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THE IMPACT OF HIV/AIDS ON DEMOCRACY IN SOUTHERN AFRICA: WHAT DO WE KNOW, WHAT NEED TO KNOW, AND WHY?

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Democracy in Africa Research Unit

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The Impact of HIV/AIDS On Democracy in Southern Africa: What Do We Know, What Need to Know, and Why?[1]

Introduction

From Botswana to Zimbabwe, the present state of democratic politics across southern Africa leaves much to be desired. Yet as imperfect as it may be, few people would wish to go back in time. Too many people remember what life was like under the former colonial, settler, one party or military regimes that this region endured. But the persistence of democracy, as imperfect as it may be, cannot be taken for granted. While HIV/AIDS kills people, damages households, and strains national economies, there are many reasons to believe it may also threaten the existence of democratic government. The purpose of this paper is to sketch out the potential challenges that the HIV/AIDS pandemic may pose to southern Africa's young and fragile democracies, assess the state of our knowledge about that threat, and identify priority areas for future research: that is, those areas where the potential threat to democracy is greatest but where our knowledge is least.

Social scientists are only beginning to understand the range of potential impacts that the HIV/AIDS pandemic may have on southern African societies. Researchers are beginning to systematise propositions and compile evidence about the demographic, economic and social impacts of the disease on infected people, their households and communities, national populations and national economies (Hamoudi and Sachs, 2001). They have only recently begun to develop propositions about the impacts of HIV/AIDS on the broader processes of governance.[2] However, the implications of the pandemic for the survival and consolidation of democratic government, in particular, remain largely unexamined. While there is a growing, though unorganised, body of

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[1] This paper is based on Robert Mattes, *AIDS and Democracy: What Are the Linkages?* and Ryann Manning, *AIDS and Democracy: What Do We Know?,* both presented to the University of Natal Health Economics and AIDS Research Unit (HEARD), University of Cape Town Democracy in Africa Research Unit, and Institute for Democracy Governance and AIDS Programme Workshop on 'Democracy and AIDS in Southern Africa: Setting the Research Agenda' (Cape Town on 22-23 April 2002). For proceedings, see www.uct.ac.za/ depts/cssr/daru.html.

[2] For an examination of the political implications of economic impacts, see Parker et al, 2000:1; For project of impacts on security forces and regime stability, see Heinecken, 2001: 7-18; Cheek, 2001: 19-28; Fourie and Shonteich, 2001: 29-44.

theoretically informed speculation about the impact of HIV/AIDS, there is virtually no body of substantive evidence.

Why a specific research focus on the impacts of HIV/AIDS on democracy? Should we strive to understand the impacts of any disease of this scope -- for example malaria, which currently kills more people than AIDS – on the stability of any political regime? We believe, the answer is 'no'. HIV/AIDS is not just any pandemic. Its primarily sexual mode of transmission allows it to spread quickly and silently throughout a population. The relatively long time span between HIV infection and death due to AIDS complications imposes a virtual death sentence on significant portions of a population. Its sexual mode of transmission brings a range of social stigma that adds to the suffering of its victims.

If HIV/AIDS has unique characteristics, is it not true that we should seek to understand the threat it would pose to the security and governance of any state? Again, the answer is 'no.' Democracy is not just any regime. Researchers should be especially interested in the plight of democracy, as opposed to other types of political regimes. Over the past two centuries, democracy has come to enjoy a privileged normative status as *the* preferred type of political regime because it is unique in recognising the moral agency and dignity of human beings, and thus their right to determine their individual and collective fates (Sen, 1999: 3-17). Yet it is precisely this moral agency and human dignity that may be most severely challenged by HIV/AIDS, an argument that will be fleshed out more fully below.

While they may be normatively privileged, democracies are fragile and more difficult to sustain than non-democratic regimes (Przeworski *et al*, 2000:47). Of the 71 democracies that were established by or after 1950, 33 had died by 1990, lasting an average of just 5.1 years (compared to the 9.4 years of dictatorships that were born after 1950 but died prior to 1990). The 38 democracies surviving after 1990 had an average life span of 13 years (compared to 26.2 years for surviving dictatorships.

In continental southern Africa, the 1990s saw eight countries achieve a successful transition from an authoritarian regime to a founding democratic election, joining the two existing multi-party systems in Botswana and Zimbabwe (Bratton and Van de Walle, 1997). Yet many of these democratisation processes are incomplete and some have undergone reversals. Even where states have implemented regular elections and secured the conditions for political competition, pluralism, and the protection of human rights, democracy remains far from consolidated.

As defined by Larry Diamond, continental Southern Africa presently contains three emerging 'liberal democracies' (countries that combine genuine political competition with a full range of political freedoms and civil rights). Based on ratings of political and economic rights, South Africa, Botswana, and Namibia are all rated by Freedom House as 'free', thus falling into this category. Yet even these countries run the risk of eventually degenerating into what Diamond has called 'semi' democracies because the existence of single, dominant political parties may over time limit effective competition. The region also contains four functioning 'electoral democracies': that is they combine genuine political competition with an insufficient protection of rights. Malawi, Tanzania, Mozambique and Lesotho are rated as 'partly free' by Freedom House, thus falling into this category. Finally, for our purposes, Southern Africa has two of what Diamond calls 'pseudo' democracies or what Richard Joseph calls 'virtual' democracies. These countries hold elections and allow opposition parties, but competition, pluralism and rights of association, speech and media are actively constrained by the state. Zambia and Zimbabwe are rated as 'partly free' by Freedom House but score sufficiently badly on political rights that they fall into the 'pseudo-democracy' category (Diamond, 1966; Diamond and Plattner, 1999; Joseph, 1998). An over time analysis of the Freedom House show retrograde trends in political freedom and civil liberties in Zimbabwe, but also in Malawi (Karatnycky, 2002; Mattes and Leysens, 2003 forthcoming).

Thus, even without the presence of HIV/AIDS, the future of democracy in the region is far from certain. None of Southern Africa's democracies can yet be considered to be consolidated, meaning there is little or no probability of breakdown or reversal to some authoritarian regime. We believe that it is possible that HIV/AIDS not only makes the probability of consolidation even more remote, it may even heighten the possibility of breakdown and reversal. This chapter is an attempt to systematise the various arguments about why this may be so, and to identify how much we actually know.

HIV/AIDS and Democracy: A Brief Overview

Social scientists have identified three key factors crucial to sustaining and consolidating democratic rule. The first factor has to do with *economics*. While wealthier countries are no more likely than poorer ones to have transited from authoritarian to democratic rule, wealthier countries are far more likely to maintain democratic rule. Poor countries can, however, increase the prospects of democratic endurance if their economies grow steadily, and if they reduce inequalities (Przeworski *et al*, 2000).

The second factor has to do with *political institutions*. Sustainable democracies require a professional civil service and strong, viable and autonomous courts, legislatures, executives and electoral systems at both national and local levels. The 'institutionalisation' of such bodies and processes requires skilled personnel with sufficient resources, developing specialised areas of expertise, and developing and following clear and predictable rules and procedures. As such the rules of democratic governance become standardised and independent of the forces of clientelism, corruption or the whims of the ruling political party.

The third factor has to do with the *attitudes* of rulers and citizens. Put simply, democracies require democrats. Democracy can only be considered consolidated if it has been legitimated. That is, all relevant elites and the overwhelming majority of citizens must see democracy as 'the only game in town' (Linz and Stepan, 1996).

