, the traditional role of the nation-state – as the sole guarantor of security- has been forced to change. The advent of globalisation: the widespread operation of businesses on a global rather than a national, level; the ease with which individuals and groups can communicate and organize across national frontiers; the global transmission of ideas, norms, and values; the spread of particular forms of political institutions; and the increasing participation of states in international political, economic, and military organisations, means that the 21st century state is no longer able to guarantee its sovereignty, territoriality and monopoly over violence (Ripsman & Paul, 2010, p. 8). Traditional mechanisms of security, such as containment, have proven to be inadequate when faced with challenges such as international terrorism and global disease epidemics such as HIV/AIDS, thus an extension of security agendas is necessary to adapt to the changing climate of international politics.

The broadening and deepening of international security ushered in by the end of the Cold War have caused a shift in conventional perceptions of security and its study. It is from this evolution in Security Studies and the field of Critical Security Studies that the concept of Human Security has emerged.

1.2 Human Security

Human Security is defined *as the protection of the vital core of human life from all critical and pervasive threats*; these threats may be environmental, economic, food, health, personal and political in nature (Owen, 2004, p. 380). The 1994 Human Development Report famously asserted "human security is not a concern with weapons – it is a concern with human life and dignity" (UNDP, 1994, p. 22). The Human Security paradigm is concerned with the insecurities that plague humanity, such as disease and famine, seeking to reduce (or if possible remove) these insecurities, and to ensure the well-being of all individuals (Sen, 1999).

The objectives of human security have close links with those of human development (UNDP, 1993, 1994; Thomas, 2000, 2001; Hettne, 2001, 2010; Tschigri, 2003; Stewart, 2004; Krause & Jutersonke, 2005; Klingebiel, 2006). Human development simply defined is the process of enlarging choices, it is both a process and an outcome that seeks to maximise human capabilities and dignity (UNDP, 2002). Freedom, good health, adequate nutrition, education and access to resources are therefore necessary for the realisation of positive human development outcomes. Inequality and poverty are the greatest threats to the realisation of these goals in the 21st century, and they are also at the heart of the human security predicament in the developing world. Therefore, human security and human development are intricately linked. Human security concerns have immediate impacts on the well-being of individuals and consequently their development. Human security serves as a prerequisite for positive human development. In addition high levels of human development enhance human security; thus the two act as mutual reinforcement for the other. An assessment of the Human Development Indices of acutely insecure regions will demonstrate the significant link between security and human development outcomes.

This study acknowledges the strong links between human security and human development but asserts that these issues should be considered as components of Security Studies rather than of Development Studies.

Development Studies is an interdisciplinary field of the social sciences, concerned with addressing matters that are of particular relevance to the developing world. It covers a wide array of issues, including demographics, studies of migration, urbanisation, gender equality, education, economic development and ecology (Summer, 2006, p. 644). While the focus of Development Studies is

humanity, its thrust towards these issues in many cases does not consider the security of the individual. By definition the concerns of Human Security are vital, that is, they are essential for the continued existence of human life, and thus require more critical responses than those offered within Development Studies. For example, the quality of life of an illiterate individual is compromised as this may reduce their access to employment and financial resources. However, an individual suffering from an infectious disease, such as malaria, faces a more vital concern, as it is not just the quality of life that is now compromised, but life itself. Such vital concerns should thus be considered as issues of security, rather than development.

Human Security challenges the foundations of traditional security in that it equates the security of the state to that of the individual, whereas traditional perceptions of security place the security of the state above all other entities. Within traditional perceptions of security, the sovereignty of the state and the integrity of its territory are imperative to international peace and order. This conception of security prioritises defending the state via militarisation and the establishment of strategic alliances, with the end goal of deterring external military threats, and establishing predictability and order at domestic and international levels. This conception negates the reality that even with all these facets intact (sovereignty and territorial integrity) the citizens of a state can still be insecure. Human security argues that for many – perhaps even most – people the greatest threats to security come from internal conflicts, disease, hunger, environmental contamination or street crime. And for others, a greater threat may come from their own country itself, rather than from an external adversary (Newman, 2010, p. 6). The contemporary world is testament to this, with states such as Sudan and Syria serving as prime examples.

Within the scope of human security, vital concerns such as hunger, poverty, disease, devastation from natural disasters and the contamination of vital natural resources (issues excluded from the agendas of state security) are recognised as legitimate security concerns. And it is threats of this nature that are prevalent in southern Africa.

Southern Africa faces a multitude of security concerns, the most vital of which is the spread of infectious disease. The region carries a disproportionate amount of the continent‟s disease burden, accounting for 49 percent of the current HIV/AIDS incidence in Africa, which translates to approximately 11.3 million people (USAID, 2011, p. 1). South Africa and Swaziland have the highest TB rates in the world, with South Africa reporting 981 cases per 100,000 people and Swaziland 1,287 per 100,000 people (WHO, 2011a, p. 1). Southern Africa has high levels of multi drug resistant TB (MDR-TB), a version of the disease that is immune to treatment. In addition to HIV/AIDS and TB, the region has high incidences of malaria and diarrhoeal diseases such as cholera, typhoid and dysentery. Infectious diseases in the region claim more lives than war, starvation and political

violence combined. The provision of public health in the region does not adequately meet the requirements of the people (Cooke, 2009, p. 4). The individual SADC states are beset with financial and technical shortages in their respective departments of public health. None of the southern African states are yet to satisfy the Abuja Agreement that stipulates that at least 15 percent of every African state"s GDP should be directed to the provision of public health (Midzi, 2012). Without a foundation of skilled human resources, healthcare systems cannot function adequately or effectively. In southern Africa there is an overall lack of personnel in key areas of the health sector; an inequitable distribution of those health personnel who are available; and a significant attrition of trained personnel from the public health sector and from the region. For example, in 1998 in South Africa, 52.7 percent of all general practitioners and 76 percent of all specialists worked in the private health sector. By 1999, 73 percent of general practitioners were estimated to be working in the private sector in South Africa, despite the fact that this sector catered for less than 20 percent of the population (Cornell, 2001). In 2001 1,596 nurses and midwives from South Africa, Malawi, Zambia and Zimbabwe were registered with the Medical Council of the United Kingdom, and of the 1,200 physicians trained in Zimbabwe during the 1990s, only 360 were still practising in the country in 2001 (Lowell & Findlay, 2001, p. 14).

It is clear from the immense disease burden of the region, and the state of public health in the individual countries that the spread of infectious disease in southern Africa presents a vital human security concern in the region.

1.3 Research Goals and Methodology

This study will employ a case study that focuses on the deterioration of the public health sector of Zimbabwe. The purpose of this is two-fold, firstly to demonstrate the vital nature of the threat that infectious diseases pose to human security in southern Africa, and secondly, to outline the regional ramifications that vital threats of this nature pose to regional security and stability. The study will draw on the various branches of International Relations and Security Studies to answer three pertinent questions: What is the nature of the security concerns specific to southern Africa? How have these concerns affected the region? How has the region responded to these concerns? It will become clear that southern Africa faces vital security concerns which are correctly characterised under the paradigm of Human Security. The spread of infectious disease in the region is the most vital of these security concerns, however, the states of southern Africa have not responded adequately to this vital concern. The study will detail the obstacles that impede the region from responding adequately to the vital human security concerns that it faces.

The goals of this study are to: Critically explore and define the concept of Human Security, as a means to correctly characterise the security concerns present in the region. Secondly, to outline and

discuss the nature and significance of the threat that infectious diseases present to human security in southern Africa (typified by the Zimbabwean case study). Thirdly, to investigate the responses of the region to the human security concerns present ; And lastly, to offer a critical assessment of the southern African subcontinent with regard to its inability to adequately respond to the vitals human security concerns in the region.

The study is structured as follows:

Chapter Two gives an appraisal of recent and relevant literature on human security, giving a clear classification of the concept, its components and its relevance to contemporary International Relations. This appraisal will pay particular attention to the developing world, southern Africa, health security and global public health. This conceptualisation of Human Security is necessary as there is an on-going debate regarding the redefining of security (Buzan 1991; Crawford 1991; Haftendorn 1991; Kolodziej 1992; Baldwin 1995; Krause 1996; Hough 2004; Thakur & Newman 2004; Callabero-Anthony 2006; Booth 2007, 2008). This debate is rooted in the realisation that previous conceptions of security that focused on the state do not adequately reflect the security needs present in the post-Cold War era. In addition, the methods previously employed to handle these threats, would be unsuitable in contemporary international politics. Various attempts have been made to provide an adequate re-conceptualisation of security, one that encompasses the individual and his/her needs.

Two main contemporary theories of International Relations have contributed to this effort: an approach based on a neo-realist theoretical framework, which maintains a continued emphasis on the primacy of the state within a broadened conceptualisation of human security, and a postmodernist or „critical human security" approach that is rooted within the pluralist theory of international politics.
Chapter Two explores the different views of human security and isolates the framework and definition of security that best fits southern Africa. It puts forward Human Security as the appropriate lens through which to analyse the security concerns of the region and provides a conceptual harness for the case study that follows.

Chapter Three functions as a precursor to the focused case study, advocating for the recognition of infectious disease as a vital human, national and regional security concern. By analysing the disease burden of the region,[4] it becomes clear that infectious diseases such as HIV/AIDS, TB and malaria claim more lives in southern Africa than any other cause. Statistics from the World Health Organisation (WHO) show that more lives were lost in DRC due to infectious diseases during the period 2010-2011, than those lost to warfare in the same period. As such, the large scale loss of

[4] The infectious disease burden is established through health indicators and statistics published by the WHO and its associated organisations

human life due to infectious disease legitimate public health and its prioritisation as a vital security concern for the region. The chapter also explores the unique nature of infectious disease, its propensity to spread and the implications this has on regional security. In light of the economic and political collapse of Zimbabwe, the contagious nature of infectious disease, the deterioration of the public health sector of Zimbabwe and the concurrent mass migration of Zimbabwean nationals into the region, Zimbabwe emerges as a unique and novel challenge to the security and stability of the region.

Chapter Four employs a case study to substantiate the assertions made by the study, illuminating the intricate interplay between public health, human security and regional security in southern Africa. An outbreak of cholera in Zimbabwe in 2008 took on a regional scope, resulting in 98,424 reported cases and 4,276 deaths in Zimbabwe (WHO, 2009b, p. 1). A further 700 cases were reported in the Limpopo province of South Africa (Muthambi, 2009) and WHO received reports from the Ministries of Health confirming cholera cases in Palm Tree (Botswana) and Guro district (Mozambique). At the conclusion of the outbreak 636 deaths had been recorded outside Zimbabwe (WHO, 2008, p. 1). The public health sector of Zimbabwe, beset with massive shortages in human and financial resources, lacked the capacity to manage and contain the cholera cases in the country, and so Zimbabwean nationals turned to migration as a last resort to ensure their well-being.

Chapter Five provides an assessment of the ramifications that the Zimbabwe case has had on the region and the responses of SADC [5] and the individual states that comprise the SADC region. This is achieved by reviewing relevant SADC policy and protocol, the actions of individual states and interviews with key actors in the public health sector of Zimbabwe.

It is apparent that infectious diseases pose a significant threat to the region and the case of the public health crisis in Zimbabwe details the adverse ramifications that such threats pose to regional security and stability. However, SADC and its member states have failed to respond adequately to the vital human security concern of infectious disease. The absence of a sound regional response to vital human security concerns has in turn raised questions of regional stability and capacity. The study will show that characteristics inherent to southern African states stand as impediments to decisive and effective action for human security at the regional level. As such, vital human security concerns such as infectious disease persist, endangering the region at large.

The study puts forward a two part hypothesis. Firstly, that southern Africa is host to a number of vital security concerns, most appropriately characterised under the paradigm of Human Security. Secondly,

[5] The premier regional governance institution

the study asserts that if not managed adequately these vital concerns to human security have the ability to permeate state borders, having serious ramifications on regional security and stability. It is the opinion of this study that it is the nature of the southern African state that lends itself as a source of human insecurity, and simultaneously impedes it from effectively confronting the security concerns specific to it. By detailing the deterioration of the public health sector of Zimbabwe and its effects on the region, this study intends to demonstrate the hypothesis it puts forward.

The last chapter provides a conclusion of the study, summarising the key arguments of the study and outlining the human security *problematique* of southern Africa.

The study employed two key mechanisms of analysis: Key informant interviews and Document Reviews. Key informant interviews tap into the special knowledge of experts on a particular issue(s) under study. For the purposes of this study, these experts were high level Zimbabwean public health specialists with experience and knowledge about the structure and function of the Zimbabwean public health sector, and the challenges it faces. Due to their immense international experience, the selected experts also gave insight to the regional aspects of public health within SADC and in southern Africa. Secondly, the study reviewed key documents with regard to migration, human security, public health and regional humanitarian cooperation. These documents included SADC policies and reports, the public health policies of individual SADC states, public health and humanitarian policies and reports of international organisations such as the UN, and independent reports and studies conducted by research institutions with regards to migration, the health of migrants and public health in southern Africa. The purpose of which was to give a critical appraisal of the policies currently in place to manage public health in the region and to assess the status of public health in southern Africa.
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The nature of southern Africa‟s security problems are complex and are thus not adequately provided for by traditional state-centred security agendas. In many instances the state is unable or unwilling to respond to human insecurity, or is sometimes itself a contributor to these security threats. The resultant insecurity at the individual level requires critical responses that the state alone is unable to provide. In addition, due to the absence of military inter-state conflict in the region, employing a method of analysis that focuses on state security alone is insufficient. By viewing southern Africa through the lens of Human Security, the nature of the security concerns of the region will become apparent. This study intends to broaden the conception of security in southern Africa to consider not only the state, but also the well-being of the individuals within those states as a vital component of regional security and stability.

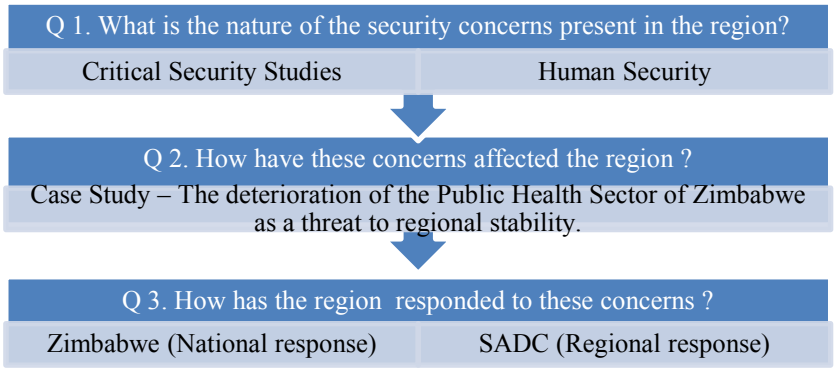

Figure 1.1: Research questions and the methods employed to answer them

Chapter Two – Conceptualising Human Security in Southern Africa

2.1 Introduction

The period between 1945 and 1989 was characterised by tense relations between the United States (US) and the Soviet Union. Chiefly concerned with increasing and strengthening their spheres of influence, the US and the Soviet Union largely ignored other international concerns, especially the protection of human rights.[6] The international arena was dominated by the „politics of alignment" as it offered states military and economic support and privilege in the international system. States considered their obligations to protect human rights and ensure peace only after their responsibility towards their communist or capitalist allies. US-Soviet tensions dominated all facets of the international system leading to the large scale neglect of pertinent international issues, the paralysis of the United Nations and the breach of numerous international laws.

During the Cold War, the US government tolerated and supported many authoritarian, repressive regimes simply because the leaders of those regimes were willing to oppose the Soviet Union, Syngman Rhee of South Korea, Pinochet of Chile and Mabuto of Zaire stand as stark examples of this. For its part, the Soviet Union was equally silent about defects in allied non-communist dictatorships, such as Iran under the leadership of Khomeini, and Cuba under the leadership of Castro, as long as those regimes were opposed to the US (Richards & Cingranelli, 1999, p. 513). In addition the US and the Soviet spurred fatal proxy wars across the globe[7] in pursuit of dominance, violating numerous international laws and treaties.[8] Movements in the Soviet bloc, such as those in Hungary and Czechoslovakia, which called for the freedoms stated in the Universal Declaration of Human Rights, were ruthlessly crushed (Josika, 2005, p. 1). One of the most potent symbols of Soviet commitment to curb individual freedoms was created in 1961: the Berlin Wall (Mews, 1996, p. 50). The US CIA financed efforts to overthrow ideologically opposed governments, regardless of whether they were democratically elected or not. Actions in Guatemala (1954) and Cuba (1961) are just two examples (Robertson, 2006, p. 47). In addition, the US bombing of neutral Cambodia rallied support

[6] At this time the human rights discourse was split between two schools of thought: first generation human rights, backed by the US and its allies, and second generation human rights favoured by the Soviet Union, Latin America, Africa, and Southern Asia. First generation human rights supported individualism in the name of liberty and served to protect the individual from excesses of the state. They included, among other things, freedom of speech, the right to a fair trial, freedom of religion, and voting rights. Second generation human rights supported social justice in the name of equality, and the state was the guarantor of these rights. They included the right to be employed, rights to housing and health care, social security and unemployment benefits. The Universal Declaration of Human Rights (1948) provided for all these rights, however the USSR abstained from ratifying the document. It is important to note that neither the US nor the Soviet Union honoured the type of human rights they claimed to support, as the examples in the text will show.

[7] A total of 21 official wars have been documented.

[8] The Universal Declaration of Human Rights (1948), the Convention on the Prevention and Punishment of the Crime of Genocide (1948), Geneva Conventions (1949), the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (1976).

for the vicious Khmer Rouge regime, which ended with the killing of an estimated 1.7 million Cambodians (Kiernan, 1989, p. 12) .

The thawing of Soviet and US tensions that began in 1985, led to the end of the Cold War and the eventual collapse of the Soviet Union in 1991.

The demise of communism and the end of the Cold War was hailed by Francis Fukuyama as the „end of history" (Fukuyama, 1989, p. 1) and by George Bush as the era for a „new world order" (Johnson, 1999, p. 5). Indeed the end of the Cold War was a time filled with contradicting possibilities and opportunities. With the world no longer polarised, politicians and commentators alike prophesied the birth of a new era in global politics and state relations. The removal of the „iron curtain" would enable states to operate freely without concerns of alignment (Mews, 1996, p. 50).

This „opening up" saw an upgrade in the status of human rights, a discourse that largely lay dormant during the Cold War. The end of the Cold War saw the formal development of International Humanitarian Law and numerous international treaties were ratified, most notably the 1998 Rome Statute which culminated in the establishment of the International Criminal Court (ICC), an independent judicial body mandated to prosecute war crimes, crimes against humanity, genocide and the crime of aggression (Arsanjani, 1999, p. 22).

The last two decades have seen an exponential growth in the discourse of human rights and the recognition of the significant role that individual security plays in the maintenance of international peace and security. Pioneering the protection of such rights, the United Nations, through its various organs and agencies has increased its activities specific to the protection of individuals and their vital needs.[9] The Security Council in turn has passed key resolutions aimed at the protection of the individual, most notably Resolution 1674 – the Responsibility to Protect – which sanctions the use of force to intervene for humanitarian purposes. In addition, numerous non-governmental organisations such as Amnesty International and Human Rights Watch have been established with the sole mandate of ensuring the protection of human rights and advocating against individuals/groups found to be violating these rights.

The study of security was particularly open to new interpretations, with authors such as Buzan calling for the rethinking of security after the Cold War (Buzan, 1997, p. 5). Traditional perceptions of international security were predominantly concerned with inter-state relations and military conflicts.

[9] Most notably the UN Human Rights Council (UNHRC), the United Nations Development Program (UNDP), the World Health Organisation (WHO), the United Nations Children"s Fund (UNICEF) and the World Food Programme (WFP). Together these agencies actively work to ensure the security of numerous facets of human life.

The field contemporarily known as Security Studies traditionally functioned in the same space as Strategic Studies, binding the analysis of security in direct relation to state politics, military power, the mechanisms of war and militarisation. Rarely would issues such as the spread of infectious disease or environmental safety be considered as legitimate or immediate security concerns. Therefore the end of the Cold War facilitated the broadening of the study of international security to encompass non-traditional concerns pertaining to the securitisation of human life.

The present academic discourse of security has become increasingly dominated by topics concerning human rights and humanitarian initiatives (Buzan, 1983; Sen, 2000; Axworthy, 2001; Alkire, 2003; Kaldor, 2006; Booth, 2007). The 21st century has seen the coming to the fore of the prioritisation of the security of the individual and the birth of the concept of Human Security. This term was first articulated at Forum of African Leadership in 1991, hosted by the Organisation of African Unity and the UN. The forum established that the concept of security needed to go beyond considerations of the military warfare, and to delve deeper to encompass the security of the individual and his/her needs (Hough, 2004, p. 13).

The rationale of Human Security is not new: mankind has since the beginning of time been formulating ways to ensure its own safety. Tales of famine, war, drought and plagues have been told throughout history, and in each scenario mankind has endeavoured not only to survive but to devise strategies to mitigate the effects of future insecurities. On a basic level, this is essentially what human security is concerned with: the quality of human life, and its protection from immediate and future threats.

Severe threats to human security range from genocide and slavery to natural disasters such as hurricanes or floods to massive violations of the right to food, health and housing (Kaldor et al, 2007, p. 273). Concerns of this nature, and not military warfare, dominate the security concerns of most people, especially in the developing world. As such, the concept of Human Security has great utility in characterising the security concerns of developing regions such as southern Africa. This chapter explores the concept of Human Security, asserting it as the most appropriate framework for viewing southern Africa‟s security concerns.

