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**AIDS AND HUMAN SECURITY IN
SOUTHERN AFRICA**

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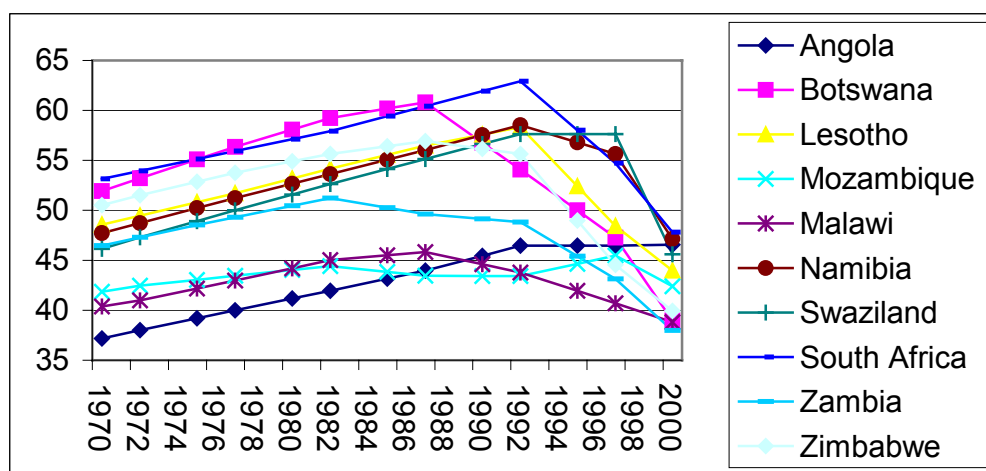
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AIDS and Human Security in Southern Africa

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HIV/AIDS is the greatest health threat facing humankind – particularly for those people living in Southern Africa. Of the estimated 40 million people infected with HIV worldwide, over two thirds live in Sub-Saharan Africa. Southern African countries top the HIV prevalence tables. According to the World Bank, if AIDS had not affected Southern Africa, ‘life expectancy would have reached 64 by 2010-15. Instead, it will have regressed to 47, reversing the gains of the past 30 years’ (2001: 139). Figure 1 shows how life expectancy rose in the 10 Southern African countries during the 1970s and early 1980s, but then fell sharply in the 1990s as the AIDS epidemic and economic crisis took their toll.

Figure 1. Life Expectancy in Southern Africa



Source: World Bank data from WEFA.

HIV prevalence rates vary across the Southern African countries (see Table 1). Although HIV trends in HIV prevalence are correlated (negatively) with trends in life expectancy, there is no correlation between the level of life expectancy and HIV prevalence across countries. This is because life expectancy is also affected by other factors such as war (which lowered life expectancy in Mozambique and Angola) and – most crucially – the level of development. As

can be seen in Table 1, Southern African countries are at very different levels of development, with *per capita* income ranging from almost \$4000 in South Africa, to less than \$200 in Mozambique.

Table 1. HIV in Southern Africa (2001)

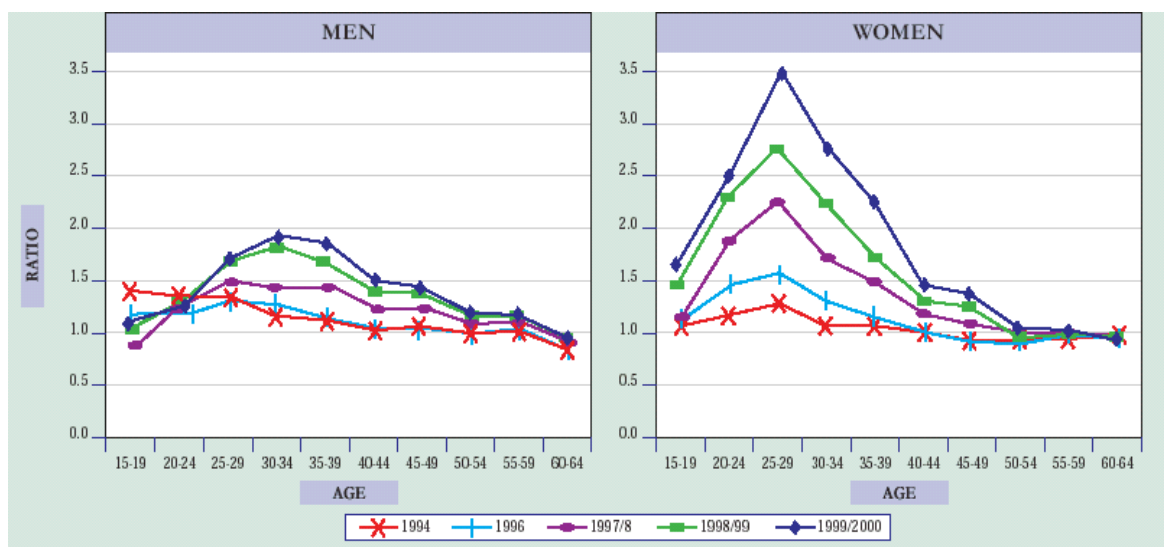
	Real GDP <i>per capita</i> (US\$, 1995)	Life expect- ancy at birth	HIV Prevalence amongst people aged 15- 49 years (2001)	Number of HIV+ people aged 15-49 years	Total AIDS deaths in 2001 (adults and children)	Number of AIDS orphans (0-14 years) alive	% who said a close friend / relative died of AIDS*
Angola	\$506	47	5.5	320000	24000	100000	N/A
Botswana	\$3951	39	38.8	300000	26000	69000	31%
Lesotho	\$551	44	31.0	330000	25000	73000	11%
Malawi	\$169	39	15.0	780000	80000	470000	65%
Mozam- bique	\$191	42	13.0	1000000	60000	420000	N/A
Namibia	\$2408	47	22.5	200000	13000	47000	40%
South Africa	\$3985	48	20.1	4700000	360000	660000	16%
Swaziland	\$1476	46	33.4	150000	12000	35000	N/A
Zambia	\$392	38	21.5	1000000	120000	570000	65%
Zimbabwe	\$621	40	33.7	2000000	200000	780000	68%

