AIDS, Security and Governance in Southern Africa
Exploring the impact

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INTRODUCTION

By undermining health and the development of human capital, it is widely acknowledged that HIV/AIDS will increasingly undermine the foundations of human and economic development, although the details of this impact are as yet poorly understood. What is known is that individuals in the prime of their lives—the parents and workers of society—are at greatest risk of being infected with the HI-virus.

AIDS related illness and death often stand at the centre of a complex web of interrelated knock-on effects with implications for the well-being of individuals, households, economies and states. Two decades after AIDS became recognised globally, such consequences are only now beginning to be felt and appreciated, and their precise nature has yet to be determined. The scale of expected illness and death, however, suggests that they will be felt not only in the generations immediately affected but also by those to come.

This paper sets out to examine some of these potential impacts on security and governance in Southern Africa—the region where global HIV-prevalence is highest. To this end, the paper considers the thinking behind HIV/AIDS as a security issue and problematises the nature of the epidemic in the region. It then pulls together existing thinking to consider in detail the potential impact of HIV/AIDS on security and governance in the region.

HIV/AIDS AS A SECURITY ISSUE

Traditionally, the concept of security has been interpreted in militaristic terms as the military defence of the state, involving "structured violence manifest in state warfare".[1] However, since the end of the Cold War, policy makers and scholars have increasingly begun to think about security as something more than the military defence of state interests.

The emphasis has shifted from state security to 'human security', which is concerned about the welfare of ordinary people.[2] The first major statement concerning human security appeared in the 1994 Human Development Report, an annual publication of the United Nations Development Programme (UNDP). "Human security", the report states, "can be said to have two main aspects. It means, first, safety from such chronic threats as hunger, disease and repression. And second, it means protection from sudden and hurtful disruptions in the patterns of daily life—whether in homes, in jobs or in communities."[3]

AIDS is causing social and economic crises which in turn threaten political stability

The UNDP's Human Development Report identifies seven specific elements that comprise human security: economic security, food security, health security, environmental security, personal security, community security and political security. As will be expanded upon below, HIV/AIDS negatively impacts on virtually all of these seven elements in one way or another.

In January 2000, the United Nations Security Council debated the impact of AIDS on peace and security in Africa. The debate was the first in the Council's history that discussed a health issue as a threat to peace and security. UN Secretary-General Kofi Annan told the Council:

> The impact of AIDS in Africa is no less destructive than that of warfare itself. By overwhelming the continent's health and social services, by creating millions of orphans, and by decimating health workers and teachers, AIDS is causing social and economic crises which in turn threaten political stability… In already unstable societies, this cocktail of disasters is a sure recipe for more conflict. And conflict, in turn, provides fertile ground for further infections.[4]

At the same Security Council meeting the president of the World Bank, James Wolfensohn, said that AIDS was not just a health or development issue, but one affecting the peace and security of people in Africa:

Without economic and social hope, there could not be peace, and AIDS undermines both. Not only did AIDS threaten stability, but a breakdown in peace fuels the pandemic.[5]

UNIQUE FEATURES OF HIV/AIDS

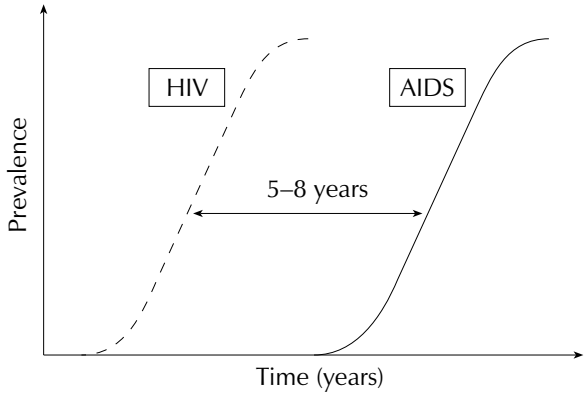
HIV/AIDS, as one of the infectious diseases to have emerged over the past few decades, is unique in several ways. In contrast to diseases such as Malaria and Tuberculosis, HIV/AIDS does not strike hardest at the young, the weak or the elderly. As Peter Piot, executive director of UNAIDS argues, HIV/AIDS "is devastating the ranks of the most productive members of society with an efficacy history has reserved for great armed conflicts".[6]

HIV/AIDS mostly infects those between the age of 15 and 49.[7] In South Africa, for example, it is estimated that the average age of those dying as a result of AIDS is 37 years.[8] This has several implications, not least of which is that individuals fall ill and die at a stage of their life when they should be contributing most to both the household and national economy. Men, and women in particular, also fall ill during the years they are most likely to have children, leaving them at particular risk of not only infecting their offspring but also impeding their ability to care for and raise their children.