2.2 The Inadequacy of Conventional Security Studies

The study of International Relations (IR) began to open up after the end of the Cold War. In addition to analysing the interactions between states, it broadened its scope to incorporate the interactions and roles of non-state entities, such as inter-governmental organisations, international non-governmental organisations, non-governmental organisations (NGOs) and multinational corporations Following this trend, human security emerged as a result of the broadening of the agenda of security studies. The

apparent divorce between human and state security was evident during the Cold War: the safety of individuals, which was once viewed as a key responsibility of the state, had now been placed secondary to the safety of the state itself. As such, there was a realisation that the conventional views of security needed expansion. On conclusion of the 1945 San Francisco Conference the US Secretary of State stated that:

> The battle of peace has to be fought on two fronts. The first is the security front where victory spells freedom from fear. The second is the economic and social front where victory means freedom from want. Only victory on both fronts can assure the world of an enduring peace (Alkire, 2003, p. 14).

However, it was only towards the end of the Cold War that there was a development in the literature surrounding the meaning of "security" and its definition in this new era. The traditional approach employed by neo-realism proved inadequate, as it placed the state as the primary referent and guarantor of security, this over-emphasis on the state, its structural and strategic abilities, was not reflective of the changing security concerns of the post-Cold War era (Buzan, 1991; Crawford, 1991; Haftendorn, 1991; Kolodziej, 1992; Baldwin, 1995; Krause, 1996). The debate surrounding the nature and definition of security was rooted in three main concerns: the discontent among some scholars with the neorealist foundations that characterised the field, the need to respond to the challenges posed by the emergence of a post-Cold War security order, and the strong desire to make the discipline relevant to contemporary concerns (Krause, 1996, p. 229).

With particular reference to academia, there are two main contemporary theories of International Relations that have contributed to the efforts in re-defining security to incorporate the individual. At one end of the continuum is an approach based on a neo-realist theoretical framework, which maintains a continued emphasis on the primacy of the state within a broadened conceptualisation of (human) security (Naidoo, 2010, p. 2). Some call this approach the „new security thinking" (Thompson, 2000, p. 14). Secondly, the postmodernist or „critical human security" approach, which is rooted within the pluralist theory of international politics, is based on a set of assumptions that essentially attempt to dislodge the state as the primary referent of security, while placing greater emphasis on the interdependency and transnationalisation of non-state actors (Naidoo, 2010, p. 2).This expansion of security analysis requires a departure from Strategic Studies and links the analysis of security in direct relation to state politics, and related factors such as geography, economics, and military power. Issues surrounding human rights and environmental security feature minimally in these considerations.

Scholars have attempted to map the changes that have been made to incorporate these new security matters into Security Studies. Emma Rothschild documented these changes in security perceptions

and ideas in her book *What is Security?* (1995) and outlines the four directions in which security has moved. Firstly, it has extended *downwards* from the security of nations to the security of groups and individuals. Secondly, it has extended *upwards*, from the security of nations to the security of the international system, or of a supranational physical environment, from the nation to the biosphere. The extension, in both cases, is in the sorts of entities whose security is to be ensured. Thirdly, security has extended *horizontally*. Different entities (such as individuals, nations, and „systems") cannot be expected to be secure or insecure in the same way; the concept of security is extended, therefore, from military to political, economic, social, environmental, or „human" security. Lastly, the political responsibility for ensuring security is itself extended: it is diffused *in all directions* from national states, including upwards to international institutions, downwards to regional or local government, and sideways to non-governmental organisations, to public opinion and the press, and to the abstract forces of nature or of the market (Rothschild, 1995, p. 55). This articulation of the shifts in perceptions of security positions Human Security as a direct result of these various changes in security agendas.

As articulated by Krause, the re-definition of security was rooted in a strong desire to make the discipline relevant to contemporary concerns (Krause, 1996, p. 229). Thus Human Security emanates mainly from the realisation that conventional perceptions of security do not adequately articulate the security needs of the globe. Orthodox perceptions of security are state-focused and based on classic realist/neo-realist conceptions of international order, sovereignty and territoriality. Such conceptions place the state as the primary actor within international politics. However, when viewed in relation to the evolution of international politics, these realist assertions no longer hold water. In addition to the state, contemporary international politics include non-state actors such as global governance organisations, multi-national companies, non-governmental organisations, special interest groups and individuals. The emergence of these new international players has been followed by an emergence of new security concerns in the international arena. In addition to military threats from other states, international peace and security is also threatened by terrorism, cyber criminals, ethnic and religious tensions, famine, poverty and climate change, to name a few. The framework offered by conventional Security Studies, that focuses on state security and military defence, can no longer ensure international security and stability.

Take for instance, the US „War on Terror", it has not delivered the expected results as prescribed by realism. The United States government launched a military war in Iraq, Afghanistan and Pakistan in response to a terrorist attack that claimed 2,996 lives on September 11 2001, orchestrated by a non-state Islamic group: al-Qaeda (Glazier, 2008, p. 1). This war was launched in pursuit of national and international security. To date no substantial progress has been made in disabling al-Qaeda, which

reportedly operates out of forty countries, even after losing its leader, Osama bin Laden, while the effects of the war on the US have been negative. An approximate 6,000 US soldiers have died in the war and 550,000 have been injured. The state has spent between $3.2-$4 trillion on the war, almost seven times more than it spent on education in 2011 (Watson Institute, 2011). There is no measurable indicator to suggest that the „War on Terror" has increased US state security or international security. Aptly expressed by Lal: "the traditional neo-realist notion of national security is paradoxical, epistemologically flawed and ontologically unstable...and produces more insecurity than security" (Lal, 2006, p. 2).

In response to the inadequacies of traditional Security Studies, theorists such as Booth, Krause, Vale and Williams have submitted an essential critique of state-focused security perceptions, and contend that the study of security should focus on the individual and individual emancipation rather than on the states. Critical Security Studies, the result of their work, asserts that individuals, not states should be the referent objects of security analyses, that political realism fails to offer either a satisfactory theory or practice of security, and that systems of security based on the insecurity of others are unsustainable (Zamarcozy, 2007, p. 1). Critical Security Studies asserts that, instead of an over-emphasis on the state, security should be centred on the individual and human emancipation. There are three key reasons for a specific focus on the individual:

A. The divorce between state security and individual security

Traditionally „security" was perceived as the security of the state (Mutimer, 2008, p. 34). This gave rise to the assumption that threats to security arose from outside the state and that these threats were primarily if not always military in nature (Ayoob, 1991, p. 261). This traditional view did not ignore the need for the protection of individuals, rather it saw national security as equivalent to individual security. This arose from John Locke"s conception of the social contract, in which the state was orientated toward the individuals who constituted it. The foundations of the state were set on the consent of the people and the state was conceived as a functionary of the people. Accordingly the security of the state was a direct reflection of the security of the individuals within that state. As the state and society became increasingly indistinguishable, the security of the individual was irrevocably connected to that of the state (Buzan, 1983, p. 21).

However, Buzan theorised that there is a phenomenon where the state has two faces. The first is minimal in nature: it perceives itself as a sum of its parts, as described above, and its purpose is to fulfil the needs of the people. The second has a maximal nature, in which the state is viewed to be more than a sum of its parts, that is, the state and the people are two separate entities and thus have separate priorities and interests (Buzan, 1983, p. 22). In this context, it is possible for a state to ignore

or antagonise the security needs of its people, or to pursue projects that are detrimental to the security of its people (Buzan, 1983, p. 24).

Ethnic cleansing in the former Yugoslavia, state-ordered violent attacks on political opposition parties during the 2008 elections in Zimbabwe and Kenya and the recent violent repression of homosexuals in Uganda are testament to the apparent divorce between state security and individual security, caused by the maximal nature of the state, The security of the individual, once safeguarded by the state according to the dictates of the social contract, can no longer be guaranteed. It is due to this divorce that a specific focus on the security of the individual is necessary.

B. Changes in the sources and targets of security threats in the post-Cold War era

In her book *New and Old Wars* (2006) Kaldor postulates the changing nature of war and conflict after 1989 and asserts that a new nature of war has emerged, one that is decreasingly characterised by military conflicts between states and increasingly by threats that emanate from within the state itself. She has coined the post-Cold War era as the age of the „new war" (Kaldor, 2006, p. 1). In addition, she notes that the source of these conflicts and the targets of these conflicts have changed. Individuals, rather than the state, are increasingly the targets of security threats, and these individuals are now under threat from external non-state actors, such as terrorists, drug cartels and cyber criminals. The Lord"s Resistance Army (LRA) of Uganda, a religious-based rebel movement, has killed and abducted citizens, mostly children, from Uganda, Sudan, the Central African Republic and the Democratic Republic of Congo since its inception in 1987 (Doom & Vlasenroot, 1999, p. 5). The LRA has no intention of challenging or toppling the governments of these states, the target of their attacks is the citizens of these states. These attacks fully exemplify the rise of the phenomenon where security threats emanate from non-state forces targeted at the individual rather than the state. This change in the nature of conflict requires a specific focus on the security of the individual.

C. The nature of threats to security in the post-Cold War era

Finally, the concept of human security is particularly significant when one confronts the myriad of new and re-emerging threats to international peace and security, and the effects these threats have on human life. At the simplest level, populations must be protected from natural disasters and war. However, hazards to human life are not limited to these two areas: individuals are susceptible to various, but equally significant dangers. One of the fastest-growing threats to human life is the inaccessibility of food. Estimates indicate that some 840 million people were undernourished in 1998–2000; 11 million in the industrialised countries, 30 million in countries in transition, and 799 million in the developing world. A 2003 estimate showed 24,000 dying from hunger daily in Africa

(Clover, 2003, p. 6). In addition to deaths caused by hunger, there are increased fatalities caused by infectious diseases. HIV/AIDS, tuberculosis, malaria, pneumonia and diarrhoeal diseases are the leading infectious diseases in developing countries. Malaria kills 7,000 Africans every day (approximately 2.5 million a year), and is the leading cause of death for children under five years of age (Green, 2003, p. 6). The World Health Organisation estimated that between 2000 and 2020, nearly one billion people would be newly infected with tuberculosis, 200 million would get sick, and 35 million would die. The largest killer is HIV/AIDS, whose death toll in 2002 was over 20 million in Africa alone (Green, 2003, p. 2). Efforts to curb this epidemic have been moderately successful: 34 million people were living with HIV worldwide in 2011, and over 75 percent of these cases were in sub-Saharan Africa (UNAIDS, 2011, p. 12). The effects of such threats are experienced at the individual level. When compared to a military attack targeted at the political apparatus of a state, it is logical to deduce that these types of threats target the individual rather than the state.

The globalisation of the world – the widespread operation of businesses on a global rather than a national level and the ease with which individuals and groups can communicate and organize across national frontiers – has facilitated the creation of a global village where borders have become increasingly become porous (Ripsman & Paul, 2010, p. 8). This development has transformed the traditional role of the state, giving it less control over its borders and the whereabouts of its citizens. As such, the state can no longer guarantee the safety of all its citizens premised on traditional theories of territoriality. For example, the outbreak of Avian Flu (H5N1) in 2003, Severe Acute Respiratory Syndrome (SARS) in the same year, and Swine Flu (H1N1) in 2009, exacerbated the state system. Previously such health risks could be managed through national containment and concentrated national initiatives for treatment. However, due to the porous nature of borders and the advances of modern transport, these health risks could not be managed with the same methods. The nature of these threats cannot be restricted by conventional techniques: unlike military attacks, diseases cannot be thwarted by increased military spending or the establishment of strategic global alliances. The advent of globalisation and technology and the creation of a global village mean nuanced threats such as climate change, piracy, terrorism and the proliferation of biological weapons have the potential to affect the globe at large. Thus the last reason for a specific focus on the security of the individual is the new nature of the threats present in the post-Cold War era.

Southern Africa and Conventional Security Studies

It is apparent that the international arena and the nature of conflict have changed in the 21st century and human security contests any conception of security that denies this reality. This is not to say that human security is in complete conflict with traditional conceptions of security: human security acknowledges that the state should be the primary guarantor of security. In an ideal setting the tenets of human security should complement rather than contend with the state. However, in instances where

the state is oblivious of or complicit in the insecurity of its citizens, human security stands in conflict with conventional security which privileges „high politics" over the individual and leaves conflicts that occur within the boundaries of a sovereign state as the responsibility of that state alone. International security, traditionally defined as territorial integrity, does not necessarily correlate with the true security needs of the globe, and an over-emphasis on state security can be to the detriment of human welfare needs (Newman, 2010, p. 7). It therefore asserts that the security of the individual should be placed on a par with that of the state, and when states antagonise the safety of their citizens, it is the security of the citizens that should take precedence and not the sovereignty of the state. What becomes apparent here is that there is a strong tension between human security and state sovereignty, between earmarking the individual as the key unit of analysis and retaining the state as the central actor or referent within the human security paradigm (Thomas & Tow, 2002, p. 181). This tension is essential in understanding the security *problematique* of southern Africa and will be discussed at length in Chapter Five.

Looking through the lens of conventional security studies it would seem that southern Africa is a peaceful and secure region. There are no interstate wars and the political independence and territory of each state remains intact and free from threat. Although there are military struggles present (DRC), these are contained within the borders of that state and are therefore considered as internal conflicts, to be handled as an internal matter by that sovereign state.

However, if the same region is viewed through the lens of Human Security a distinctly different analysis would be made. It becomes apparent that there are a myriad of security concerns present in the region, ranging from the unavailability of food, poverty, disease, racial, ethnic and religious tensions, political oppression, state-orchestrated violence, gender-based violence and environmental degradation. Some of these security concerns have the ability to affect both state and regional security and stability.

This study asserts that the lens of conventional security studies incorrectly portrays the region as stable and secure due to its realist, state-focused prescriptions. The Critical Security Studies" Human Security paradigm more appropriately sheds light on the real security concerns of the region and their effects. The study therefore posits Human Security as the lens through which southern Africa"s security concerns should be analysed. The following sections will detail the concept of Human Security so as to correctly characterise the security *problematique* of southern Africa.

2.3 The Concept of Human Security

The concept of Human Security is highly contested. With some authors advocating for a broad approach which considers all threats to human integrity, including issues of underdevelopment, poverty and deprivation (Commission on Human Security, 2003; Thakur and Newman, 2004; Tadjbakhsh and Chenoy, 2006). Other opt for a more narrow approach which focuses on the human consequences of armed conflict and the dangers posed to civilians by repressive governments and situations of state failure (Ayoob, 1995; Thomas and Wilkin, 1999; Mack, 2004; Kaldor, 2006; MacFarlane and Khong, 2006; Booth, 2007). Critics of the broad approach argue that it "sacrifices analytical precision in favour of general normative persuasion" which limits its applicability for policy makers (Newman, 2010, p. 8). However, to limit human security to the analysis of the effects of war alone negates the plethora of insecurities emanating from other sources. There are numerous definitions of Human Security, some focusing on tangible physical threats to human life whose impact can be measured (King and Murray, 2001, 2002; Thakur and Newman 2004; Mack, 2005) and some that are non-material, embracing intangible values such as sense of well-being and human dignity (Commission on Human Security, 2003).

Due to its complexity several questions have emerged with regard to the definition of Human Security, that is, the nature, qualities, and boundaries of human security as a concept. To this end this section will endeavour to explore the various definitions of human security and their accompanying features in order to tease out a definition of Human Security that appropriately characterises the security *problematique* of southern Africa.

Defining Human Security

The definitional debate will begin with the work of the United Nations Development Programme (UNDP) and their seminal publication, *The 1994 Human Development Report on Human Security* drafted and championed by Mahbubul Haq (Rothschild, 1995, p. 53). This report was crafted for the Copenhagen Social Summit, and spoke to the heart of the security needs of the decade. It asserted that rather than fear of external military attack, people had more pressing security concerns: Will they and their families have enough to eat? Will they lose their jobs? Will their streets and neighbourhoods be safe from crime? Will they be tortured by a repressive state? Will they become victims of violence because of their gender? Will their religion or ethnic origin target them for persecution? The report famously asserted that "Human security is not a concern with weapons – it is a concern with human life and dignity" (UNDP, 1994, p. 22).

The report identified four central features of human security: human security is a *universal* concern, relevant to people everywhere, in rich nations and poor; the components of human security are *interdependent*; human security is *easier to ensure through early prevention* than later intervention,

and is less costly to meet these threats upstream than downstream; Human security is *people-centred*, and concerned with how people live and the quality of their lives. The report correctly states that human security is better identified by its absence rather than its presence. Human Security is thus defined as safety from chronic threats such as hunger, disease and repression, and protection from sudden and hurtful disruptions in the patterns of daily life – whether in jobs, in homes or in communities (UNDP, 1994, p. 23). This definition was designed to relate to the seven dimensions of human security: personal, environmental, economic, political, community, health, and food security. Since this report the UNDP has been heralded as the premier international organisation with regard to human development and human security. Their annual Human Development Reports give the most expansive and recognised information on various concerns ranging from HIV/AIDS rates to levels of literacy. The UNDP has developed the Human Development Index (HDI) as a statistical measure to compare and gauge levels of development across the globe.

The work of the UNDP is the foundation upon which many authors have based their definitions of human security. These definitions have been labelled as *broad*, as they seek to include *all* threats to human life. Following this broad approach to human security Kofi Annan, former UN Secretary General, defined Human Security in his 2000 report *We the Peoples of the World*:

> Human security in its broadest sense embraces far more than the absence of violent conflict. It encompasses human rights, good governance, access to education and health care and ensuring that each individual has opportunities and choices to fulfil his or her own potential. Every step in this direction is also a step towards reducing poverty, achieving economic growth and preventing conflict. Freedom from want, freedom from fear and the freedom of future generations to inherit a healthy natural environment – these are the interrelated building blocks of human – and therefore national security (Annan, 2000, p. 8).

This definition advocates for the recognition of all threats to human life as legitimate security threats. This view is also shared by Lloyd Axworthy, former Minister of Foreign Affairs of Canada, who asserts that:

> Human security today puts people first and recognises that their safety is integral to the promotion and maintenance of international peace and security...no longer are we limited to discussions of states" rights and national sovereignty. Protecting civilians, addressing the plight of war-affected children and the threat of terrorism and drugs, managing open borders and combating infectious are now part of the dialogue (Axworthy, 2001, p. 20).

By tracing the distinct roots of human security – in human rights, in sustainable development, and in safety of the peoples, Hampson et al. (2002) call for the definition of security to be broadened to: "the absence of threat to core human values, including the most basic human value, the physical safety of the individual." Their view includes other core values: physical security, and the protection of basic

liberties such as freedom of speech, economic needs and interests. This narrative of the protection of „core human values" is shared by Alkire (2003) and Ramesh Thakur of the United Nations University (UNU). The UNU hold that:

> Human security is concerned with the protection of people from critical and life-threatening dangers, regardless of whether the threats are rooted in anthropogenic activities or natural events, whether they lie within or outside states, and whether they are direct or structural. It is „human centred" in that its principal focus is on people both as individuals and as communal groups. It is „security oriented" in that the focus is on freedom from fear, danger and threat (Thakur, 2004, p. 347).

As shown by the UNDP's work, Human Security and Human Development share the same theoretical space. As such, Leaning and Arie developed a human security approach based on human development, with specific reference to Africa. Their definition emphasises the psychological and non-material aspects of security. According to them human security is:

> An underlying condition for sustainable human development. It results from the social, psychological, economic, and political aspects of human life that in times of acute crisis or chronic deprivation protect the survival of individuals, support individual and group capacities to attain minimally adequate standards of living, and promote constructive group attachment and continuity through time (Leaning & Arie, 2000).

Caroline Thomas formulated a definition of human security that is reflective of the contemporary age of globalisation. She outlines how globalisation is increasing inequality and the inadequacy of the existing international organisations to address these inequalities, and says:

> Human security describes a condition of existence in which basic material needs are met and in which human dignity, including meaningful participation in the life of the community, can be met. Thus, while material sufficiency lies at the core of human security, in addition the concept encompasses non-material dimensions to form a qualitative whole. Human security is oriented towards an active and substantive notion of democracy, and is directly engaged with discussions of democracy at all levels, from the local to the global (Thomas, 2001, p. 161).

The above definitions all favour the broad, all-inclusive conception of human security. A number of authors have criticised this conceptualisation of human security. Edward Newman describes human security as "normatively attractive, but analytically weak" (Newman, 2010, p. 11). It classifies all and any hazard to human life as „threat" and as such loses any real meaning or analytical significance. In reality, the threats to human life are so far-reaching that even the most skilled policy maker would be perplexed, at the least, if tasked with assembling a coherent proposal to apply to human security, as it is broadly defined. With no markers for measurement or guidelines as to which threats to prioritise,

the broad definition of human security is justly critiqued for its amorphous nature. As Keith Krause argues:

> The broad vision of human security is ultimately nothing more than a shopping list; it involves slapping the label of human security on a wide range of issues that have no necessary link, and at a certain point, human security becomes a loose synonym for "bad things that can happen." At this point, it loses all utility to policymakers – and incidentally to analysts – since it does not allow us to see what is distinctive about the idea of "security" (Krause, 2004, p. 44).

Other opponents to this broad definition echo this same narrative. Mack argues that "conflating a very broad range of disparate harms under the rubric of „insecurity" is an exercise in re-labelling that serves no apparent analytic purpose" (2004, p. 49). MacFarlane and Khong argue that the "conceptual overstretch" of the broad definition of human security makes it "meaningless and analytically useless" (2006, p. 237, 247). MacFarlane and Khong (2006, p. 17) also deny that rebranding development, the environment or health as security challenges has produced a greater flow of resources to addressing them. They argue that this re-labelling actually adds confusion to the field, and distracts from other pressing security concerns.

The above contestations to Human Security are legitimate. However, if it is agreed that the individual is the "irreducible base unit" of security (Buzan, 1991, p. 35) what becomes apparent is that although these definitional debates do exist, at the core they all recognise the validity of placing the individual, and not the state, at the centre of security analysis. This shared ideal provides a foundation to bridge a compromise between the broad and narrow approaches. To this end, scholars have attempted to characterise human security in a way that is complementary to both opinions.