Source: UNAIDS (2002: 190), WEFA data, * Data from the *Afrobarometer* (Whiteside *et al* (2002: 16, 28)).

South Africa dominates the Southern African region economically, and is a major epicentre of the AIDS pandemic. Almost half the number of HIV positive people in Southern Africa lives in South Africa. This is already having a devastating effect on young adults. As can be seen in Figure 2, South African death rates have increased dramatically in the age-group 15 to 39. Commenting on this trend, Dr Makgoba, the then head of South Africa's Medical Research Council, commented that only a war could result in comparable deaths amongst young people (cited in Van der Vliet, 2000).

But unlike a war situation, the increase in mortality has been especially horrific for women (especially young women) who are more vulnerable than men to HIV infection. Figure 2 shows a sharp increase in the number of deaths for South African women in their twenties over the past five years. This is a function of the biology of HIV infection (women are more easily infected than men¹), and of the social and economic disadvantages experienced by women (Walker and Gilbert, 2002). This pattern of increased vulnerability of women to HIV infection is replicated across Africa (see UNAIDS (1999) and Baylies and Bujra, 2001: 1-24).

Figure 2. Increase in Adult Death Rates in South Africa



Source: Dorrington *et al*, 2001:29

Why is it that AIDS has proved so much more deadly in Africa than anywhere else in the world? Early approaches to the AIDS pandemic focussed on the pathogen (the HI virus) and on the behavioural determinants of HIV transmission. More recent research has focussed on the immune system's

¹ All else being equal, women are between two and four times more likely than men to experience HIV infection from a sexual encounter. Reasons include higher concentrations of HIV in semen than in vaginal fluid, the larger area of exposed female than male genital surface area, the longer period of exposure of semen in the vaginal tract, and the greater permeability of the mucous membranes in the vagina compared to the penis (see summary of evidence in Baylies and Bujra (2001: 5)).

response to HIV. There is now a strong body of biomedical evidence showing that ‘malnutrition and parasite infection increase HIV susceptibility, not only to opportunistic infection after HIV infection, but also to HIV transmission, just as they increase susceptibility to other infectious diseases’ (Stillwaggon, 2002: 4).² Given that malnutrition is a function of poverty, there is thus good reason for assuming that poverty helped hasten the spread of HIV in Sub-Saharan Africa. As Stillwaggon observes, “From 1988 to 1998, when nascent or concentrated AIDS epidemics developed into generalised epidemics in Sub-Saharan Africa, 30 percent of the region was malnourished” (2002: 5). Micro-nutrient deficiencies (particularly Vitamins A, C, and B) undermine the body’s natural defences against HIV infection – i.e. skin integrity and mucous membranes), thus contributing further to the vulnerability to HIV infection. Parasite infections, mainly malaria, schistosomiasis (bilharzia), trypanosomiasis (sleeping sickness) and intestinal parasites undermine nutritional status and compromise the immune system yet further – effectively by exhausting it. Such parasite infections are endemic in Africa, but the situation is made worse by inadequate health care (which leaves most parasite infections untreated) – itself a function of poverty and low levels of development. There is, in other words, a strong link between poverty, low levels of development and the pace of HIV transmission. Figure 3 summarises these pathways.