Reaching the appropriate thresholds across each of these factors will be difficult for southern Africa's nascent democracies, even under normal circumstances. However, across each factor, the HIV/AIDS pandemic threatens to make consolidation even more difficult, if not completely unattainable. It may threaten the economic growth that seems so vital to sustaining democracy in low to medium income countries. It may threaten the processes of political institutionalisation that are so vital to young democracies. Finally, the burden of illness and death that the pandemic places on individuals and households may be so great that the value of popular self government pales in comparison to mere survival.

The Economic Impact of HIV/AIDS on Democracy

Declining Growth and Increasing Inequality

Social scientists have been aware of the strong correlation between wealth and democracy ever since the pioneering work of Seymour Martin Lipset (1959: 69-105). The most recent work by Adam Przeworski and his colleagues (2000) has given us the clearest specification of the linkages between economic development and democratic endurance. Wealthy democracies do not die. The wealthiest democracy ever to revert to authoritarian rule was Argentina, in 1974, with a GNP per capita of $6,055. Under that threshold, the death rate of democratic systems increases monotonically as national wealth declines. While those with a GNP per capita between $6,001 and $7,000 have a probability of reversion in any single year of 0.0080 (or an average life expectancy of 125

years), those with a GNP per capita of $1,000 or less have a probability of reversion of 0.1216 (or an average life expectancy of around just 8 years).

Given these findings, none of Southern Africa's multiparty systems could be given a very long 'life expectancy'. Botswana and South Africa are the region's wealthiest countries, yet all other things being equal, their GNP per capita would suggest a democratic life expectancy of just thirty six years. Democracies with Namibia's level of wealth have lasted, on average, just eighteen years. The national wealth of the rest of the region's multiparty systems would on average last just eight years.[3]

National Wealth and Life Expectancies of Continental Southern African Democracies

Country	GNP Per Capita (1999)	Rank (1999)	Probability of Democratic Breakdown	Average Life Expectancy
Botswana South Africa	3240 3160	84 86	0.0278	36.0
Namibia	1890	105	0.0556	18.0
Lesotho Zimbabwe Zambia Tanzania Mozambique Malawi	550 520 320 240 230 190	152 154 176 190 193 199	0.1216	8.2

Source: World Bank. 2001. *World Development Report, 2000/2001: Attacking Poverty.* Washington: Oxford University Press / World Bank; and Przeworksi *et al,* 2000: ch. 2.

Przeworski *et al* (2000) also demonstrate that poor countries can sustain democratic rule if they grow and reduce inequalities, India being the most prominent example. Where per capita income has grown in the previous year, a democracy's probability of extinction in any given year is 0.161 (or 1 in 66), and if growth is 5 percent or higher, the probability of reversal declines even further to 0.0133. The odds fall to just 1 in 135 if a democracy's economy has grown for three or more consecutive years.

[3] In using Przeworki *et al's* results to assess life expectancy of southern Africa's democracies, an important caveat is in order. No country in continental southern Africa would qualify as a democracy under Przeworski *et al's* criteria, which include at least one turnover in government. However, we are proceeding on the basis that had they coded Botswana as a democracy in their data set of countries from 1950 to 1990, the results would have been essentially the same, and thus can be used to assess the life expectancy of regular elections and multi-party competition.

However, the opposite is also true. In the words of Diamond and Linz (1989: 1-58), 'economic crisis represents one of the most common threats to democratic stability'. Where incomes have contracted in the previous year a democracy is three times as likely to break down as one that has grown (0.0512, or 1 in 20), and when incomes have declined for two or more consecutive years, the chances of breakdown are 1 in 13. Of the 39 democratic deaths observed between 1950 and 1990, 28 were accompanied by a fall in per capita income in either one or two of the preceding years (Przeworski *et al*, 2000).

Democracies are more sensitive to economic stagnation and crisis than authoritarian regimes, and poorer democracies are more sensitive than richer ones. Poorer democracies, those with per capita GNP under $2,000, broke down in approximately one out of every ten occasions where incomes had declined in the previous year (12 times of 116 country years). Middle income democracies, those with per capita GNP between $2,000 and $5,000, collapsed approximately one out of every 16 times that incomes declined (17 out of 113 country years). No democracy has ever died where the figure is above $6,055 (Argentina, 1974) (Przeworski *et al*, 2000: 109-111).

None of this bodes well for southern Africa's low to lower middle income democracies. As of 1998-1999, growth was generally low with only one country (Mozambique, 6.6 percent) above the 5 percent threshold. Positive growth rates were also recorded in Malawi (4.4), Tanzania (3.1), Botswana (3.0), Namibia (0.6) and Zambia (0.4), while per capita income declined in Lesotho (-3.0 percent), Zimbabwe (-1.8 percent) and South Africa (-0.9) (World Bank, 2000/2001: 274-275).

Finally, Przeworski *et al* (2000: 120-121) have found that inequality reduction is also an important factor in poorer democracies. While the available data is limited, they found that out of 358 country years where a democracy had a GINI Index below the international mean (.35), there was only one reversal. However, of the 379 occasions where a democracy had a GINI index above .35, five democracies broke down. There is also some evidence that democracies are less stable when the income share of the bottom 40 percent declines.

While data is incomplete, inequality is extremely high in at least three countries in the region: South Africa (59.3), Zimbabwe (56.8) and Lesotho (56.0). But it is still above the international mean in three other countries: Zambia (49.8), Mozambique (39.6) and Tanzania (38.2) (World Bank, 2000/2001: 282-283). Indications are that income inequality is increasing in South Africa, and that income of the bottom two-fifths has declined since 1994 (Whiteford and Van Seventer, 1999: 3 and 11-19).

Again, this is not encouraging news. It becomes even more depressing once one considers that the HIV/AIDS pandemic is widely expected to limit growth, increase inequality and reduce national wealth across the region. Because HIV infection is spread predominantly through sexual activity, AIDS related illness and death occurs disproportionately amongst younger, economically active people. This is expected to reduce household earnings and personal savings, as well as human capital and the size and skills of future work forces. Firms are expected to face higher wage bills due to increased employer contributions to pension, life and medical benefits, as well as higher training and replacement costs. Productivity is expected to decrease due to a decreased skills base, lower worker morale, increased absenteeism and the necessity of constantly replacing skills.

Based on these assumptions, economists project an average reduction in per capita income growth of between 1 and 1.5 percentage points per annum for the entire sub-Saharan sub-continent (Over, 1992: 19). For South Africa, studies forecast declines between 0.2 to 0.3 percentage points until 2005 and between 0.3 and 0.4 points thereafter (Quattek and Fourie, 2000: 21). In cumulative terms, growth would be 0.5 points lower in year two of the projection and 2.6 points lower by year eleven.[4] The impact on overall per capita income, however, is less clear. While AIDS is expected to slow income growth, it will also slow population growth. *If* populations fall faster than national incomes, GDP per capita income may actually *increase* (Nattrass: 2002: 5.)

Economists also expect the pandemic to increase inequality, at least in South Africa. While relatively skilled workers may benefit from greater demand and higher wages for their labour, a larger supply of goods produced for their niche market, and a possibly longer life span due to access to anti-retroviral drugs provided by their firms, the relatively unskilled and unemployed will face declining income, fewer and more expensive goods produced for them, and greater morbidity and mortality. While total GDP shrinks, the skilled may enjoy an increasing share (Nattrass: 2002: 1).

