Downward Spiral

HIV/AIDS, State Capacity, and Political Conflict in Zimbabwe

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Summary

In the post–Cold War era, diverse new threats to long-term global political and economic stability have emerged. Such threats include terrorist activities, the proliferation of nuclear technologies and delivery systems, and biological threats that include both bioweapons and naturally occurring epidemic diseases such as HIV/AIDS.

While it is now increasingly understood that the HIV/AIDS pandemic constitutes a threat to the security of all nations, the process by which the disease destabilizes societies, economies, governance structures, and the national security apparatus remains opaque. Indeed, one of the greatest problems in understanding the threat posed by the pandemic emanates from the fact that prior studies have often examined only one facet (say, the effect of HIV/AIDS on unemployment) of the epidemic's impact on a given country. The purpose of this study is to demonstrate, by focusing on the case of Zimbabwe, how HIV/AIDS operates simultaneously across various domains—demographic, economic, and governance—to destabilize states and threaten their national security.

Given the complex mix of factors that are contributing to Zimbabwe's current malaise (political corruption, a land distribution crisis, and an enduring drought), it is perhaps best to think of the HIV/AIDS epidemic as a powerful "stressor" that is exerting a significant negative influence on the nation's economic health and political stability. The epidemic's impacts are both direct—HIV/AIDS is projected to take the lives of over 30 percent of the Zimbabwean population over the next decade—and indirect. Among the latter category, three threats stand out. First, the HIV/AIDS epidemic is dramatically reducing Zimbabwean life expectancy and quality of life through disease-induced morbidity and mortality and by increasing disease-related poverty. Second, the disease is systematically eroding the economic strength of the country, shrinking productivity, precipitating a decline in savings, increasing the country's debt load, and diminishing its store of human capital. Third, the epidemic is systematically eroding the institutions of governance (such as police and military forces) while depleting state capacity, thus dramatically narrowing the range of policy options available to policymakers. These factors combine to produce both the motive and the opportunity for intrastate violence between political elites, classes, or ethnicities and may even generate state failure. The epidemic may also provide increasing incentive for the Zimbabwean state to engage in violence against its own citizens, as political elites seek to maintain their grip on power in a destabilized and disaffected society.

HIV/AIDS-induced declines in population health are generating a significant decline in Zimbabwean state capacity. These findings are generalizable, as the effects of debilitation and mortality will exhibit similar effects upon the macroeconomy and apparatus of governance across all similarly afflicted societies. If the pandemic continues to spread unchecked throughout the developing world, it has the potential to generate widespread economic and political instability and to generate and exacerbate existing conflicts both within and between nations.

As shown in neighboring Botswana, where the government has led the effort to diminish the impact of the epidemic, good governance can compensate to some degree for relatively low levels of state capacity. In Zimbabwe, however, the Mugabe regime had until recently not given a high priority to containing and treating the disease. If the government is to exhibit stronger leadership in the fight against the epidemic, various domestic and international actors need to collaborate much more closely and pressure Harare to do more. The study's concluding chapter makes a number of recommendations that call for improved partnerships between the international community, Washington policymakers, and Zimbabwean nongovernmental health providers and community service agencies.

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One

Introduction

Once regarded as the emerging star of postcolonial Africa, Zimbabwe is now a nation teetering on the brink of economic and political collapse. In recent years, the country has been wracked by rising levels of politically motivated violence, elections marred by widespread fraud, an ill-advised military involvement in the Democratic Republic of Congo (DRC), the seizure of farms from white populations without due regard for the law, and violence against supporters of the political opposition.[1] Aside from its rampant governance problems, Zimbabwe is also beset with a declining GDP, a high rate of inflation, persistently high unemployment, and increasing poverty. To make matters worse, the southern portion of the country has experienced significant drought over the past few years. Finally, Zimbabwe exhibits one of the highest levels of HIV/AIDS seroprevalence in the world, with approximately 34 percent of the adult population now infected with the human immunodeficiency virus.[2]

This study traces the effects of the HIV/AIDS epidemic on both the withering economy and the tottering apparatus of governance in Zimbabwe. This task is complicated by the presence of other factors contributing to Zimbabwe's malaise, namely, extensive political corruption within the Mugabe regime, a land distribution crisis, and an enduring drought in the south of the country. Given the complex mix of factors working to destabilize Zimbabwe, it is perhaps best to think of the HIV/AIDS epidemic as a powerful "stressor" that is exerting a significant negative influence on the nation's economic health and political stability. In the context of poor governance (i.e., low levels of political will and state capacity), HIV/AIDS reinforces a vicious spiral within affected societies, threatening the stability of the state. In the case of Zimbabwe, HIV/AIDS-induced mortality and morbidity have already begun to destabilize the country, and this effect will intensify in the near future.

Infectious disease has recently come to be seen as a threat to both international development and national security. The nascent field of "health security" is fast developing; as yet, however, few studies have assessed the threat posed by infectious disease to states and societies at both the microlevel and the macrolevel.[3] This study illustrates how HIV/AIDS is acting across various domains—demographic, economic, and institutional—to compromise Zimbabwe's economy and structures of governance and, ultimately, to undermine its national security.

Although Zimbabwe is beset with many other infectious diseases (notably, tuberculosis) that promise to impede its economic development, the HIV/AIDS epidemic threatens to have by far the most severe impact in the decades to come.[4] HIV/AIDS constitutes both a *direct* and an *indirect* threat to Zimbabwean governance and national security. It also promises significant economic and social dislocation for many other states in sub-Saharan Africa whose populations exhibit high HIV seroprevalence levels, including Swaziland, Zambia, South Africa, Botswana, and Nigeria.

We begin this report by briefly chronicling the influence that epidemic disease has had on the stability of human societies throughout history, noting the social and political

destabilization that occurs as a result of extensive contagion. Next, we review the utility of the concept of state capacity and apply it to the case of HIV/AIDS and Zimbabwe. The report then moves on to dissect the corrosive effect of HIV/AIDS on Zimbabwe's national institutions. First, we examine the demographic effects of the disease, in the process examining the economic and political consequences of the large cohort of orphans generated by HIV/AIDS-induced mortality. Second, we detail how HIV/AIDS undercuts economic productivity at the microlevel (the level of family and firm) and the macrolevel. Third, we analyze the deleterious effects of the epidemic on the institutional structure of the state, including national military forces, to assess the ultimate effect of the disease on governance. Finally, after briefly reviewing the Zimbabwean government's response to HIV/AIDS, we offer a set of policy recommendations for the international community in general, and for the U.S. government in particular, designed to ameliorate the spread of HIV in Zimbabwe.

Two

Epidemic Disease and History

Over the span of recorded human history, infectious disease has significantly and profoundly destabilized societies and polities. Historians have noted the significant role of disease in the shaping of historical outcomes.[5] The Athenian general and historian Thucydides, in his account of the Peloponnesian War, noted the highly destructive effects of a plague upon Athenian social stability:

> For the catastrophe was so overwhelming that men, not knowing what would happen next to them, became indifferent to every rule of religion or law. Athens owed to the plague the beginnings of a state of unprecedented lawlessness. Seeing how quick and abrupt were the changes of fortune, . . . people now began openly to venture on acts of self-indulgence, which before then they used to keep in the dark. As for what is called honor, no one showed himself willing to abide by its laws, so doubtful was it whether one would survive to enjoy the name for it. No fear of God or law of man had a restraining influence. As for offences against human law, no one expected to live long enough to be brought to trial and punished.[6]

Rome, too, was prey to the plague. According to the eighteenth-century English historian Edward Gibbon, when, during the sixth century AD, "the plague of Justinian" was at its height, "five and at length ten thousand persons died each day at Constantinople; and many cities of the East were left vacant, and that in several districts of Italy the harvest and the vintage withered on the ground. The triple scourges of war, pestilence and famine afflicted the subjects of Justinian; and his reign is disgraced by a visible decrease of the human species."[7] The contemporary scholar William McNeill argues that the plague of Justinian was directly responsible for the destruction of the Byzantine Empire. McNeill also contends that the successive waves of bubonic plague (the Black Death) that swept across the European continent from the fourteenth to the seventeenth century gradually destabilized and delegitimized the preexisting structures of authority in feudal societies, particularly the Roman Catholic Church.[8] This undermining of power relationships led to the rise of the Protestant Reformation in Europe, thereby contributing to the pan-European conflagration of the Thirty Years' War.