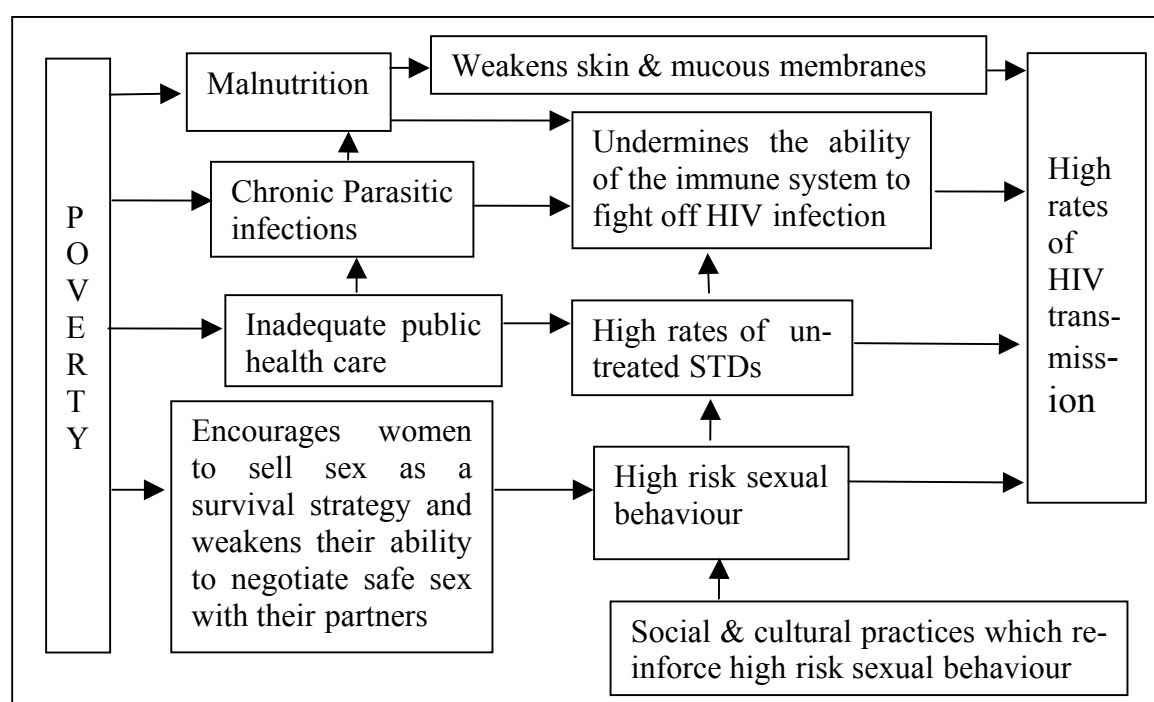
Sexual behaviour is obviously an important driver of the epidemic – especially in Africa where transmission is overwhelmingly heterosexual. However, it is important to note that it is the *combination* of socio-economic and biomedical factors with unsafe sexual practices that produces the lethal basis for the spread of HIV in Africa. Sexual behaviour on its own cannot account for the spread of HIV. According to a study of difference in HIV spread in four Sub-Saharan African cities, high rates of partner change, contacts with sex workers, and concurrent sexual partnerships were not reported more systematically in the high prevalence than in the low prevalence sites (UNAIDS, 1999). Co-factors such as male circumcision (which appears to provide a degree of protection from HIV infection), the presence of untreated STDs and the age of marriage for young women were highlighted by the study.

Economic factors reinforce unsafe practices – especially where sex is a currency by which African women and girls are frequently ‘expected to pay for life’s opportunities, from a passing grade in school to a trading license or permission to cross a border’ (UNAIDS quoted in Baylies and Bujra, 2001: 7). Poverty

² See Stillwaggon (2002) for a useful summary of this evidence. See also Poku (2002).

exacerbates the situation by encouraging women to engage in sex as an economic strategy for survival (Akeroyd, 1997). A recent newspaper article on Zambia (which is experiencing famine in many parts of the country) reported that women were charging two Zambian dollars for sex – and double if the man did not want to use a condom. According to the local medical officer, these women ‘are educated about the virus, but say that they would rather die of AIDS than hunger’ (*Mail and Guardian*, November 1-7, 2002). In other words, it is important to address the issue of sexual behaviour and behavioural change when combating the AIDS pandemic. But such programmes need to be relevant to the specific economic and bio-medical circumstances of the people they are aimed at – and most importantly, should be introduced as part of a broader strategy to boost economic development and empower women.

Figure 3. The Links between Socio-Economic, Biomedical and Behavioural Determinants of the spread of AIDS in Africa.



Having touched on the patterns and determinants of the HIV epidemic in Southern Africa, let me now turn to the main topic of the paper: the implications of HIV/AIDS for human security in Southern Africa, and for global security more generally. The answer to this difficult question depends in large

part on what is meant by the term ‘security’. In this paper, I will not be addressing the relationship between AIDS and security/peace-keeping forces (as is, for example, addressed by the *UNAIDS Initiative on HIV/AIDS and Security*.³). I will instead be adopting a more socio-economic perspective on the issue.