In support of, and drawing from the work done by both the UNDP and the Canadian Government on the topic, Kanti Bajpai presented a paper inclusive of the positive elements of human security. He asserts that contrary to the opinions of some critics, who say the concept is too woolly and broad to be useful either analytically or practically, "the idea of human security can be clearly delineated in relation to the dominant, neo-realist conception of security[10] and that its elements can be presented compactly enough for further refinement"[11] (Bajpai, 2000, p. 2). He proposes that human security can be analysed both quantitatively and qualitatively. To do this there are two key components to consider: *direct and indirect threats* to individual bodily safety and freedom and *the capacity to deal*

[10] As suggested by Buzan (1991), human security can be approached from a neo-realist perspective that retains the sovereign state as the chief guarantor of security, but extends security agendas to include political, economic, social and environmental threats, while also considering traditional military threats. This analysis is examined from three perspectives: the international system, the state, and the individual.

[11] Mapping human security in relation to neo-realism addresses critiques of its theoretical ambiguity, as it can clearly be traced back to an established IR theoretical framework. Presenting it compactly serves to streamline its analysis, creating clear boundaries for policy makers and analysts.

with threats, namely, the fostering of norms, institutions, and democratisation/representativeness in decision-making structures. Thus an audit of human security would consist of (i) an accounting of the growth or decline in threats (quantitative) and (ii) an estimate of the capabilities to meet those threats (qualitative). The construction of a Human Security Index (HSI), a *quantitative* measure, similar to the Human Development Index used to measure levels of development, would allow for cross-national and intra-national comparisons of threats to human security. Secondly, those factors that are not susceptible to measurement can be assessed *qualitatively*; these factors are generally at the international/global level, such as policies and resolutions passed to deal with specific threats. What Bajpai suggests is that, in addition to the comparison of numbers of woman and children involved in trafficking on an annual basis, there should be an analysis of the international, intergovernmental and governmental policies with direct regard to trafficking (Bajpai, 2000, p. 55).

Also in the effort of making the concept more palatable for practical application, King and Murray have formulated a definition of human security with boundaries. They define an individual's human security as his or her expectation of years of life without experiencing the state of generalised poverty (King & Murray, 2002, p. 592). They have identified five domains of well-being: health, education, income, political freedom, and democracy. Thus generalised poverty is based on falling below critical thresholds in any of these domains of well-being. They propose an index of human security that includes "only those domains of well-being that have been important enough for human beings to fight over or to put their lives or property at great risk" (King & Murray, 2002, p. 593). Their index sets thresholds in each domain that are in some sense absolute; the index would identify a person as insecure if he or she fell below a threshold in *any* of the domains. Their approach does not include violence, but rather focuses on issues associated with the „freedom from want" (Alkire, 2003, p. 15).

Contributing further to this conceptualisation of a threshold based definition, Owen (2004) points out that:

> A principle critique of traditional security is that it inappropriately limits what are and are not legitimate threats. However, by artificially choosing which of the UNDP categories are and are not relevant, most human security proponents are guilty of the same reductionism. Threats should be included not because they fall into a particular category, such as violence, but because of their actual severity. In this conception, human security is not defined by an arbitrary list (either broad or narrow), but by the threats actually affecting people (Owen, 2004, p. 382).

Owen puts forward a hybrid definition that would not pre-choose threats but rather include them based on their severity. That is, all concerns would be considered but only those that pass a specific threshold of severity would be labelled as a threat to human security. The threshold would be based on two factors: it must be selective without being limiting, and it must have clear categories into

which threats may fall for analytical purposes. He therefore defines human security as *the protection of the vital core of all human lives from critical and pervasive environmental, economic, food, health, personal and political threats* (Owen, 2004, p. 383). In his opinion this definition accommodates both narrow and broad conceptions of human security and includes all human security concerns but sets out clear categories into which these threats may fall into,. It is this definition that the study will use when analysing the security concerns of southern Africa.

It is clear from this analysis that there are many divergent views of what the concept of Human Security entails. While some authors vie for the broad conception of human security which accommodates all threats to human life, others contend that this view is too extensive and impedes the pragmatic application of the concept as a policy and an analytical tool. To remedy this some authors have sought to negotiate a conception that encompasses both views, by suggesting the use of thresholds and indices to measure human security, while including all threats. This debate, however, takes place against the backdrop of a widespread consensus that the analysis of security must encompass the individual. Aptly summarised by Hubert (2001), although the debate may at first appear polarised (narrow vs. broad), there is in fact significant convergence among proponents. Hubert asserts that the differences observed in this debate are not of substance but of packaging. The fundamental focus of Human Security is the security of the individual.

The definition put forward by Owen (2004) best articulates the nature of the security concerns specific to the southern African sub-continent, and therefore for the purposes of this study: *Human security is the protection of the vital core of all human lives from critical and pervasive environmental, economic, food, health, personal and political threats* (Owen, 2004, p. 383).

As pointed out by Owen (2004), by arbitrarily selecting security threats analysts and policy makers run the risk of excluding real threats on the basis that they do not fit into specific categories. Rather a threshold should be established by which the vitality of each threat is assessed; placing those threats most vital to human life at a higher priority than those which are less vital. This establishes a hierarchy of threats which allows for clearer and more strategic policy responses. In addition, this definition speaks to the nature of the security threats in southern Africa, that is they are critical (threatening the very life of individuals) and/or pervasive (persistent, with the tendency to permeate/spread).

Considering the areas covered by the chosen definition – the spread of infectious diseases emerge as the most vital human security threat in the region. The provision of public health is therefore a vital human security concern, that is, it is essential for the continued existence of human life. While SADC reports that a total of 2.9 million people in the region were food insecure at the end of 2011 (SADC,

2011, p. 6), an astounding 11.3 million people were living with HIV/AIDS in the same period. Of the 23.3 million people living with HIV in Africa, southern Africa accounts for 49 percent of these cases (USAID, 2011, p. 1). In addition southern Africa has the highest burden of tuberculosis and subsequently the lowest life expectancies in the world. Infectious diseases in southern Africa are the most critical concern to human security, they claim more lives than any other concern, and therefore the concern of health in the region is the focus of this study.

2.4 Conclusion

It is apparent from this analysis that human security is a complex concept. However, at the core, the objective of human security is simple: to ensure the safety of human life. Definitions of human security oscillate between two key standpoints: the broad conception, most famously promulgated by the UNDP and its 1994 Human Development Report, calling for the securitisation of every aspect of human life; and narrower definitions that seek to prioritise some threats over others, so as to enhance the analytical and practical relevance of the concept. Both these conceptions vary in their interpretation of human security, but agree on the fundamental need to place the individual as the key referent of security analysis and practice. For the purposes of this study Human Security has been defined as the protection of the vital core of all human lives from critical and pervasive environmental, economic, food, health, personal and political threats (Owen, 2004, p. 383) . This definition best suits the security concerns of southern Africa.

Conventional Security Studies would not consider issues of disease, famine, crime, ethnic and religious persecution, gender violence or environmental degradation as relevant to international peace and security. However, as asserted through Critical Security Studies, it is these very issues that are of more relevance in the world today than interstate conflicts and military attacks. This is especially true in southern Africa, where the largest killer is disease rather than military warfare. The absence of inter-state warfare in southern Africa is not an indication of regional security, as the following chapter details. Southern Africa faces significant security concerns, the most vital of which is the spread of infectious disease.

The following chapters detail the significance of this threat, and its ramifications on regional security and stability.

Chapter Three – Public Health in Southern Africa

3.1 Introduction

In the previous chapter it was established that conventional security analysis, predicated on strategic studies, would consider the southern African region as largely secure and stable due to the absence of military conflict. However, when this same analysis is made through the lens of human security, a different narrative would be presented. Human security is defined as the protection of the vital core of all human lives from critical and pervasive threats, and this study asserts that southern Africa is host to significant security concerns, most adequately characterised as threats to human security.

Public health is one such concern, and is at present the most vital concern to human security in the region. The WHO defines public health as all organised collective, public or private measures whose objective is to prevent disease, promote health and prolong the life of entire populations (WHO, 2007, p. 3). It is also the term used to describe the overall state of health of the population in a specific location. For the purposes of this study „public health" will be used to as a measure of the health of a society as well as the abovementioned efforts whose aim is to prevent the spread of disease, specifically infectious diseases such as HIV and TB. Due to the negative consequences that infectious diseases have on the quality of life and life itself, the area of public health has received much attention as a legitimate challenge to many facets of security, including human security (Brockington, 1985; Peterson, 2002; Bower & Chalk, 2003; Thomas & Weber, 2004; Youde, 2005; Callabero-Anthony, 2006; Elbe, 2006; O'Manique, 2006; Filder, 2007; MacLean, 2007, 2008). Its negative effects are most easily established through quantitative measures, of which mortality rates are the clearest indicator. The purpose of this section is therefore to characterise public health as a vital human security concern in southern Africa. By giving an overview of the disease burden present in the region and the mortality rates due to various diseases it will become apparent that infectious diseases not only pose a significant threat to human life, but they claim more lives than civil conflicts, starvation or violent crime in the whole region. Recent WHO and UN statistics confirm the immense disease burden present in southern Africa. The region accounts for 33 percent of the whole globe's HIV incidence and 47 percent of HIV/AIDS related morbidity (UNAIDS, 2011). Other infectious diseases such as TB and malaria have high incidence levels, and an analysis of the causes of death in southern African states show that infectious diseases, not crime or military conflict or political violence, account for over 50 percent of deaths in the region. The large scale loss of human life due to infectious disease legitimate public health and its protection as a vital security concern for the region.

This study further asserts that if not managed adequately specific concerns to human security have the ability to permeate state borders and affect regional stability. Threats of this nature require regional attention if the state involved lacks the political will, policy or resources to manage the threat on its own. This analysis aims to situate the public health crisis in Zimbabwe as a concern to the region. The disease burden of Zimbabwe ranks amongst the highest in the region, and the enduring political and economic crisis in Zimbabwe has crippled the state, eroding its ability to adequately meet the welfare needs of its citizens. This has led to the mass migration of Zimbabwean nationals throughout the region. The deterioration of the public health sector of Zimbabwe coupled with the extreme disease burden in the region presents a significant concern to regional security and stability. Due to intra-regional human mobility and the trade routes linking all SADC countries, the spread of infectious disease presents a case of interdependence requiring regional cooperation as the transnational nature of disease cannot be contained by state borders. The situation in Zimbabwe gives credence to the idea that unmet individual needs have the ability to destabilise a state and affect the region, the case of public health in Zimbabwe presents such a case in southern Africa.

This section serves as a precursor to the main case study, giving an overview of the disease burden of the region, and the vital threat that infectious diseases pose to human security in southern Africa.

3.2 The Disease Burden of Southern Africa

A 2009 report on public health in Africa published by the Center for Strategic and International Studies (CSIS) outlined that although sub-Saharan Africa was host to only 13 percent of the world‟s population it carried 24 percent of the global disease burden (Cooke, 2009, p. 1): a disproportionate amount when compared to the rest of the world and to equally less developed regions. The World Health Organisation (WHO) has further supported these claims: through various reports on HIV/AIDS and other infectious diseases, [12] it can be seen that indeed the acute challenges posed by global public health and the spread of disease in the 21st century have been most heavily felt in the African continent. The direct effects of poor public health are easily determined by mortality rates; however, the subsequent negative consequences are far-reaching, leading to social, economic and political instability across the continent. The continent‟s immense disease burden and weak health systems are imbedded in a broader context of poverty, underdevelopment and inadequately managed government institutions, which are further weakened due to the crippling effects of widespread disease.

[12] The various status reports on global health trends can be accessed via the WHO website: http://www.who.int/en/.

Although the region faces health concerns of various types,[13] infectious diseases constitute the majority of the cases, and of these HIV/AIDS, tuberculosis and malaria, known as the "big three", are the highest causes of mortality on the continent. Of the regions in the continent the southern African sub-continent is host to the highest incidence of HIV/AIDS and tuberculosis. In addition, due to poor water and sanitation systems, diarrhoeal diseases such as cholera, typhoid and dysentery also pose a major threat to public health in the region. Although the southern African region is host to other security and development concerns, the top cause of mortality in the region is infectious disease (Cooke, 2009, p. 7).

HIV/AIDS

The Human Immunodeficiency Virus (HIV) is a sexually transmitted infectious disease that compromises the immune system of its host. When fully matured, HIV develops into the Acquired Immune Deficiency Syndrome (AIDS) which further compromises the immune system, a person infected with AIDS is susceptible to numerous infections, known as opportunistic infections, which eventually overwhelm the immune system leading to death (Inungu, 2006, p. 17). The global HIV/AIDS epidemic has received an unprecedented amount of attention and funding. It has generated new global institutions such as UNAIDS, a UN institution solely focused on the prevention and management of the epidemic, and the Global Fund to Fight AIDS. It has mobilised new players in the international arena: religious organisations, private organisations and corporations, and elevated the profile of Africa and global public health among states, foreign policy experts, scholars and NGOs (Cooke, 2009, p. 1). The response to HIV/AIDS is the largest collective effort in the 21st century. Much of the focus of these initiatives is in Africa. To date an estimated total of 30 million people have died of HIV/AIDS worldwide, with 68 percent of these from sub-Saharan Africa. Southern Africa is the epicentre of this epidemic: of the 23.3 million people presently living with HIV in Africa, southern Africa accounts for 49 percent of these cases, translating to approximately 11.3 million people (USAID, 2011, p. 1). The disease is most prevalent in young adults between the ages of 15-25 and is the chief cause of low life expectancy, high child mortality and adult mortality rates in the region. Figures 3.1, 3.2 and 3.3 show the prevalence and effects of HIV/AIDS in southern Africa.

[13] Communicable and non-communicable diseases, mental health conditions and disabilities.

Country	HIV/AIDS Prevalence (%)[14]	World Rank (HIV Prevalence)[15]	Life Expectancy[16]	World Rank (Life expectancy)[17]
Angola	2.00	30	38.20	190
Botswana	24.80	2	61.85	146
DRC	3.40	16	46.50	162
Lesotho	23.60	3	40.38	188
Malawi	11.00	9	43.82	183
Mozambique	11.50	8	41.18	187
Namibia	13.10	7	52.90	172
South Africa	17.80	4	48.98	176
Swaziland	25.90	1	31.88	191
Tanzania	5.60	12	52.01	170
Zambia	13.50	6	38.63	189
Zimbabwe	14.30	5	45.77	180

Table 3.1: HIV/AIDS and Life Expectancy Data for Southern Africa (2011)

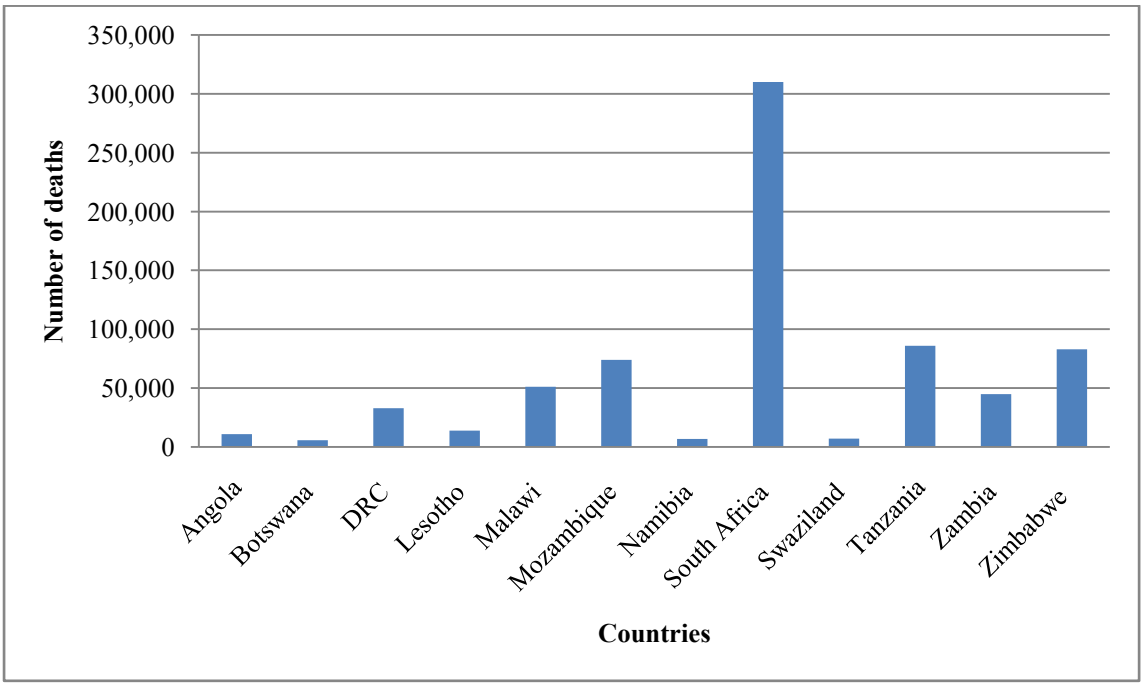

Figure 3.1: Mortality due to HIV/AIDS in Southern Africa (2011)[18]

The effects of HIV/AIDS have been devastating to southern African demographics: reducing life expectancy, increasing mortality, lowering fertility, and leaving millions of orphans and vulnerable children as a result. Swaziland, Botswana, Lesotho, South Africa and Zimbabwe have the highest HIV prevalence rates in the world, and subsequently the lowest life expectancies (UN, 2011).

[14]Source: WHO, Global HIV/AIDS Epidemic Report 2011.
[15] Rank established by CIA World Fact Book (1 denoting highest adult HIV prevalence in the world).
[16] Source: UN World Population Prospects: 2011.
[17] Rank established by UN Population Division, of 191 member states that submitted data for 2011 (1 denoting lowest life expectancy in the world).
[18]Source: WHO, Global HIV/AIDS Epidemic Report 2011

When compared with the rest of the world, southern Africa"s 12 states fare badly against the remaining 239 sovereign states. Southern Africa accounts for 33 percent of the world"s HIV adult incidence. The WHO estimated that 34 million people were living with HIV/AIDS in 2011, 11.3 million of these resided in southern Africa, the remaining 22.7 million in the rest of the world. Southern Africa also accounted for a disproportionate amount of the worlds HIV deaths in 2011: 47 percent. An approximate 1.8 million people died of HIV-related causes in 2011, 846,000 in southern Africa, the remaining 945,000 in the rest of the world.

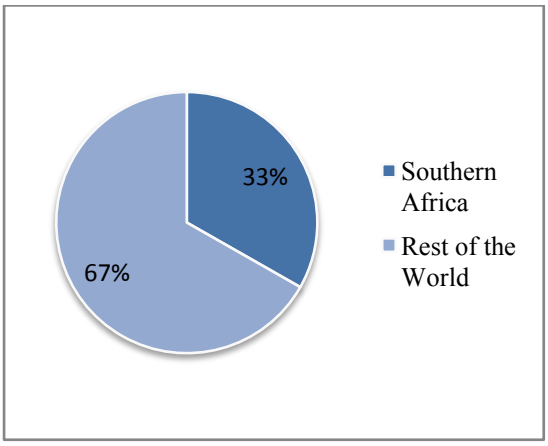

Figure 3.2: HIV Incidence 2011

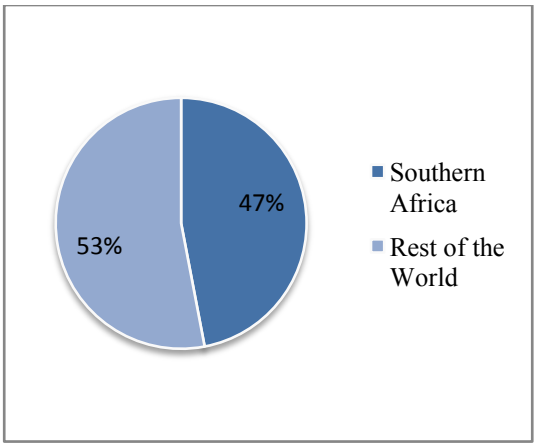

Figure 3.3: HIV Mortality 2011[19]

Tuberculosis (TB)

Tuberculosis is a common, and in many cases lethal, infectious disease caused by various strains of mycobacterium, usually *Mycobacterium tuberculosis*. It is an air borne disease that typically affects the lungs but can also affect other parts of the body. In 2010, 8.8 million people fell ill with TB and 1.4 million died from TB. Over 95% of TB deaths occur in low- and middle-income countries, and it is among the top three causes of death for women aged 15 to 44 (WHO, 2012, p. 1).

South Africa and Swaziland have the highest TB rates in the world, with South Africa reporting 981 cases per 100,000 people and Swaziland 1,287 per 100,000 people (WHO, 2011, p. 1). In addition southern Africa has high levels of multi-drug-resistant TB (MDR-TB), a version of the disease that is immune to treatment. The spread of TB is exacerbated by the HIV epidemic: it is the most common opportunistic disease present in people living with HIV/AIDS and TB-related deaths are the most prevalent. Southern Africa has the highest number of people co-infected with TB and HIV in the world, and has the highest TB-HIV mortality rates.