Disease has also played a central role in destabilizing non-European societies. When European forces arrived on the shores of the Americas, they brought with them numerous pathogens to which the Amerindian populace had no inherent immunity. Smallpox was the most virulent of these pathogens, and it ravaged Amerindian societies to the extent that, when European forces pushed into the interior, they often found villages filled with the dead. This helps to account for the considerable military success that European forces enjoyed on their missions of conquest. Smallpox, writes Alfred Crosby,

> quickly exterminated a third or half of the Arrawacks on Espaniola, and almost immediately leaped the straits to Puerto Rico and the other Greater Antilles, accomplishing the same

> devastation there. It crossed from Cuba to Mexico. . . . The disease exterminated a large fraction of the Aztecs and cleared a path for the [Spanish] to the heart of Tenochtitlan and to the founding of New Spain. Racing ahead of the conquistadores, it soon appeared in Peru, killing a large proportion of the subjects of the Inca, killing the Inca himself and the successor he had chosen. Civil war and chaos followed, and then Francisco Pizzaro arrived. The miraculous triumphs of that conquistador, and of Cortes, whom he so successfully emulated, are in large part the triumphs of the virus of smallpox.[9]

Even in this modern age, humanity remains vulnerable to the depredations of disease. The destabilization engendered by epidemics is about to be repeated (albeit perhaps in alternative forms) in the twenty-first century.

Three

Health, State Capacity, and National Security

Health and State Capacity

State capacity is a concept of high utility when analyzing the effect of the HIV/AIDS epidemic on the stability of sovereign states. Theda Skocpol posits that there are five central components of state capacity: sovereign integrity, financial resources, loyal and skilled officials, stable administrative-military control, and the authority and institutional mechanisms to employ the state's resources.[10] Joel Migdal argues that strong states are capable of penetrating society, extracting and appropriating resources and regulating social relationships.[11] Pierre Engelbert seeks to narrow the definition of state capacity to the government's ability to maintain effective institutions and markets and to foster economic development.[12] With a nod to Migdal, we have refined our definition of state capacity to refer to one country's ability to maximize its prosperity and stability, to exert de facto and de jure control over its territory, to protect its population from predation, to extract resources, to regulate social relationships, and to adapt to diverse crises.[13]

Developed countries possess significant internal levels of state capacity in the form of economic resources, human capital, infrastructural investments, and scientific capability. Such countries have enjoyed considerable success in responding to the HIV/AIDS epidemic and mitigating its effects on their populations. States with lower levels of state capacity have fared less well. However, states battling the spread of HIV/AIDS can, we argue, compensate to some degree for relatively low levels of state capacity with good governance. In Uganda and Thailand, for example, political elites have used their power to mobilize civil society in a bid to reduce behavior that boosts the risk of infection. Both countries have seen their seroprevalence levels of HIV infection decline significantly over the past decade. In contrast, countries with middling to low levels of state capacity that do not enjoy good governance have failed to contain the spread of the contagion and mitigate its adverse economic and political effects. Zimbabwe is a case in point.

A strong positive correlation exists between population health and state capacity. Population health can be calculated from indicators of life expectancy and infant mortality. State capacity can be measured by an empirical index of variables that are logical indicators of a state's ability to deliver on its central functions. In an empirical cross-national study of twenty nations, drawing on forty years of data, Andrew Price-Smith demonstrated that public health is a major driver of state capacity.[14] This study also revealed the existence of a feedback loop between population health and state capacity, which demonstrated that health is a stronger long-term driver of state capacity than the obverse. This suggests that significant declines in population health (regardless of the source of the decline) will generate significant declines in state capacity over the long term. In Zimbabwe, where adult HIV

seroprevalence rates are at 34 percent, the HIV/AIDS epidemic has dramatically eroded life expectancy and significantly compromised the health and welfare of the population as a whole. As the collapse of public health accelerates, so will the erosion of state capacity. Indeed, in the years since 1999 the epidemic has already begun to destabilize Zimbabwe; over the next ten years, as more individuals become infected with HIV, develop AIDS, sicken, and die, the epidemic will exact an ever-larger toll on Zimbabwe's economic and political health.

Why is Zimbabwe reeling under the epidemic, whereas neighboring Botswana, which has a marginally higher adult HIV seroprevalence rate (of 36 percent), remains generally stable, despite the high levels of debilitation and death induced by HIV/AIDS in that country? The answer can be found in the fact that, as just noted, state capacity combines with political will to influence downstream political stability. Botswana is a relatively prosperous rentier state with significant mineral wealth, relatively high per capita annual income (U.S.$3,100), and higher levels of state capacity than Zimbabwe. Moreover, Botswana possesses excellent political leadership in President Festus Mogae, an Oxford-trained economist who is fully engaged in efforts to blunt the negative effects of the epidemic on the people of Botswana. To that end, the Mogae administration has provided significant leadership in mobilizing communities to reduce endogenous transmission and has promised that infected persons will receive free antiretroviral therapy to reduce the viral load in their systems. (The present study is by and large limited to the case of Zimbabwe, but future assessments of the effect of HIV on governance might do well to examine the effects of political will and state capacity on state stability in countries with roughly equivalent levels of HIV seroprevalence.)

Health and National Security

The definition of what constitutes a threat to national security has changed over the years to include such phenomena as terrorism, resource scarcity, migration, and, now, threats to population health. During the first session of the UN Security Council of July 17, 2000, the United Nations adopted Resolution 1308 (2000) and declared the HIV/AIDS pandemic a threat to global security. This represents the first time in history that an issue of public health was elevated to such status, and it illustrates the recent transformation in thinking about threats to security in the post–Cold War era.

Robert Ostergard notes that security studies have been tainted by an ethnocentric bias that grew particularly acute during the Cold War. Given the bipolar animosity between the superpowers, attention was centered on European and North American security, deterrence, polarity, and the relationships between great powers.[15] Such subjects were of little relevance to the security of the developing world, where other problems, such as famine, poverty, disease, and resource scarcity, have proved to be the perennial threats. One early challenge to the purely militaristic conceptualization of security came from Barry Buzan, who argued that national security encompasses various spheres of activity, including military, economic, political, societal, and environmental dimensions.[16] Richard Ullman redefined security in a manner that transcends traditional definitions that focus purely on military threats. Ullman argued that "defining national security in purely military terms conveys a profoundly false image of reality [and] causes states to concentrate on

military threats and to ignore other and more harmful dangers."[17] He defines a threat to national security as "an action or sequence of events that (1) threatens drastically and over a relatively brief span of time to degrade the quality of life for the inhabitants of a state or (2) threatens significantly to narrow the range of policy choices available to the government of a state or to private, non-governmental entities (persons, groups, corporations) within the state."[18] This redefinition of security is useful in that it includes nonmilitary threats, such as the destruction of a state's population by a pathogenic agent such as HIV.