However, these are all *projections* based more on *assumptions* about how people, firms and governments will react to HIV/AIDS than actual evidence. Nicoli Nattrass has demonstrated how projections may vary in important ways depending upon the assumptions underlying the model. Take for example, assumptions about the how the costs of HIV infections affect firms' decisions on investment, projection, pricing and hiring. The costs of anti-retrovirals has

[4] Parker *et al* (1995: 17) note a recent trend toward cautious optimism, however, citing cross national studies that find no evidence of slower growth in economies where HIV/AIDS is advanced. Indeed, modeling the impacts of HIV/AIDS is so difficult because the disease is so different from other epidemics (1995: 10-12).

plummeted so much that firms may soon be able to share costs with workers and provide access to medication, at least to their highly skilled personnel. If this happens, existing models will have over-estimated effects on the workforce. At an even more fundamental level, economist have assumed that firms have the necessary basic information to calculate the labour costs of AIDS and its impact on their profits, and that they do in fact perform such calculations. However, recent research in South Africa suggests that firms either have not collected or used existing information and thus have only the vaguest sense of indirect costs. Moreover, direct costs may comprise less than 5 percent of the total wage bill, mostly because most firms provide so few pension and medical benefits to unskilled workers in the first place, but also because many employees choose to leave their jobs once they discover they are HIV positive (Nattrass, 2002: 6-21; Kennedy, 2002). In fact, a DFID sponsored survey of South African firms found that most firms expected either a moderate (53 percent) or little or no (38 percent) impact on their business (Beresford, 2002: 13).

Nattrass (2002: 6-12) notes that existing projections also fail to 'trace through' the 'second order' impacts that occur after people, firms and governments respond to the 'first order' impact of AIDS on things like consumption, investment, savings and the size of the labour force. These are things that we simply do not know, but need to find out. Will firms respond to higher medical costs by replacing workers with machines, raising costs, reduce profits or share costs with workers? Will governments increase health spending, and if so will it come at expense of other items, and if so which ones? Will they finance this through increased taxes or increased borrowing? While these are necessarily future-oriented questions, almost certainly there is enough evidence provided by current and recent behaviour across the region to provide firmer guidance as to what is likely to happen in the future. The fact that the pandemic has a different age, severity and curve in each country across the region, and even in differing provinces and regions within countries, provides fertile ground for cross-sectional and some limited longitudinal research.

Alex de Waal (2002) observes that existing models are also linear, in that they model the particular economic impacts of a range of factors and then sum them. However, he argues that we need to understand development as a *process*, modeling the interactions amongst these effects, as well as second order reactions to first order effects. Dynamics may accelerate if they reach critical thresholds or co-occur in specific combinations. This may prove to be more difficult to assess, at least at present, since the pandemic is still so young. However, it does shift our attention to longitudinal analysis in countries such as Zambia and Zimbabwe where the disease is oldest.

Perhaps more fundamentally, de Waal (2002) notes that no models attempt to forecast the way in which sharply decreased adult longevity may reshape economic rationality and thus the decisions of firms, households and individuals. Virtually all economics, rooted firmly in the logic of developed economies, is based on the principle that individuals rationally consider future expectations, which in many ways is based on one's anticipated life span. He argues that over the past century, most people in developed societies – once they have reached their teens -- have been able to expect to live into their 70s. But under conditions of a highly uncertain adult life span, the rationale to invest time and resources in one's own education or training, or to save and invest becomes questionable. As de Waal puts it (2002: 9): 'Why save for a future that does not exist?' 'Just as a doubling of longevity would entail major structural transformations of developed economies, a halving of adult lifespan in much of sub-Saharan entails a structural change in the region's economies that make it impossible for it to follow existing models for economic development.'. In contrast to the assumptions of *homo economicus*, people's emphasis turns to spending and consuming, to liquidating assets to pay for health care, but also to enjoy one's short life span.

If true, this would seem to have fundamentally important implications, not only for micro-economic behaviour but also for citizenship behaviour, as we discuss below. We may be able to begin to assess the relationship of adult longevity and individual behaviour in a few different ways. We could use cross-national survey data, such as the Afrobarometer or the World Values Study, to assess the link between individual attitudes and behaviour and national rates of life expectancy. But we can imagine innovative scholars also approaching this question through imaginative experimental designs that observe subjects' behaviour under different life-prospect scenarios.

Budgets and Taxes: Increased Demands and Decreased Supply

Existing levels of HIV infection mean that southern African societies will experience drastically increased levels of severe illness, increasing demands for access to government clinics, medical stocks, and available hospital beds and threatening to push the region's limited public health systems to, and past their limits. And as governments increase health spending to catch up with the increasing demand for medicine and hospital beds, as they struggle to replace dying nurses and doctors from an increasingly scarce labour pool, and as they attempt to alleviate the burden of families caring for orphans, public spending

on HIV/AIDS related matters threatens to consume the entire health budget and/or increase the overall national budget.

Evidence, albeit often anecdotal and episodic, is beginning to accumulate that suggests these impacts are already occurring. In South Africa, recent government reports have admitted that substantial increases in AIDS patients are steadily displacing other patients (Ensor, 2001a: 4). In its industrial heartland, Gauteng province, Soweto's Chris Hani Baragwanath Hospital, the country's largest, has seen a 500 percent increase in HIV patients since 1996. One half of all beds in the province's public hospitals are occupied by AIDS patients (Cheek, 2001: 22). The country's health system is unable to meet these increased demands. A 2002 survey of AIDS affected households in four South African provinces found that between 40 to 60 percent of people living with AIDS had never been admitted to a hospital (Beresford, 2002: 8). Just sixteen percent of households were able to obtain a state grant, even though they were eligible (Clarke, 2002: 4). Current government estimates see the number of orphans rising from the current 150,000 to 2,000,000 by 2010, far outstripping the existing welfare system (Business Day, 10 Oct. 2001:12).

While much of this is certainly a problem of institutional capacity, we focus here on what these demands entail for national budgets in the region's multi-party systems. Economic policy makers will come under increasing pressure to allocate larger and larger shares of the national budget to public health and welfare for AIDS orphans and the families or institutions that care for them. Significant shifts have already occurred. By 1997, public health spending on AIDS exceeded 2.5 percent of GDP in seven of 16 sampled African countries, an extremely high proportion since total health spending accounted for only 3 to 5 percent of GDP in these same countries (Heinecken, 2001: 10; Cheek, 2001: 10). As of 1998, 12 percent of South Africa's national budget went to health, but 21 percent of provincial budgets went specifically to HIV/AIDS spending (Budget Watch, November 2002a: 8; 2002b: 2). The total proportion of the South African government's budget devoted to AIDS will increase by 22 percent (1.4 billion to 1.8 billion) just between 2003 and 2004 (HEARD *et al*, 2002). Yet recent government reports admit that even with current levels of real growth in future health budgets the system would not be able to keep pace with increased demand for services (Ensor, 2001a: 4).

Zambia's AIDS spending rose from $1.7 million in 1990 to $12.9 by 1995, and is expected to rise to $21 million by 2005 (Cheek, 2001: 22). Zimbabwe currently spends almost half of its health budget on treating AIDS patients (Heinecken, 2001:10), a figure expected to rise to almost two-thirds by 2005 (Cheek, 2001:21). In Malawi, senior government health officials have publicly

worried that one half of their health budget would soon have to be devoted to treating AIDS patients.[5]

Regardless of whether or not they decide to go down the path of providing drugs that reduce mother to child transmission, or anti-retroviral therapies, all countries with any form of public health system will be ultimately forced to confront these costs. As Nattrass and Skordis (2001:2) conclude from their costing of mother to child transmission drugs in South Africa, 'unless the government is planning to deny hospital care to children with HIV/AIDS (which would be unconstitutional in South Africa), it costs the government more to let the children contract HIV from their mothers, get sick and die, than it does to save them'.