[19] Data for both pie charts calculated from WHO, Global HIV/AIDS Epidemic Report 2011

Country	TB Prevalence (# per 100,00 people)	% Co-infection with HIV	Mortality (excluding HIV)
Angola	304	28	6,500
Botswana	503	65	430
DRC	327	18	34,000
Lesotho	633	77	290
Malawi	219	63	1,700
Mozambique	544	61	11,000
Namibia	603	55	580
South Africa	981	60	25,000
Swaziland	1,287	82	380
Tanzania	177	38	5,800
Zambia	462	65	2,600
Zimbabwe	633	75	3,400

Table 3.2 TB Data for Southern Africa (2011)[20]

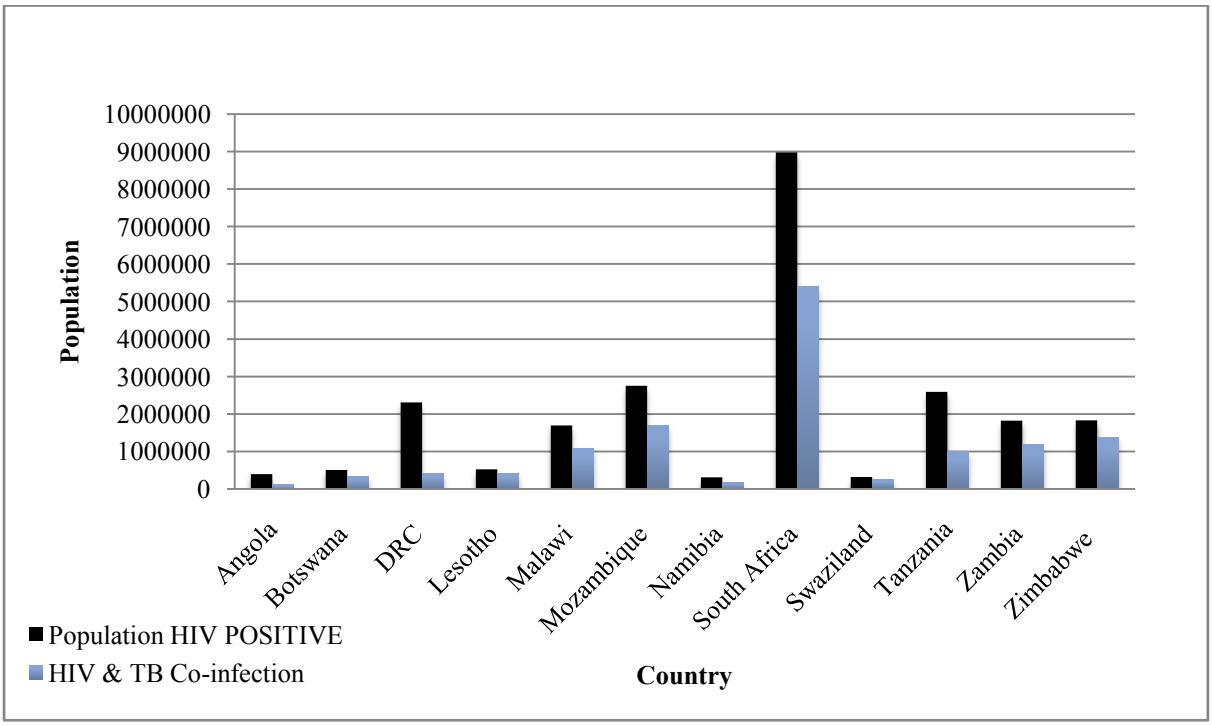

Figure 3.4: TB Co-infection Data for Southern Africa – 2011[21]

[20]Source: WHO, Tuberculosis country profiles (2011)
[21] Data calculated from WHO, Tuberculosis country profiles (2011) and the WHO, Global HIV/AIDS Epidemic Report 2011

Malaria and Diarrhoeal Diseases

HIV/AIDS and TB constitute the largest disease burden in Southern Africa, however, populations are also affected by malaria and diarrhoeal diseases.

Malaria is an infectious disease caused by a parasite called *Plasmodium* which is transmitted via the bites of infected mosquitoes. The disease affects the blood cells of its host, stopping the supply of blood to vital organs which eventually leads to death if untreated (Warrell, 1990, p. 68). Africa accounts for 85 percent of malaria cases and 90 percent of malaria deaths worldwide. Sadly, 85 percent of malaria deaths occur in children under five years of age. The WHO estimates that every 30 seconds a child dies from malaria in the world. Within southern Africa Angola, DRC, Malawi, Mozambique, Namibia, Tanzania, Zambia and Zimbabwe are classified as high risk malaria areas by the WHO. The most affected are Angola, Malawi and Tanzania, which reported 8,114, 8,206 and 15, 819 deaths due to malaria respectively in 2011 (WHO, 2011b).

Diarrhoeal diseases such as cholera, typhoid and dysentery are common in underdeveloped and rural areas in the region with inadequate water and sanitation facilities. Cholera cases have been reported across southern Africa since 2005, the most severe having been in Zimbabwe in 2008 and Mozambique in 2010.

In comparison to other threats to human life – war, starvation or violent crime – infectious disease is the highest killer. In addition, other health-related causes of death constitute the majority of deaths other than infectious diseases. Figure 3.5 gives a comparative analysis of the crude deaths accounted for by the WHO (2010–2011)[22] and those attributed to infectious diseases. It can be seen that in South Africa, which had the highest crude deaths in the region (869,425), almost half of these were due to infectious diseases, including influenza, pneumonia and diarrhoeal diseases. Other health, non-infectious, related deaths account for a significant proportion of the remaining causes with strokes, coronary heart disease and diabetes claiming 23,139, 20,506 and 19,530 lives respectively. Of the southern African states Zimbabwe, Mozambique and Zambia reflect significantly high data, with 65 percent, 58 percent and 57 percent of recorded deaths being due to infectious disease. Of note also is the DRC, which is the only state currently enduring civil conflict of a military nature: 67 percent of deaths recorded in the DRC were due to infectious disease, other causes included maternal/birth complications, road traffic accidents and malnutrition, while death due to direct warfare constituted only 3 percent of the recorded deaths.

[22] Data compiled from WHO and UN Population and Health Reports 2010 & 2011. Calculations detailed in Appendix B.

From the above analysis it is clear that infectious disease is the chief cause of death in southern Africa, and consequently, public health emerges as the most significant concern to human security at present in southern Africa.

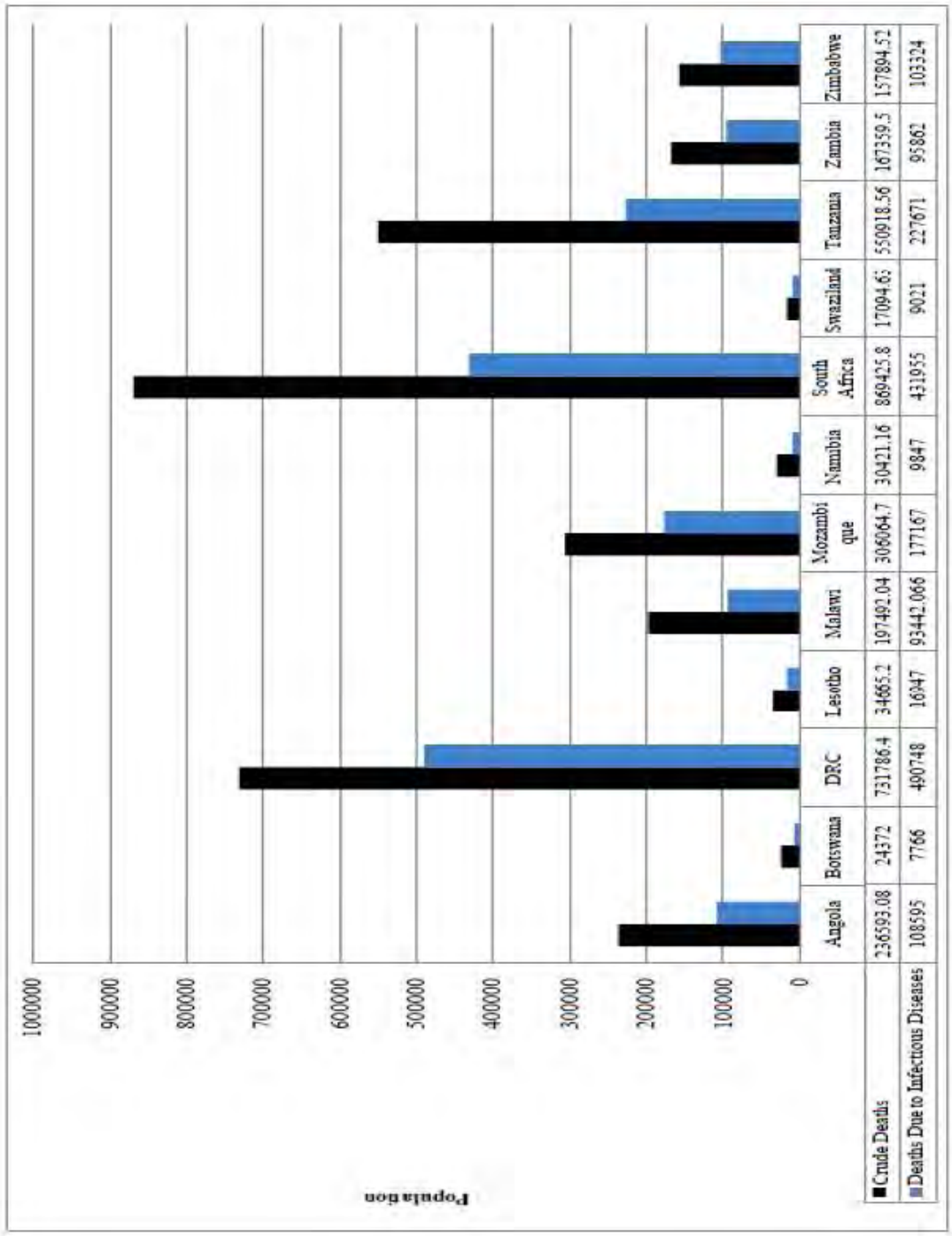

Fig 3.5: Causes of Death in Southern Africa 2010 – 2011

3.3 Conclusion

In light of the compelling data presented above it is apparent that the high disease burden in southern Africa has had adverse effects on human security in the region: lowering life expectancy, increasing child and adult mortality rates and eroding the quality of life of individuals across the region. The threat that infectious diseases pose to human life far surpasses concerns of military warfare in southern Africa. This high disease burden is of particular concern in the face of inadequate state and regional structures to manage and curtail the spread of life-threatening diseases such as HIV/AIDS and TB. As such the Zimbabwean case presents a unique challenge to the region. At the height of the political and economic crisis in Zimbabwe in 2008 the public health sector of Zimbabwe had deteriorated so dramatically that it failed to provide even the most basic of treatments to the Zimbabwean populace.

The following chapters will detail the deterioration of the public health sector of Zimbabwe and the ramifications this crisis has had on the southern African region. Through interviews with key actors in the public health sector of Zimbabwe, and a review of SADC policy and action, it will become apparent that SADC and its member states have not responded adequately to the public health concern in the region, raising further concerns of regional stability and capacity.

Chapter Four– The Public Health Crisis of Zimbabwe

Figure 4.1: Map of Zimbabwe and its neighbouring states[23]

4.1 Introduction

The southern African landlocked country of Zimbabwe has received unprecedented attention in the past decade, due in no small part to the authoritarian leadership of its president, Robert Mugabe, who has been described by political commentators as a „tyrant" a „brutal dictator" and even a „political thug" (Meredith, 2007, p. 5). The political landscape of the former British colony has long been plagued with controversy. In an act of unprecedented defiance of the British monarchy the white minority government of Ian Smith unilaterally declared independence from Britain in 1965, drawing much international attention to the southern African state. Again in 1979 the government of Ian Smith prematurely declared independence after a series of negotiations with the African elite. However, the liberation movements representing the African majority, the Zimbabwe African People"s Union (ZAPU) and the Zimbabwe African National Union (ZANU), continued the guerrilla war across the country, ignoring the peace accord. This foiled attempt at independence once again drew the world"s attention to the turbulent internal politics of the nation.

[23] Source: http://www.infoplease.com/atlas/country/zimbabwe.html

However, it is the leadership of incumbent President Mugabe in recent years that has captured the attention of international media, political commentators and academics.

Zimbabwe attained political independence in 1980, this saw the replacement of the British colonial government of Rhodesia with a democratically elected African Government. President Mugabe, who has led the nation since 1980, also leads the Zimbabwe African National Union – Patriotic Front (ZANU-PF),[24] a political party which traditionally enjoyed almost absolute support due to its liberation credentials. The once prosperous state is presently caught in an enduring economic and political collapse: rampant corruption, the disregard of democratic practices, bilateral sanctions, and state-sponsored violence against political opposition, coupled with a mismanaged land re-distribution programme have resulted in the widespread collapse of the economy and the inability of the state to provide basic services to its citizens. This situation is commonly referred to as the „Zimbabwean Crisis".[25] Unlike states such as Afghanistan, Iraq or the DRC which are considered as failed states (Zartman, 1995; Rotberg, 2003), Zimbabwe is the only state undergoing such crises in the 21st century in the absence of military conflict.

A great deal of attention has been placed on the economic and political collapse of Zimbabwe and the resultant effects on the political climate of the nation. Numerous reports, task papers, academic articles and commentaries have been published in the last decade probing the lack of democratic processes, the decay of state function, and the complicity of the state in the repression of citizens and political opposition in Zimbabwe (Addison, 2000; Goredema, 2001; Maclean, 2002; Maroleng, 2003; Dansereau et al., 2005; Hentz, 2005; Chitiyo, 2006; Brett, 2008; Coltart, 2008; Mamdani, 2008). These analyses have focused largely on matters of high politics, that is, matters concerned with the survival of the state, such as national security and political stability, largely ignoring matters of non-state/social concern. Similarly, international policy and recommendations aimed at resolving the Zimbabwe situation have focused on concerns of „high politics", with the European Union (EU) and USA calling for sanctions to be placed on Zimbabwe, such as those placed on Iraq in 1990. Similar calls have been made for legal action through the International Criminal Court or even military intervention (IOLNews, 30; AllAfrica, 2006; Peacock, 2009; Guma, 2012). Much pressure was placed on the Security Council in 2008 to deal more forcibly with Mugabe and the ZANU-PF government after a violent election saw Mugabe retaining the presidency. However, due to support from the veto wielding China and Russia Mugabe and his party have managed to escape any global action through the UN (Nasaw, 2008, p. 1).

[24] An amalgamation of the two major liberation movements: Zimbabwe African People"s Union (ZAPU) and the Zimbabwe African National Union (ZANU).
[25] The study will use this term when speaking about the economic and political collapse of Zimbabwe.

All these recommendations, though valid, negate the significant non-political crises in Zimbabwe. Apart from the work done by human rights NGOs[26] and UN institutions such as WHO, UNICEF and UNAIDS, much less attention has been paid to matters of „low politics" in Zimbabwe, such as acute shortages of clean water, shelter, health care and education.

Matters of low politics have been completely overshadowed by concerns of state survival, political stability and independence. The primary role that the political rule of ZANU-PF has played in the demise of Zimbabwe has largely obscured the responses to the Zimbabwe situation, which are mostly aimed at limiting the political rule of ZANU-PF and at restoring democratic rule. Yet it is not just the political apparatus that has suffered, but the entire fabric of the nation. In particular, the situation in Zimbabwe has crippled the state"s ability to provide adequate social services, such as education, housing and health care; eroding the capacity of these departments to function due to the relentless migration abroad of its skilled personnel. Basic amenities such as electricity and clean water are scarce even in urban cities. The effects of the political instability and economic downward spiral in Zimbabwe have extended to matters of social cohesion, national identity and the rule of law.

This situation was aptly summarised by Raftopoulos (2010):

> Although popularly referred to as the „Zimbabwean crisis", what has been occurring in the country since the turn of the new millennium is a complex and inter-related multi-layered and pervasive catastrophe that can, perhaps, best be described as a series of „Zimbabwean crises", for no aspect of Zimbabwean existence escaped the deleterious effects of this phenomenon. The crisis has been evident in the country"s economic and socio-political life and the negative ripple effects that emanated from a progressively dysfunctional state (Raftopoulos et al., 2010, p. 1).

The Zimbabwe scenario presents a complex case of political and economic collapse, which has led to equally complex consequences for the Zimbabwean society. This chapter aims to single out the key elements of the „Zimbabwean crisis", in particular those elements which led to the deterioration of the public health sector. It will then explore the effects that this deterioration has had on the region, with particular reference to human security and regional stability. It will become apparent that the inability of Zimbabwe to provide its citizens with adequate social services, in particular public health, and the subsequent mass migration of Zimbabwean nationals into the southern African region, has had adverse effects on the SADC region: threatening regional health and human security, and overwhelming the regional structures of SADC and individual SADC states.

[26] Particularly Médecins Sans Frontières and the International Commission of the Red Cross.

4.2 The Deterioration of the Public Health Sector

There are a plethora of resources focused on the descent of Zimbabwe into political and economic collapse, most of which point to the rule of Mugabe and ZANU-PF. However, this simplistic view negates the complex web of events leading up to the Zimbabwean Crisis. Any objective analysis must therefore look at all aspects of the crises regardless of popular opinion and rhetoric. This section outlines key policies and events in the history of Zimbabwe that were instrumental in the breakdown of social service provision in Zimbabwe. It will become clear that the deterioration of the public health sector of Zimbabwe is a result of the implementation of ill-considered political and economic policies by the government of Zimbabwe, which systematically eroded the public health system.

For the purposes of clarity, these events will be detailed in chronological order, focusing on the periods 1990–2000, 2000–2008 and 2008 onwards.[27]

The Deterioration of the Public Health Sector: 1990–2000

Raftopolous and Phimister, premier Zimbabwean historians, assert that the current crisis is a result of a combination of the complementary dynamics of domestic tyranny and developmental collapse (Raftopolous & Phimister, 2004, p. 356). Key to this observation is the period between 1990 and 2000. During this period the ZANU-PF government made three key decisions that adversely affected the public health sector: the implementation of the IMF-sponsored Economic Structural Adjustment Programme (ESAP), the choice to go to war in the DRC, and the mismanagement of the land issue.

In 1990 the government of Zimbabwe introduced ESAP, an economic programme that initiated a series of economic reforms which aimed to create a more modern, competitive, export-led and industrialised economy. Although each country was treated as a separate economic unit, such programmes had set formulas of structural adjustment measures that included devaluation, deregulation, desubsidisation and privatisation. In the early 1980s, Zimbabwe had been a star performer in Africa in the provision of social services and in the reconstruction and development of its public infrastructure, most of which was financed by the government without jeopardising relative macroeconomic stability (Saunders, 1996, p. 6). However towards the end of the 1980s the government was faced with decreased local production, stagnant local demand and a worsening unemployment problem that threatened to become politically troublesome. The new government had unwisely taken on a role similar to that of the Rhodesian regime, in which a form of „state-capitalism" developed that allowed the state to serve as a buffer, protecting elites and workers from political and

[27] These periods are of relevance as 1990 saw the introduction of significant economic reforms in Zimbabwe, 2000 marked the official endorsement of the fast-track land redistribution programme, and 2008 saw the introduction of the Government of National Unity in Zimbabwe. The significance of these events will be detailed in this section

economic competition and the small vulnerable economy from external shocks and pressures. Maintaining a stable corporatism in Zimbabwe‟s class- and racially-divided society was dependent on preserving a delicate economic equilibrium of growth with equity. Initially, in 1980-81, the hope that this precarious balance might be preserved was fuelled by an economic boom which helped to finance the substantial increase in expenditures on social services. However, such prosperity was short-lived and, for the remainder of the 1980s, the growth rate hovered around 3 percent per annum (compared with a projected 8 percent), net investment levels were low (average 3.6 percent), gross fixed capital formation declined and the budget deficit increased (Maclean, 1997, p. 159). Due to a lack of participation of the local private sector and capital inflows from overseas, ESAP emerged as the most viable solution to avoid a further economic downturn.

The reforms enforced by ESAP included trade and currency deregulation, devaluation of the Zimbabwe dollar, movement towards high real interest rates, the lifting of price controls, significant cuts in social spending and the removal of consumer subsidies. A central component of these reforms was the extension of credit from the IMF to fuel the economy: in 1992, the IMF made the first disbursement of US$216 million. Further amounts of US$65 million, US$76 million and US$75 million followed in 1993, 1994 and 1995 respectively (Coltart, 2008, p. 12). The combined measures of these reforms were meant to translate into the reduction of the government deficit, civil service reform and shedding of public enterprises. However, in a country where local production was highly integrated and often efficient, and where a large state provided a range of quality social services, for most the reforms represented more peril than promise (Saunders, 1996, p. 9). Only five years after the implementation of ESAP, the Zimbabwean economy was described to be in a “quagmire of mounting debt and erratic growth” (Saunders, 1996, p. 8).

The economic reforms ushered in a recession: the economy contracted by an estimated 7.5 percent, and in 1992 the country suffered a severe drought which affected its agriculture-based production sector. At the same time, price control relaxation saw inflation explode and consumer demand shrink by as much as 30 percent. Trade-union analysts outlined that employment growth had fallen from 2.4 percent in the late 1980s to 1.55 percent in the period 1991-97 (Mamdani, 2008, p. 2). A review of ESAP after five years showed that the percentage of households living in poverty throughout the country increased by 14 percent, economic growth slowed and became erratic, averaging only 1.2 percent, not the projected 5 percent. Inflation remained high, averaging 28.8 percent between 1991–94, instead of falling to the projected 10 percent (Kanyeze, 2006). The Zimbabwe Programme for Economic Transformation (ZIMPREST) was implemented between 1996 and 2000, as a continuation of ESAP.

These reforms had adverse effects on the social services. As noted by Saunders:

> There was a shift in emphasis in the redesign of the state"s social programs, away from a concern with issues of equity and access, towards a system of management driven primarily by the problem of how to administer the supply of services given defined, limited resources. The negative social and economic consequences of this shift were immediately and abundantly clear for ordinary Zimbabweans. Of particular note was the rapid deterioration in the country"s acclaimed health and education sectors (Saunders, 1996, p. 9).