While the emerging concept of "health security" has its historical basis in the threat originally posed by the use of biological weapons, scholars have argued that the concept of health security must be extended to cover the broad spectrum of threats to population health as a result of emerging and reemerging infectious disease.[19] In line with this broader conception, we argue here that the HIV/AIDS epidemic poses a grave and intensifying threat, both direct and indirect, to the national security of Zimbabwe.

Any agent that promises to destroy a significant proportion of a state's population constitutes a *direct* threat to that country's national security. Given that the HIV/AIDS epidemic is projected to take the lives of over 30 percent of the Zimbabwean population over the next decade, the epidemic clearly qualifies as a direct threat to the national security of the Zimbabwean state.

Among the numerous *indirect* threats posed by the HIV/AIDS pandemic, three stand out. First, the HIV/AIDS epidemic is dramatically reducing Zimbabwean life expectancy and quality of life through disease-induced morbidity and mortality and by increasing disease-related poverty. Second, the disease is systematically eroding the economic strength of the country, shrinking productivity, precipitating a decline in savings, increasing the country's debt load, and diminishing its store of human capital. Third, the epidemic is systematically eroding the institutions of governance (such as police and military forces) while depleting state capacity, thus dramatically narrowing the range of policy options available to policymakers. These factors combine to produce both the motive and the opportunity for intrastate violence between political elites, classes, or ethnicities and may even generate state failure. The epidemic may also provide increasing incentive for the Zimbabwean state to engage in violence against its own citizens, as political elites seek to maintain their grip on power in a destabilized and disaffected society.

Four

Demographic Projections

The prevalence of HIV/AIDS in Zimbabwe has increased alarmingly, rising from an estimated 12 percent of the population in 1990, to 29 percent in 1997, to an estimated 33.7 percent in 2001, when an estimated 200,000 deaths induced by HIV/AIDS occurred.[20] More than 600,000 Zimbabweans have died from the disease since 1998. As of December 2002, over 2.3 million Zimbabweans were infected with HIV,[21] 600,000 had full-blown AIDS, and more than 2,500 were dying each week as a result of the disease. Within the country, the distribution of HIV infection is varied, with Masvingo province exhibiting the highest prevalence (49.4 percent), followed by the Midlands (45.1 percent) and then by Harare and Bulawayo (30 percent each).[22]

The demographic impact of the disease is devastating. As a result of the dramatic winnowing of the adult population, the national population distribution is expected to transform from a pyramidal shape to a chimney-type form, with similar numbers of adults of different ages perched on a large base of children and adolescents.

In a dramatic illustration of the crisis, Zimbabwean life expectancy at birth has declined precipitously, from 52 years in 1970 to 40 years in 1999, and it is predicted to fall to a meager 27 years by 2010, according to UNICEF. The average life span in Zimbabwe fell 5.2 years between 1990 and 1998.[23] Infant mortality, meanwhile, increased as a result of the HIV/AIDS epidemic, from a rate of about 58 deaths per thousand in 1997 to 69 per thousand in 2001. Under-five mortality also increased, from 98 per thousand in 1997 to 108 per thousand in 2001.[24] Data on HIV seroprevalence in Zimbabwe are drawn from "sentinel sites," which in this case are prenatal clinics where prospective mothers are tested for the presence of the virus. This gives a rough measure of the distribution of the virus throughout the adult population. The process of estimating seroprevalence levels accurately is complicated by factors such as chronic underreporting of HIV due to the lack of adequate testing infrastructure in rural areas. The concentration of national medical capacity within urban areas may in fact contribute to underreporting of HIV infection on a national level.

The principal activities that foster the spread of contagion in Zimbabwe include polygamous sexual relations, prostitution along major transportation arteries, a general societal aversion to the use of condoms, and intravenous drug use in major urban centers. It should be noted that, unlike with the cases of expanding epidemics in Russia and Ukraine,[25] HIV is well entrenched within the general heterosexual majority of the Zimbabwean populace and its principal vector of transmission is currently unprotected heterosexual activity.

Given that HIV/AIDS generates significant mortality within the fifteen- to forty-five-year age range, it is no surprise that the epidemic has generated significant cohorts of orphans. UNAIDS estimates the number of Zimbabwean children who have lost one or

both parents to HIV/AIDS at 780,000 as of 2002 (up from 600,000 in 2000); the cumulative number of AIDS orphans (including the deceased) exceeds one million.[26]

The orphaned population is sure to become a severe drain on state resources in the years to come and will further strain Zimbabwe's already overtaxed budget. The burden of caring for the children will also fall upon extended family members, placing additional strains on declining household incomes and savings. Indeed, a large cohort of orphans threatens to overwhelm existing support systems. The majority of these children will grow up impoverished, poorly educated, prone to criminal behavior, and disenchanted with society.

Peter Fourie and Martin Schonteich argue that the large cohort of orphans has significant negative ramifications for societal stability, as youth are more frequently involved in criminal activity and more likely to be recruited by destabilizing movements such as militias, paramilitaries, and terrorist organizations.[27] Schonteich has argued that the HIV/AIDS epidemic will directly increase the frequency and severity of crime in Zimbabwe in the decades to come, primarily as a function of the inexorably growing population of AIDS orphans: "Growing up without parents, and badly supervised by relatives and welfare organizations, the growing pool of orphans will be at greater than average risk to engage in criminal activity."[28] These concerns are echoed in a report issued in 2000 by the U.S. National Intelligence Council, which concluded:

> With as much as a third of the children under fifteen in hardest-hit countries expected to comprise a "lost orphaned" generation by 2010 with little hope of educational or employment opportunities, these countries will be at risk of further economic decay, increased crime, and political instability as such young people become radicalized or are exploited by various political groups for their own ends; the pervasive child soldier phenomenon may be one example.[29]

Furthermore, as the HIV/AIDS epidemic continues to expand throughout the region, it will destabilize the governments in the area, and this in turn will create opportunities for terrorist organizations to move in, set up shop, and recruit from among the disaffected, particularly the enormous orphan populations. This is particularly worrisome given that terrorist organizations are already active in eastern Africa and are moving into southern Africa to set up bases of operations and recruit personnel. In 2002, suspected members of al Qaeda were detained after they were found to be moving large quantities of cash into South Africa. Thus, the AIDS orphan problem threatens not only to create governance problems within affected states but also to contribute to problems of global governance (notably, terrorist activity) in the future. These assertions will be examined in greater depth in the sections that follow.

Five

Economic Impacts

In the early 1990s, Zimbabwe was heralded by other African societies as one of the great economic and social success stories of the continent. Yet, over the past decade, President Robert Mugabe and his Zimbabwe African National Union–Patriotic Front (ZANU-PF) have made a litany of errors in managing the Zimbabwean economy. These egregious lapses in judgment include the seizure of white-owned farms and the perpetration of violence against the white minority, the sending of troops to the DRC, and rhetoric about the nationalization of industry (mining in particular). Presently, the Zimbabwean economy exhibits high levels of income inequality, with approximately 20 percent of the population receiving 60 percent of the income. Roughly 60 percent of the population lives below the poverty line, with between 33 and 50 percent of the poor's total annual expenditures going to food and health care.[30] Zimbabwe is also experiencing significant shortages of foreign exchange and increasing arrears on its foreign debt to the extent that in 2003 the International Monetary Fund (IMF) ruled the country ineligible for further financial assistance.