HIV/AIDS is unique in terms of the shape of the epidemic. Like other infectious disease epidemics, HIV/AIDS follows a 'S' curve. Initially, the number of people infected with HIV climbs slowly and gradually until a critical mass of people is infected. After this 'tipping point' is reached, the number of new infections accelerates, and many of those susceptible to infection contract the disease. In the final phase of the epidemic, the curve flattens and then begins to turn downwards as people either regain their health or the number of deaths as a result of the disease begins to outnumber new infections.[9]

What sets the HIV/AIDS epidemic apart from other infectious disease epidemics is the presence of two 'S' curves: one illustrative of asymptomatic HIV, the other symptomatic of 'full-blown' AIDS. The HIV curve precedes the AIDS curve by about five to eight years (Figure 1).[10] This long incubation period has helped to make HIV/AIDS more deadly than other life threatening diseases such as cholera or Ebola fever. In the case of the latter diseases, victims progress from infection to visible illness and possible death in a matter of days or weeks. This serves to immobilise sufferers—thereby restricting the spread of the disease—and alert health authorities who can then act to combat its spread.

Figure 1: The two pandemic curves



Source: Barnett and Whiteside 2002

In the case of HIV/AIDS the long period between infection and the appearance of symptoms allows the virus to spread unabated, and facilitates ignorance and denial of the disease.[11]

Finally, the fact that HIV/AIDS is transmitted primarily through sexual intercourse embeds it in the most intimate aspects of people's lives. It attaches notions of propriety and retribution to the disease that often serve to keep HIV/AIDS strictly within the realm of the private, facilitating secrecy and further ignorance and denial. Sexual connotations, combined with ignorance also serve to create and perpetuate stigma around AIDS.

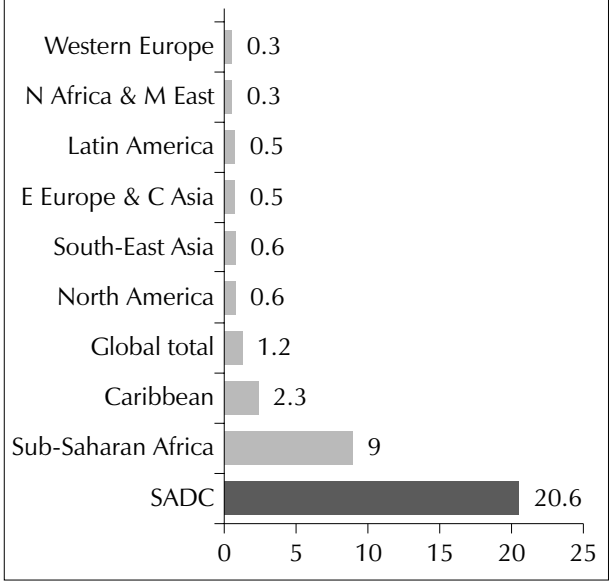
HIV-prevalence rates are seventeen times higher in the SADC region than the average global rate

HIV/AIDS IN SOUTHERN AFRICA

In the developed world, HIV/AIDS is concentrated among specific populations such as men who have sex with men and injecting drug users. In sub-Saharan Africa the epidemic is spread predominantly through heterosexual sex and affects a broad range of societal groups. Susceptibility and vulnerability to HIV/AIDS are linked to the economic and social characteristics of both individuals and society, with risk tied up with physiology as well as relative wealth and need, mobility, stability and power relations.[12]

Of the almost 40 million people living with HIV/AIDS globally at the end of 2001, approximately 28 million or 70% were living in sub-Saharan Africa even though only a tenth of the world's population lives in the region. At the end of 2001 the global total adult HIV-prevalence rate was 1.2%. The 12 continental member states of the Southern African Development Community (SADC) had an average adult HIV-prevalence rate of 20.6%, followed by sub-Saharan Africa as a whole (9%).[13] HIV-prevalence rates are thus seventeen times higher in the SADC region than the average global rate (Figure 2).[14]

Figure 2: Adult HIV prevalence rate (%) by region, December 2001



Source: UNAIDS 2002

In the late 1990s it was believed that Southern Africa's HIV/AIDS epidemic had reached its natural limit, beyond which HIV-prevalence rates would not rise.[15] Yet between 1997 and 2001 adult HIV-prevalence rates increased in ten out of 12 continental SADC member states, notwithstanding the fact that prevalence rates were already exceptionally high in most of these countries in 1997 (Table 1).[16]

The change in HIV-prevalence levels varies considerably between SADC member states. For example, the HIV-prevalence rate in Lesotho increased from 8.4% in 1997 to 31% in 2001—an increase of 269% in the prevalence rate over a four-year period. In Tanzania, however, the HIV-prevalence rate declined from 9.4% in 1997 to 7.8% in 2001—a decrease of 17% in the prevalence rate.

Out of the 12 continental SADC member states, nine contain populations of which more than 10% of adults between the ages of 15 and 49 years were living with HIV/AIDS at the end of 2001.[17] In three of these countries, at least one in every three adults was thought to be living with HIV/AIDS, while in a further four countries at least one-fifth of all adults were HIV-positive. The ten countries with the highest HIV-prevalence rates in the world are, with the exception of Kenya, all SADC member states (Table 2).