Public expenditure on health care declined by 39 percent in 1994/95 (Saunders, 1996, p. 9). Health allocation in 1990 constituted 3.1 percent of GDP (US$22 per capita) but had fallen to 2.1 percent (US$11 per capita) in 1996, and fell further by 2000 (Dhliwayo, 2001, p. 5). This decrease implied diminished spending on common drugs, preventive health services, specialist facilities and treatment, and other components of quality health care delivery. The term "ESAP deaths" became common after 1992, describing deaths caused by the inability of patients to pay for the minimal length of time in the hospital, or for prescription medicine. ESAP resulted in the emergence of a two-tier health care system, where individuals who had private resources to access quality healthcare could do so, and those who were unable to pay, who were the majority, became increasingly marginalised from quality services (Saunders, 1996, p. 9). The effects of this under-spending on health was most clearly demonstrated by the decline in health indicators: life expectancy declined, mother and infant mortality rates increased, and the incidence rates of infectious diseases such as HIV/AIDS and TB rose to among the highest on the continent. In addition, the widespread wage cuts of civil servants triggered the relocation of public health personnel to the more lucrative private health sector, and abroad. Of the 1,200 physicians trained in Zimbabwe during the 1990s, only 360 were still practising in the country in 2001 (Lowell & Findlay, 2001, p. 14).

The implementation of ESAP had two key consequences on the provision of public health care in Zimbabwe. Firstly, it caused a decline in government spending on public health, eroding the human resources base, reducing positive health outcomes and the overall quality of health care available to the public. Secondly, it created a dependency on external funding for vital domestic social services. Due to mandatory limits on government spending on social services, Zimbabwe became increasingly dependent on international aid, development funds and international donations to buttress the budget of the public health sector. This overdependence on external funding proved detrimental to the public health sector at the turn of the new millennium, when extreme international debt and the political choices of ZANU-PF led to the expulsion of Zimbabwe from the IMF and the World Bank.

The economic decline during this period was exacerbated by the economic mismanagement of the government of Zimbabwe. The outcomes of the structural adjustment programmes were further

limited by the government‟s inability to restrict spending and domestic debt as prescribed by the IMF. Although reviews of structural adjustment programmes initiated in other developing states have yielded similarly disappointing results (Klein, 2007; Maclean, 1997), assessments of the Zimbabwe case point to fiscal mismanagement as a major contributor to the negative economic outcomes of that decade (Dhlodhlo & Mabugu, 2000; Coltart, 2008). In 1998 Mugabe made a widely unpopular decision to intervene in the DRC. The choice to go to war was motivated firstly by a need to shore up the SADC collective security structures, and more importantly the war in DRC was seen as an economic opportunity by the ruling elite to secure mining and military partnerships (Dashwood, 2000, p. 104). The war began to eat into the national reserves, further weakening the fragile economy, as early as 1996 Mugabe had already donated US$5million to Kabila to finance his revolt against Mabuto (Nest, 2001, p. 484). In 2000, the Minister of Finance reported that since joining the war in August 1998, Zimbabwe had spent US$5.2 million in its first five months, US$78 million in 1999, and US$120 million in the first six months of 2000, placing the cost at around US$200 million – just above Z$10 billion (Makoni, 2000). This extravagant spending took place against the backdrop of diminishing domestic social spending with funding cuts to health, education, and other social services.

Towards the end of the millennium the most prominent issue in Zimbabwe‟s internal politics was the concern of land redistribution. The need to address the unequal distribution of land began at independence but by 2000 it dominated the entire sphere of Zimbabwean politics. Ten years after independence ZANU-PF found itself facing increasing opposition from two separate yet equally significant groups. The Zimbabwe Congress of Trade Unions (ZCTU), a ZANU-PF ally, which had become disgruntled with increased mismanagement and corruption within the party, and the Zimbabwe National Liberation War Veterans Association (ZNLWVA),[28] war veterans of the liberation struggle who had been disenfranchised by the Lancaster House Agreement.[29] The initiation of ESAP had led to increased unemployment, inflation and poverty, all of which created a downturn in development, employment rates and wages. ZCTU emerged as a formidable social force, mobilising its autonomous national base to present a direct challenge to the ruling party‟s economic and political policies. The second source of opposition, the war veterans, posed a novel challenge to ZANU-PF. Although their strength lay in the countryside, the war vets formed the only alliance that was independent of both Mugabe and ZANU-PF that could legitimately lay claim to the liberation credentials that ZANU-PF so readily exploited to garner national support (Mamdani, 2008, p. 18). The inability of the state to maintain high levels of social expenditure, control labour wages and

[28] Formed in 1988.

[29] The Lancaster House Agreement was the independence agreement brokered between the government of Rhodesia, Britain and the leaders of the Zimbabwean liberation movements. It stipulated conditions for the introduction of an African-led majority government, but also set key limits on the acquisition of land. No land resettlement was to take place until 1990, after which all transfers must be on a „willing buyer, willing seller‟ basis, which would be funded by the British government. It also reserved 20 percent of seats in the House of Assembly for whites, giving the settler community an effective veto over any amendment to the Lancaster House terms.

resettle the growing numbers of landless people, meant that combined these two forces stood as a significant threat to the legitimacy and reign of the party.

The issue of land was especially contentious. At independence approximately 6,000 white farmers owned 15.5 million hectares of prime land, 39 percent of the land in the country, while about 4.5 million black farmers (a million households) in „communal areas" were left to subsist on 16.4 million hectares of the most arid land (Moyo, 2000, p. 5). As such, the unequal distribution of land translated into an unequal distribution of wealth. However, due to the limitations of the independence agreement the transfer of land during the first ten years was minimal. The government sought to remedy this with the Land Acquisition Act of 1992, which gave the state powers of compulsory purchase. However, this mechanism depended on British compensation. The British government provided minimal assistance in this regard, releasing only £44 million between 1990 and 1992 (Moyo, 2000, p. 7). In 1997 the New Labour government relinquished its responsibility to Zimbabwe altogether, claiming that they could not be held to account for agreements made by a previous administration. This effectively violated the Lancaster House Agreement and tacitly indemnified the Zimbabwean government to take full responsibility for the land redistribution project. At this time there was widespread squatting on all types of land, from communal areas to state land, commercial farms, resettlement areas and urban sites. The number of landless individuals was increasing and the government of Zimbabwe simply could not afford to compensate farmers for land at market value. Under increased pressure from ZNLWVA to acquire commercial farm land without compensation, in 1998 Mugabe decided to roll out an unbudgeted Z$50,000 in gratuities and monthly pensions of Z$2,000 to war veterans, in a bid to appease their frustrations (Raftopoulos et al., 2010, p. 2). These payments further strained the already depleted state reserves, and their ability to appease ZNLWVA was ephemeral.

These three factors primed the public health sector for collapse: ESAP cut social spending and created a pattern of dependence on external funding for the provision of public health care. The decision to go to war in DRC and the use of payments to ward off political opposition from ZNLWVA led to the depletion of national reserves, and further under spending on public health. The resultant exodus of health personnel left the public health sector without adequate financing or human resources to provide quality health care to the Zimbabwean populace. It is important to note that these factors affected not only the provision of public health care, but the entire scope of social services: education, water and sanitation, shelter etc, creating a „ripple effect" of destabilisation.

The Deterioration of the Public Health Sector: 2000–2008

By 2000 every aspect of Zimbabwean politics had became engulfed by the politics of the land. In February 2000 ZANU-PF was dealt a devastating blow when the nation rejected a referendum for constitutional reform. This referendum would have allowed the government to acquire land with no compensation from white farmers and to prolong Mugabe‟s terms as president. The ZCTU, which had now transformed into a political party, the Movement for Democratic Change (MDC), received much support and financing from the British Government and white commercial farmers to lobby the urban masses to vote „no‟ to the new constitution – an outcome they managed to secure. So when members of ZNLWVA began forcibly and illegally invading white-owned farms in June 2000, the ZANU-PF government did little to impede them. In the face of the rejected referendum and increased pressure from the war veterans, the government endorsed the land acquisitions and so commenced the „fast track‟ land reform programme. At the end of 2003 land had been seized from nearly 4,000 white farmers and redistributed: 72,000 large farmers received 2.19 million hectares and 127,000 smallholders received 4.23 million hectares (Mamdani, 2008, p. 17). This led inevitably to the destabilisation of Zimbabwe‟s agricultural sector. The tobacco industry, which was Zimbabwe‟s single largest generator of foreign exchange and accounted for almost a third of Zimbabwe‟s foreign exchange earnings in 2000, collapsed almost completely. The crop that earned some US$600 million in 2000 generated less than US$125 million in 2007. Annual wheat production has plummeted from a high of over 300,000 tons in 1990 to less than 50,000 in 2007 (Coltart, 2008, p. 4). This resulted in food insecurity and diminished national export revenues, further shrinking the finite resources available for social spending.

Leading up to the 2002 elections ZANU-PF began a tactical, violent and costly anti-MDC campaign. In 2010 it was revealed that the Reserve Bank of Zimbabwe had released Z$1.1 billion during this period to fund a pro-ZANU-PF farm mechanisation programme, aimed at cementing rural support for the party (Nyambabvu, 2011). The country‟s foreign exchange reserves had declined exponentially, from US$830 million, representing three months‟ import cover in 1996, to less than one month‟s cover by 2006 (Mamdani, 2008, p. 11). By 2003 spending on health had declined by US$197 million since 2000 (Clemens & Moss, 2005, p. 3). Doctors, nurses and other skilled personnel, whose salaries had not been paid in months, left en masse to find work in the region and abroad. A 2003 study estimated that more than 80 percent of doctors, nurses, pharmacists, radiologists and therapists trained since 1980 had left the country, and that by 2003 Zimbabwe had lost more than 2,100 medical doctors and 1,950 certified nurses, mostly to South Africa, Botswana, Namibia, Britain and Australia (Chetsanga & Muchenje, 2003, p. 3). For those that stayed the lack of medication, resources and even water made the provision of healthcare very difficult.

The government of Zimbabwe, which had previously managed to balance both its political and social responsibilities, was now focused squarely on the land and its politics. The survival of ZANU-PF dominated the policy initiatives of the government. The depleted reserves were channelled to fortify the success of the land redistribution programme which ZANU-PF desperately needed to maintain support.

The second factor to consider is the economic climate of Zimbabwe during this period. In 2000 the World Bank and the African Development Bank suspended their loan facilities to the government of Zimbabwe, whose account was in arrears of US$900 million and US$406 million respectively (Jones, 2011, p. 14). In 2001, Zimbabwe started to incur arrears to both the General Resources Account (GRA) and the Poverty Reduction and Growth Trust (PRGT) facilities offered by the IMF. As a result, the IMF‟s Executive Board imposed a number of escalating measures, eventually declaring Zimbabwe ineligible to use the general resources of the IMF, removed Zimbabwe from the list of countries eligible to borrow resources under the PRGT, and suspended the provision of technical assistance to Zimbabwe (IMF, 2001). In 2006, Zimbabwe fully settled its GRA arrears to the IMF, which led to a cancellation of the procedures for the compulsory withdrawal, however, it was not till May 2009, after the incorporation of the MDC into the government of Zimbabwe, that the IMF began to consider the restoration of Zimbabwe‟s voting rights and its eligibility to use resources from the GRA. In 2010 the Executive Board decided to restore Zimbabwe‟s voting and related rights, stating that "notwithstanding the restoration of the eligibility to use GRA resources, Zimbabwe will not be able to use resources from the GRA or the PRGT," which in essence restored Zimbabwe onto the list of eligible states but denied it access to the funding and credit facilities it previously enjoyed (IMF, 2010).

International forces further constrained the provision of social services. Unable to secure formal action against the Mugabe regime through the UN, interested international players[30] began to isolate the ZANU-PF government. This was triggered by the choice to go to war in DRC, by the land invasions of 2000 and by ZANU-PF‟s subsequent violent and undemocratic campaign to remain in power in the 2002 elections. Several international measures were implemented to restrict the reach of ZANU-PF as the international community argued that had the 2002 presidential elections been conducted under free and fair conditions, Mugabe and ZANU-PF would not have retained power (EISA, 2002). There was a mass exodus of international firms from the private business sector, foreign direct investment shrunk from US$444.3 million in 1998 to US$50 million in 2006. Donor support, even to the vital public health sector, dried up. For example Danish support for the health sector, US$29.7 million in 2000 was suspended (Mamdani, 2008, p. 20). The United States

[30] Mostly the United States and the European Union.

government passed the Zimbabwe Democracy and Economic Recovery Act of 2001 (ZIDERA)[31] which was intended to "provide for a transition to democracy and to promote economic recovery in Zimbabwe" (United States Congress, 2001). This Act prevents the government of Zimbabwe from accessing international credit, bars US companies from trading with the government of Zimbabwe and any third party representatives, and restricts any international financial institution from cancelling or reducing any debt incurred by the government of Zimbabwe. So while this Act was constructed to facilitate democratic transition, its prescriptions translate into restrictions similar to those imposed by global sanctions. The Ministry of Health is still unable to access much needed global credit from any institution while ZANU-PF is in government.

These international measures were initiated in a bid to impede the rule of ZANU-PF, however, the withdrawal of foreign business, foreign aid and donations have negatively impacted the government structures tasked with the provision of social services. These factors, coupled with the legacy of ESAP and the mismanagement of ZANU-PF, brought the public health sector of Zimbabwe to near collapse. By 2008 the public health sector of Zimbabwe was grossly understaffed and underfinanced, and the physical infrastructure and machinery were in crucial need of maintenance and replacement. In rural areas it was reported that women delivering children were requested to bring their own water, candles, gloves and sterilising fluids (Madzimbamuto & Todd, 2010, p. 606). The public health sector simply could not provide even the most basic services required by the populace.

The Deterioration of the Public Health Sector: 2008 and onwards

The year 2008 was of particular political significance as the much anticipated presidential and parliamentary elections were to be held in March. An intense and controversial first round of elections saw MDC gaining a parliamentary majority but its presidential candidate, Morgan Tsvangirai, failing to acquire the required 51 percent majority over incumbent Mugabe. Defeated in the first round ZANU-PF initiated a violent campaign leading up to the second round of presidential elections. ZANU-PF militia reportedly assaulted and tortured civilians in pro-MDC areas, abducted and/or arrested numerous MDC leaders and banned MDC campaigning. Amid the increasing violence Tsvangirai pulled out of the election race, delivering an overwhelming victory to Mugabe. ZANU-PF"s campaign of intimidation secured them another term in government, but the public unrest continued. Post-election violence erupted across the country, especially in urban areas (MDC strongholds) that refused to recognise the victory of ZANU-PF (EISA, 2008). Under the leadership of SADC Thabo Mbeki led a diplomatic team that managed to broker a unity agreement between the two factions of MDC and ZANU-PF in February 2009. This Global Political Agreement (GPA) saw the introduction of a Government of National Unity (GNU) that included Morgan Tsvangirai as the Prime

[31] Bill passed in 2001 and renewed in 2003 and 2010.

Minister of Zimbabwe and Professor Arthur Mutambara and Thokozani Khupe as the two Deputy Prime Ministers (Government of Zimbabwe, 2009). In the background of these intensely volatile political events the social services of Zimbabwe were simply not a priority.

Chris Beyrer, public health specialist at Johns Hopkins, told *The Lancet* that "access to health care has collapsed for all except the tiny minority who can pay for care in US dollars. The public system has truly ceased to function" (Wakabi, 2009, p. 147). Precipitated by the factors detailed above the public health sector was beset with acute shortages of supplies and personnel. With 80 percent of all doctors, nurses, pharmacists, radiologists and therapists now working abroad, and those who remained earning an average of US$30 per month, the provision of public health care was at a standstill (Chetsanga & Muchenje, 2003, p. 3). This problem was further compounded by the fact that, due to staff shortages, the University of Zimbabwe medical training hospital in Harare was forced to reduce its annual intake of medical students from 120 to 70, so not only was the system haemorrhaging massive numbers of skilled health workers, the state"s capacity to train more professionals was diminishing (Leslie, 2008, p. 20).The dilapidated infrastructure and the recurrent strikes by grossly underpaid medical workers left the health care system in disarray. In some instances it was shown that the lack of doctors and medication at some government hospital was in fact fuelling the intensity of infectious diseases in the country (Wakabi, 2009, p. 147).

Amon Siveregi, President of the Zimbabwe Hospital Doctors Association, said shortages of drugs, equipment, and staff had rendered the opening of most public hospitals futile. He said heath care workers were poorly remunerated, which greatly affected their performance, and the crisis had prompted thousands of well-qualified medical workers to leave the country in search of better working conditions (Wakabi, 2009, p. 147). Without a foundation of skilled human resources, health care systems cannot function adequately or effectively, particularly in the public sector and at the primary level of care.

In addition to the massive loss of medical staff, the majority of public hospitals lacked adequate funds and equipment to operate. Increasing numbers of HIV patients required Anti – Retroviral Treatment (ART), which was costly and difficult to source. Sikhumbuzo Mvinjelwa (Zimbabwe National Network for People Living with HIV/AIDS, Harare, Zimbabwe) reported that access to antiretroviral drugs and treatment had been hampered by frequent closures of hospitals. In the capital, Harare, three top antiretroviral dispensing hospitals – Chitungwiza, Harare Central and Parirenyatwa – were operating only occasionally since November 2008 when the government closed public hospitals and police attacked striking doctors, nurses and medical students at the teaching hospital. According to Mvinjelwa, lack of resources and staff shortages had also forced health centres to keep their HIV/AIDS units closed (Wakabi, 2009, p. 147). In 2007 140,000 people died of AIDS in Zimbabwe,

largely due to the unavailability of medication (WHO, 2011, p. 10). Health workers say that aside from drug shortages, hospitals often lack basic medical supplies such as bandages, cleaning agents, and surgical gloves. At the height of the political crisis in 2008 both Médecins Sans Frontières and Physicians for Human Rights (PHR) suggested that the department of public health "be taken into a kind of receivership by a UN-designated agency or consortium, until a functioning government capable of providing a minimum standard of care is in place" (Wakabi, 2009, p. 147). While the public health sector began to recover after the introduction of the GNU in 2009, public hospitals are largely understaffed and the shortage of vital resources, such as water and electricity, pose a serious challenge for the basic functioning of hospitals. As of February 2012 only 8.2 percent of the US$64 million budgeted for health had been released (Zimbabwe Treasury, 2012). The provision of private health care has in part supplemented the inadequacies of the public sector. There are four private hospitals in Harare, two of which offer accident and emergency services, and an increasing number of private clinics and well-equipped trauma centres. Bulawayo, Mutare and other centres also have private facilities. However due to the continued political impasse and slow economic recovery the majority of Zimbabweans still do not have the finances to access private health care.

It has been established that southern Africa is host to many human security concerns, of which public health is the most significant. Chapters Two and Three of this study recount in detail the advances in Security Studies that have allowed for the incorporation of public health into security agendas, the vital nature of this threat, and the significant burden of disease present in southern Africa. The study asserts that if such threats are not managed adequately, these concerns to human security have the ability to permeate state borders, and affect regional security and stability.

Contemporary international politics is characterised by increased levels of interdependence and the connectivity of states and populations, more so than in any other era. It is now well accepted in academic and political circles that the spread of disease constitutes a real concern to both national and international security (Youde, 2004). The provision of security requires increased collaboration between states, especially those that share borders. Focusing on southern Africa it can be seen that the high burden of infectious disease in Zimbabwe, the inability of the national structures to ensure public health and the continued migration of Zimbabweans into the southern African region, present a significant security concern for the region, one that requires attention and collective action from the SADC nations. As noted by Frank Donaghue: "since contagious disease needs no passport, the [Zimbabwean] government's abrogation of its responsibility is now a regional health and security threat" (Wakabi, 2009, p. 147). The outbreak of cholera in Zimbabwe in 2008 serves as an apt example to demonstrate the hypothesis put forward by this study: the outbreak of cholera in Zimbabwe, unabated by a deficient public health sector, rapidly progressed into a national epidemic claiming 4,276 lives in Zimbabwe, and a further 636 in the region (WHO, 2008).

4.3 Regional Dimensions of Public Health: The Cholera Outbreak of 2008

Cholera is an acute intestinal infection caused by the consumption of food and water contaminated with the bacterium *Vibrio cholera*, which manifests itself as a diarrhoeal sickness. The provision of safe drinking water, adequate sanitation and food safety are critical to preventing and reducing the spread of cholera. Public health messages to enhance communities‟ preventive behaviour to halt further contamination and infection are equally important. Whist interventions to mitigate the spread of cholera are relatively simple and cheap, they are dependent upon functional health systems, effective surveillance, early detection and rapid response mechanisms (CDC, 2011, p. 1). At the time that cholera broke out in August 2008, the provision of clean water in most urban areas of Zimbabwe was insufficient. Warnings of a possible cholera outbreak were tabled to the incumbent Minister of Health, Dr D. Parirenyatwa, however they were not effectively heeded. The government health systems, incapacitated by the surrounding political and economic environment, were severely compromised and their response to the outbreak was delayed and inadequate. The national outbreak deteriorated dramatically before concerted responses were initiated. The government only acknowledged the crisis five months after its onset, by which time Zimbabwe‟s national health systems were under severe pressure and its capabilities overwhelmed (Hwenda, Mahlathi & Maphanga, 2011, p. 15).

The concomitant exodus of people into neighbouring countries allowed cholera spill over into the entire SADC region. SADC, for its part, did not have an appropriate response mechanism to mitigate the spread of the epidemic into the entire SADC community, and so cases of cholera were reported in every SADC state, mostly at border posts and border towns. Across countries, differences in reported cases, case fatality rates and the total number of deaths, as shown in Table 4.1, illustrate the different response capacities within countries. Countries without a concurrent internal crisis whose health systems were not under severe stress, such as Botswana (2 deaths) and Namibia (9 deaths), had fewer cases, lower case fatality rates and lower total recorded deaths.