What is not often understood is that the HIV/AIDS epidemic has been contributing to the decline of the Zimbabwean economy for some time, exacerbating income inequalities, undermining societal productivity, and generating capital flight out of the country. It would be fatuous to argue that all of this economic turmoil has resulted from the epidemic alone, but to ignore the role of the contagion in fostering widespread economic decline would be to engage in denial. In this section, we document the negative observed effects of HIV/AIDS on the domestic economy at both the microeconomic and the macroeconomic levels.

Microeconomic Impacts

Household Income

At the household level, HIV/AIDS will have a dramatic negative effect on production and earnings, resulting in reduced income, declining productivity, and the reallocation of labor and land to deal with debilitated or dead breadwinners. HIV/AIDS-induced debilitation generates a number of negative demand- and supply-side shocks to households, including the loss of income from infected breadwinners, significant medical expenditures, and the loss of employment as healthy individuals must care for ill family members. Premature AIDS-induced mortality results in the permanent loss of income, large funeral costs, and permanent labor substitution as children are removed from school to generate income for the family. Lori Bollinger reports that "funeral costs can be as much as Z$4,500 . . . [and] tombstones have become unaffordable; people instead use a concrete slab or a pile of soil."[31] Furthermore, widows may lose their land when their husbands die of AIDS, as male relatives may lay claim to the dead individuals' belongings (including their spouses), according to custom. Given that most Zimbabwean women lack legal

certificates (such as wills or marriage certificates), their rights are not protected. This in turn helps to spread the disease, as infected widows may pass the illness on to their new partners.

Moreover, it is evident that the burden of disease falls unequally upon classes, with poorer populations bearing the greater burden.[32] The indigent may be forced into sexually exploitative situations to generate income. The poor will also be most vulnerable to infection, given their lower levels of nutrition and lower basal health conditions. Finally, such economically marginalized people will be unable to afford antiretroviral therapies that may slow the progression of the disease. Therefore, it is important to understand that, because the burden tends to fall upon the middle and lower classes, HIV/AIDS accentuates the gap in income disparities between classes in Zimbabwean society. The consequences of such increasing economic inequities for societal stability are explored below.

Human Capital

Economic development may be regarded as a "generalized process of capital accumulation" wherein capital consists of both physical and human capital and institutions.[33] The epidemic's pernicious influence on the formation and consolidation of human capital within Zimbabwean society is significant. AIDS will take the lives of a significant proportion of the brightest minds of Zimbabwe. This in turn will hamper efforts toward economic development and impede the consolidation of democratic government. It is important to recognize that the HIV/AIDS epidemic simultaneously drains reserves of human capital and prevents its accumulation, thereby weakening the institutional capital of a given society.

The net outcome of HIV-induced decline in a society's stock of human capital is to impede economic development and to set in train a long-term process of serious economic decline. As government funding is diverted from education to the health care sector, levels of literacy and other skills among the young will diminish. Malcolm McPherson argues that the HIV-induced decline of savings and loss of efficiency are very much like "running Adam Smith in reverse." "As an increasing number of workers become debilitated and drop out of the labor force, many of the advantages of specialization and the division of labor are lost. Moreover, the loss of labor is a direct reduction of the nation's productive capacity."[34] Thus, the HIV/AIDS epidemic will have a pronounced effect on the accumulation and consolidation of knowledge and skills within the Zimbabwean population while simultaneously depleting the preexisting stock of human capital through the premature mortality of skilled workers. The long-term effects for Zimbabwean prosperity will be dire.

Sectoral Impacts

HIV/AIDS is seriously affecting Zimbabwe's labor supply, debilitating and killing skilled employees and generating a decline in human capital that impedes worker productivity. At the macrolevel, HIV is diminishing the stock of endogenous human capital in Zimbabwe, as it takes time and money to train workers to take over jobs vacated by their infected peers. AIDS-induced debilitation and mortality will not, however, dramatically lower Zimbabwe's unemployment rate of approximately 45 percent, because the contraction of the macroeconomy will lower the demand for labor. Moreover, the epidemic will exacerbate the preexisting shortage of skilled workers. Thus, the long-term prognosis is for persistently high unemployment and a dearth of skilled labor.

Zimbabwe's economy is largely dependent on the export of primary products, particularly agricultural crops such as sugarcane, tobacco, and cotton. Other significant domestic industries include sugar production, textiles, and mining. Considerable decline has been witnessed across important sectors, ranging from a 25 percent loss of manufacturing capacity since 1998, a loss of 20 percent of mining output since 1999, and a decline in earnings from tourism of roughly 50 percent since 1999.[35] This is not to suggest that the HIV/AIDS epidemic is solely responsible for this decline in productivity; undoubtedly, however, the epidemic significantly limits the productive possibilities of the Zimbabwean economy. The impact can be seen in all specific sectors of the economy.

Agriculture

The food supply in Zimbabwe has deteriorated significantly over the past four years. For example, cereal production declined 24 percent between 2000 and 2002, dramatically undermining food security for the Zimbabwean population. In that same span of time, the large-scale commercial sector saw a 30 percent decline in area planted under all crops, with maize alone showing a decline of 54 percent in area planted.[36] Recent assessments of the deteriorating food supply in Zimbabwe typically focus on the problems generated by the Mugabe regime's policy of coercive land redistribution and on the significant drought that has blighted southern regions of Zimbabwe over the past several years. However, they exclude a significant variable—the negative effects of the HIV/AIDS epidemic. A number of studies have demonstrated that HIV/AIDS has had significant negative effects on agricultural productivity, notably through its reduction of the labor supply, the declining productivity of workers, and a decline in remittance income. As HIV/AIDS generates greater losses in productivity, farmers will find it expedient to shift to less labor-intensive crops. Typically, this implies shifting from export crops to food crops, which will reduce national export earnings over the long term.

While some analysts argue that food insecurity in rural areas is due to declining purchasing power, it is also readily apparent that disease-induced declines in smallholder productivity also constrain the productive capacity of that sector. As rural workforces become increasingly infected, labor-intensive industries will exhibit declines in productivity, a situation already clearly evident in the declining productivity of the agricultural sector.

More than half of Zimbabwe's populace lives in rural areas and depends on smallholder agriculture for food and employment. A study in 1997 by P. Kwaramba examined the impact of AIDS mortality on household production in Zimbabwe and found that maize crops were reduced by 61 percent, cotton by 47 percent, vegetables by 49 percent, groundnuts by 37 percent, and cattle by 29 percent.[37] The Food and Agricultural Organization has determined that HIV generated a loss of 9.6 percent of the agricultural labor force between 1997 and 2000, and this figure was projected to grow to 22.7 percent by the year 2020. The balance of evidence suggests that massive infection of the populace will compromise the nation's endogenous capacity to produce food. Undoubtedly, the current food shortage in Zimbabwe is at least partly caused by the HIV/AIDS epidemic.

Mugabe's forced redistribution of land from whites to blacks may compound the food shortage. Most black-owned farms are small and far more labor intensive than the mas-

sive farms operated by white-owned corporations. Smallholder farms will thus be far more vulnerable to HIV-induced debilitation and mortality as the virus increasingly colonizes the workforce. As a result, smallholder farms are likely to be even less productive than previously thought, which will seriously reduce both the domestic food supply and the amount of export-oriented crops that generate much-needed foreign exchange. Moreover, the failure of smallholder farms will also serve to exacerbate existing income inequality in Zimbabwe. This will likely increase resentment among the poor and add fuel to the burgeoning racial conflict between white and black landowners.