Startling as these prevalence levels are, they are even higher in specific age groups. Thus, prevalence rates among 25–29 year old women attending urban antenatal clinics were 34% in Swaziland (2000), 40% in Zimbabwe (2000) and 56% in Botswana (2001).[18]

Despite advances in health care provision, life expectancy in Southern Africa is expected to decline dramatically as a result of AIDS. The United Nations Development Programme projects that between 2005 and 2010 average life expectancy in the world's ten worst affected countries will decline to 44 years instead of rising to 61 years as was projected in the absence of AIDS.[19] In Botswana, for example, average life expectancy in 2000 was 39 years. It would have been 70 years were it not for AIDS. In Zimbabwe average life expectancy in 2000 had declined by almost 50%, from 70 to 38 years, as a result of AIDS (Figure 3).[20]

Table 1: Adult HIV-prevalence rates (%) in continental SADC states, 1997–2001

	Dec. 1997	Dec. 1999	Dec. 2001	% change in HIV-prevalence rate, 1997–2001
Angola	2.1	2.8	5.5	+162
Botswana	25.1	35.8	38.8	+55
DRC	4.4	5.1	4.9	+11
Lesotho	8.4	23.6	31.0	+269
Malawi	14.9	16.0	15.0	+1
Mozambique	14.2	13.2	13.0	–9
Namibia	19.9	19.5	22.5	+13
South Africa	12.9	19.9	20.1	+56
Swaziland	18.5	25.3	33.4	+81
Tanzania	9.4	8.1	7.8	–17
Zambia	19.1	20.0	21.5	+13
Zimbabwe	25.8	25.1	33.7	+31

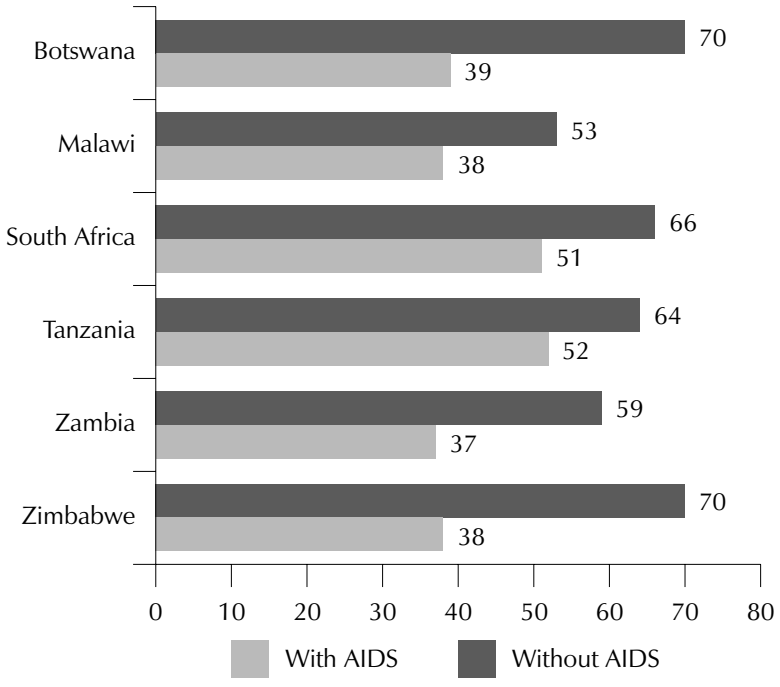
Source: UNAIDS 1998, 2000 and 2002

Table 2: Infection rates in SADC countries, end of first quarter 2002

Global HIV rank[i]:	Country	% adults (15–49 years) HIV-positive	Adults and children HIV-positive
1	Botswana	38.8	330,000
2	Zimbabwe	33.7	2,300,000
3	Swaziland	33.4	170,000
4	Lesotho	31.0	360,000
5	Namibia	22.5	230,000
6	Zambia	21.5	1,200,000
7	South Africa	20.1	5,000,000
9	Malawi	15.0	850,000
10	Mozambique	13.0	1,100,000
17	Tanzania	7.8	1,500,000
25	Angola	5.5	350,000
27	DRC	4.9	1,300,000
			Total: 14,690,000

Source: UNAIDS 2002, UNDP Human Development Report 2002
i Countries ranked by adult HIV-prevalence rates (excluding non-SADC states)

Figure 3: Life expectancy in 2000, with and without AIDS, selected SADC countries



Source: US Census Bureau, Population Reference Bureau, UNAIDS, WHO

Child mortality, an important indicator of human development and state stability, is increasing as a result of AIDS.[21] By 2010 child mortality, measured as the number of children who will die before their fifth birthday out of 1,000 live births, is likely to be two to six times higher in a number SADC states because of AIDS.

In Botswana, for example, the child mortality rate is expected to be 170 deaths per 1,000 children in 2010. Without AIDS the child mortality rate would have been 27 deaths per 1,000. In other words, by 2010 out of 1,000 live births 143 children will die before their fifth birthday as a result of AIDS (Table 3).