Human Security Understood in Developmental Terms as ‘Economic Security’

If we understand human security in developmental terms,⁴ i.e. by focussing on issues like: ‘food security’, ‘income security’ and ‘security of health’, then the answer is direct and negative: AIDS undermines economic security by reducing the productivity of (and eventually killing) income-earners whilst simultaneously diverting scarce household resources towards medical expenditure. This double squeeze on household security is increasingly well documented in the growing body of research on the impact of AIDS on households in South and Southern Africa.⁵ Women are especially hard-hit because they carry the burden of the disease and yet are expected to care for other members of the household who are also HIV positive (Walker and Gilbert, 2002: 82).

However, the devastating economic impact of AIDS does not stop at the household level. HIV/AIDS also reduces productivity at work and increases production costs for firms (Aventin and Huard, 2000). This, together with the negative impact of HIV/AIDS on income and consumption, acts to slow growth. According to Bonnel: ‘...in the case of a typical sub-Saharan country with a prevalence rate of 20 percent’, the growth rate of *per capita* income would be reduced by 1.2 percentage points a year because of AIDS (2000: 846).⁶

³ See <http://www.unaids.org/security.org/security>

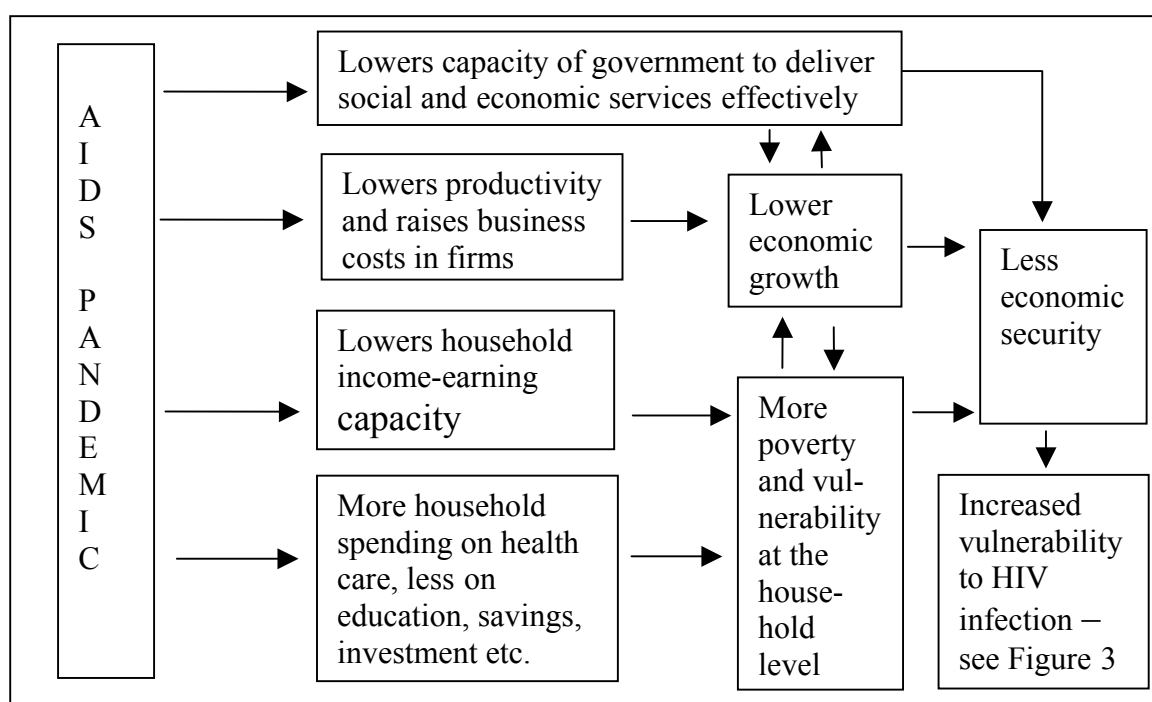
⁴ See the 1994 Human Development Report (UNDP, 1994) for a discussion of human security as a developmental objective.

⁵ See Parker *et al*, 2000: 41-7 for a bibliography of the impact of HIV/AIDS on households. Recent South African survey data indicates that AIDS-affected households draw down savings to finance medical expenditure and funerals (Booyesen *et al*, 2001) and cut back on expenditure on clothes, electricity, food and school fees (Steinberg *et al*, 2002: 39).

⁶ Note that the estimated impact of AIDS on *per capita* income is sensitive to underlying assumptions – especially HIV prevalence across skill bands and the proportion of health care that is financed out of savings (Over, 1992). According to Bloom and Mahal (1997), AIDS will have no impact on *per capita* income in developing countries (because population and

Government efficiency is also likely to be undermined by HIV/AIDS – thus reducing the capacity of government to deliver social and economic services. Slower growth in turn reduces the tax capacity of the economy, thus undermining any potential developmental role for the state. Household economic security is thus threatened directly (through the morbidity and mortality of household members) and indirectly (via the negative ‘second-round’ impact of AIDS on the macro economy and on government). Increased poverty in turn increases vulnerability to HIV infection. These connections are summarised in Figure 4.