Given this dire combination of HIV/AIDS-induced debilitation and mortality, persistent drought, and an ill-conceived land distribution policy, the long-term implications for food security in Zimbabwe are indeed grave.

Health

The HIV/AIDS epidemic will generate significant and persistent problems in the health sector. The epidemic will increase the demand for health services personnel to care for the ill and dying while reducing the supply of such personnel, who will themselves succumb to infection. Furthermore, as the epidemic constrains macrolevel economic productivity, the government will see a corresponding loss of revenue through taxation, and this loss of revenue will ultimately translate into declining levels of fiscal support for the health sector. This shortfall will in turn combine with the depletion of skilled health services personnel to further weaken the national health infrastructure over time. Marcus Haacker estimates that the direct costs of HIV-related health services consumed 2.1 percent of the Zimbabwean GDP in 2000, a figure that will rise to 3.5 percent in 2010.[38] The indirect costs of the epidemic, it should be noted, are estimated to be far greater.

Education

The epidemic will have a variety of negative effects on the education sector. First, HIV/AIDS-induced morbidity and mortality will deplete the national supply of skilled teachers. According to Raymond Majongwe of the Zimbabwe Progressive Teachers Association, an estimated 25 percent of the workforce was infected with HIV in July 2002.[39] A study in Manicaland found that 19 percent of male teachers and almost 29 percent of female teachers were infected with HIV.[40] Unfortunately, teachers in Zimbabwe are generally poorly informed about the nature of HIV and how to prevent transmission. Moreover, growing evidence suggests that sexual relations between teachers and their students are amplifying viral transmission throughout the community.[41]

Many of the orphans created by the epidemic may not be able to afford education. According to the World Bank, the number of primary students in Zimbabwe will be 24 percent lower in 2010 than in 2000 because of the HIV/AIDS epidemic.[42] If Mugabe's government is wise, it will choose to invest in education of orphans to limit societal destabilization in the coming years. Children in families in which one or more parent is dead or debilitated may find themselves working to support the family unit. Such labor substitution, of course, will limit those children's ability to attend school and learn new skills. As greater numbers of children are kept out of school due to labor substitution, the development and consolidation of human capital throughout Zimbabwean society will be

significantly impeded, leading to a grim future in which the workforce will be undereducated, unskilled, and disaffected.

Despite the decline in the number of students seeking education, HIV/AIDS-induced morbidity and mortality will produce a shortfall of teachers and a decline in the teacher-pupil ratio. "The number of newly trained teachers already needs to increase substantially in order to avoid a deterioration in pupil-teacher ratios," notes Haacker.[43]

Transportation

The transportation sector is particularly vulnerable to HIV/AIDS-induced declines in productivity and revenue. The construction and maintenance of transportation infrastructure and the operation of trucks, trains, and ships and barges are both labor intensive and call for male workers to spend long periods far from their families, during which they often engage in risk-prone sexual behavior. In their study of the National Railways of Zimbabwe, Lori Bollinger and John Stover found that the company reported an absenteeism rate exceeding 15 percent in 1997 as a result of HIV/AIDS. Initial studies determined that HIV/AIDS cost the company Z$39 million in 1996, equivalent to roughly 20 percent of the company's profits. In 1997, absenteeism-related costs reached Z$80 million. Bollinger and Stover predicted that direct costs from HIV/AIDS would rise to Z$108 million in 2005.[44] Lovemore Kadenge, president of the Zimbabwe Economics Society, said in July 2002 that research by a local bus company had revealed that HIV/AIDS-related absenteeism contributed 89 percent to overall costs.[45]

Macroeconomic Impacts

The HIV/AIDS epidemic places severe constraints on the development of the national economy, constraints that no government can long ignore or easily overcome. By depleting the national reservoir of human capital and impeding its formation, HIV/AIDS limits long-term development potential. HIV/AIDS-induced shortages of skilled workers create higher domestic production costs, which in turn erode international competitiveness. Haacker estimates that the HIV/AIDS epidemic in Zimbabwe will result in a loss of output per capita of 7.3 percent per annum due to a change in total factor productivity of –1.3 percent.[46] R. Bonnel estimates that current levels of adult HIV seroprevalence will slow the growth rate of the macroeconomy, such that disease-induced morbidity and mortality will reduce GDP growth by approximately 1.5 percent per annum.[47] While this may not sound like a significant decline, for the developing countries of southern Africa it is an economic catastrophe in the making.

As the rate of population growth declines and the economy contracts, personal incomes, corporate profits, and consumption will also decline. Government revenues are also projected to fall as the tax base stagnates—at the same time that the government will be attempting to boost expenditure in the health sector. Increased deficit spending in the wake of a contracting endogenous revenue base is likely. Zimbabwe's GDP declined from U.S.$8.6 billion in 1991 to U.S.$7.2 billion in 2000, which may reflect HIV's increasing drag on national productivity. Similarly, gross domestic investment declined precipitously from 20.8 percent of GDP in 1981 to a meager 7.8 percent in 2001. Gross domestic savings fell over the same period from 14.3 percent to 9.0 percent of GDP, while gross national savings

dropped from a high of 12.5 percent of GDP in 1991 to 7.4 percent in 2001. This reflects the depletion of individual savings by HIV/AIDS-induced costs generated by debilitation and premature mortality. Simultaneously, total debt as a percentage of GDP grew from 39.8 in 1991 to 55.8 in 2000, although much of this growth is attributable to heavy borrowing by the Mugabe regime.[48]

Under the Mugabe regime, Zimbabwe experienced moderate economic success throughout the 1980s, with GDP growth from 1981 to 1991 averaging 3.6 percent per annum. However, concurrent with the onset of massive infection rates in the early and mid-1990s, the annual growth rate of GDP fell to –4.9 percent in 2000 and –8.4 percent in 2001. Moreover, the growth rate of GDP per capita also declined, from 0.3 percent in 1991 to –7.7 percent in 2000 and –10.1 percent in 2001. Meanwhile, inflation increased from 32 percent in 1998 to 59.4 percent in 1999 and 108 percent in late 2001.[49] To offset declining domestic productivity and increased government spending, the Mugabe regime has incurred an enormous debt load. The total external debt of Zimbabwe in 2001 was estimated to be U.S.$4.45 billion, with debt-servicing costs running at 69 percent of revenues generated through agricultural exports.[50]

In sum, the HIV/AIDS epidemic has already begun to generate serious negative outcomes for the Zimbabwean economy, including declining GDP and GNP, in terms of both absolute and per capita measures. It also promises diminishing national and individual savings, declining productivity, and falling rates of foreign investment. The overall picture is one of sustained economic stagnation and the accelerating contraction of the Zimbabwean economy. This slowing of national economic growth, declining savings, chronically high levels of unemployment, and declining real per capita GDP will intensify the poverty experienced by the middle and lower classes. Economic contraction is likely to intensify in the years to come, as more HIV-infected individuals develop AIDS and succumb to the illness. It is difficult, however, to determine empirically what proportion of Zimbabwe's economic decline is a direct result of the contagion and what proportion is attributable to the Mugabe government's increasingly poor management of the economy. Subsequent studies may throw more light on this issue.

Foreign Aid and Foreign Investment

The continuing absence of the rule of law in Zimbabwe, widespread corruption, electoral fraud, and the government's renowned propensity to default consistently on loans have generated significant mistrust of the Mugabe regime by foreign donor countries. As a result, most Western donors have suspended their most significant aid efforts and Harare no longer has an effective working relationship with the World Bank or IMF. Indeed, in 2003, Zimbabwe's economic and political troubles (and government mismanagement) grew so grave that the IMF declared that no more funds would be made available to the Mugabe government.