Table 3: Projected child mortality rate in SADC countries, with and without AIDS, 2000 and 2010

Country	2000			2010		
	Without HIV/AIDS	With HIV/AIDS	Net difference	Without HIV/AIDS	With HIV/AIDS	Net difference
Angola*	–	–	–	–	–	–
Botswana	39	136	*+97*	27	170	*+143*
DRC	139	154	*+15*	108	126	*+18*
Lesotho	86	133	*+47*	62	145	*+83*
Malawi	176	220	*+44*	137	203	*+66*
Mozambique	175	226	*+51*	140	225	*+85*
Namibia	63	139	*+76*	45	165	*+120*
South Africa	66	120	*+54*	48	147	*+99*
Swaziland	118	183	*+65*	89	204	*+115*
Tanzania	101	128	*+27*	73	109	*+36*
Zambia	107	169	*+62*	80	146	*+66*
Zimbabwe	41	133	*+92*	29	153	*+124*

Source: US Census Bureau, Population Reference Bureau, WHO from: US Census Bureau's country HIV/AIDS profiles
** No projections available*

POLITICAL SECURITY

Conflict and peacekeeping

War is an instrument for the spread of HIV/AIDS. With a number of violent conflicts, tens of thousands of troops and guerrilla fighters in the field, and millions of refugees and internally displaced persons, conflict has become a major factor in the spread of HIV in sub-Saharan Africa.[22]

Military conflict brings economic and social dislocation, warns UNAIDS, including the forced movement of refugees and internally displaced persons. Conflict results in a loss of livelihoods, separation of families, collapse of health services, and dramatically increased instances of rape and prostitution. All this creates conditions for the rapid spread of HIV and other infectious diseases.[23]

The impact of HIV/AIDS on civilian populations lies in the high rates of sexual interaction between military and civilian populations, whether through commercial sex, or in rape as a weapon of war; and in the extreme vulnerability of displaced and refugee populations to HIV infection.[24]

Refugee populations—many of which are single women and unaccompanied children—are particularly vulnerable to being pressured into having sex or being raped. In the early stages of conflict situations, when a large number of refugees are on the move, their need for food and other basic necessities can be acute. Exchanging sex for money or food can therefore be commonplace. It has been shown that women, for example, are six times more likely to contract HIV in a refugee camp than the general outside population.[25]

In the case of HIV, soldiers having defeated an external enemy or completed their tour of duty in another part of their country often unwittingly introduce a lethal enemy into their communities and homes. Soldiers coming from communities with low prevalence levels are thus likely to abet the spread of HIV in their communities after they return from their tour of duty. As one researcher puts it, the HI-virus uses returning combatants as 'Trojan Horses' to enter a low-prevalence area and then spread itself among the civilian populations surrounding military bases.[26]

As with military personnel generally, peacekeepers may face a higher than average risk of exposure to sexually transmitted diseases (STDs), including HIV. For example, Nigerian military personnel who worked as peacekeepers in the late 1990s had a HIV-prevalence rate of 7% after one year of peacekeeping duties. This increased to 10% after two years, and 15% after three years.[27]

Approximately one-third of the 38,000 soldiers and civilian police officers under UN command are serving in Africa, often in countries with some of the highest HIV-prevalence levels in the world. As a result, some nations may be unwilling to send peacekeeping forces to high-risk areas, raising important questions regarding foreign relations and regional security.[28]

Former United States ambassador to the UN, Richard Holbrooke, is on record as stating that:

> the US will never again vote for a [UN] peacekeeping resolution that does not require action by the UN's Department of Peacekeeping Operations to prevent AIDS from spreading to peacekeepers.[29]

High HIV-prevalence levels may consequently jeopardise future humanitarian and peacekeeping operations, especially in African countries.

While HIV/AIDS may hinder international attempts to respond to conflict, the epidemic is also likely to complicate attempts at post-conflict reconstruction in countries with high HIV-prevalence rates.[30] Efforts at demilitarisation and reintegrating combatants may be threatened when combatants return to dying families and villages; and by the breakdown of government, police and civil society to the point that they may be useless in filling the gap the military leaves behind.[31]

National security

The perceived inability of a government to fulfil all its functions could undermine its public support and legitimacy, with the state increasingly seen as "part of the problem rather than the solution".[32] Moreover, as argued by the US' National Intelligence Council, the impact of HIV/AIDS is likely to aggravate and even provoke social fragmentation and political polarisation in the hardest hit countries in the developing world.[33]

HIV/AIDS may impact with population pressures and trends (particularly migration and urbanisation) to create more volatile social and political situations. The latter, in turn, could produce heightened competition for limited resources and foster more intense rivalries among groups in countries marked by ethnic, religious, or other diversity.[34] The severe social and economic impact of HIV/AIDS, and the infiltration of the epidemic into the ruling political and military elites and middle classes of developing countries may intensify the struggle for political power to control scarce state resources.[35] Such dynamics, even singularly, have the potential to lead to political instability.

In some cases the impact of such dynamics could be profound, with the International Crisis Group (a private multinational organisation devoted to understanding and preventing conflict) arguing that the synergy between infectious diseases, disruptive population dynamics, environmental degradation and weak government structures might manifest itself in a specific time and place, giving rise to 'complex emergencies' in some nations. Such complex emergencies could weaken the fabric of a society, potentially making such disruption enormously destructive.