Country	Reported Cases	Reported Deaths	Case Fatality Rate	Time Period
Zimbabwe	98,349	4,276	4.4%	15 Aug 2008–24 May 2009
Mozambique	17,761	140	0.8%	1 Jan 2009–9 May 2009
Swaziland	17,448	0	0.0%	22 Dec 2008–16 May 2009
South Africa	12,752	65	0.5%	15 Nov 2008–31 May 2009
Zambia	8,312	173	2.1%	10 Sept 2008–7 May 2009
Angola	7,495	134	1.8%	1 Jan 2008–17 May 2009
Malawi	5,269	113	2.1%	15 Nov 2008–24 May 2009
Namibia	203	9	4.4%	22 Oct 2008–17 Apr 2009
Botswana	15	2	13.3%	1 Nov 2008–24 May 2009
Total	**167,604**	**4,912**		

Table 4.1: Cholera Deaths in SADC 2008–2009 Cholera Season[32]

The cases of cholera reported in the region were not haphazard: an analysis of the circumstances specific to the epidemic confirms a causal relationship between the regional cases and those in Zimbabwe.[33] Although there had been outbreaks of cholera in Zimbabwe prior to 2008, none had taken on a regional dimension as seen in 2008. Previous outbreaks that took place while the public health sector of Zimbabwe was intact were contained and managed (Hwenda, Mahlathi & Maphanga, 2011, p. 17). The only differing factor in the cholera outbreak of 2008 was the absence of functioning public health structures to combat the disease. Secondly, although some SADC states have had similar significant outbreaks of diarrhoeal diseases, such as cholera and typhoid, the correlation of the time frames of the outbreak of cholera in Zimbabwe, the contagious nature of the disease and the subsequent cases reported throughout the region point to the migration of Zimbabwean nationals as the main contributing factor. In addition, the locations where these cases were reported is of significance: the majority of cases were reported in the Limpopo Province of South Africa (Muthambi, 2009), while the WHO received reports from the Ministries of Health confirming cholera cases in Palm Tree (Botswana) and Guro district (Mozambique), all of which are regions that share borders with Zimbabwe (WHO, 2008, p. 1). It is clear that the regional cases of cholera were precipitated by the Zimbabwe epidemic, which itself was a direct consequence of the deficient public health structures of Zimbabwe.

4.4 Migration and Regional Security

The key factor that has lead to vital human security concerns such as public health taking on regional dimensions, as opposed to their traditional domestic reach, is the intensification of migration in the

[32] Source: United Nations Office for the Coordination of Humanitarian Affairs Regional Update 2009

[33] Cases in Angola are independent of the Zimbabwe case. Due to geography Angola is not a common site if humanitarian migrants from Zimbabwe. In addition, Angola has enduring Cholera problem due to extended rainy seasons and poor sanitation infrastructure.

region. There is a long history of migration within the southern African region dating from the pre-colonial times (Crush & James, 1995; Worger, 1987; MacDonald, 2000). It is beyond doubt that these migration patterns have been produced and influenced by different events throughout history. However, the unprecedented migration of Zimbabweans into the region since 2000 has been generated largely by the economic and political collapse.

The Forced Migration Studies Programme (FMSP) at the University of the Witwatersrand conducted extensive studies on migration patterns in southern Africa, in particular the migration of Zimbabwean nationals. In their report *Zimbabwean Migration into Southern Africa: New Trends and Responses* they assert that Zimbabweans are „humanitarian migrants" who they define as individuals "who are fleeing extreme deprivation or starvation for themselves or their families" (Monson & Kiwanuka, 2009, p. 5). These migrations are categorised as forced rather than voluntary as these distinct flows occur against the background of political instability and economic collapse in Zimbabwe. And while the profile of Zimbabwean migrants is mixed, that is, shoppers, traders, borderline residents and transit migrants, FMSP found that the majority are humanitarian migrants. They also found that Zimbabwean migration is circular and temporary, with migrants preferring to return to Zimbabwe on a regular basis to deliver necessities and remittances to family. Very few Zimbabwean migrants are recognised refugees: the provisions for individuals who seek refugee status and/or political asylum place strict limits on mobility, impeding them from returning to their country of origin, and are thus unfavourable to Zimbabwean migrants (Monson & Kiwanuka, 2009).

Estimates place at least 3 million Zimbabwean migrants in South Africa, a significant number have also migrated into other southern African states, mainly Botswana, Malawi, Mozambique and Zambia (Leslie, 2008, p. 2). The 2009 FMSP report gave findings of focus group studies conducted in these four countries. They found that few Zimbabweans noted political persecution, including harassment and persecution of MDC supporters by ZANU party leaders, as the main reason for their move. The majority of Zimbabweans pointed to the economic crisis as the main driver of their decision to migrate. Economic conditions cited included unemployment, hyperinflation and devaluation of the currency, poverty, acute shortages of foodstuffs, and the collapse of major economic and public service sectors, especially health care (Monson & Kiwanuka, 2009, p. 25). Another study focused on health found that since the March 2008 elections there were increased numbers of Zimbabweans receiving treatment in the South African Musina border due to the shortage of medicines in Zimbabwe. This situation presented for the first time a clear example of migration occurring for the purposes of accessing healthcare (Pophiwa, 2009, p. 4). This trend has continued, with reports in May 2012 of Zimbabweans suffering from „sleeping sickness" in the Zambezi region migrating to Zambia due to drug shortages in Zimbabwean hospitals (Sunday Mail, 2012).

The mass migration of Zimbabweans in the region has far-reaching effects on the security of both the individuals who migrate and the locations they migrate to. With regard to public health the most direct concern to security is the spread of disease. As demonstrated through the Cholera example above, the contagious nature of infectious diseases means that any people exposed to such diseases are at risk of infection. In an interview conducted in May 2012, Dr Midzi,[34] the head of Health Systems and Policies at WHO Zimbabwe, outlined that the danger of infectious diseases such as cholera. Of the individuals infected by cholera only 10 percent actually present symptoms, the remaining 90 percent are carriers who do not present symptoms and in most cases are unaware that they are infected. This presents a dilemma with regard to Zimbabwean migrants as they cross borders and introduce pathogens into the communities in which they live, and due to their economic constraints these communities are usually informal settlements with inadequate sanitation, thus the potential for disease to spread increases exponentially. In addition, Dr Midzi outlined that some diseases such as malaria flourish in areas with specific weather conditions. People who live in such areas may gain immunity to these pathogens, which allows them to accommodate the pathogen without presenting symptoms, and so they only act as carriers. When such individuals migrate, they introduce this pathogen into an area where there is no immunity, putting the security of the whole community at risk. He noted that when cases of malaria are detected in South Africa they are categorised as „imported cases" from either Mozambique or Zimbabwe, as South Africa does not have favourable conditions for the spread of malaria. Furthermore, as such diseases are not common to the community, community public hospitals or clinics may have limited expertise to manage such cases (Midzi, 2012).

The intensity of the HIV epidemic in southern Africa demands particular attention. Southern Africa is host to the highest HIV prevalence rate in the world. Therefore, the migration of infected individuals unable to access treatment in their own states poses a risk to the region at large. Mozambique, Malawi, South Africa and Zambia provide free ART to all HIV infected persons, regardless of nationality. Botswana however does not, its health policy is silent on the topic of migrant and refugee healthcare, and only nationals receive free ART. The lack of resources in southern African states is a real challenge to the provision of ART to patients, nationals and migrants. Due in part to lack of planning or budgeting for additional clients generated by migration from Zimbabwe, the absorption of migrants into mainstream services has been said to put strain on available services in Mozambique and Malawi. In an interview conducted in May 2012 Mr Ignatius Madzongi, head of Human Resources at WHO Zimbabwe, outlined the problem that the migration of Zimbabweans, especially those who are unskilled, may have on the resources of the recipient state. These individuals become dependent on the social services that are meant for South Africans, or the people of Botswana, Lesotho, or Swaziland. "It means if they are budgeting for a certain denominator, their budget is going

[34] In addition Dr Midzi previously served as Director, Epidemiology and Disease Control, Ministry of Health and Child Welfare of Zimbabwe.

to be stretched. Because on the ground if someone comes with cholera, you cannot deny them treatment just because they are Zimbabwean, they will be attended to, but with resources that were not meant for them. That can create a situation where a 12-month budget is exhausted in 9 months." He went on to say that the South African government then looks as if it is not planning adequately, which may cause internal political strain, which may lead their citizens to demonstrate. Conversely the people of South Africa can petition their government to say "these Zimbabweans are bringing diseases, deport them" (Madzongi, 2012).

While a move to South Africa would in theory be a beneficial to a migrant from a resource-poor country, the gains are limited in practice due to several constraints in healthcare service delivery. As such, the migration of Zimbabweans to states with limited resources can have adverse effects on that state, its government and security. The eruption of xenophobic violence in May 2008 in South Africa is indicative of this. South African citizens in townships in Limpopo, Johannesburg and Cape Town assaulted, killed and burnt the property of foreign nationals, mainly Zimbabweans, Ethiopians and Somalis, stating that these foreign nationals were „stealing their jobs" among other reasons (Crush, 2000, p. 107). Within the context of violence towards Zimbabweans it is important to note that there was a marked increase in Zimbabwean migration into South Africa due to intensified economic and political instability triggered by the March elections. As such, at the height of the political turmoil in Zimbabwe, neglected and endangered citizens migrated to South Africa, where their presence ignited violent reactions from South African nationals, creating a series of security risks in the areas affected. Médecins Sans Frontières (MSF) reported that they had observed high levels of stress and anguish among foreign nationals during and after these attacks because of the continued intimidation and threat of arrest by police, which hindered their ability to access health care. Such individuals were more vulnerable to disease and exploitation. MSF treated thousands of Zimbabweans in the wake of the attacks as people feared further persecution in state hospitals. A February 2009 statement said that:

> MSF remains concerned about the continued disregard for Zimbabweans" dignity and access to health care in South Africa. There is a great need for a comprehensive public campaign to raise South Africans" awareness about the plight of displaced people, in order to defuse simmering tensions – and to ensure vulnerable foreigners are accorded the same dignity and treatment accorded to everyone under the South African Constitution (MSF, 2009, p. 1).

Indeed the reception of migrants within the public health systems of recipient states is highly problematic. A 2012 report published by the Southern African Migration Programme (SAMP) stated that South Africa received more medical migrants than any other state in the continent, the number increased from 327,000 in 2006 to over 500,000 in 2009. Of the total medical travel flow to South Africa, 80 percent were formal and informal movements from countries neighbouring South Africa,

especially Lesotho, Swaziland, Mozambique and Zimbabwe. However the study shows that there is considerable evidence that migrants living in South Africa are regularly denied their constitutional right to medical treatment and care by personnel at hospitals and clinics (Crush, 2012, p. 4). A specific study on the treatment of Zimbabwean migrants in South African public hospitals, *Medical Xenophobia: Zimbabwean Access to Health Services in South Africa*, reviewed the treatment of 100 Zimbabwean migrants in public hospitals in both Johannesburg and Cape Town. It was found that Zimbabweans received compromised health care due to „medical xenophobia" which they define as the negative attitudes and practices of health sector professionals and employees towards migrants and refugees (Crush & Tawodzera, 2011, p. 6). Medical xenophobia manifests itself in several ways in the public health system. Amongst the practices uncovered by this study were the following: first, patients were required to show identity documentation, proof of residence status and evidence of a home address before treatment was provided. Patients who, for one reason or another, did not have such documentation on their persons could be denied treatment. Second, communication difficulties arose when health staff refused to communicate with patients in a common language or to allow the use of translators. Third, treatment was often accompanied by verbal abuse and xenophobic statements and insults. Fourth, non-South African patients often have to wait until all South African patients have been attended to even if they have been waiting longer for treatment. Finally, migrants and refugees had such difficulty accessing ART for HIV in public institutions that many were forced to rely on the NGO sector (Crush & Tawodzera, 2011, p. 8). Such practices are a fundamental breach of South Africa"s Constitution and Bill of Rights, international human rights obligations and various professional codes of ethics governing the treatment of patients. However, the underlying sentiments of hostility towards Zimbabweans have permeated even the public health sector. Such considerations negate the fact that when foreign nationals are denied treatment for infectious diseases, not only are their own lives threatened but their potential to infect other individuals is increased.

The collapse of the public health sector of Zimbabwe and the subsequent migration of its nationals into the region has led to the increased incidence of disease in border regions, the introduction of unfamiliar or alien strains of pathogens into recipient states and an overall increase in regional disease burden, all of which are a significant concern to the security of individuals in the region. In addition to those migrants motivated by the need for health care, many Zimbabwean migrants engage (voluntarily or out of desperation) in activities that compromise their own health and that of their communities. Zimbabwean female migrants who trade sex for money have been singled out as having a direct effect in the spread of HIV and other sexually transmitted diseases in border towns, with some reports alleging that Zimbabwean women were charging a mere US$3 for sexual transactions in certain guesthouses in Lusaka and Francistown, and offering unprotected sex at a higher charge (SALAN, 2007, p. 3). The effect of such trends on the spread of HIV is apparent. FMSP notes that unlike the voluntary economic migrant who migrates to raise his or her quality of life and/or save money for

hard investments in the home country, livelihood-seeking humanitarian migrants migrate to meet their own and their dependants‟ basic survival needs. The migrants‟ quality of life in the host country remains very low, many informal cross-border traders sleep outdoors in town centres, border areas and bus shelters, which puts them at risk of crime and sexual violence, since a large number of these are women. In Manica province, Mozambique, migrants often live in shacks with no bedding, eating only one meal a day in order to optimise cash and in-kind remittances for the survival of dependants in Zimbabwe (Monson & Kiwanuka, 2009, p. 52). Literature has noted the same phenomenon in Botswana (Garcia & Duplat, 2007). The overall conditions that these migrants exist in are detrimental not only to health, but to their security and quality of life.

The mass migration of Zimbabwean nationals due to the inadequate domestic provision of social services poses a vital and unique threat to regional security, the ramifications of which have been felt largely at the individual level. It is the individual that made insecure when social security provisions are not met, it is the individual who is forced to migrate to mitigate these conditions, and the 636 deaths that were reported outside Zimbabwe during the 2008 cholera epidemic, show that even at the regional level it is the security of the individual that is threatened. As such, regional efforts to manage these regional security challenges must focus on the individual, as it is the individual and not the state alone that is largely affected.

4.5 Conclusion

The deterioration of the public health sector of Zimbabwe has clearly had adverse effects on the southern African region. The initiation of economic structural adjustment reforms, the costly intervention in the DRC war and the mismanagement of the land re-distribution programme primed the public health sector of Zimbabwe for collapse. Facing increasing opposition the ZANU-PF government became less concerned about its national obligations and focused instead on its political survival, channelling the remaining national reserves to its pro-land pro-ZANU-PF policies. The withdrawal of essential international aid and credit from Zimbabwe saw the final fall of the public health sector. By this point the public health sector had experienced the mass exodus of underpaid skilled health care workers to overseas facilities and the private sector. The grossly underpaid health workers that remained frequently went on strike as the government could not supply them with basic resources such as water, medication and gloves to ensure the continued functioning of their facilities. The physical infrastructure further deteriorated and most hospitals lacked the medical equipment to carry out basic procedures. The public health sector of Zimbabwe had deteriorated so dramatically that a 2008 outbreak of cholera triggered a mass exodus of Zimbabwean nationals into the region to access basic health care. Beset with massive shortages of staff and financial resources, the public health structures of Zimbabwe were completely overwhelmed. This forced the government of Zimbabwe to declare the outbreak a national crisis, requiring immediate international assistance.

When the outbreak was finally concluded, a total of 98,349 cases had been reported in Zimbabwe and 69,255 in the rest of the region; claiming a total of 4,276 lives in Zimbabwe and 636 in the southern African region. This regional health crisis fully exemplifies the vital nature of the threat that infectious diseases pose to human security in southern Africa.

It is crucial to understand that migration emerged for many Zimbabweans as the only solution to an economic situation that depleted access to a number of basic social services, most notably access to basic health care. The deterioration of the public health sector of Zimbabwe and the resultant exodus of its citizens throughout the region raises concerns not only of human security, but also of regional stability and capacity. SADC as the premier regional governance institution has failed to adequately meet the needs of migrating Zimbabweans, and to formulate policy to manage similar situations in the future. This situation has revealed fundamental shortcomings within SADC and among its member states with regard to managing vital concerns of human security at the regional level.

The following chapter details the policy framework and functioning of SADC with regard to public health, making particular reference to the Zimbabwe case. It will also explore facets of the individual SADC states that have influenced their responses or lack thereof to matters of human security.

Chapter Five– Public Health and Migration: The Regional Ramifications

5.1 Introduction

The advent of migration for health purposes has raised concerns of regional stability and capacity within SADC as a regional institution and the individual member states of SADC: Angola, Botswana, the Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. Through the SADC Treaty the individual states of the region have pledged collectively to "consolidate, defend and maintain democracy, peace, security and stability" (SADC, 1992). Central to this task is the recognition that the security and stability of the region is dependent on the cooperation of each state; as such, it is imperative that each state not only harmonise its national policies with those of SADC, but ensure that the directives of such protocols are enforced at both the national and regional level. The constitution of the organisation puts forward lofty ideals of cooperation and integration to ensure among other things the "freedom and social justice, peace and security of all the peoples of Southern Africa" (SADC, 1992).

Notwithstanding these desires SADC has not fully realised these aspirations, in part due to a lack of institutional capacity and resources. As noted in Chapter 4, the cholera epidemic in Zimbabwe claimed 4,276 lives in Zimbabwe, and a further 636 in the region (WHO, 2008). While the state structures of the SADC nations were affected in various ways by the political and economic crisis in Zimbabwe, it is apparent that the largest effects were felt at the individual level. However, it will become apparent through this chapter that SADC is yet to fully realise the vital nature of human security, and the fundamental role that safeguarding the individual and his/her needs plays in ensuring the security of the region. The chief impediments to this realisation is due to the inherent character of the individual states that comprise the SADC region: Mixed profiles of state function, rigid notions of state sovereignty and fragmented democratic practices impede states from fully co-operating on security concerns, most notably concerns to human security. This section seeks to interrogate these impediments, with particular reference to the Zimbabwe case, the purpose of which is to further understand the enduring human security *problematique* in southern Africa.

5.2 SADC and the Status of Public Health

The WHO defines public health as all organised collective, public or private measures whose objective is to prevent disease, promote health and prolong the life of entire populations (WHO, 2007, p. 3). The collective response of the region to infectious diseases and public health is articulated through SADC. The SADC Protocol on Health, tabled in 1999, establishes that the member states acknowledge that a healthy population is a prerequisite for sustainable human development and increased productivity. As such the member states pledge to offer a full range of cost-effective and

quality integrated health services through regional co-operation. The key objectives of the organisation with regard to health are to identify, promote, co-ordinate and support those activities that have the potential to improve the health of the population within the region; to co-operate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases; to promote and co-ordinate the development, education, training and effective utilisation of health personnel and facilities; to foster co-operation and co-ordination in the area of health with international organisations and co-operating partners; and to progressively achieve equivalence, harmonisation and standardisation in the provision of health services in the region (SADC, 1999).

To achieve this SADC has established the following offices to implement their protocol, collectively known as the Health Desk: the Health Sector Co-ordinating Unit; Health Sector Committee of Ministers; the Health Sector Committee of Senior Officials; and Technical Sub-Committees. The Health Desk collaborates on key health issues, and in addition has established strong relations with global health organisations such as the World Health Organisation and Médecins Sans Frontières. Through regional cooperation and collaboration with its partners, the SADC Health Desk has established policies with regard to HIV/AIDS, STDs, tuberculosis control, malaria control, reproductive health, childhood and adolescent health, chronic diseases, emergency health services and disaster management (SADC, 1999).

The most comprehensive SADC policy document with regard to peace and security is entitled the *Strategic Indicative Plan for the Organ on Politics, Defence and Security Co-operation* (SIPO). Originally tabled in 2004 and reviewed in 2010, SIPO spells out in detail the plans and objectives of the SADC Organ on Politics, Defence and Security Co-operation (OPDSC).[35] SIPO covers five main sectors of security: Politics and Diplomacy, Defence, State Security, Public Security, and Police. Under each sector the document outlines objectives, challenges posed to the realisation of these specific objectives and expected outcomes. Surprisingly, under both state and public security the issue of public health is only mentioned once. The first objective under state security states that SADC seeks to protect the people and safeguard the development of the region against instability arising from the breakdown of law and order, intra-state conflict, inter-state conflict and aggression. It is in this regard that public health is mentioned, the document identifies three strategies that pertain to health, that is: prevent the spread of the HIV and AIDS pandemic through public awareness and advocacy campaigns; identify the sources of opportunistic and communicable diseases and other pandemics; undertake HIV and AIDS education against stigmatisation and discrimination; and an additional umbrella objective: to promote the observance of human rights in security related issues.

[35] Informally the 2004 document is referred to as SIPO I while the reviewed 2010 version is referred to as SIPO II.

The utility of these objectives is questionable, for instance, the second strategy states that SADC seeks to „identify the sources of opportunistic and communicable diseases and other pandemics" but to what end? To simply identify the source of a pandemic does not ensure its eradication, even a pandemic that has been identified and characterised can go on to claim many lives if a concerted strategy of treatment and management is not implemented. As such, these strategies are incomplete; they lack direction and purpose, functioning more as ideals rather than objectives. In addition, they lack detail and clear intent which makes the successes of such vague objectives difficult to measure. This anomaly is not common throughout the document; in fact the objectives with regard to conflict management are well articulated and detailed. For instance the goals of disarmament, demobilisation and repatriation, reintegration and resettlement are spoken about in detail, each specific category explained in depth, taking consideration of outcomes and challenges. The lax nature in which public health strategies are articulated is indicative of the lack of value that is placed on matters of individual security.

No further mention is made of infectious diseases as a security matter throughout SIPO. As mentioned above SIPO is the most comprehensive security policy document of SADC and therefore its contents are reflective of the collective security concerns of the region. The omission of public health as a key security objective is not an oversight but rather an indication of the concerns that the states of the region consider vital. It is clear that infectious disease and the provision of public health is not a critical priority on the security agenda of SADC and its states.