Private investors have also grown increasingly wary of Zimbabwe, thanks in part to President Mugabe's persistent threats to nationalize industry and to his government's egregious economic mismanagement. But these are not the only causes of Zimbabwe's poor investment climate: the HIV/AIDS epidemic has also had a profoundly negative effect. The increasingly gloomy economic future of HIV/AIDS-wracked Zimbabwe is prompting capital flight, as prudent investors pull their capital investments out of the Zimbabwean economy. Meanwhile,

new investment is likely to go to countries with lower risk exposures. According to a Business Map investor survey published in 2002, Zimbabwe and its neighbors are witnessing a rapid decline in foreign direct investment, as the HIV/AIDS epidemic has increased the risk profile for regional investment and investors are requiring a premium rate of return exceeding 25 percent throughout southern Africa.[51] The great uncertainty (due to a paucity of information) regarding the ultimate economic effects of the epidemic also worsens the investment climate in Zimbabwe. As McPherson comments:

> Investors are more likely to wait (defer investment) when they have information indicating that the spread of HIV/AIDS will affect adversely the cost structure of any investment they are contemplating. As the perceived costs of dealing with the spread of HIV/AIDS rise, the rate of investment tends to decline. This has reinforced the decline in the supply of investible resources, already under pressure through falling productivity due to the spread of HIV/AIDS. Thus, while the spread of HIV induces the need for higher rates of investment to help maintain worker productivity, it erodes the means by which such investment can be financed.[52]

Economic Impacts on the Military

A modern, well-trained, and well-equipped fighting force cannot be created and fielded without a substantial national economic engine to power it. The HIV/AIDS epidemic, by generating significant long-term constraints on the Zimbabwean economy, is increasingly limiting Zimbabwe's military power. Indeed, the Mugabe regime may be compelled to withdraw its weakening armed forces from the protracted conflict in the DRC.

Harare's intervention in the DRC has proved to be unpopular with the Zimbabwean population at large, but it has provided a significant economic boon to the ZANU generals, who have sought to exploit valuable natural resources throughout the territory held by Zimbabwean forces.[53] Zimbabwean soldiers currently occupy mineral-rich areas of the DRC and are contracting with the government for mining rights. Should the Zimbabwean military prove incapable of holding these areas of the DRC, the generals' resentment at their consequent loss of income may pose a challenge to Mugabe's control of the military.

Challenges to Mugabe's power from members of the country's military, political, and economic elites may also be prompted by the general contraction of Zimbabwe's economy, which will create competition over increasingly scarce fiscal resources. The growing potential for political violence and coups d'état may be welcomed by opponents of the Mugabe regime, but they should recognize that any successor regime would face a similar situation of worsening economic and political destabilization while the HIV/AIDS epidemic rages unabated.

Six

Governance Impacts

> Any one of the political, humanitarian, and public health situations prevailing in Zimbabwe could fairly be described as a crisis in its own right. The convergence of all of them with the looming threat of mass starvation due to drought and the disruptive effects of farm seizures by the Mugabe government portend a truly catastrophic state of affairs. Mass deaths due to starvation and civil violence, a refugee exodus, increased crime, and economic ruin all appear possible. These looming eventualities threaten greater crises not just for Zimbabwe, but also for all of southern Africa.
>
> —John Brinkley, *Zimbabwe and the Politics of Torture*

Zimbabwean society today faces immense barriers relating to the implementation of good governance practices. The Mugabe government and ZANU-PF have systematically implemented strategies to confound democratic governance processes such as respect for basic human rights and fiscal transparency in governmental operations.

The suppression of fundamental democratic principles such as freedom of the press, of speech, and of public assembly is increasingly common. Recent legislation has included the Access to Information and Protection of Privacy Act, which effectively criminalizes free speech, the Public Order and Security Act, which outlaws public meetings, and the Law and Order Maintenance Act, which prohibits the publication of anything "likely to cause alarm and despondency."[54] The net effect has been to effectively censor the media and crush dissent.

The Mugabe government employs torture as a tool of political control. President Mugabe seeks to ensure compliance with the government's draconian laws and public policy practices by torturing dissidents and political opponents, including members of the main opposition party, the Movement for Democratic Change (MDC). Torture, however, is not administered merely to stifle opposition by party activists. Tony Reeler, clinical director for Zimbabwe's Amani Trust, suggested in 2001 that "probably 20 percent of the entire population has had intimate experience with torture."[55]

Governance in Zimbabwe, already exhibiting considerable potential for violence and institutional instability, likely will worsen further as a result of the HIV/AIDS epidemic. As we have seen from historical experience, significant levels of disease-induced mortality and morbidity undercut both the economic and the political stability of societies over the long term. The nature of sociopolitical instability experienced in Zimbabwe today, coupled with rising levels of mortality and morbidity resulting from AIDS, will magnify the sense of hopelessness and despair among Zimbabwe's citizens. Rising individual and collective frustration will be expressed through increasing acts of lawlessness, personal behavioral recklessness, and callousness toward fellow Zimbabweans. Under these circumstances, one should anticipate a growth in crime, including violent crimes such as murder and rape.

Over the next decade, Zimbabwe will also lose a substantial portion of its existing law enforcement personnel. The Zimbabwe Republic Police serves Zimbabwe's eight provinces and its two major "provincial cities" (Harare and Bulawayo). Premature displacement of personnel will cut critically into law enforcement's capacity to maintain the peace at the community level. Already, Zimbabwe's HIV/AIDS epidemic makes a bad situation worse for its people. The mixture of high and rising unemployment, rampant poverty, rapidly growing cohorts of orphans, severe food and fuel shortages, and an economy in a state of hyperinflation, coupled with the prevalence of HIV, has induced skyrocketing crime rates.

A comparison of Interpol crime statistics for Zimbabwe in 2001 with those for 1995 shows the degradation that has occurred. Zimbabwe's population grew 15.5 percent between 1995 and 2001, but crime grew substantially more, with reported murders increasing by 68.7 percent, sexual assaults by 26.9 percent, and rape by 58.5 percent. The incidence of rape of young girls has soared because of the myth that an individual can rid himself of HIV if he has sexual intercourse with a virgin; in some instances, females aged five and younger have been victimized. Other criminal activities showing notable increases during this period include robbery and violent theft (89.8 percent), auto theft (49.1 percent), and aggravated theft (37 percent).[56]

These startling increases point to a society spiraling into greater lawlessness and chaos. The growing practice among the citizenry of shunning assistance from law enforcement warrants equal concern. Many victims in Zimbabwe—particularly those with known affiliations to political, media, or labor alliances out of favor with the Mugabe government—do not report incidents, believing that their calls for aid will be ignored. The future of effective governance through law enforcement efforts is increasingly at risk in Zimbabwe. In part, this will result from growing attrition rates among police personnel. Decline in law enforcement's credibility as a primary source of intervention and assistance to victims of crime also explains the growing lack of confidence in this governance unit.

Effects on Public Service

Zimbabwe's HIV/AIDS epidemic affects the nation's ability to sustain and deliver quality public services for its citizens. Since the early 1990s, the Zimbabwean government has been under increased pressure to reform its civil service systems. International funding sources (e.g., the World Bank and the International Monetary Fund) have linked continued support to the imposition of structural changes that would reduce Zimbabwe's bloated civil service. In 1997, J. M. Makumbe characterized Zimbabwe's civil service in the following terms: "weak government capacity to ensure minimal services, highly compressed wages, inability to attract and retain skilled manpower resources, and a large civil service (192,000) absorbing 18% of GDP in salary and wages by 1990/91."[57] IMF estimates for October 2000 placed Zimbabwe's public service employment at 194,500.[58] Thus, the size of Zimbabwe's government has remained virtually the same over the past decade but may be marginally more efficient today given the growth in its population over this same period.