Figure 4. AIDS and Economic Security



Not everyone, of course, will be affected equally by the AIDS pandemic. Indeed some people may benefit absolutely (e.g. undertakers, the suppliers of certain drugs, etc.) and others may become relatively better off (although not

output growth are projected to fall by the same amount). Two out of the three macroeconomic models of the impact of AIDS in South Africa predict that AIDS will result in rising *per capita* incomes (as population is more adversely affected than growth), whilst a third model predicts that *per capita* incomes will fall (see Nattrass, 2002). Modelling results should thus be treated with great caution.

necessarily absolutely better off) as the economy declines. There is no reliable data on the impact of AIDS on inequality, but there is some South African evidence to suggest that inequality may well rise in that country. HIV prevalence is higher amongst the unskilled and unemployed than it is for the more skilled and employed sectors of the population.⁷ If firms react to this by decreasing their reliance on unskilled labour (a trend that started before the AIDS pandemic) and by moving out of economic sectors whose customer-base comprises lower-income consumers (i.e. those most likely to be affected by AIDS), then poor households will find themselves doubly disadvantaged. Not only will their access to the labour market become ever more tenuous, but the products that they purchase may become scarcer (and more costly). Conversely, relatively skilled workers could benefit from greater employment opportunities (as production becomes more skill- and capital-intensive) and from higher wages (as the relative demand for skilled labour increases). Those who are HIV positive may also live longer and more productive lives as firms begin to provide them with access to anti-retroviral medication. The size of the pie may shrink as a result of AIDS, but employed (especially skilled) workers may well enjoy a growing share.

This scenario of rising inequality is, however, probably pertinent only to South Africa (and to a limited extent also to Botswana). Unlike their poorer neighbours, South Africa and Botswana have a significant minerals and industrial base. Large companies in both countries have an incentive (and the resources) to maximise the working lives of their skilled workers. The large mining companies in both countries, for example, provide anti-retroviral medication to their workers. I am not aware of any similar programmes anywhere else in Southern Africa. In poor, war-damaged countries like Angola and Mozambique, AIDS is likely to have a greater levelling effect. Skilled and unskilled workers in towns and peasants in rural areas will probably all suffer and die with little hope of life-prolonging treatment. Lower productivity in agriculture will, in turn, reduce both food security and economic security.

⁷ This is in large part due to the fact that the highest rates of HIV prevalence are amongst Africans, who tend to bear the brunt of unemployment and perform almost all the unskilled work (see discussion in Nattrass (2002). According to the World Bank (2001: 139), the South African pattern conforms to the general shift in the profile of HIV positive people from being initially (in the 1980s) based amongst higher socio-economic groups, to a disease of poor people (from the mid-1990s onwards).

Human Security Understood as Policing/State Security

If we understand ‘human security’ in the older sense of ‘state security’ and a ‘crime-free society’, then the focus of discussion becomes more oriented towards policing. Analysts in the ‘security studies’ industry have attempted to portray AIDS as a security threat of this kind. For example, Schonteich (2001) argues that children orphaned by AIDS pose a very serious threat to Southern Africa in terms of future levels of crime. He argues that as AIDS orphans are likely to be traumatised, uncared for, discriminated against and socially excluded, they will tend to display delinquent and violent criminal behaviour. Whilst admitting that there is insufficient African research on the matter, he nevertheless goes on to predict that Southern Africa will experience ‘a significant increase in violent interpersonal crime such as murder, rape and assault’ (2001: 7). Accordingly, he argues that ‘adequately staffed and resourced juvenile detention centres, rehabilitation and diversion programmes for young offenders and effective children’s court systems will have to feature more prominently on governments’ list of priorities in the future’ (Schonteich, 2001: 8).

Orphans are obviously a tragic social problem. But is the problem they pose a policing/security one? According to UNAIDS, there are 3 124 000 AIDS orphans in Southern Africa, of which 660 000 live in South Africa (see Table 1). This is clearly a humanitarian disaster of epic proportions. However, there is little evidence as yet to cast the issue as a policing/security problem – and none whatsoever to justify the argument that building juvenile detention centres is an appropriate policy response.

Firstly, it is not obvious that African orphans will be inadequately socialised if they lose one or both parents. Given the combination of the extended family system and the migrant labour system in Africa, it is fairly common for children to be brought up in households headed by neither parent – and for both parents to be missing for a large part of the time.⁸ Prime ‘role-models’ for African children could be grandparents or uncles, aunts or cousins. Zambian research

⁸ For example, a recent survey of African working-class areas in Cape Town revealed that 18% of Africans grew up during some or all of their childhood in households that were not headed by either their mother or father, and that 11% grew up in households in which neither mother nor father was present for some or all of the time (own analysis of the Khayelitsha/Mitchell’s Plain data set).

suggests that the main problem with losing biological parents appears to be not an absence of alternative role models and care-givers – but rather emotional distress (Poulter, 2001: 15). Psychological distress is in turn exacerbated by poverty. As Grainger *et al* conclude from their overview, the ‘psychosocial impacts of HIV/AIDS are closely linked with other factors such as declining household income, hunger and poor health status’ (2001: 29).