Armed forces form the basis of a country's defence and constitute the underpinning of stability both within states and between them. If they become debilitated by disease, national security is potentially compromised. Foreign and domestic threats to a country's national security may be aggravated by the security vacuum left by weakened military forces. The International Crisis Group warns that "even the perception that a neighbour's military is suffering from an AIDS epidemic, suggesting a tactical advantage, may trigger wars".[36] In weak states with divided societies—a common feature of many countries in Southern Africa—opposition groups could be tempted to exploit the weaknesses of armed forces debilitated by disease, by instigating civil unrest or toppling the ruling elite.[37]

Governance

Governance is the act, process, or power of governing and government.[38] HIV/AIDS could detrimentally affect the capacity of governments, especially on the delivery of basic social services. Whiteside argues that the illness and death of prime-aged adults in their thirties and forties will thin the ranks of the citizens who will "keep the wheels of commerce and state turning, and [who] will provide the next generation of leaders".[39] At present, however, the theory in this regard tends to be grounded in speculative analysis as opposed to substantive evidence.[40]

In Zambia, more teachers died of HIV/AIDS in 1996 than were produced by all the country's training colleges that year

HIV/AIDS on an epidemic scale could detrimentally affect the capacity of governments as civil servants experience illness and death, resulting not only in labour and productivity losses but also the loss of institutional memory. AIDS may decimate the ranks of skilled administrators and other government employees and diminish the reach or responsiveness of governmental institutions, or reduce their resilience.[41] This may impede the operational effectiveness of such institutions as the armed forces, police, and social services.

While evidence in this regard is scarce, Zambia's Ministry of Education, for example, reports that 2.2% of its teachers died of HIV/AIDS in 1996. This amounted to more than the number of teachers produced by all the country's training colleges that year, with the number of fatalities expected to triple by 2005.[42] This could have major implications for education provision in the country. Similarly, research has shown that increased absenteeism amongst nurses, allegedly due to HIV/AIDS, was already observable in Zambian hospitals as far back as the early 1990s.[43]

Beyond a reduction in human resources, HIV/AIDS is likely to result in a reduction in public revenues as taxpayers die prematurely or are simply unable to pay their dues. It is also likely to result in a reorientation of spending towards coping with the epidemic's impact, with activities perceived as non-HIV/AIDS related likely to experience declining budgetary allocations. That is, as HIV/AIDS diminishes human capital in a society, the state's ability to serve the needs of all its citizens is likely to decline, as is its fiscal capacity to respond. Yet fiscal pressure on the state will be met with increased fiscal demand to confront the epidemic, further exacerbating the problem.[44]

According to a report published by the Center for Strategic and International Studies, the negative synergy between infectious disease (in particular HIV/AIDS), population dynamics, weak government structures, and long-standing grievances in segments of the population creates a downward spiral between infectious disease and state capacity to respond to it.[45] This negative spiral stands to be most intense in many Southern African countries where state capacity is already severely limited because they have fewer human, financial, and other resources from which to draw to break the cycle.

ECONOMIC AND SOCIAL SECURITY

Development and investment

HIV/AIDS could have a detrimental impact on the economies of a number of Southern African states. Both the production and the consumption levels of economies will be affected, which could have dire implications for foreign investors' willingness to make long-term investments in the region.[46] According to BusinessMap SA (a not-for-profit think-tank producing research on South Africa's economic transformation and foreign investment), as a result of HIV/AIDS investors now seek premium rates of return of 15%–20% in South Africa and an even higher 25% or more in the rest of the region.[47]

It is projected that around 2010, South Africa, which generates about 40% of sub-Saharan Africa's economic output or almost two-thirds of SADC's, is likely to have a real Gross Domestic Product (GDP) 17% lower than what it would have been without AIDS.[48]

The mining sector, for example, is a major sector of most national economies in the SADC region, not only in terms of the number of people employed but also the foreign exchange generated by mineral exports (Table 4).[49] It is, however, also one of the sectors most affected by the HIV/AIDS epidemic. The South African Union of Mineworkers estimates that their members could see between 12,000–14,000 AIDS-related deaths per year by 2010.[50] These deaths, and the illness that precedes them, are becoming increasingly costly for the mining sector in South Africa. Projections suggest that the total cost of preventing and treating HIV/AIDS, and replacing workers lost to the disease, will increase from R114 million in 1995 to R1.5 billion in 2010.[51] Despite these efforts, however, it is plausible that illness and death will impact on production in the future. This in turn has implications for the export earnings of countries in the region.

Table 4: Estimates of the mining and minerals sector's economic contribution to economies of continental SADC states in 1999

SADC Member	Mining and minerals sector's economic contribution
Angola	US$2.7 billion
Botswana	US$2 billion out of a total US$2.7 billion
DRC	28% of GDP and 70% of exports
Lesotho	US$ 85,000
Malawi	<1% of GDP and US$1 million
Mozambique	<0.25% of GDP and 1.4% of exports
Namibia	49% of exports by value
South Africa	33% of export revenue
Swaziland	2% of GDP and US$20 million in export earnings
Tanzania	2.1% of GDP and 14.5% of export earnings
Zambia	20% of GDP and 85% of foreign exchange earnings
Zimbabwe	6% of GDP and 40% of foreign exchange earnings
Source: MIGA African Mining 2000 Symposium, cited by Elias and Taylor 2002	

The International Crisis Group also raises some worrying international economic consequences of rising HIV prevalence levels in sub-Saharan Africa:

> If left unchecked [HIV/AIDS], could cut severely into world supplies of key natural resources, including oil from Nigeria and Angola, and minerals from… sub-Saharan Africa.[52]

With this in mind, it is worth noting that South Africa's mining industry—one of the worst HIV-affected sectors in that country—produces more than two-thirds of the world's platinum.