While relatively wealthier countries like South Africa or Botswana may be able to redistribute expenditures between budget sectors, or embark upon limited, disciplined deficit spending, the poorest countries in the region will be forced to increase their dependence on foreign assistance. International donors already account for approximately two thirds of HIV/AIDS budgets in low and middle income countries across the world, largely through overseas development assistance. As of 1996-97, sub-Saharan African governments were contributing an average of just 9 percent of all HIV/AIDS spending in their countries. Even in South Africa, which is much more able to support its own efforts, a 2000 Futures Group International study found that it still received around one half of its total HIV/AIDS funding from external sources (Budget Watch, 2002b: 2, 4).

This will mean a sharply increased demand on the international community. Zimbabwe's foreign assistance needs in the next few years have reportedly already increased by 27 percent due to AIDS (Bollinger et al, cited in Youde, 2001:26). Such increased demand for donor assistance in health may crowd out other development assistance funds that countries badly need (Youde, 2001: 27). If widely known, such dependence on donor funding may also reduce the recipient government's popular legitimacy because of the conditions with which donor funds usually come. The current controversy over the UNAIDS Fund grant to the South African province of KwaZulu-Natal illustrates some of the potential complications this reliance can generate.

At the same time that the HIV/AIDS pandemic results in growing public demands for increases in public health expenditures, rising levels of death and severe illness will reduce the tax base from which governments finance their budgets. HIV/AIDS has a disproportionate impact on the most productive part

[5] Grace Hiwa, Malawi Ministry of Health, cited in Cheek, 2001: 22.

of the labour force, which then reduces the numbers of those most able to contribute to the national treasury through payroll taxes.

How will government pay for such increased budgetary allocations in the face of decreasing tax bases? If they choose deficit financing, they will crowd out the private investment that could otherwise increase employment and growth. If they choose expenditure switching, they will crowd out the government investment in infrastructure or development programmes (e.g. housing, education or land redistribution) that might otherwise help reduce inequality and build public confidence in democratic government.

Again, we are left with much more conjecture and anecdote than real evidence. In order to understand the ability of governments across the region to meet these challenges we need far more systematic macro-level, cross-national research on national budgets and the proportions allocated to health in general, and HIV/AIDS in particular, as well as the additional amounts contributed by foreign donors. Again, given the variation in the age, scope and speed of the disease across the region, a cross-sectional analysis would enable some basic tests of propositions about how and whether budgets respond to the actual pandemic, or to other institutional and political factors. Over time analysis of budgetary trends throughout the 1990s might provide us with useful guidance to how they are likely to respond in the future as the pandemic proceeds.

Political scientists and economists could contribute through intensive, country-specific research into the political, economic and ideological constraints imposing on national governments. Do they have the will, predisposition and political space to expand their budgets to fight the disease? Is there room for increased taxation on surviving taxpayers? Is their any possibility of improving tax collection systems to enhance national revenue? Can we simply assume that a rise of X percent in sick people will result in more health spending? Is national spending on health care more determined by levels of wealth and government allocation than any real need? Can survey research help us understand whether it actually matters that countries come to depend increasingly on foreign donor assistance? Do people really care, especially if the funds are used for the purpose of fighting AIDS?

The Institutional Impacts of HIV/AIDS on Democracy

Democracy, above all, is a system of rules and procedures by which free and equal people elect representatives to make decisions for them, and a system of

rules and procedures by which those representatives make those decisions. A consolidated democracy is one in which these rules are widely known and predictable – where the processes of democratic governance become a matter of habit.

These rules are given effect through political institutions, such as legislatures, executives, courts and regulatory and security agencies, that both embody and enforce these rules. To work effectively, these institutions require people with sufficient skills, expertise and resources to develop sufficient political autonomy and power to fulfil their functions, whether it is to make laws, oversee the executives, prosecute criminals, or deliver public services impartially. In this sense, the development of a strong and effective state is a necessary, though certainly not sufficient, condition for the consolidation of democracy.

There is little reason to believe that state employees across southern Africa are any more immune to HIV infection than the rest of the population. While the greatest number of infections and deaths are projected to occur in the unskilled and semi-skilled part of the workforce, skilled and highly skilled sectors will be hit heavily. In South Africa, HIV infection rates have been projected to peak at 23 percent of skilled and 13 percent of highly skilled workers by 2005. This would result, by 2015, in a skilled work force that is 18 percent smaller, and a highly skilled force that is 11 percent smaller (Quatteck and Fourie, 2000: 1, 7, 10). Thus, the pandemic is likely to devastate large portions of policy-makers, national legislators, local councillors, election officials, soldiers and civil servants, including doctors, nurses, teachers, ambulance drivers, fire-fighters and police. Internal South African government reports have concluded that AIDS will become the leading cause of death among public servants by 2002, totalling to as many as 250,000 deaths in the public service by 2012, or 23 percent of a current workforce of 1,100,000 (Youde, 2001: 19; Business Day, 2001a).

According to newspaper reports, at senior political levels South Africa has already lost to the disease one senior presidential advisor, a sitting cabinet minister, and an influential legislative back-bencher in the ruling party, and Zimbabwe is believed to have lost at least three cabinet ministers to AIDS in the recent past (Youde, 2001: 8). However, some of the first systematic research has been done at the local council level by Ryann Manning (2003 forthcoming) who analysed the Durban Metropolitan Council's records over a 21 month period and found sharp increases in the extent of Councillor absenteeism due to illness (from less than one in the first half of 2001 to over four in mid 2002) as well as in the proportion of total absenteeism due to illness (from less than 5 percent in the first half of 2001 to 37 percent in late 2002). She also found a 32 percent turnover in personnel in the previous six months in its Parks, Recreation

and Culture department, while the Electricity department estimated that for the past two years, they had four to five employee deaths and two medical boardings per month, double their previous rates.

However, besides causing the deaths of increasing numbers of public servants and elected officials, the pandemic could severely damage the process of political institutionalisation in several ways. First, increasingly smaller proportions of civil servants, policy makers and legislators will be at their jobs long enough to develop the specialised skills, expertise and professionalism needed to do these jobs. Second, it will be increasingly difficult for legislatures, ministries and agencies to pass on the skills that they do have. There will be fewer experienced officials available to train younger personnel in key formal skills (such as programme design, budgeting, cost/benefit analysis, monitoring and evaluation, or personnel management), or pass on more informal standard operating procedures or norms such as ministerial accountability, bureaucratic neutrality, or official ethics. It will also be difficult for managers to generalise from existing ante-natal clinic prevalence data to their own departments to anticipate future hiring and training requirements (Manning 2003 forthcoming). Identifying training needs and grooming replacements is likely to be made even more difficult by the stigma of AIDS which means that civil servants may leave work and die with little warning.