Secondly, there is no substantive evidence that care-givers systematically treat AIDS orphans differently to other members of the household. According to a recent study in Lusaka, there was no correlation between orphan status and stunting – thus indicating that ‘orphans were not being fed a poorer diet than other children in the household’ (Poulter, 2001: 12). The study also found that ‘families are providing support to relatives who are sick and to orphans, despite the hardships that many families are experiencing (2001: 17). This finding was echoed by another Zambian study: ‘despite the devastating impact of AIDS on family structures in the country, the extended family is still the main care provider for almost all the orphaned children in the survey’ (Nampanya-Serpell, 2001: 16). A Uganda study noted that while care-givers are increasingly burdened by the AIDS pandemic, ‘most experts do not believe that the African family structure has “collapsed” under the weight of AIDS’ (Gilborn, 2001: 4).

There is, of course, evidence indicating that HIV-positive children and children of HIV-positive parents are vulnerable to stigmatisation and discrimination at school, in the community and sometimes even in the home (see Strode and Grant, 2001: 15-26, Grainger *et al*, 2001: 13-41). There is also evidence that orphans face particular economic hardships – especially those who find themselves heading households at a young age, or living with elderly relatives with little or no source of income (Gilborn *et al*, 2002). Reports such as these are worrying. But rather than indulging in what amounts to little more than a ‘moral panic’⁹ about orphans and arguing, on this basis,¹⁰ that more resources

⁹ In the early 1990s in South Africa, there was a media outcry about the problem of the so-called ‘lost generation’ of African youth – i.e. young people who had had their education disrupted by the anti-apartheid struggle. The fear was that these people would boost the ranks of criminals and exercise a severely disruptive impact on society. Seekings (1995, 1996) argued that this amounted to a ‘moral panic’ and that there was no evidence to substantiate these fears. Current arguments about orphans – especially by security studies consultants – have the same hysterical, prejudiced and unsubstantiated ring to them.

¹⁰ Crime is clearly an issue for people living in Southern Africa. As can be seen in Table 2, it featured fairly high up on people’s political agendas. But the crime problem preceded AIDS, and is closely connected to poverty.

should be put into policing and the criminal justice system, we should be thinking about how to address the dual scourge of AIDS and poverty. Family and community resources are clearly being stretched and sorely tested by AIDS. The appropriate response is to empower households economically to cope with all dimensions of the AIDS pandemic. AIDS is an issue for human security in the developmental sense of the term – rather than the security/policy sense of the term.

What, then, does this mean for the main focus of this conference: ‘HIV and Global Security?’ What is the connection between AIDS and human security in Southern Africa on the one hand, and global security on the other?

AIDS and Government in Southern Africa

Let me start out by saying that I am no expert on global security! I have no idea if one can even begin to trace out a theory which links issues of human security and global inequality to security issues like international war and terrorism. Rather than attempt such a task, I will proceed on the basis of a simple fact – that no democracy has ever gone to war with another democracy – and ask whether AIDS has any implications for democratic transition and sustainability in Southern Africa.

In their definitive cross-country analysis, Przeworski *et al* (2000) show that the probability of a democracy surviving ‘increases steeply and monotonically as *per capita* incomes get larger’ and that ‘democracy is almost certain to survive in countries with *per capita* incomes above \$4000’ (2000: 273). According to this analysis, democracies are fragile in poor countries. As shown in Table 1, most Southern African countries are poor and only two (South Africa and Botswana) come close to *per capita* incomes of \$4000.

In other words, to the extent that AIDS undermines *per capita* economic growth in Southern Africa, it will also increase the likelihood of democratic failure. Southern African countries have democratic institutions – but for the most part, these do not function very well (the most notable case at present being Zimbabwe where democracy has been all but destroyed). Given the fragile basis for democracy in Southern Africa, it is possible that the burden of AIDS on growth could tip the balance in favour of dictatorship in some counties. And, given that non-democratic regimes are more likely to threaten global security

than democratic regimes, the suggestion is thus that AIDS in Southern Africa has implications for global security – albeit via this rather indirect route.

A related fear is that AIDS could somehow result in greater political instability (perhaps through its corrosive impact on social structures, social capital, political participation, etc.) which in turn could undermine development and democracy – and hence threaten global security. There are, however, several problems with this analysis. Firstly, it is not clear what relationship (if any) exists between AIDS, democracy and forms of political participation. For example, research from the *Afrobarometer* revealed no evidence for any adverse impact of illness on political participation:

‘...illness does not significantly decrease people’s interest in politics, or their trust in other people (a factor often identified as a crucial component of public participation). Neither does ill-health decrease levels of participation in community organisations in non-voting forms of political participation, or the rate at which people contact elected leaders. Thus, the least healthy Africans appear as likely to participate in political procedures and civil society as the most healthy’ (Whiteford *et al*, 2002: 34-5).