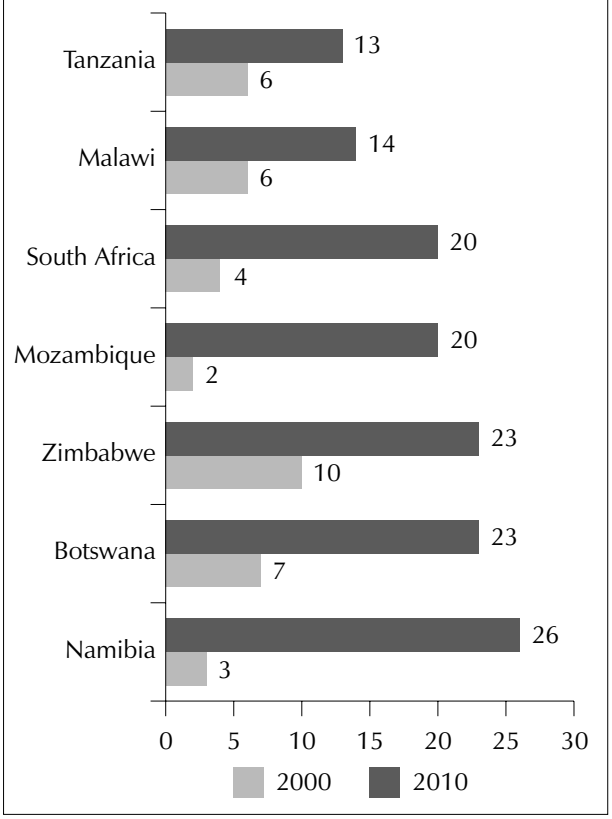
Production and work

It is likely that HIV/AIDS will have devastating consequences on an economic and social level in heavily affected societies. This is because HIV/AIDS is almost always lethal to those infected, and different to most other infectious diseases in that it affects primarily young adults.

Juan Somavia, director-general of the International Labour Office (ILO), is in little doubt that the HIV/AIDS epidemic will have a profound effect on the social and economic fabric of societies:

> HIV/AIDS is a major threat to the world of work: it is affecting the most productive segment of the labour force and reducing earnings, and it is imposing huge costs on enterprises in all sectors through declining productivity, increasing labour costs and loss of skills and experience.[53]

Figure 4: Proportion (%) of agricultural labour force lost due to HIV/AIDS in selected SADC countries, 2000 and 2010



Source: UN Food and Agricultural Organisation

Barnett and Whiteside observe that 'for profit' enterprises make money by selling goods and services for more than the cost of production.[54] HIV/AIDS may raise costs, reduce the productivity of individual workers and alter the commercial operating environment through:

- increased absenteeism because of employee ill health, or because employees take time off to care for sick relatives and attend funerals;
- reduced productivity as workers debilitated by ill health work less productively and effectively;
- additional recruitment and training costs for new employees who replace those too sick to work;
- premium salaries that have to be paid to attract skilled workers—as the epidemic reaches an advanced stage in a country, the pool of skilled workers will become progressively smaller; and
- a depressed business environment as markets shrink and investors become reluctant to commit funds if they think the impact of AIDS will undermine their investments.

In many African countries, agriculture provides a living for as much as 80% of the population. As adults in rural areas fall ill, it has been shown that productivity drops off dramatically. Patterns of cropping shift from cash crops to subsistence farming, reducing household income and forcing families to sell off their assets to survive.[55] Even the loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest.[56]

The UN's Food and Agricultural Organisation's (FAO) Committee on World Food Security notes that in the 27 most HIV/AIDS-affected countries in Africa, seven million agricultural workers died as a result of AIDS between 1985 and 2000. Sixteen million more deaths are likely by 2020. The FAO provides a grim picture of the agricultural labour force decreases in a number of SADC countries. In five SADC states, one-fifth or more of the agricultural labour force is expected to succumb to HIV/AIDS by 2020 (Figure 4).[57]

Taken together, the impact of HIV/AIDS on production at the household and at the sectoral level is likely to jeopardise food security at multiple levels in the future. Indeed, declining agricultural production, in part as a result of HIV/AIDS related morbidity and mortality, has already been highlighted as an important contributing factor in the food crises currently being experienced by countries such as Zimbabwe, Malawi, Zambia, Lesotho, Mozambique and Swaziland.[58]

Family and household

There is considerable empirical evidence that the consequences of adult ill health are substantial, and

larger than the consequences of illness in non-adults.[59] This is particularly the case with HIV/AIDS that causes primarily the death of 25 to 49 year olds. This age group generally includes not only the most productive members of society, but those who are responsible for caring for both the young and elderly.

Terminal illness is emotionally demanding, physically exhausting and financially costly.[60] HIV/AIDS related illness and death may strain and diminish household income. Thus, UNAIDS estimates that income in poor households with an HIV-positive member, may decline by as much as 40–60%.[61]

This happens in several ways. Due to the age group most affected by the disease, AIDS often debilitates and kills those most likely to be supporting the household financially, while other income earners may have to give up work to provide care. In many parts of Africa the illness of a household member also draws family labour and resources away from subsistence agriculture, as people are either too ill to work or have their time taken up caring for the sick. In addition to such losses in production, however, households must find the funds necessary to pay for medication and health care during the members' illness, and the funeral after their death. With generally limited access to health insurance and company treatment programmes in Southern Africa, most households in this situation must either draw on savings, sell assets such as land or livestock, take up additional employment or take out loans to pay for such expenses.