In South Africa, recent government reviews have concluded that the country is not training enough nurses and teachers to cope with current demand, and pointed to similar problems looming in the police and justice system (Ensor, 2001b: 1). In Zambia and Malawi, deaths among doctors and nurses have exceeded the rate at which replacements can be trained (Cheek, 2001:22). Again, however, besides newspaper reports, there is little in the way of serious systematic evidence on these questions. Manning (2003 forthcoming) found in her Durban research with fire department managers that while it takes three months to train a fire fighter (and Durban officials note that their training section is already severely understaffed), it takes years to create one with enough skills to pass knowledge onto younger members through informal training. When asked about their ability to coordinate and plan the recruitment and planning or replacements, several city managers related stories of processing applications for medical boarding on a Friday only to find out on Monday that the person had died over the weekend.

Third, where civil servants do endeavour to deliver public services according to rational principles of need or merit, the rapidly changing demographic impacts of the HIV/AIDS pandemic on the citizenry may make it increasingly difficult to anticipate demand accurately and plan the types, amounts and locations of services to be supplied. National and local governments may invest in services

that end up under utilised because of an unanticipated fall in demand, or they may face unanticipated demands because their ability to supply has fallen faster than the decline in the overall population (Manning, 2003 forthcoming).

Manning (2003 forthcoming) found that Durban's municipal housing program managers admitted that they had little knowledge about how HIV/AIDS would affect patterns of household formation. South Africa awards subsidies to households, not individuals. Thus, even if they could make a relatively accurate projection of decreases in eligible individuals, it would be difficult to know whether the number of households would actually decrease or not. The pandemic may reduce demand for housing if splintered families combine into new households; but it may also increase demand it families splinter and scatter into new, smaller households, or if the spurs increased urban migration. The housing department estimates that approximately 20 percent of awarded deeds are in the names of people who have either already died or simply disappeared. The likely increase in orphans also places new challenges on housing planners who must find new ways to increase the capability of communities to absorb these children.

All this is even more worrying since the region's nascent democracies are not known for strong political institutions. The dominant view of political institutions across the region, and indeed most of sub-Saharan Africa is one of neo-patrimonialism whereby 'strong man' political leaders manipulate patronage, region and ethnicity to gain and hold political loyalty. Patronage relationships shape the behaviour of legislators and civil servants as much as any legal-rational principles of a bureaucratic state (Bratton and Van de Walle, 1997). A civil service characterised by a high degree of turnover and increasing proportions of inexperienced personnel will be even less likely to develop and enforce institutional boundaries and autonomy, and more likely to succumb to the short term patronage or corruption payoffs of neo-patrimonial executive branch and party officials or business people.

While the pandemic will affect all state institutions, there are two that are intrinsically important for the development of young democracies. The first is the set of institutions responsible for organising and conducting regular free and fair election, the irreducible minimum of democratic government. The loss of non-partisan supervisory officials, combined with the complicated voter registration procedures of southern Africa's multi party systems may increase opportunities for voter fraud. This will necessitate more frequent vetting of voter rolls, otherwise rapidly increasing death rates may increase opportunities for governments to utilise hundreds of thousands of 'ghost voters' to inflate vote totals. Increasing proportions of ill voters may also necessitate more, or more

strategically located polling places, or greater use of absentee ballots to enable the ill to vote (Costarelli, n.d.: 8-10).

Thus, better electoral administration skills may become more necessary at precisely the same time that electoral commissions begin to lose skilled personnel. Moreover, the funds necessary to register persons maintain voter rolls and hold free and fair elections may also be crowded out by the increased shares of national budgets going to health care or anti-HIV/AIDS programmes (Youde, 2001: 10, 11-20). All of these prospects threaten to damage popular perceptions of the impartiality of elections.

Countries with specific types of electoral systems may come under additional pressures. Increased deaths among MPs and local councillors in constituency systems will increase the number of by-elections that are necessary. A steady flow of by-elections may increase government sensitivity to shifts in public opinion, but may also be financially unsustainable. Countries may be forced to abandon constituency representation for party list proportional representation. While the list provides for swift and cheap replacement of sick or dead legislators it also removes a fundamental linkage between governors and the governed.

The second set of key democratic institutions is national, regional and local legislative bodies, the *sine qua non* of representative democracy. Legislatures best represent constituent views when they develop institutional autonomy *vis a vis* the executive. This is usually achieved through the development of a seniority system that encourages the accumulation of skills in the use of legislative procedures and rules, as well as substantive specialisation and expertise in specific policy areas to enable informed oversight of executive policy. Such skills help create stronger portfolio committees. This applies both to elected members as well as researchers, administrative assistants and clerks. Rapid membership turnover due to AIDS illness and death, however, threatens these processes.

We simply need much more research to find out the actual rate of public service personnel loss and whether it differs across countries, institutions and level of skill. Intra-institutional research is needed to assess the degree to which personnel loss is affecting aspects of institutionalisations such as overall skill levels, training capacity, seniority, role differentiation and autonomy.

In terms of service delivery, we need to know to what extent the loss of personnel and skills actually diminishes delivery capacity, and even if it does, whether that loss is simply matched by diminished demands caused by smaller populations. Education, where more systematic work has recently been done,

offers a good example of the caution we should exercise before we make sweeping statements. While a great deal of attention has focused on a possible education crisis caused by high infection rates amongst teachers in places like Botswana, Zimbabwe, Zambia and South Africa (United Nations Integrated Regional Information Network, 2001; and Whitelaw, 2000. In Youde, 2001: 36, 37), analysts have often neglected to factor in the reduced demand produced by fewer students, which may simply cancel out the effects of teacher mortality (World Bank, 2000. In Bennell *et al*, 2002: Ch. 6). Earlier assumptions have not been born out that, as relatively well-paid professionals often on assignment in remote areas, teachers were especially prone to infection. In fact, evidence from a study of schools in Botswana, Malawi and Uganda has found that more poorly paid primary school teachers are more likely to die than much better paid secondary teachers (mortality rates also differed according to gender, marital status and whether they lived in urban or rural areas (Bennell et al, 2002: xii and ch.6). Their latest evidence seems to suggest that if it ever did exist, the positive relationship of socio-economic status and HIV prevalence has disappeared. If anything, teachers are a relatively low-risk occupation group in Sub-Saharan Africa. In addition, teacher turnover is already so high in many countries due to low pay and morale that AIDS mortality will not present a serious threat.

Cultural Impacts Of HIV/AIDS On Democracy

Democracies require democrats. They require citizens who believe democracy is preferable to all alternatives, and who give life to the democratic processes by obeying the law, participating in democratic life, refraining from supporting elites who would endanger or end democratic processes, and who are willing to stand up and defend democracy if it were under threat (Mattes and Thiel, 1998).

As noted earlier, democracy as a political regime uniquely recognises and is designed to maximise human agency. But the unique combination of HIV/AIDS' characteristics attacks this sense of human agency. First, because it disproportionately affects large numbers of those in the younger age cohorts, it results in a drastically reduced adult life span for those people. Second, the combination of its scope and its incubation period means that at any given moment, a large proportion of society will be living under a death sentence. Third, the length of the incubation period means that many of these people will live under this sentence for a particularly prolonged period.

Fourth, at least in southern Africa, HIV infection and the onset of AIDS illness imposes significant economic burdens on individuals and their households in the form of increased medical costs, the prospect of losing wage earners, as well as

the prospects of significant burial costs.[6] And fifth, given that few people can be confident about the HIV status of current or prospective sexual partners, the uninfected are also likely to experience a sense of helplessness and lack of control over their future. For example, where national prevalence is 15 percent and this rate applies throughout one's lifetime, more than one half of today's 15 year olds will die from AIDS (Fourie and Shonteich, 2001: 31). Given the lack of any clear, positive message of hope to uninfected people in those age groups about how they can confidently avoid infection over an extended period of time, a large number of teenagers and young adults may conclude that they have little hope of avoiding this death sentence themselves.