The epidemic also has a profoundly negative impact on service delivery and quality of services provided to the citizenry. Clearly, citizens will pressure the government to spend a greater proportion of national revenue on health care over the next five to ten years. In

a country as strapped for cash as Zimbabwe, there is little elasticity for moving money from one area of expenditure to another. Thus, the national government has some difficult choices to make. Does it transfer funds from other service areas (such as the military) to provide treatment for and to fight the spread of HIV/AIDS, or does it simply ignore the problem and allow underfunded and overworked HIV/AIDS nongovernmental organizations (NGOs) to carry this burden? The current government will likely choose the second option. In the longer term, this strategy will create heightened frustration among a weary citizenry, thereby creating an increased potential for further civil unrest.

HIV/AIDS will create a slow degradation of the quality of services provided by national public servants. Traditionally, in developing nations such as Zimbabwe, the best and brightest have chosen careers first in public service. Civil service employees often represent the most highly educated in underdeveloped societies, many having received graduate education from European and American universities. Moreover, these professionals, because of their higher incomes and elevated social status, have fallen victim to HIV earlier than have members of the general populace.[59] HIV/AIDS will cut deeply into Zimbabwe's professional civil service talent pool in all areas of government. Costly losses in professional fields such as civil engineering, medicine and health care, education, financial administration, and developmental planning are a particular worry.

Anticipated professional losses looming as high as 40 percent fuel great concern about sustaining a viable professional staff in government, and much discussion among human resource planners has revolved around the issue of finding adequate replacements. Government leaders must prepare now through the planning and training of replacement workers if the Zimbabwean government hopes to sustain current levels of public service delivery over the next decade.

Professional losses also will result from the voluntary retirement of talented public servants who are not HIV-positive but who fear that their pension plans will be whittled away before they can enjoy them by the high costs of paying retirement benefits to individuals who retire early because of HIV/AIDS. As John L. Daly has discovered, this phenomenon occurred in Swaziland, where highly placed public servants with notable marketability opted for early retirement and a reduced benefits package rather than risk waiting to retire on full benefits.[60]

Zimbabwe's endogenous state capacity determines the scale of adaptive resources that the nation can mobilize to mitigate the negative effects of HIV/AIDS. Unfortunately, the country is trapped in a vicious cycle: as the HIV/AIDS epidemic progressively takes its toll, so Zimbabwe's state capacity declines, and as Zimbabwe's state capacity declines, so the nation's ability to institute creative HIV/AIDS intervention strategies correspondingly diminishes.

This decline in state capacity, coupled with a government and an economy on the verge of collapse, suggests that exogenous assistance from developed countries, principally from the G-8 nations, and from other international sources such as UN agencies and major private-sector donors will be necessary to avert further degradation of Zimbabwe's socioeconomic and political structures. Without these efforts, Zimbabwe will be incapable of returning to a system of good governance practices. However, such aid is not likely to be forthcoming until the Mugabe regime respects the rule of law and human rights and conducts free and fair elections. The desire voiced by African leaders for purely "African

solutions" to the HIV epidemic fails to acknowledge the epidemic's inexorable and negative effect on endogenous state capacity. Furthermore, given that many societies in sub-Saharan Africa now reel under the strain of HIV/AIDS, the cumulative effect will be to erode the capacity of the region as a whole, so that those states will find it increasingly difficult to come to each other's aid. Nonetheless, Ugandan leaders have proven remarkably effective in generating endogenous solutions to HIV, having dramatically reduced HIV prevalence in that country over the past decade. A recent study indicates that while state capacity is a major factor in determining whether states are effective in reducing HIV prevalence, it is moderated by effective governance.[61]

In a climate of increasing lawlessness, a stagnant or contracting economy, increasing institutional fragility, and declining revenue from taxes, the capacity of the state will be, at a minimum, strained. The demand from all sectors that the state deal effectively with the epidemic will increase, even as the epidemic inexorably erodes the state's capacity to respond effectively. Simultaneously, as the population becomes increasingly infected, morbidity and mortality will grow, poverty will deepen as people deplete their savings, and crime will burgeon. Citizens will feel a greater sense of relative deprivation and injustice and increasingly see the government as illegitimate. It is precisely this dynamic of a weakening state, combined with increasing real or perceived deprivation, that increases the probability of political violence against the state.

Furthermore, rival political elites in Zimbabwe may attempt to seize power from what they view as an increasingly inept or corrupt ZANU-PF government. The probability of intrastate political violence and state failure inexorably increases as the epidemic intensifies.

History has shown that outbreaks of epidemic disease often result in the curtailing of civil liberties. Thus, the HIV/AIDS epidemic may induce a shift from democratic to more authoritarian modes of government, particularly in unstable nascent democracies. Indeed, faced with disease-induced disorder, scarce resources, and declining government legitimacy, the state may increasingly resort to policies of divide and rule, encouraging the use of violence by competing groups within its own population.[62] The lessons of history are useful here as well, as epidemic disease has generated conflict between rival ethnicities over the centuries, typically with minority populations being scapegoated. While there is no evidence that the Shona and Ndebele consider Zimbabwe's white population to be the cause (or principal carriers) of the disease, whites nevertheless have been targeted for political violence as the majority sinks deeper into poverty and chaos. As the epidemic continues to intensify and generate increasing deprivation for the majority, there is every reason to believe that violence against whites will increase, particularly if the Mugabe regime continues to encourage anti-white sentiment as a means to distract the populace from their many grievances.[63]

In addition to increasing the probability of violence between ethnic groups, classes, and political elites, disease-induced deprivation combined with a weakened state may also foster the deliberate use of violence by the state against its own citizens in an attempt to retain control. This phenomenon is already widespread. For example, the Mugabe regime has sporadically employed veteran paramilitary forces to attack its political enemies when expedient, and particularly during election campaigns. One can expect an intensification of authoritarian rule as the government grows less able to meet the demands of the population and more desperate to hold on to power.

The Impact of Relative and Absolute Deprivation

HIV/AIDS will have a significant long-term negative effect on the prosperity and quality of life of the majority of the Zimbabwean people, increasing levels of relative and absolute deprivation throughout the populace. Relative deprivation will increase for the lower and lower-middle classes, who bear a relatively greater cost of HIV/AIDS-induced morbidity and mortality. All Zimbabweans will experience absolute deprivation as the economy stagnates and begins to contract as a result of the HIV/AIDS epidemic. Increasing deprivation generates increasing frustration and aggression by both individuals and collectivities, thereby increasing the probability of social violence and political chaos.[64] However, if deprivation alone could generate political violence, then the majority of states in the world would be perpetually consumed by the fires of internal rebellion. Collective violence against the state tends to occur when deprivation is exacerbated by stressors (such as the HIV/AIDS epidemic), creating both the incentive and the opportunity for citizens to rebel. A stressed state will have a lower degree of state capacity, including the capacity to maintain political and social stability.