61% of Zambian households that have lost a member to HIV/AIDS moved to cheaper housing, while 21% of girl and 17% of boy children dropped out of school

The presence of an HIV-positive member may also strain the mental and physical well-being of household members. Caring for an HIV-positive spouse, child or relative puts physical and emotional strain on the caregivers involved, potentially undermining health at the most basic level. As reported by a caregiver on the realities of living and dying with AIDS in KwaZulu-Natal (South Africa):

> When you are the only person looking after a person who is ill you end up going mad, because you are alone and you don't know what to do next, especially if you have to cook, feed, wash and clean up after that person. When people come to visit, they must find him and the house clean… You have to nurse them and feed them. It becomes very difficult to see someone not being able to eat.[62]

In cases where children return to their parents' home to die, caregivers are often elderly. Alternatively, where the caregiver is a spouse, the caregiver may also be suffering from the effects of the AIDS infection. The provision of care may be particularly taxing on such people. As families have less to spend and produce less food, the quality and quantity of the food consumed by household members also declines. Food, and better quality food, is also often diverted away from other household members in favour of the ill.[63] Declining nutrition may impact on health. A study conducted in Tanzania suggests that elderly caregivers in particular suffer from poor mental and physical health as a result of caring for a dying child.[64]

Caring, combined with the financial implications of AIDS-related illness and death stand to impact on well-being in other ways. Children may be withdrawn from school, to assist with caring or other household tasks such as cleaning or looking after younger relatives, or in order to save or earn money. Standards of living may also decline. According to the UNDP, 61% of Zambian households that have lost a member to HIV/AIDS moved to cheaper housing, 39% lost their access to piped water, while 21% of girl and 17% of boy children dropped out of school.[65]

Where sick members are repaying a mortgage or have the right to reside vested in them, households may also loose access to their home or land following the death of such a family member. An example of this is given in a South African study, where a respondent explained the loss of her home following her daughter's death:

> She used to work and she wanted to buy us a house. When she died the bank repossessed the house… There was absolutely nothing we could do, the bank told us.[66]

Death or impending death often forces families to splinter, as children lose their parents, or families are unable to support their members financially.[67] Where children go to live with relatives, live in child headed households, or are left to fend for themselves, they may often find themselves in precarious circumstances, which leave them open to exploitation and abuse. In the absence of adult role models, socialisation may also be poor.[68] Young people, sometimes children themselves, may be faced with the responsibility of raising their even younger siblings. This means taking on not only the role of a parent, but also having to earn money to support the household. In many cases this results in children dropping out of school in order to search for work.

A number of studies have been conducted on the circumstances of orphans and their caretakers in various African countries. It has been shown that families that foster children in Kenya usually live below the poverty line, and that orphan households in Tanzania have more children, are larger, and have less favourable dependency ratios.[69] Orphans run greater risks of being malnourished and stunted than children who have parents to look after them.[70] They may also be the first to be denied education when extended

families cannot afford to educate all the children of the household. This lack of schooling, often combined with a lack of nutrition, may make it particularly difficult for orphans to escape poverty.[71]

Crime and social exclusion

Increasing numbers of children with fewer life chances and support, an over-representation of youth in heavily affected populations and desperation may provide an environment conducive to crime. The dynamics of this relationship are, however, only beginning to be examined and are at this point entirely speculative.

In 2001, 90% of the 11 million orphans left by the global AIDS epidemic were children living in sub-Saharan Africa. The United States Agency for International Development (USAID) predicts that by 2010 Southern Africa will contain 5.5 million maternal or double orphans (16% of all children under the age of 15 years), of which 87% will be orphaned because of AIDS.[72]

As the HIV/AIDS epidemic progresses, there will be fewer adults of normal parenting age to care for the children they leave behind. The burden of care will increasingly fall upon relatives and the growing proportion of elderly people. However, the large number of anticipated AIDS orphans has led the United Nations Children's Fund (UNICEF) to conclude that Africa's age-old social safety net for such children—in the form of deep-rooted kinship systems and extended-family networks—will be unable to cope with the strain of AIDS and soaring numbers of orphans in the most affected countries.[73] Thus, although child fostering has long been common in Southern Africa, the magnitude of the HIV/AIDS epidemic may result in the demand for fostering outstripping the supply.[74] This may not only serve to increase the poverty and marginalisation of orphaned children described earlier but may lead to an increase in the number of child headed households.

The loss of parents to HIV/AIDS may increase the emotional vulnerability of children. Children who lose a parent to AIDS suffer loss and grief like any other orphan. However, their loss may be exacerbated by prejudice and social exclusion.[75] That is, the shame, fear and rejection that often surrounds people affected by HIV/AIDS can create additional stress and isolation for children—both before and after the death of their parent or parents. In addition to stigma and exclusion, children may suffer additional trauma:

> as they may be evicted by unscrupulous relatives, siblings may be split up, and their life may suddenly be devoid of any continuity, security, regular food and shelter.[76]

Such factors may have a number of implications for levels of crime and victimisation. As alluded to in the previous section, children deprived of parental protection may be more vulnerable to becoming victims of crime, as perpetrators know that the level of supervision of such children may be relatively low as may be the likelihood of recrimination.[77] Alternatively, children left to fend for themselves may be tempted, or even obliged for the sake of their survival, to commit a range of property crimes. Older children may resort to mugging and robbery to make ends meet.