Akin to De Waal's arguments (2002) about the need to revise traditional assumptions about *homo economicus*, we also need to consider what such a sharp reduction in adult life expectancy means for our assumptions about the behaviour of *homo politicus*. It is likely to recalibrate the context of citizens' rational decision making, in particular reducing the incentives for cooperative behaviour and increasing incentives for opportunistic behaviour. Thus, the pandemic not only damages the human body, but may also 'damage' the 'body politic' (Whiteside and FitzSimmons, 1992: 26). This is likely to have several different important political results.

Decreased Citizen Support for Democratic Government

At its most extreme, HIV/AIDS may turn citizens into authoritarians because mounting death and sickness makes them so desperate as to try *any* set of political entrepreneurs who promise to offer a solution, whether they use democratic means or not. These could be alternative political or religious movements who seek to place the blame for the pandemic on personal immorality, religious transgressions, minority groups, or external forces (De Waal, 2002). This level of desperation could become even more likely if the region's democratic governments are widely perceived to be incapable of preventing the pandemic from growing, caring for its victims or preventing a sharp deterioration in quality of life (Brower and Chalk, 2002: 6; Youde, 2001:5).

[6] In South Africa, average household expenditure on health is approximately 4 percent of total income, but a survey of 771 AIDS affected households in four provinces found that they were spending on average a third of their income on health care, rising to over half of all income in rural households. Half of the families had paid for a funeral in the previous twelve months, usually consuming more than three months income. The vast majority of households were poverty stricken with an average household income of under R1000 per month. Two thirds reported that they had lost some income due to AIDS. See Beresford, 2002b; 2002c and Clarke, 2002.

More likely, the pandemic may reduce the importance which people attach to democracy simply because of the competition of more urgent priorities such as simple survival. The degree to which the question of democratic versus authoritarian government matters to someone infected with a fatal disease, or whose life is burdened with caring for such people, or who believes they have little prospect of avoiding infection, is an open question.

Decreased Citizen Participation in Democratic Government

HIV/AIDS may also directly reduce overall levels of public participation in democratic politics. Obviously, mounting AIDS deaths and illness will reduce the absolute number of citizens able to vote or participate in public life. But again, the question becomes whether the death sentence imposed on the infected, or the threat of infection facing the uninfected, reshapes traditional incentives to become involved in public affairs. Moreover, the burden of caring for ill family members or friends is likely to reduce those people's time and resources available to participate. To take just one example, many countries in the region require people to make multiple efforts to obtain multiple forms of identification to register to vote, which places both the ill and those caring for them at a severe disadvantage (Youde, 2001: 10, 11-20). [7]

However, it is also possible that some types of counter trends could occur. As medical research brings down the costs of anti-AIDS medication, or nears an AIDS vaccine, the infected and their loved ones might be galvanised into a strong and active constituency who participate to demand that their governments devote increasing effort and budgets to making these drugs widely available. Though it is composed of a relatively small number of activists, South Africa's Treatment Action Campaign may be one such example of a broader type of social movement that could develop in the future.

A Damaged Civil Society

The level of public participation in any democracy is not determined solely by the choices of ordinary citizens. Mass participation in the political system is also facilitated by civil society organisations and interest groups who mobilise, channel and structure public participation between elections. Civil society

[7] For a discussion of ways to empower HIV-affected people to vote, see Costarelli, n.d..

across southern Africa is already quite weak. However, the types of people who form the backbone of most civil society organisations may be especially susceptible to HIV infection: while they tend to be better educated, they also tend to be younger, more mobile, and often spend time away from their home offices to do extension work. Many organisations may be very vulnerable to the disease since each lost staff member may have unique skills that took many years to develop. HEARD estimates that a medium to large civil society organisation with thirty staff and eighty volunteers, based in South Africa's Kwa Zulu/Natal province, will lose 1 to 2 employees and 1 to 2 volunteers annually to AIDS by 2009 or 2010, increasing to nineteen staff and twenty two volunteers by 2021. This would mean, by 2009, losing 158 days of staff time and 212 days of volunteer time annually due to AIDS related illness (Manning, 2002: 14-26, 29). Thus, the pandemic may indirectly reduce overall levels of public participation in democratic processes by further damaging the capacity of civil society organizations. The loss of long term staff members or volunteers is likely to be particularly devastating because, as stated by the Director of a KwaZulu-Natal democracy promotion organisation, they have experience that is vital to understand the culture, traditions and dynamics of the communities where they work, and have built up mutual trust and understanding with communities, churches and traditional leaders, relationships that are the very strength of these organisations (Manning, 2002:16).

At the societal level, an analysis of Afrobarometer surveys of representative samples in seven southern African countries found that those countries with the highest measured levels of severe illness (due to any cause) also have the lowest overall levels of attendance in local community meetings and participation in local service and welfare groups. Because this relationship persists even after controlling for levels of poverty, this may be due to the fact that AIDS has already killed critical proportions of those who do things such as organise and drive community meetings or local welfare groups (Whiteside *et al,* 2002: 36-37). At the organisational level, a HEARD survey of 59 KwaZulu-Natal civil society organisations found that three quarters reported some form of AIDS-related impact on their organisations. One third of the Durban-based organisations noted increases in absenteeism or loss of staff members to HIV/AIDS (Manning, 2002: 1, 10-11).

The 'Uncivil' Society

Finally, the pandemic may have important effects on the 'civility' of society, decreasing popular compliance with the law, and increasing violent protest, social intolerance and criminal activity. Those individuals or households who suffer and AIDS illness, or have already lost a wage earner to severe illness or

death, will simply be less able to pay local taxes or rates, or for public services such as electricity or user fees for schools or health clinics. However, HIV infection or AIDS illness may reduce or totally remove any incentive to do so, especially if payment is only required after a services has been provided rather than before. In contrast, the incentive would appear to dictate getting whatever you can for as little money as possible. As De Waal (2002:8) notes: 'Those who feel they have nothing to lose cannot be deterred by a judicial system that imposes custodial sentences, or even the death sentence'.

Game theory has demonstrated the importance of an uncertain end to any game in order to maintain incentives for cooperation. However, incentives for 'defection' or uncooperative behaviour increase once players can see the end of a game on the horizon (Axelrod, 1984). The seven country Afrobarometer study of survey responses across southern Africa also found that societies with the lowest levels of severe illness also tended to have the lowest numbers of citizens who say they would avoid citizenship duties such as paying rates or taxes for services (Whiteside *et al*, 2002: 36).

People infected with HIV and ill with AIDS also tend to be lonely and depressed. Such conditions often lead to hopelessness and apathy, but they may as likely lead to frustration and aggression, which could turn into non-compliance or even political violence (Schell, 2000: 19-20; Gurr, 1970). One potential factor that may aggravate and inflame such simmering frustrations is the fact that falling prices of some anti-retroviral drugs may place firms, and eventually governments, in the position of deciding who does and who does not receive life-prolonging drugs. The crucial period will occur *after* it becomes affordable to provide anti-retrovirals to some employees, but *before* it becomes possible to provide them for all. During this period firms will have an incentive to begin to provide limited drug therapy and to target their most highly skilled workers. This is likely to reinforce class divisions and inequalities between middle class and everyone else if done widely enough, and for a prolonged period (Nattrass, 2002: 1). Even if firms are able to afford universal coverage, in the context of high levels of unemployment, this will still increase inequality and fuel class-based conflict between those with a decent job and those who either work in the informal sector or are jobless.