The *Regional Indicative Strategic Development Plan* (RISDP) of SADC covers the organisations" 15 year plans for integration and development. Once again this policy document does not focus on matters specific to human development and security, but rather on broad strategies to guide member states, SADC Institutions, regional stakeholders, and International Cooperating Partners in the process of deepening integration for the, "achievement of the Community"s overarching goals" (SADC, 2001, p. 3). The document does acknowledge the essential role that the protection of human rights and security play in ensuring the achievement of positive development goals, but does not go further to detail how the organisation seeks to ensure security for development, or specific areas of securitisation. Similar to SIPO, RISDP mentions HIV/AIDS and the need to bolster support to control the epidemic but offers no practical strategies for implementation.

Each document recognises, separately, the need to secure people but not enough detail is paid to specific human security threats or initiatives to mitigate human insecurity. In addition, there lacks congruence between the two documents, indicative of the disconnect between security and development policy in the region. SIPO neglects concerns of human security as the region does not recognise such factors as legitimate security concerns; RISDP speaks to human development and

human security separately but fails to merge the two to create a solid link between development and security. The combined result of these disparities is the large scale neglect at the policy level of vital threats to human security. The consequence of which is felt at the individual and regional levels, as the Zimbabwe case study has detailed.

5.3 SADC: Concerns of Regional Capacity, Co-operation and Stability

The Southern African Development Community would be described by Bull (2002) as a society of states; that is, a group of states that share common interests and values, conceive themselves to be bound by these common interests and values, and choose to operate in common institutions to ensure the achievement of shared goals and initiatives (Bull, 2002, p. 14). Central to the mandate of such regional bodies is the maintenance of stability and order: order being a pattern that sustains the elementary and primary goals of the societies and stability denoting the resistance of the region from unwanted change, disturbances or fluctuation (Bull, 2002, p. 17). With regard to security, SADC is therefore tasked with ensuring that there is a pattern of peace at individual, societal, national and regional levels; and measures/policies that protect the region from disturbances to this peace. The SADC Treaty is but one of the many protocols established by SADC to ensure the maintenance of stability in the region. When common treaties and protocols are not followed by member states this lack of co-operation may breed instability at the regional level.

However, as mentioned above the inadequate response of SADC to concerns of human security is in part due to the lack of institutional resources and capacity. This analysis first will discuss the complex matter of regional capacity and move onto concerns of regional co-operation and stability

Concerns of Regional Capacity

A major impediment to the functions of SADC is funding; SADC and by default the Health Desk, is heavily dependent on external international funding. Due to the global economic downturn, and the Euro zone crisis, many of SADC‟s traditional funders have been unable to honour their pledges in recent years. As such the efficacy of the Health Desk in the implementation of policies and offering assistance to it‟s‟ member states have been greatly affected. In an interview conducted in January 2012 in Harare, Dr David Parirenyatwa,[36] former Minister of Health of Zimbabwe, recounted the constraints he experienced as a Minister within the Health Desk. Stating that, “the SADC Health Desk needs to be strengthened, methods need to be harmonised and governments need to realise that more money needs to channelled to the health desk”. He affirmed that though health was recognised as a crucial component of ensuring the well being of individuals, health was not given due priority

[36] Dr D. Parirenyatwa is the Former Minister of Health and Child Welfare of Zimbabwe (2002 – 2009), a member of the ZANU-PF Politburo and currently the Director of the Centre for Health Strategies (CHEST), a SADC funded Health Policy NGO

(Parirenyatwa, 2012). When faced with limited resources, the provision of regional healthcare is viewed as secondary when compared with more pressing issues such as military and political conflicts. For instance, SADC has endeavoured to focus solely on the political facets of the Zimbabwe Crisis, engaging both ZANU-PF and MDC in a series of diplomatic missions since 2008, whose goal is to find a political agreement that is assumed will restore normalcy to the state.[37] While the introduction of the GNU has restored some economic stability, by design it was formulated to bring an end to a political impasse not to rehabilitate the ailing social service sectors of Zimbabwe. As such, the state-centered political engagements of SADC have done little for the people of Zimbabwe in desperate need of health care, education and shelter. Three years after its installation, the GNU has failed to restore much needed basic services to the country. Public hospitals in the capital Harare are still without regular supplies of water or electricity. Low salaries have led to the private sector retaining the most skilled personnel; a 2010 report estimated that only 47 surgical doctors remained to service the whole country (Dube, 2010).The SADC Health Desk is yet to offer any significant financial or technical assistance to the public health sector of Zimbabwe.[38] The SADC Secretariat is, instead, channelling the available resources to dissolve the political stalemate between ZANU-PF and MDC.

In an interview in May 2012 conducted with Dr Timothy Stamps [39] who serves as the Health Advisor in the Office of the President of Zimbabwe, he outlined the inherent contradictions that are present in the Health Desk due to its overdependence on external funding. "As the Health Desk is not funded by the individual states but by international health movements – which I call the disease management movements – it has become more inclined to responses rather than prevention" (Stamps, 2012). Major components that ensure successful health outcomes, such as preventative education, are omitted to maximise finite financial resources. Dr Stamps is adamant that the commercialisation of public health management has diminished the reach of public health initiatives, both nationally and regionally. He also points to the dominance of South Africa in SADC as an impediment to the efficacy of regional health efforts, "for a long time Mr Mbeki and the so called „Dr. Beetroot"[40] denied the threat to health that HIV was; On the contrary it was not just a health hazard, but a hazard to the entire fabric of the community" (Stamps, 2012). As such, while other SADC states struggled with limited national budgets to provide ART to HIV patients, the Government of South Africa, with ample resources,

[37] This diplomatic mission is ongoing, and is now lead by President Zuma of South Africa
[38] In 2008 SADC launched the Zimbabwe Humanitarian & Development Assistance Framework (ZHDAF) which reportedly handed over R300 million in 2009 to the Zimbabwe government for assistance in local governance. According to the SADC website the country used R240 million for the procurement of inputs such as maize and sorghum seed, according to a report by the Ministry of Agriculture, Mechanisation and Irrigation Development. The balance of R60 million was used for the procurement of fertilizer for the 2009 winter wheat season. No further reports of continued assistance have been published by SADC. No financial aid has been offered through SADC specifically for public health in Zimbabwe.
[39] Dr Timothy Stamps is currently the Health Advisor in the Office of the President of Zimbabwe, the former Minister of Health and Child Welfare of Zimbabwe (1990 – 2002) and a member of the ZANU-PF Central Committee
[40] The name given to the late Minister of Health of South Africa, Manto Tshabalala-Msimang by South African media, due to her insistence that natural foods such as beetroot were a better treatment for HIV/AIDS in comparison to ART.

denied ART not only to migrants but to its own citizens. This had adverse effects on the disease incidence in the region, as South Africa still remains the main destination for migration in the region. Furthermore, Dr Stamps asserted that due to the hegemonic projections of South Africa in SADC and AU, the problematic domestic HIV policies of the Mbeki regime went unchallenged. Such cases expose the intricate interweaving of politics and political considerations at play in regional bodies such as SADC. Though it is unquestionable that the health of the regions‟ population is a vital component of security, the translation of such an ideal into action requires a level of co-operation, political will, and political sacrifice that the member states of SADC are unwilling to make.

With specific reference to the health of migrants, SADC published the *Policy Framework for Population Mobility and Communicable Diseases* in 2009, in which SADC acknowledges the gaps that exist in the provisions available for migrants in the region, and the risk this poses to their security and the security of those they come in contact with. The framework gives directives to the member states to ensure uniform policies with regards to the management and protection of the health of migrants and people affected by migration.[41] It recognises that population mobility is a key factor in the spread of disease, and while some member states have strong public health services to curtail the spread of disease within their borders, the migration of people from states with fragile public health structures to such states is a reality that must be provided for. The policy makes provisions for five key areas: Regional harmonisation and coordination of communicable disease control; Equitable Access to Health Services by Cross-border Mobile Populations; Coordinated regional public health surveillance and epidemic preparedness; Information, Education and Health Promotion in Mobile Populations; Operational research and strategic information; and Legal, Regulatory and Administrative Reforms (SADC, 2009). The above policy stands on the shoulders of the SADC Protocol on Health. This protocol fully articulates the mandate of the organisation with regards to health and the provision of public health in the region. It makes provisions for the successful management of specific health concerns in the region, especially communicable diseases such as TB and Malaria. It asserts that close co-operation in the area of health is essential for the effective control of communicable diseases, the provision of equal health care to all people, and to enrich the quality of health care in the region (SADC, 1999). The implementation of these policies is supervised and enforced by the SADC Health Desk.

The collective directives of the above-mentioned protocols set out methods to manage and secure the health and livelihoods of migrants. It is therefore both ironic and unfortunate that Botswana, a SADC member state and the site of the SADC Health Desk headquarters, has yet to adopt and implement the

[41] People who are not mobile may also be vulnerable to the health consequences of population mobility. For example, those who live in places where mobile people pass through (transit) or settle (destination) may be at risk of infection through interactions with mobile people. When mobile people return home (source) with new infections, their source community may experience the impacts of the disease.

SADC Policy Framework for Population Mobility and Communicable Diseases in the SADC Region. Botswana is documented as having the most exclusionary policy towards Zimbabwean migrants, regularly deporting large numbers of Zimbabweans, committing acts of refoulement [42]and limiting their access to basic social services. At present Botswana is the only SADC country that by policy, denies free ART for HIV to non-nationals. (Monson & Kiwanuka, 2009, p. 47). In addition Botswana denies health care to refugees and individuals with asylum status, which contravenes not only the SADC Policy Framework for Population Mobility and Communicable Disease, but the WHO International Health Regulations (IHR) of 2005. It is apparent that the Government of Botswana does not feel obliged to follow SADC directives, the absence of any binding principles at the regional level means that states, such as Botswana may continue to abscond from their regional responsibilities.

Although Zimbabwean nationals do not need to apply for access visas to travel to any of its neighbouring states, individuals must present a passport to be issued with a permit to cross the border. As noted by FMSP, these instruments do not address the type of migration caused by the crisis in Zimbabwe. The requirement to produce a passport, pay a fee, and provide evidence of sufficient funds for travel, as well as the spatial and time restrictions applicable in some cases, make these permits unsuited to what is in effect forced livelihood-seeking migration from an economically collapsed state (Monson & Kiwanuka, 2009, p. 56). Most Zimbabwean migrants do not have the financial resources to acquire a passport which ranges from US$53 to US$550. As a result, many Zimbabweans migrate through clandestine channels or use the available legal routes tactically for purposes beyond those intended by policy.

Two key concerns emanate from the above cases: the dismissal by SADC member states of SADC policy and its directives; and the absence of a complete and sound policy to adequately manage the unique challenge that Zimbabwean migrants present. The former is due to the innate survival instinct of a state. State leaders and governments will consider first the consequences of each regional policy on domestic politics; if a policy has the potential to negatively affect domestic stability and/or the political legitimacy of said government, then without regard of the validity of the policy, it will in most cases not be implemented or enforced. Such is the case with the SADC Policy Framework for Population Mobility and Communicable Diseases in the SADC Region and the SADC Protocol on Health. Though the directives put forward by these protocols are to the benefit of the region and the security of its people, the potential of implementing all the prescriptions would bode negative consequences for some states. As such, though the states agree with the initiatives of the protocols, they are incompatible with the pragmatic political agendas of the state and are thus dismissed.

[42]*Refoulement*is the act of returning a refugee to a country where his or her life or freedom is at risk. Non-refoulement is a principle of the United Nations Convention on the Status of Refugees

The second issue presents a more convoluted problem than the self-centered nature of states. Literature on migration has long acknowledged the shortcomings of the binary distinction between refugees and voluntary migrants (Turton, 2003). Refugees benefit from guarantees of entry and protection under international law, while voluntary migrants who are seen as synonymous with those who do not apply for asylum, are left to fend for themselves. This presents a predicament when dealing with Zimbabwean humanitarian migrants. They opt for „dependency-resistant strategies" mostly due to the confinement imposed on asylum seekers and their desire to return to Zimbabwe without impediment. As the migrants coming out of Zimbabwe for the most part leave in search of economic and social services that Zimbabwe is no longer able to offer, they are distinctly different from the type of refugees fleeing military conflict. In addition the requirement of passports for entry dissuades migrants without these official documents from using safe and legal methods of entry. Even South Africa"s initiative to regularise the documentation of Zimbabweans in South Africa failed to significantly curb the number of „border jumpers" and undocumented Zimbabweans in South Africa. It seems the Zimbabwe quandary has pushed SADC and its member states to the limit of their capacity. It is clear that this case requires a novel response, one that SADC has yet to formulate.

Concerns of Regional Co-operation and Stability

The individual SADC states account for the organisation"s inertia. The inherent characters of southern African states have permeated to the regional level impeding SADC from fully recognising and responding to concerns of human security, such as public health. The three main characteristics that stand in contention with effective regional action for human security are:

A. State sovereignty

While the traditional role of the state in the 21st century has been altered significantly due to the advent of globalisation, technology and modern travel, the state still remains the chief referent in international politics and principles of „state-hood" dominate the international arena. The concept of sovereignty has therefore retained a primary role in dictating the way states interact on an international level.

State sovereignty is defined as „the quality of having supreme, independent authority over a territory" (Malanczuk, 1997, p. 47). Such perceptions are based on realist foundations that assert that the state is the supreme actor and authority in the international arena (Dunne, 1997, p. 112). Central to this the principle of sovereignty is the notion of non-interference. International society as we describe it can only exist if each state recognises and respects the political independence of other states, and conducts itself in a way that is cognisant of this condition. For order to prevail, no state has the right to interfere in the internal affairs of or threaten the territorial integrity of another state. In essence this condition

allows every state the right to conduct itself in any way it deems fit within its borders, as long as its actions are not a threat to international peace and security (Krasner, 2001, p. 22).

The conflict with human security is apparent. Due to the „non-interference factor" all actions and policies taken within a state are permissible, and are considered as acts of „political independence" even when these actions threaten the safety of the citizens within that state. Only when an internal state policy impacts the *international*, is it considered as a concern to international peace and security. Thus, many instances of grave human suffering go unchallenged, as they are covered under the umbrella of „internal affairs". The endurance of the apartheid regime in South Africa is a significant example of this factor, numerous threats to the security of non-white South Africans went unimpeded by the international community, as the actions of the apartheid government were categorised as the internal affairs of a political independent sovereign state.

The deterioration of the public health sector of Zimbabwe is largely considered as an internal concern, even though it has had adverse effects on the region. Thus SADC has not responded to this concern as a regional security concern, but rather endeavoured to lobby the political parties of Zimbabwe to resolve an enduring political impasse. The tussle between human security and state sovereignty is at the core of the southern African human security predicament, and accounts in part for the inadequate responses by SADC and individual states to the human security concerns present in the region. Responses to insecurities of this nature are viewed as the responsibility of the individual state concerned and not the region, thus vital human security concerns such as the spread of infectious disease permeate through the region unabated.

B. State supremacy

The second point of contention follows on from the principle of sovereignty: the prevailing notion of state supremacy. When asked whether the states of southern Africa recognised the effects public health had on the region, Dr Stamps reluctantly admitted that they did not. "They are more concerned about political survival and money flows than about the health of individuals or communities... Because in Zimbabwe, and in Africa we undervalue the individual, and therefore their health is not as important as things like cash flow, political domination or even military activity" (Stamps, 2012).

Even in the thick of the public health crisis, the government of Zimbabwe was reluctant to request assistance, asserting its right as a politically independent state to manage its own internal affairs. In an

interview conducted in January 2012 with Mr Samkange,[43] the Head of Postgraduate Studies at the University of Zimbabwe, School of Medicine, he accounts for this:

> The party does not want to admit that it created a crisis, if it were to go and sit with South Africa and say please look after our people, it means it is admitting that it caused the migration. But it doesn"t want to do that. It will label these people as ones who have run away (like Assad is doing in Syria), as ones who lack patriotism and would rather build South Africa than its own country, anything except refugees. And yet that is what they are – they are economic refugees, political refugees, security refugees – government doesn"t want to admit any of those three (Samkange, 2012).

The need to assert Zimbabwe as a viable, politically independent sovereign state continues to supersede the government"s pledge to protect and provide for its citizens. This follows the assertions of Buzan (1983) who posits the existence of a *maximal state*, in which the state is seen to be more than a sum of its parts, and thus has interests and concerns of its own. In this instance the state can stand above the citizens, prioritising its own interests above those of its citizens (Buzan, 1983, p. 22). This is the prevailing nature of the state in the 21st century, and concerns of human security, such as public health, are not a vital concern to regional bodies or individual states.

The neglect of human security in individual southern African states is a reflection of the priorities of the individual governments and their leaders. Mr Samkange outlined a fundamental concern with regard to southern African states:

> The crux of the matter is this: on a fundamental level, to what extent to do the agents of the various countries recognise their responsibility to the public? Without good governance within any one of those countries, inter-governmental activity is a waste of time. And that is really the problem in the region. Where is accountability? Where are principles of governance? Superseding the parochial interests of the parties in power? There are none, so the various attempts that are being made to form regional bodies and movements to form regional solutions to deal with problems manifesting at the national level are being thwarted by the fact that none of the governments are actually accountable to their own people (Samkange, 2012).

The absence of essential components of democracy and good governance, that is, equality, representation, accountability and transparency, has lead to the widespread neglect of individuals and their security. Without avenues to hold their leaders to account, acutely insecure populations turn to migration as a last resort to alleviate the insecurities they face.

[43] Mr C. Samkange is a practising Urologist, Director of the Institute for Continuing Health Education (ICHE) College of Health Sciences, University of Zimbabwe, and Advisor of Human Resources for Health for the Ministry of Health and Child Welfare, Zimbabwe.

C. State dysfunction

The last factor to be considered is state function; state function is a key category of analysis as it is widely and correctly accepted that weak, failing, failed and collapsed states are a source of insecurity and instability in their regions. Many definitions have been put forward for state failure (Helman and Ratner, 1993; Zartman, 1995; Herbst, 1997; Gurr, 1998; Mazrui, 1998; Dorff, 1999, 2005; Debiel, 2002; Milliken, 2003; Rotberg, 2003, 2004; State Failure Task Force, 2003; Bilgin and Morton, 2004; Fukuyama, 2004). However, the lack of consensus on what actually constitutes a „failed state" makes the use of this concept for practical analysis and measurement ambiguous. This study rather makes use of the concept of state function, which acts as a positive reciprocal of the state failure narrative.

Rotberg (2003) puts forward a sound approach to assessing state function that includes specific markers and indicators. According to Rotberg (2003) there is a hierarchy of positive minimal state functions: security, institutions to regulate and adjudicate conflicts and to ensure the rule of law, political participation, service delivery, infrastructure and the regulation of the economy. Strong states perform well across these areas, weak states have a mixed profile of performance in these areas, while failed states fall short in all these areas. No one indicator is a marker for state failure, rather a combination of state performance across these areas gives a measure of the degree of state function.

When one analyses southern Africa with regard to state function, a mixed profile is presented. Three particular types of states emerge. While some state in the region can claim partial functionality,[44] as they meet most of their citizens needs, the majority of southern African states are acutely dysfunctional.[45]

The provision of social services such as health, education, food, shelter, water and sanitation are key functions of the state. Acutely dysfunctional states are unable to provide basic amenities and regulate the economy. Without access to these basic services, individuals are at risk of numerous threats to their security in the form of disease, malnutrition and crime to name a few. As the Zimbabwe case has shown, state dysfunction can lead to the mass migration of acutely insecure populations. However, due to the lack of adequate social services in other southern African states, these insecurities may not be alleviated by the recipient state.[46] State dysfunction acts a source of human insecurity and simultaneously impedes states from responding adequately to these concerns at both national and regional levels.

[44] Botswana, Namibia, South Africa and Tanzania fall into this category.
[45] Angola, Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe. It can be argued that the DRC is not a functioning state.
[46] It must be qualified that the lack of provision of social services is not always due to state negligence, but in some instances a mere lack of state capacity. Protracted liberation struggles, slow paced development and training programmes, coupled with common state problems such as corruption, have left many states without the technical expertise needed to function efficiently.

A state that lacks essential principles in its internal apparatus cannot be expected to project these principles at a regional level. This quagmire is at the heart of the region‟s inability to fully recognise and respond to concerns of human security: dominating notions of state sovereignty coupled with state dysfunction across the southern African sub-continent prevail at the regional level, and SADC as a regional body cannot be expected to engage effectively with concerns which the individual states that comprise it do not recognise or prioritise.

5.4 Conclusion

The advent of migration for health purposes has raised concerns of regional capacity, co-operation and stability within SADC and the SADC states.

The SADC Health Desk under the SADC Secretariat has played a minimal role in enforcing regional health protocols. This is due in part to a lack of funds which come mostly in the form of international donations. In the face of limited resources the SADC Secretariat prioritises concerns of high politics, such as diplomatic missions, over issues of lower concern such as regional health. With particular reference to the Zimbabwe case, evidence shows that though there are comprehensive protocols to direct SADC states with regard to regional health and the health of migrants, states such as Botswana selectively enforce sections of these protocols, while dismissing others, to the detriment of the health of migrants, their own nationals and the region as a whole. The Zimbabwe case also reveals the inconsistency of SADC states, individually and collectively. While pledging through various agreements to “consolidate, defend and maintain democracy, peace, security and stability” (SADC, 1992) in the region, the pragmatic undertaking of such a pledge requires levels of co-operation and political sacrifice that the SADC states are unwilling to make. Lastly, the Zimbabwe case has also revealed a disparity that currently exists with regard to SADC policy. Though various policies exist to manage health and human security in the region, the combination of these still do not meet the need presented by the unique flow of migrants out of Zimbabwe. Due to the economic and political collapse, and the subsequent inability to access sound social services, Zimbabwe nationals have migrated throughout the region. However, the need for official documents such as passports impede financially strapped migrants from using legal routes of entry, and the imposition on mobility restrictions deters Zimbabwean migrants from seeking political asylum in other southern African states. The migration of Zimbabwean nationals in the region is thus largely uncontrolled, and outside the scope of regional migration policy. The Zimbabwe case requires novel conceptions of security policy that SADC is yet to formulate.