AIDS orphans deprived of parental protection and support may be more vulnerable to becoming victims of crime– and to perpetrating crime

Significant numbers of child migrants moving to their nearest cities in search of livelihoods may also increase the already high numbers of street children in many countries.[78] Street children have been shown to be both the victims and perpetrators of a range of crimes. Many such children are assaulted, abused, raped and drawn into prostitution rings, while petty thefts, muggings and burglaries are crimes associated with street children.[79]

The dynamics surrounding orphanhood may also leave children emotionally and psychologically vulnerable. A South African Department of Health publication, which looks at the impact of AIDS in South Africa, predicts that as a result of such stress children orphaned because of AIDS could be at risk of engaging in delinquent behaviour:

> As [orphaned] children under stress grow up without adequate parenting and support, they are at greater risk of developing antisocial behaviour and of being less productive members of society.[80]

Similarly, an exhaustive review of family factors as correlates and predictors of juvenile conduct problems and delinquency found that, inter alia, poor parental supervision or monitoring and low parental involvement with the child (factors present in orphaned children) were important predictors of such behaviour.[81]

The absence of a father figure early in the lives of young males has also been shown to increase later delinquency.[82] Moreover, such an absence may affect a boy's ability to develop self-control:

> The secure attachment or emotional investment process [a father figure provides] facilitates the child's ability to develop and demonstrate both empathy and self-control. By extension, an insecure attachment will lead to lower levels of empathy and self-control, and to an increase in violent behaviour.[83]

This said, the erosion of strong kinship ties, the lack of father figures for children, and the disintegration of families has characterised the Southern African region, and South Africa in particular, for decades. At this

stage it is unclear whether the dynamics surrounding orphans represent a 'special case' in this regard, or whether the potential impact lies simply in the scale of the epidemic. The relationship between orphans and crime is thus an area in which more empirical studies are required.

The HIV/AIDS epidemic can also cause crime in more direct ways, with children generally becoming victims of crimes as a result of certain belief systems. The belief that sex with a virgin can cure HIV/AIDS appears to be widely spread in Southern Africa.[84] There is, however, little incontrovertible evidence to show that this belief has lead to any significant number of rapes.[85] Rapists may, however, be targeting young girls in the belief that, being less sexually active, they are less likely to have HIV or AIDS.[86]

Finally, criminological theory suggests that demographic change may result in increasing levels of crime and violence in the region. In the worst affected countries, HIV/AIDS will alter population structures in significant ways, leading to an over-representation of young men between the age of 15 and 29.[87]

It has been suggested that "probably the most important single fact about crime is that it is committed mainly by teenagers and young adults".[88] According to a National Institute for Justice paper on violent crime by young people:

> age is so fundamental to crime rates that its relationship to offending is usually designated as the 'age-crime curve'. This curve, which for individuals typically peaks in the late teen years, highlights the tendency for crime to be committed during the offender's younger years and to decline as age advances.[89]

Similarly, an empirical study by Mesquida and Wiener demonstrates that 'coalitional aggression'—violence perpetrated by groups rather than individuals—is a function of changes in the proportion of young men within a society: those aged 15 to 29 in relation to those 30 years of age and older. They conclude that:

> the relative abundance of young men is associated with occurrence of coalitional aggression and the severity of conflicts as measured by reported casualties.[90]

Taken together, the theory thus suggests that both crime and group based aggression stand to increase as HIV/AIDS profoundly alters traditional population structures in the most affected countries in the Southern African region.

CONCLUSION

The HIV/AIDS epidemic in Southern Africa will have deep-seated consequences for the people and countries of the region, whether infected or affected by the epidemic. As more and more people develop full-blown AIDS, current thinking suggests that few, if any, aspects of society will remain unaffected by the disease. The implications of HIV/AIDS will not be uniform and are difficult to predict. Some sectors of society are likely to experience the detrimental affects of the epidemic more profoundly than others. Equally, how individuals and institutions respond to the threat and reality of the epidemic will also determine the net extent and nature of the impact.[91]

It is crucial that attention is given to better understanding the nature and consequences of HIV/AIDS, and that governments and institutions acknowledge that AIDS is more than merely a problem of individual suffering and death. HIV/AIDS has become a human security and governance issue, with the potential to undo decades of human, economic and national development and progress in Southern Africa. This needs to be acknowledged and examined critically with a view to taking the steps necessary to ameliorate the impact of the epidemic.

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About this paper

It is widely acknowledged that HIV/AIDS will increasingly undermine the foundations of human and economic development. This is largely because individuals in the prime of their lives–the parents and workers of society–are at greater risk of being infected with the HI-virus.

This paper examines some of the potential impacts of security and governance in Southern Africa–the region where global HIV-prevalence is highest.

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