Secondly, it is not clear what impact AIDS will have on political demands by citizens. Is AIDS likely to result in mass mobilisation in favour of increased health care? Could this be destabilising – either politically or economically if government budgets balloon to unsustainable levels? Recent data from the *Afrobarometer* can help shed light on these questions.

The *Afrobarometer* collected data on political attitudes, socio-economic indicators and various other attitudes (including those on AIDS) in seven Southern African countries between July 1999 and July 2000. Each survey comprised a random, stratified, nationally-representative sample of approximately 1 200 individuals.¹¹ The following open-ended question was asked: ‘What are the most important problems facing this country that the government should address?’ Given the high HIV prevalence rates amongst adults in Southern Africa and the large number of AIDS deaths per year (see Table 1) one might have expected HIV/AIDS to feature high on the public agenda. However, as indicated in Table 2, economic issues – especially job

¹¹ See Whiteford *et al* (2002: 13) for more detail about the samples.

creation – were clearly the top priorities. Only in Zambia did people spontaneously refer to health issues more often than economic issues.

Table 2: Spontaneously Reported Political Priorities

<i>Botswana</i>	<i>Zimbabwe</i>	<i>Zambia</i>	<i>Malawi</i>	<i>Lesotho</i>	<i>Namibia</i>	<i>South Africa</i>
Job creation (58%)	Economy (74%)	Health (41%)	Economy (48%)		Job Creation (54%)	Job Creation (76%)
AIDS (24%)	Job Creation (37%)	Job Creation (32%)	Health (29%)		Education (46%)	Crime / Security (60%)
Education (20%)	Health (18%)	Education (31%)	Crime / Security (28%)	Food (20%)	General Services (21%)	Housing (25%)
Job Creation (63%)		Agri-culture (26%)	Food (26%)		Health (18%)	Edu-cation (13%)
Crime/ Security (28%)		Economy (20%)	Transport (16%)		AIDS (14%)	AIDS (13%)
Agriculture (14%)		Transport (18%)	Water (16%)			Health (12%)
Crime / Security (12%)		Poverty (14%)	Agri-culture (13%)			Poverty (11%)
			Education (12%)			
			Poverty (11%)			
			Job Creation (11%)			

Source: Whiteside *et al*, 2002: 30. Only those problems referred to by more than 10 percent of respondents.

According to Whiteford *et al*, the relative ranking of HIV/AIDS for government action by *Afrobarometer* respondents did not vary systematically with HIV prevalence, the proportion of respondents who knew someone who had died of AIDS, or the number of cumulative deaths from AIDS (2002: 29). They suggest that this could be because economic conditions in Southern Africa are so dire

that issues pertaining to immediate income needs were forced to the forefront of people's consciousness. The fact that poorer people were less likely to cite AIDS as a problem than richer people perhaps constitutes evidence for this position (*ibid.* 31). Whatever the reason, the bottom line is that AIDS and health issues are not, for the most part, perceived as political priorities by the general Southern African population.

If governments are to feel any direct political pressure to do anything dramatic about AIDS, this is likely to come from well-organised, single-issue NGO's like the Treatment Action Campaign¹² in South Africa.

But what about the future? Are citizens likely to alter their political priorities in favour of health care as the AIDS pandemic continues to reap its grim harvest? This is impossible to predict – especially given the close relationship between AIDS, poverty and vulnerability. AIDS kills young productive adults, thus plummeting poor households into poverty. Under such conditions, it would hardly be surprising if job creation and welfare continue were to continue to be prioritised over health expenditure – even by those most devastated by AIDS.

One could hypothesize that the socio-economic crisis resulting from AIDS will undermine political stability if citizens believed that not enough is being done to address the key issues pertaining to incomes, jobs and welfare. It is impossible to tell whether this is likely or not, but even if it were, the question remains whether it *matters* if there is greater political instability or not. According to one influential view (popularised by Huntington (1968)), any political instability is bad because it undermines development. In terms of this framework, maintaining 'order' is a key development objective – even if that means supporting non-democratic regimes to maintain power. This argument has, however, been devastated by Przeworski *et al* (2000). They show that political instability has no effect on growth in democracies and has negative (but short-term only) effects on growth in dictatorships (2000: 193-9). In other words, a blanket concern with political instability is inappropriate. Some forms of instability (such as a change in government following a democratic election) are desirable politically and have no adverse economic consequences. Other forms of instability (such as pro-democracy demonstrations in a dictatorship) may adversely affect short-term growth – but may still be worth it in developmental

¹² The Treatment Action Campaign (TAC) is a well organized South African NGO. Its hard-hitting and well-researched campaigns have forced the South African government to provide anti-retroviral treatment to HIV positive pregnant women. TAC is currently negotiating with government, business and labour about a treatment programme for adults with AIDS.

terms if they contribute to democratic transition. People are better off under democracies – both in terms of economic development and of human freedom. It is thus highly dubious to portray all political instability as a human security issue. Human security is best linked clearly and absolutely to democracy.