Increasing private sector provision may eventually increase pressure on governments across the region to provide therapy to public sector employees (De Waal, 2002) and citizens not already covered by their employers. Governments will also confront decisions, at least initially, about where to target drug therapy. As with firms, governments may be tempted to use skills and education as criteria of eligibility for treatment in order to protect their investments in training and education. Alternately, governments may be tempted

to prioritise cronies and or supporters. While these possibilities may seem stretched, we have already witnessed the ability of Zimbabwe's Mugabe government to manipulate the distribution of food aid to favour its political supporters. We also know that Zambia already screens applicants for management positions in its mines for HIV, and Botswana restricts its prestigious study-abroad scholarships to those who are HIV-negative (Cheek, 2001: 24-25).

Whether or not government decisions are based on political expedience, fertile ground for the perception that such decisions are so based is provided by the fact that South Africa's highest HIV rates are located in KwaZulu-Natal, political heartland of the opposition Inkatha Freedom Party, or that Zimbabwe's non-Shona population suffer higher infection rates and have less adequate heath care than the Shona, or that Namibia's Herero and Damara have less access to government resources and health care. Even with the best of intentions, the distribution and infrastructure problems of existing health care systems may privilege certain groups and areas. For example, just one out of every twelve pregnant Batswana women are actually receiving mother-to-child-transmission treatment, most of these living in urban areas (Cheek, 2001: 24-27). In any case, political decisions around AIDS treatment hold the potential to give rise to tensions and political conflict between workers and unemployed, both urban and rural, and between different ethnic groups.

Another dimension of 'uncivility' may arise in the form of increased public intolerance amongst the uninfected through scapegoating of stereotyped 'high risk' groups such as homosexuals, truck drivers, orphans, sex workers, miners or released prisoners. We know that South Africans, for example, already demonstrate high levels of predisposition to partake in intolerant behaviours against disliked social groups, political tendencies, and foreigners (Gibson and Gouws, 2002; Mattes et al, 1999).[8] Given the fears created by the epidemic, governments may come under increasing popular pressure to deny political and economic rights to these groups. Or, local groups may simply take it upon themselves using terror and intimidation to force these people out of their schools and communities.

One tenth of AIDS-affected households in South Africa told interviewers in a 2002 survey that they had faced hostility or rejection from their community. Many specifically complained about the attitudes of health care workers: some reported being chased away, refused help, or confronted with uncaring attitudes (Beresford, 2002b: 8; 2002c: 8). On the other hand, a three country study of 41

[8] For South Africans' attitudes toward ordinary and skilled immigrants, see Mattes, Taylor, McDonald, Poore and Richmond, 2000: 196-218; and Mattes, Crush and Richmond, 2000: 21-30.

schools in Botswana, Malawi and Uganda found that while AIDS orphans were subject to insensitive treatment by teachers and administrators at school, instances of deliberate discrimination were quite rare (Bennell *et al*, 2002: xi).

Finally, besides increasing the incentives for non-compliance, many analysts worry that HIV/AIDS will also contribute to lawlessness by orphaning large numbers of children across the region over the next two decades. Without AIDS, orphans comprise an average of 2 percent of all children aged 15 and under in developing countries (Fourie and Shonteich, 2001: 38 fn. 42). Thus, sub-Saharan and southern Africa already have very high numbers of orphans (6.4 million), usually as a result of political conflict. According to UNICEF, orphans exceed 20 percent of the under 15 population in Congo, Malawi, Rwanda, Uganda, Zambia and Zimbabwe. As of 1999, they estimated that just under one third of all orphans in the sub-continent were AIDS orphans ((Hunter and Williamson, 2000. In Bennell *et al*, 2002: 48). In southern Africa, specifically, USAID places the total number of maternal or double orphans, as of 2000, at 2.9 million, or 8 percent of all children 15 and under. They estimate that 65 percent were AIDS orphans (Fourie and Shonteich, 2001). A recent study of 1400 students from schools in high prevalence districts in Botswana, Malawi and Uganda found 8 and 6 percent of attending students in Botswana secondary and primary schools respectively who were either maternal or double orphans, and 19 and 16 percent in Malawi (figures for paternal orphans were even higher) (Bennell *et al*, 2002: 50).

UNICEF projects the total number of maternal and double AIDS orphans to increase from 6.4 to 14.4 million across sub-Saharan Africa between 1999 and 2010, with particularly sharp increases in Botswana, Central African Republic, Lesotho, Mozambique, Namibia, South Africa, Swaziland and Zimbabwe, amounting to around 30 to 40 percent of all children (Bennell *et al*, 2002: 66,68). In southern Africa, USAID expects the total number of orphans to increase to 5.5 million by 2010, by then accounting for 16 percent of all children 15 and under, of which 87 percent will attributable to AIDS (Fourie and Shonteich, 2001: 38 fn. 42). In South Africa, a Medical Research Council report estimates that one third of children born in 2002 will be orphaned by 2015, with a total of around 1.85 million orphans under 15 and 3 million under 18 (Smetherham, 2002).

All orphans suffer the trauma of losing parents, and of higher levels of impoverishment, exclusion and abuse. The education of orphaned children is often one of the first casualties if extended families suffer losses of income (Fourie and Shonteich, 2001: 38 fn. 47). Demographic and Health Surveys from 15 sub-Saharan African countries in the 1990s found that ‘out of school’ rates of orphans aged 10 to 14 were on average 19 percentage points higher than non-

orphans (UNICEF, 2000. In Bennell et al, 2002: 58). The Botswana, Malawi, Uganda study of schools in high prevalence districts found that orphans, especially double orphans, were considerably more likely to interrupt their schooling at some point than other children (Bennell et al, 2002: 59).

AIDS orphans may suffer even higher levels of trauma as a result of watching parents endure prolonged, often painful periods of illness and depression prior to death. Social stigmatisation may further increase these higher levels of discrimination and maltreatment (Fourie and Shonteich, 2001: 39, fn's 51-52).

All of this may lead to exceptionally high levels of crime and other anti-social behaviours over the next two decades as this increasing and disproportionately large share of children move through the 15 to 24 age range, the years of greatest propensity to commit crime, and do so with little or no adult guidance (Shonteich, 1999). British and South African studies of children or young adults who have committed violent crimes have found unusually large proportions of them who have been orphaned, abandoned or rejected by parents or guardians (Fourie and Shonteich, 2001: 40, fn's. 55-56).

However, we need to be careful. Southern Africa already possesses an abnormally high proportion of orphans, or children who do not live with both parents. The Botswana, Malawi and Uganda schools survey has yielded several findings that do not conform to the typical expectations. In Botswana primary schools, for example, orphans have lower rates of absenteeism than non-orphans. In poorer societies in Malawi and Uganda, absenteeism is already very high amongst all children, though it is slightly higher amongst orphans. There is no evidence that orphans are any sicklier, or 'needed at home' more often than other children, neither is there any evidence that they are more likely to repeat a grade (Bennell *et al*, 2002: ch. 4). In fact, the economic impacts of AIDS may be so great that they simply affect all children, rather than orphans in particular. A survey of 771 AIDS-affected households in four South African provinces found that pressures of losing income have forced families to liquidate their investments in the future, especially the education of their children. Approximately one child out of ten was out of school either because of cost or needed labour at home (Beresford, 2002b). Again, this cautions against making sweeping generalisations about orphans, and reminds us of the need to examine such mitigating factors as overall levels of poverty, the cost of school fees, the presence of school feeding schemes, and the extent to which national cultures value children and education (Bennell et al, 2002: ch.4).