While public health emanates as the most vital human security concern in southern Africa at present, it is by no means the only concern requiring regional attention. There are acute shortages across the

region of food, water, sanitation and shelter; these concerns are critical to human life and have the potential to affect the region. It is therefore imperative that SADC and its member states adapt their security perceptions and agenda‟s to recognise the security of the individual as a vital regional security concern. Linking security to development is an essential component to this reorientation, if SADC policy recognised matters of human development as security concerns, significant and enduring solutions could be effectively initiated across the region to ensure its security. In addition, SADC must prioritise the work of the organisation‟s organs already established to manage matters of human security, such as the abovementioned SADC Health Desk. The work of these organs could be assisted by the numerous international humanitarian organisations such as UNICEF, WHO, and MSF which have country offices in several southern African states. Several regional programmes aimed at mitigating regional human insecurity, could be initiated between state governments, SADC and regional NGO‟s. Numerous policy options exist to ensure the region avoids and mitigates further regional instability caused by threats to human security.

Chapter Six – Conclusion

It is apparent that for southern Africa the most vital concerns to security are matters of human survival rather than military warfare. Concerns of pervasive poverty, deepening inequality and the provision of basic amenities such as water, shelter and healthcare have become increasingly pertinent concerns in under-developed regions across the globe. It is concerns of this nature, rather than fears of nuclear attack, that dominate the security needs of most – if not all – people in the southern African region. However, as the public health crisis of Zimbabwe has detailed, while SADC and its member states recognise the potential threat that vital human security matters pose to the region and the subsequent need to intensify security at the individual level, this recognition has not translated into effective pragmatic action to manage these threats to human security.

At the heart of this regional inertia are three main obstacles: the disconnect between regional security and development policy; the nature of the SADC security architecture; and the lack of common values at the state level. No one factor stands in isolation, instead these three factors function simultaneously, forming an intricate web of impediments resulting in inadequate responses to vital human security threats.

The necessity of linking security and development has become a policy mantra: from the United Nations to the African Union, from national governments to academic institutions to operational NGOs. Aptly stated by the United Nations, "In an increasingly interconnected world, progress in the areas of development, security and human rights must go hand in hand. There will be no development without security and no security without development" (UN, 2005). These vigorous calls for integrating security and development perspectives and policies emanate from the realisation that development is dependant on security and that security at the individual level is the most pertinent of the security concerns (Tschirgi, 2006, p. 40).

At the basic level development is considered as progress in human well being. The purpose of which is to enlarge people"s choices in a way that enables them to lead longer, healthier and fuller lives (UNDP, 1993). The wellbeing of individuals can not be enhanced in the face of enduring warfare. Therefore, the immediate development costs of insecurity is shown by the low levels of development in conflict and post- conflict regions, Sudan and the DRC stand as stark examples. However, even in the absence of warfare, a population must have access to adequate health care, food, water and sanitation, education and shelter in order to live lives free of fear and want. Security at the individual

level thus functions as an objective of development, as global endeavours such as the UN Millennium Development Goals, are dependant on and cannot be realised without first ensuring the security of individuals.

Security at the individual level also functions as an instrument of the non-security elements of development (Stewart, 2004, p. 261). For instance, national economies grow and become more stable in the absence of conflict and human insecurity. Consequently, strong national economies ensure employment and income security, increased social spending by governments and the overall enrichment of human capabilities. In addition, high levels of development diminish insecurity at the individual level, as development ensures access to basic amenities such as water and shelter. Furthermore, highly developed states have fewer incidences of violent internal conflicts as the cost to societal progress is much higher.

6.1 The Mutually Beneficial Connection between Security and Development

Traditional security agendas that focused on the territorial integrity and political independence of a state could afford to neglect concerns of development, as matters such as healthcare and education had little bearing on their main objectives. However, the interconnectedness of the international arena in the 21st century and the evolving role of the state require an appropriate reorientation and restructuring of security agendas. Within the political context of the 21st century the causal relationship between insecurity and under-development requires the harmonisation of security and development policies at a national, regional and continental level. When individuals are involved in warfare, or are killed or displaced they can no longer work productively. In addition human security concerns such as political instability or the unavailability of adequate food supplies also adversely diminishes an individual‟s capacity to work and enhance their choices. Conversely, when a population has access to adequate food supplies, health care, education, water, sanitation and shelter (that is their basic needs are met) and their governments provide a stable economy and political climate to operate in – such a society is equipped with the necessary tools to maximise their human capabilities and choices; which will inevitably translate into the achievement of positive individual and societal development outcomes.

It is therefore problematic that SADC has not adequately fused these two – a disparity that forms a major component of the security *problematique* of the region. There does not exist at the regional level an adequate policy initiative that seeks to integrate regional security concerns (which are predominantly human security concerns) with the goals of development. The Strategic Indicative Plan for the Organ on Politics, Defence and Security Co-operation (SIPO) and the Regional Indicative Strategic Development Plan (RISDP), SADC‟s most extensive policies with regard to security and development, respectively, do not speak to each other. While each one recognises, separately, the

need to protect human rights not enough detail is paid to specific human security threats or initiatives to mitigate human insecurity. The neglect of these concerns is indicative of structural and organisational impediments within SADC in responding to and managing vital human security concerns such as infectious disease. As such, these vital human security concerns are sidelined, subsequently leading to high levels of under-development across the region. The mutually detrimental relationship between human insecurity and under-development has resulted in systemic regional weakness. Which the Zimbabwe case has shown may lead to the mass migration of insecure individuals across the region – spelling numerous negative ramifications for the region and its states.

A policy link between security and development would ensure that matters of human security are rightfully identified as regional security concerns. This categorisation would prioritise matters such as the provision of public healthcare, and ensure regional action in these areas. Secondly, as the region invests in these security areas, it would ultimately be investing in development, resulting in the aforementioned mutually beneficial positive development and security outcomes. This approach, rather than military or political strategies best suits the security *problematique* of the region.[47]

6.2 The Security Architecture of SADC and the Lack of Common Values

The security apparatus of SADC, encompassed in the OPDS was formed under much dispute between the leaders of the individual states. At the onset there were disagreements with regard to its function, structure, leadership and jurisdiction. The major impasse was with regard to the jurisdiction of the Organ: would it function under or independently of SADC? The Zimbabwe delegation argued that SADC was an inappropriate body to preside over sensitive security matters because it was funded by foreign donors. Therefore, they argued that for the Organ to operate effectively it must not be bound to the economic forum of SADC.[48] Due to these fundamental contentions The Protocol on Politics, Defence and Security Co-operation of the OPDS was only approved in 2001 and the Organ in 2003. Though the states agreed to allow the Organ to function under SADC, this agreement was reached after years of negotiations, which did not yield genuine consensus. As such, the Organ has never fully come under submission to SADC, failing in many instances to control or mobilise member states to act to ensure the security of the region; the controversial SADC interventions in Lesotho and DRC are testament to this (Neethling, 1999; ISS, 2004).

[47] This is not to say that diplomatic/political interventions no longer serve a purpose in dealing with southern Africa¨s security concerns, but rather that they should be utilised in conjunction with sound human security and development policy initiatives. As the security concerns of the region are predominantly at the individual level.

[48] The Zimbabwe camp argued that if the Organ submitted to SADC it would open the region to manipulation from its economic donors. They instead envisioned a security body much like the Front Line Sates that was formed to fight colonialism and apartheid, functioning in a military capacity similar to the North Atlantic Treaty Organisation.

Furthermore, the protocol deals with prescriptions to manage human rights or regional interventions for humanitarian crises in a cursory manner.[49] An amendment to reverse this disparity is unlikely when one considers the contentious environment that dominated the passing of this protocol, and the tensions that would certainly arise in light of the regions perspectives on state sovereignty.

As it stands, the protection of human rights and the provision of human security do not feature prominently in the security agenda of SADC, this speaks to a lack of common values between the individual states of the region. There must be congruence in values and principles for a regional organisation to operate effectively and cohesively. As noted by Nathan:

> I distinguish between the internal and external logic of a regional organisation as separate requirements for cohesion and effectiveness. The external logic, which is strong in southern Africa, refers to the interests, gains and material conditions that make the organisation a beneficial venture in the assessment of member states. The internal logic, which is weak in the case of SADC, refers to the normative congruence in the policies of member states that enables these states to engage in close political and security co-operation. In the absence of sufficient congruence, states are unable to build trust, develop common policies, resolve or transcend their major disputes and act with common purpose in crisis situations. Whereas the external logic is the fuel that drives a regional organisation, the internal logic is the glue that holds it together (Nathan, 2006, p. 606).

The lack of shared principles and values at the state level impedes cohesive action at the regional level. States that do not prioritise the protection of human rights within their own borders will inevitably not propagate for the protection of human rights outside their borders. This disparity is evident in southern Africa where modes of fragmented democracy prevail and accountability and good governance are scarce. As such, when faced with a crisis as that of Zimbabwe, SADC did not respond adequately as its member states do not share common purpose with regards to the value of human life and the security of the individual.

At a basic level, a state that lacks essential principles in its internal apparatus cannot be expected to project these principles at a regional level. This quagmire is at the heart of the region‟s inability to fully recognise and respond to vital concerns of human security. SADC as a regional body cannot be expected to engage effectively with concerns that the individual states which comprise it do not recognise or prioritise. Regional efficacy cannot exist where there is a vacuum in national initiative.

[49] Article 2 and 11 of the protocol deal in little detail with the protection of human rights. Part of the negotiations with regard to the mandate of the Organ focused on the nature of concerns the Organ would deal with. One camp, comprising Botswana, Mozambique, South Africa and Tanzania, viewed the Organ as a common security regime whose primary basis for co-operation and peacemaking would be political rather than military. The other camp, comprising Angola, Namibia and Zimbabwe, preferred a mutual defence pact and prioritised military co-operation and responses to conflict. The protocol of the organ leans toward the Zimbabwe camp‟s desire for military cooperation; perhaps as a compromise to the previous camps desire to have the Organ submit to SADC which was also approved in the Protocol.

6.3 Towards Human Security in Southern Africa

The vital human security threats present in the region require a merger between security and development policies at the regional level; substantial investment in matters vital to human survival such as the provision of public health care and adequate food supplies; and state reform in the areas of good governance and accountable democracy. While there are other avenues to tackle these concerns to human security (perhaps increased collaboration between NGOs, civil society or special rights groups with the individual departments of the governments concerned) the most significant responses must come from the regional level. As SADC is state composed it serves as the appropriate mantle to initiate regional responses to regional concerns. In addition state driven regional action would provide the most effective, pervasive and enduring solutions to regional concerns, when one considers the state dominated political climate of southern Africa. If the region is to mobilize its resources effectively to manage and prevent further threats to human security spreading across the region, SADC as the premier regional body must be the core driver of such action.

The public health crisis in Zimbabwe coupled with political and economic collapse has translated into a regional concern. However, due to the high disease burden in the region similar crises in other southern African states could potentially follow the Zimbabwe model. While infectious disease accounted for 65 percent of the lives lost in Zimbabwe in the period 2010-2011, infectious diseases accounted for 57 percent of total deaths in Mozambique and Zambia, 50 percent in South Africa and 47 percent in Malawi.[50] These figures, which are expected to rise, are indicative of not only of a high disease burden but state weakness in the area of public health provision.

When one views these statistics in light of state dysfunction and the interconnected nature of the region, the potential for the Zimbabwe case to be replicated becomes more probable. Zimbabwe‟s government is infamous for its human rights abuses; however, this profile is not isolated. Clashes between anti-government forces and the defence forces of the late President Mutharika of Malawi injured 44 individuals, and left 19 dead in January 2012 (Mapondera, 2012, p. 1). Acute food shortages in Mozambique led to the eruption of violent clashes between demonstrators and police in Maputo in 2010, resulting in the death of 13 people, 142 arrests and 443 injuries (BBC, 2010, p. 1). Even the government of South Africa, which has been heralded for its progressive constitution, has come under immense criticism for sanctioning the use of live ammunition on striking miners, claiming 34 lives in August 2012 (White, 2012, p. 1). Taking these factors into consideration: the high disease burden in the region, the inadequate provision of public healthcare at the state level, the mixed state profiles of political instability and dysfunction, and the propensity for individuals to

[50] Figures inferred from Fig 3.5

migrate to mitigate their insecurities; it becomes apparent that though Zimbabwe serves as the pioneer example of the scope and nature of the threat vital human security concerns pose to the region, many other southern African states have the potential to pose similar threats to the region.

While public health emanates as the most vital human security concern in southern Africa at present, it is by no means the only concern requiring regional attention. There are acute shortages across the region of food, water, sanitation and shelter; these concerns are critical to human life and have the potential to affect the region.

So how does one conclude a study on a matter as complex as that presented here? I propose that this final thought serves not as a conclusion but as a strong recommendation of the principal step the region must employ in order to effectively manage its unique security concerns. The security *problematique* of southern Africa is multi-faceted and extensive in its scope. However, at the fundamental level it requires a departure from the state-centered security approach that dominates not only the study of security but international security agenda"s in the 21st century. The study began by quoting the African Leadership Forum, as it aptly conceptualised the impediment at the core of the regions security predicament:

> *The concept of security goes beyond military considerations. (It) must be constructed in terms of the security of the individual citizen to live in peace with access to basic necessities of life while fully participating in the affairs of his/her society in freedom and enjoying all fundamental human rights (*African Leadership Forum, 1991 cited in Hough, 2004).

SADC must mobilise its member states and reform its security architecture to recognise insecurity at the individual level as a legitimate regional security concern. Human security concerns dominate the security needs of the region, any effort that negates the primacy of securing the individual stands in contention with the realisation of a stable and safe sub-continent. Any effort to ensure the safety of the region must begin with this fundamental change in the conceptualisation of security in the region.

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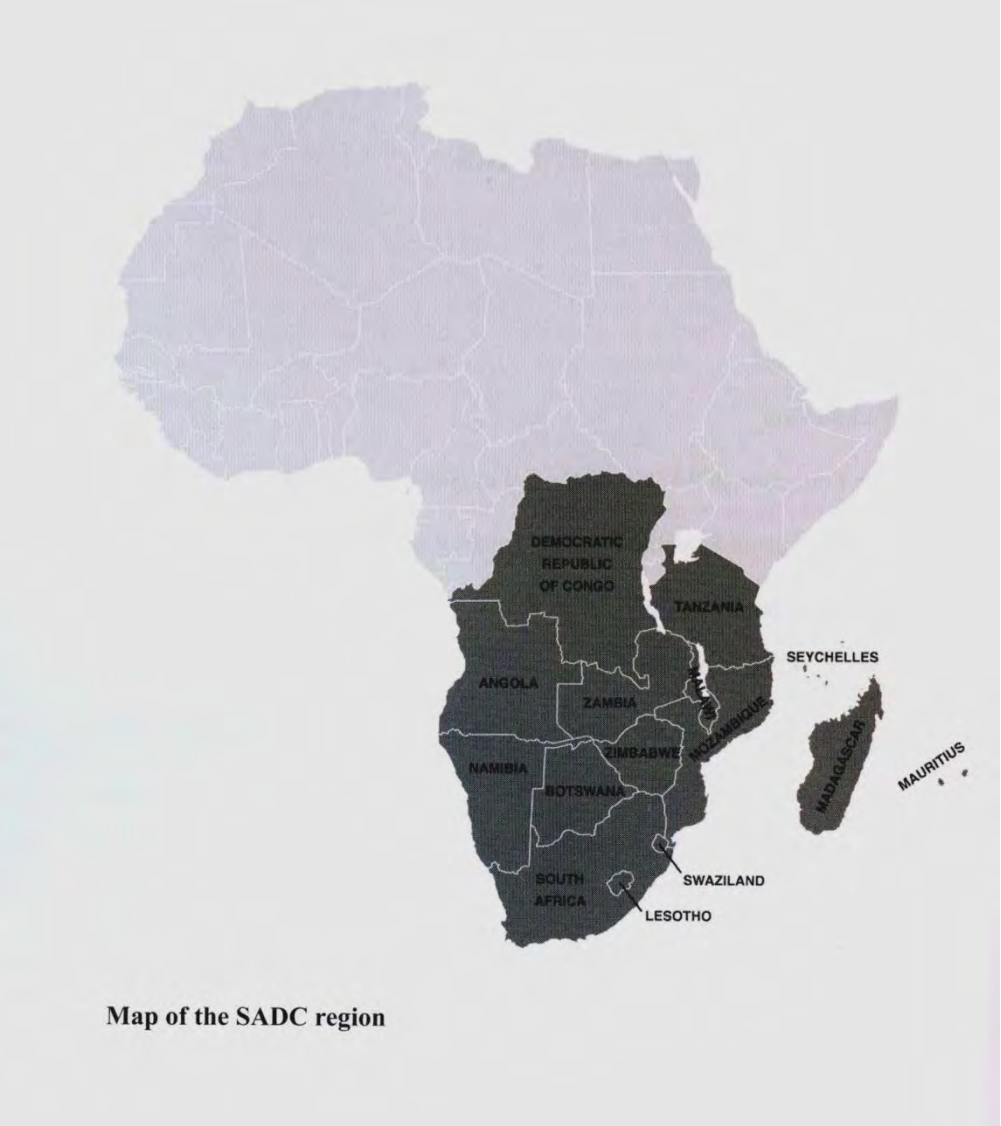
Interviewees

- Mr Ignatious Madzongi: NPO, Human Resources, World Health Organisation (Zimbabwe Country Office)
- Dr Stanely Midzi: Head of Health Systems and Policies, World Health Organisation (Zimbabwe) and former Director, Epidemiology and Disease Control, Ministry of Health and Child Welfare of Zimbabwe.
- Dr. David Parirenyatwa: Director, Centre for Health Strategies (CHEST – a SADC funded Health Policy NGO), Chairperson of Parliamentary Portfolio Committee on Health; Member of ZANU-PF Polit Bureau and Former Minister of Health and Child Welfare, Zimbabwe (2002 – 2008)
- Mr Christopher Samkange: Practising Urologist, Director of Institute of Continuing Health Education (ICHE) College of Health Sciences, University of Zimbabwe and Advisor HRH (Human Resources for Health) for the Ministry of Health and Child Welfare, Zimbabwe
- Dr. Timothy Stamps: Health Advisor in the Office of the President of Zimbabwe; Member of the ZANU-PF Central Committee and Former Minister of Health and Child Welfare of Zimbabwe (1990 – 2002)

Appendix A

Map of southern Africa[51]



Map of the SADC region

[51] Source: Nathan. L (2012) Community of Insecurity: SADC"s Struggle for Peace and Security in Southern Africa. Aldershot: Ashgate.

Appendix B

Raw Data and Formula for Figure 3.5 - Causes of Death in Southern Africa 2010–2011

Country	Population[52]	Death Rate per 1000[53]	Crude Deaths[54]
Angola	19,618,000	12.06	236,593.08
Botswana	2,031,000	12.00	24,372
DRC	67,758,000	10.80	731,786.4
Lesotho	2,194,000	15.80	34,665.2
Malawi	15,381,000	12.84	197,492.04
Mozambique	23,930,000	12.79	306,064.7
Namibia	2,324,000	13.09	30,421.16
South Africa	50,460,000	17.23	869,425.8
Swaziland	1,203,000	14.21	17,094.63
Tanzania	46,218,000	11.92	550,918.56
Zambia	13,475,000	12.42	167,359.5
Zimbabwe	12,754,000	12.38	157,894.52

Deaths due to TB	Deaths due to HIV/AIDS	Deaths due to other infectious diseases[55]	Total Deaths Due to Infectious Diseases[56]	Percentage of Deaths due to Infectious Disease[57]
6,500	11,000	91,095	108,595	46%
430	5,800	1,536	7,766	32%
34,000	33,000	423,748	490,748	67%
290	14,000	2,657	16,947	49%
1,700	51,000	40,742.07	93,442.07	47%
11,000	74,000	92,167	177,167	58%
580	6,700	2,567	9,847	32%
25,000	310,000	96,955	431,955	50%
380	7,000	1,641	9,021	53%
5,800	86,000	135,871	227,671	41%
2,600	45,000	48,262	95,862	57%
3,400	83,000	16,924	103,324	65%

[52] Data derived from *United Nations World Population Prospects: 2011 revision*: http://esa.un.org/unpd/wpp/Excel-Data/mortality.htm
[53] Data derived from *United Nations World Population Prospects: 2011 revision*: http://esa.un.org/unpd/wpp/Excel-Data/mortality.htm
[54] Calculated with the following formula: [DEATH RATE/1000] X POPULATION
[55] Data for Causes of Death for each state derived from: http://www.worldlifeexpectancy.com/world-health-rankings
[56] Calculated with the following formula: SUM of DEATHS DUE TO TB, DEATHS DUE TO HIV/AIDS, DEATHS DUE TO OTHER INFECTIOUS DISEASES
[57] Calculated with the following formula: [TOTAL DEATHS DUE TO INFECTIOUS DISEASE/ CRUDE DEATHS] X 100

Appendix C

In-Depth Interview Questions

- Do you think Health is a Security issue/concern?
- Does the government/department of public health recognise that its deterioration is a threat/concern to the region?
- Do you think there has been adequate inter-governmental interaction and/or policy with regard to health in the region?
- Can the SADC Health Desk adequately meet the health needs of the region?
- Does Health receive the adequate attention in the country that it requires?
- Does Health receive the adequate attention in the region that it requires?
- Do you have any additional comments?