What, then, should Southern African governments do – or be encouraged to do – about AIDS? Should they concentrate on prevention, treatment, or a mixture of strategies? And if treatment is to be rationed, who should get it? Given that women are particularly vulnerable to HIV infection, is there any way of targeting them especially – or is their lower socio-economic status so intractable that it requires major social transformation to empower them adequately? Similarly, what sort of AIDS education awareness and prevention programmes are needed to impact on a culture in which men are expected to have multiple partners?

Such questions of design are very important – and there are as yet few clear answers to any of them. Evaluations of AIDS policy programmes typically stress the complex inter-relationships between socio-economic and behavioural determinants of HIV transmission, and the burden these place on policy design. Successful programmes need to be relevant to the cultural and economic context in which they are applied, should include the target audience as active participants in design and implementation, and should empower people to transform their behaviour (see e.g. Baylies and Bujra (2001), Grainger *et al* (2001) and Strode and Grant (2001)). They also need to be consistent with an overall developmental and anti-poverty orientation to government economic policy.

This is a pretty tall order. As Poku puts it:

‘Until poverty is reduced there will be little progress with either reducing transmission of the virus or creating an enhanced capacity to cope with its socio-economic consequences. It follows that sustained human development is an essential precondition for any effective response to the pandemic in Africa. Herein lies Africa’s predicament: how to achieve the sustainable development essential for an effective response to the pandemic under conditions where the pandemic is destructive of the capacities essential for the response – namely, killing the most economically productive members of the continent’s people. Simple answers to this problem do not exist, but recognition of its nature is a step towards its solution’ (2002: 545).

Recognition of the nature of the problem is an important step – but it really is not necessarily clear what the next step should be. Governments have to decide how many resources to allocate to AIDS-related programmes – and at what opportunity cost for other programmes. Should government spend less on road construction, or small business development, or on the tertiary educational system, in order to fund AIDS interventions? One could, of course, argue that Southern African governments should restructure their budgets at a fundamental level in order to deal with the epidemic. Obvious candidates include cutting expenditure on defence and improving public sector efficiency. However, given that governments had good developmental reasons to embark on such changes many years ago, there are clearly institutional and political obstacles in the way of making them. Until such time as strong democratic pressures arise for governments to be more accountable and efficient, very little is likely to change in this respect. Southern African governments will thus almost certainly continue to address the AIDS pandemic unevenly, unsystematically, and with limited resources.

Implications for the Donor Community

So what should the donor community do under these circumstances? I am no expert on this either, but here are three principles which I think should guide policy responses.

Principle one: *keep focussed on the development objective*. Southern African citizens clearly prioritise income needs over immediate health needs, and there is a strong link between economic insecurity and the spread of AIDS.

- Support labour-intensive growth strategies – particularly those that channel jobs and resources to poor areas.
- Support calls for debt relief, but keep pressure on beneficiary governments to allocate the resources thereby freed up to genuinely developmental objectives.
- Support programmes that provide food security for people – especially in times of famine – and those that improve the socio-economic position of women in society.
- Where possible, build an AIDS-awareness and education component into existing development projects (e.g. in schools, clinics and small business development programmes).

Principle two: *where additional donor resources are available, support interventions which are relevant to the context and which empower people to change their lives – particularly those at greatest risk.*

- Research the local situation and make sure that the AIDS treatment and prevention programmes are appropriate and genuinely transformative.
- Pay specific attention to the needs of, and constraints facing, young women and poor households.

Principle three: *keep hope alive.* Given the already high rates of HIV prevalence in Southern Africa, it is important to reach the large constituency of HIV positive people, and not simply to concentrate on AIDS-awareness and prevention campaigns. Anti-retroviral (ARV) treatment is conventionally regarded as ‘too expensive’ for developing countries (especially those in Africa). However, the cost of ARV treatment has fallen sharply over the past two years, and with the growth of generic medication, is likely to fall further. This, together with the fact that people on ARVs get sick less often – thus freeing up public health resources in this regard – puts ARV treatment in the range of viable health interventions for many developing countries.¹³ Offering the possibility of life-lengthening treatment to HIV positive people has the additional benefit of encouraging more people to be tested and to receive post-test counselling – which in turn should help change behaviour and reduce new HIV infections. Donors should thus also:

- Put pressure on pharmaceutical companies to lower their drug prices for developing countries.
- Encourage and assist Southern African countries to provide access to ARV treatment for HIV positive people.

¹³ See Nattrass (2001) for a discussion of the ethics and economics of providing anti-retroviral treatment in South Africa.

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