Thus, what we have is more informed speculation and proposition rather than evidence. Psychologists can make an important contribution with basic

experimental research examining the impacts of changing levels of adult life expectancy on human agency and predispositions to cooperative behaviour.

Cross-national or even national or sub-national surveys with sufficient cross-sectional variance in terms of the extent of the pandemic are needed to test more vigorously whether those individuals who are infected with, or affected by HIV/AIDS are any different with respect to their commitment to democracy, trust in government, or satisfaction with the output of government. Do they exhibit lower rates of participation or predispositions to participate? To what extent do people attach importance to the sustenance of democracy as compared to the need to fight HIV/AIDS? Does this differ according to individual or societal levels of HIV infection or AIDS impact? Are infected or affected persons, or those living in highly infected or affected societies, any less likely to obey the law? How do the uninfected really feel about the infected and the sick? Do they see them as social deviants? Do they blame their condition on their moral flaws? Are they willing to extend them civil and political rights? What do people want firms and government to do with regard to anti-retroviral and anti-mother-to-child-transmission drugs? Do egalitarian values dictate that their distribution must wait until all eligible people can be provided, or are they willing to tolerate a targeted and staged roll out? And if so, what criteria do people think should be used to determine who gets these drugs first? While it may be possible to address some of these questions with existing data sets, a specialised regional survey on HIV/AIDS and its possible impacts would be extremely valuable. However, where individual level data does not exist, innovative research designs using aggregate data might be able to test whether national, or intra-national provincial or district differences in voter turnout, tax compliance, or crime rates correlate in any way with HIV infection rates?

We also lack any kind of systematic picture of how HIV/AIDS is affecting civil society organisations. Either through specially designed surveys of a sample of such organisation, or through the inclusion of new batteries of questions on ongoing projects measuring the scope and capacity of organised civil society, such as Civicus, we need obtain better information on the extent of organisational AIDS impacts, such as absenteeism, death, replacement and training costs, and estimated skill losses. Alternatively, using snowball sampling, researchers could investigate whether there is any evidence of increased political organisation around HIV/AIDS? If so, it would be important to know what these organisations are doing in terms of political advocacy and mobilisation and whether such organisations tend to be dominated by professional activists or ordinary citizens.

Finally, while some studies have found abnormally high numbers of abandoned children and orphans amongst selected samples of violent criminals, we need

more systematic comparison of orphans and non-orphans in terms of school attendance and performance, integration into households, and their basic social values. To what extent is orphanage *per se* a driving force, versus the amount of nurturing provided by either parents or foster care-givers. To what extent can government support to extended families, or effective foster family schemes ameliorate anti-social tendencies amongst orphan? Since abnormally high proportions of children in southern Africa are already orphaned from other causes, and since so many children already live with only one parent, we need to ensure that we are able to separate the effects of AIDS orphanage from the impact of ordinary orphanage. Panel designs tracking these two groups over time would be invaluable.

Conclusions

Democracy is the preferred political system in the world today. It is the only political regime that is based on and designed to maximise human equality, freedom and agency. Southern Africa was no exception from the 'Third Wave' of democracy that swept the world in the 1980s and 1990s. Beginning in 1990, multi party systems with regular elections emerged in Namibia, Zambia, Malawi, South Africa, Lesotho, Mozambique and Tanzania joining the existing regimes of Botswana and Zimbabwe. Recent political changes suggest that Angola may not be far behind.

However, in none of these countries can democracy be characterised as 'consolidated'. 'Strong man' Presidents and/or dominant political parties threaten political pluralism in the face of weak legislatures, weak party systems, and weak civil societies. Yet with the major exception of Zimbabwe, civil and political rights, and reasonably free and fair elections persist.

HIV/AIDS, however, threatens to block and even reverse democratic development across the region. Lost incomes, sharply increasing health costs, shrinking tax bases, increased labour costs, and decreased productivity all conspire to threaten the economic growth that seems so necessary to sustain democratic practice in poor countries. Increasing death and illness in cabinets, legislatures and government ministries threatens the institutionalisation that young democracies need to create the strong and effective states that give effect to the rules of democracy. Sharply decreasing adult life expectancy and increasing proportions of people living with effective death sentences remove incentives for large sections of the populace to participate in democratic politics or comply with the rules of the democratic state. Stigma, discrimination and conflict over scarce resources threaten to increase political conflict and criminal behaviour.

However, virtually all of this set of scenarios is based on logic and conjecture, rather than evidence. The truth of the matter is that we know little about why or how citizens, elites and institutions infected, affected or threatened by HIV/AIDS change their political behaviour. This paper has attempted to lay out a research matrix into which prospective research can fit and researchers can try to specify conjecture into testable hypotheses. Our ultimate objective is to assess the ways in which HIV/AIDS may threaten the survival of democracy, and future-oriented questions are inherently not answerable without a crystal ball. However, the advancing but varied state of the pandemic across the region and within each country would seem to provide sufficient data and variance with which to test a large number of questions suggested in this paper through comparative cross-sectional and longitudinal designs. It is only with the knowledge that such research yields that we can offer informed projections about the threats to democracy, and thus what democrats can do to ensure that government of the people, by the people, and for the people does not perish from this region.

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The CSSR is an umbrella organisation comprising five units:

The Aids and Society Research Unit (ASRU) supports quantitative and qualitative research into the social and economic impact of the HIV pandemic in Southern Africa. Focus areas include: the economics of reducing mother to child transmission of HIV, the impact of HIV on firms and households; and psychological aspects of HIV infection and prevention. ASRU operates an outreach programme in Khayelitsha (the Memory Box Project) which provides training and counselling for HIV positive people

The Data First Resource Unit ('Data First') provides training and resources for research. Its main functions are: 1) to provide access to digital data resources and specialised published material; 2) to facilitate the collection, exchange and use of data sets on a collaborative basis; 3) to provide basic and advanced training in data analysis; 4) the ongoing development of a web site to disseminate data and research output.

The Democracy In Africa Research Unit (DARU) supports students and scholars who conduct systematic research in the following three areas: 1) public opinion and political culture in Africa and its role in democratisation and consolidation; 2) elections and voting in Africa; and 3) the impact of the HIV/AIDS pandemic on democratisation in Southern Africa. DARU has developed close working relationships with projects such as the Afrobarometer (a cross national survey of public opinion in fifteen African countries), the Comparative National Elections Project, and the Health Economics and AIDS Research Unit at the University of Natal.

The Social Surveys Unit (SSU) promotes critical analysis of the methodology, ethics and results of South African social science research. One core activity is the Cape Area Panel Study of young adults in Cape Town. This study follows 4800 young people as they move from school into the labour market and adulthood. The SSU is also planning a survey for 2004 on aspects of social capital, crime, and attitudes toward inequality.

The Southern Africa Labour and Development Research Unit (SALDRU) was established in 1975 as part of the School of Economics and joined the CSSR in 2002. SALDRU conducted the first national household survey in 1993 (the Project for Statistics on Living Standards and Development). More recently, SALDRU ran the Langeberg Integrated Family survey (1999) and the Khayelitsha/Mitchell's Plain Survey (2000). Current projects include research on public works programmes, poverty and inequality.