The HIV/AIDS epidemic will generate increased competition between interest groups for increasingly scarce economic resources, particularly as federal funding is diverted to health care and away from other sectors, such as law enforcement, education, and the military. The epidemic has placed rapidly escalating demands on the Zimbabwean government to provide additional services to its population, even as the government's capacity to provide these services has been reduced by the expanding HIV/AIDS epidemic. Furthermore, the federal government may have to increase taxation of the populace significantly to restore depleted government coffers. This reduction of services combined with increased taxation in a climate of increasing deprivation will further erode the government's legitimacy. Thus the HIV/AIDS epidemic will simultaneously increase absolute and relative deprivation, increase perceptions of government ineptitude and illegitimacy, and erode state capacity. This equation will increase the probability of internal collective political violence against the state, or violence by the state against its own population, and thus increase the probability of state failure. The upshot is that the HIV/AIDS epidemic may not only kill and impoverish a significant proportion of the Zimbabwean people but also contribute to macrolevel political and social destabilization that will jeopardize the stability and security of the nation.

Seven

Security Implications

The Impact on National Security

As in most nations, in Zimbabwe the military and paramilitary (i.e., law enforcement) forces serve as control mechanisms to maintain the peace within society. In Zimbabwe, however, these units also function as instruments of terror. President Mugabe and the ZANU-PF party use these units to prop up and fortify a government that is widely accused of stealing the national presidential election in March 2002 through corruption, vote rigging, and voter intimidation.[65]

A growing body of literature sees HIV/AIDS-induced destabilization as a major contributing factor to conflict. Stefan Elbe and Robert Ostergard have argued that HIV/AIDS-induced mortality and morbidity jeopardize the efficacy of military institutions and may thereby promote conflict between states.[66] Elbe argues that HIV/AIDS is eroding the functional efficacy of African military institutions along four dimensions:

> [First, HIV/AIDS generates] the need for additional resources for the recruitment and training of soldiers to replace those who have fallen ill, have died, or are expected to die. . . . Additional resources are also required to provide health care for soldiers who are sick or dying. Second, the spread of HIV/AIDS is affecting important staffing decisions. High HIV prevalence rates lead to (1) a decrease in the available conscription pool from which to draw new recruits, (2) deaths among officers higher up the chain of command, and (3) a loss of highly specialized and technically trained staff who cannot be easily or quickly replaced. Third . . . it can result in increased absenteeism and reduced morale. Fourth, HIV/AIDS is generating new political and legal challenges for civil-military relations.[67]

In 2001, South Africa's Institute for Security Studies estimated the sizes of the Zimbabwe National Army (ZNA) and the Air Force of Zimbabwe (AFZ) at 35,000 and 4,000 staff, respectively.[68] Military and paramilitary organizations serve as primary vectors for the spread of HIV. According to Lindy Heinecken's estimates, Zimbabwe's armed forces exhibit an aggregate seroprevalence rate of 55 percent.[69] Extensive planning will be needed now to replace the losses of more than one thousand professionally trained personnel per year just to maintain minimal levels of professional competency. AIDS losses in the AFZ over the next decade can be expected to range between a low of 1,300 and a high of 2,600 personnel. AIDS-induced mortality has a relatively greater impact in the AFZ than in the ZNA because of the greater challenge to sustain the former's higher level of professional competency. The skills and talents of pilots, air traffic controllers, mechanics, and other technical staff often are in short supply in Zimbabwe and will not be easily replaced. Even within the ZNA, however, the loss of technical talent in the form of computer and information specialists, accountants, procurement officers, and so forth significantly weakens the force's capabilities.

HIV-related attrition will create a loss of continuity at the command level and in the ranks, as experienced, higher-ranking officers are forced into early retirement. Rodger Yeager of the Civil-Military Alliance to Combat HIV and AIDS notes that military staff attrition also results in "increased recruitment and training costs for replacements, and a general reduction in preparedness, internal stability, and external security. In this sense, HIV/AIDS can easily serve as a domestic and regional destabilizer and a potential war-starter."[70] Thus, Mugabe's military strength, which serves as an instrument of control over legitimate democratic processes, will slowly and almost invisibly erode over the next decade. Losses of more seasoned military staff through HIV/AIDS-related attrition will induce institutional fragility in the apparatus of coercion and thereby reduce ZANU-PF control over the governance process in Zimbabwe.

In 1998, Zimbabwe dispatched military personnel and arms to support Laurent Kabila's regime in the DRC. By 2001, eight thousand members of the Zimbabwean military were deployed to that country.[71] Deployment of Zimbabwean military personnel further compounds the transmission of HIV, as separation from family often results in increased sexual contact with high-risk partners (e.g., commercial sex workers). The fact that other sexually transmitted diseases (STDs) often go unchecked within a deployed military, especially when it is involved in active hostilities, exacerbates the problem. HIV seropositivity levels among the Zimbabwe servicemen returning from the DRC have been estimated to run as high as 80 percent.

Zimbabwe's air force also will degrade substantially without a plan to overcome likely human capital losses caused by HIV and AIDS. Compulsory HIV screening is not used in Zimbabwe's army, but it is selectively employed in its air force. For example, AFZ aircrew and medical officers receive regular testing. HIV-positive pilots and medical officers may be grounded, reassigned, and eventually discharged.

The Impact on Regional Stability

Increasing levels of HIV/AIDS infection throughout sub-Saharan Africa threaten to destabilize not only Zimbabwe but also Botswana, South Africa, Zambia, Angola, Malawi, Namibia, and Mozambique. The epidemic is also burgeoning in Nigeria, Kenya, Tanzania, Swaziland, and Lesotho. The increasing destabilization of Zimbabwe and its neighbors by the HIV/AIDS epidemic will lead to substantial flows of refugees throughout the region. A significant proportion of such refugee populations will be infected with HIV, and these population movements will serve as efficient vectors for the further dissemination of pathogens (including HIV, cholera, and tuberculosis) to uninfected populations. This, in turn, will accelerate the spiral of disease-induced instability throughout sub-Saharan Africa, heightening the potential for the economic and political destabilization of the Southern Cone of Africa. This bodes ill for the spread and consolidation of democracy in the region but will provide fertile ground for the growth of radical and terrorist operations.

One important element typically overlooked in discussions of the impact of infectious disease on national security is its effect on the relative power of states, particularly within a regional context. To be sure, the HIV/AIDS epidemic will reduce Zimbabwe's absolute power over the long term, given its profound negative effects on the country's military and economy. The effect on Zimbabwe's relative power (that is, its power relative to other states)

will depend on varying HIV infection rates throughout sub-Saharan Africa. If infection rates remain much as at present, the epidemic will have a greater negative effect on the relative power of Zimbabwe than on neighboring states such as South Africa and Mozambique, which have lower HIV/AIDS prevalence rates. Zimbabwe's power relative to Botswana and Zambia (which have similar prevalence rates) will remain essentially unaltered by the HIV/AIDS epidemic, even as the absolute power of these countries is diminished by the contagion. While it is unlikely that contagion-induced shifts in relative power will generate interstate war, the epidemic does have the long-term potential to alter regional balances of power. [72] This impact will become increasingly evident not only in southern Africa but also elsewhere in the world, as the pandemic intensifies in key states such as India, Russia, Ukraine, and China.

The HIV/AIDS-induced decline of effective governance throughout the entire Southern Cone will require an increasingly effective military to guarantee the integrity of Zimbabwe's borders. However, as discussed above, the spread of HIV/AIDS promises increasing institutional fragility for the military and diminishing levels of tax revenue that can be spent on the military. Thus, while the required *demand* for military power and efficacy is growing, the *supply* of military power and efficacy is rapidly declining due to the epidemic's decimation of military personnel. In short, the regional epidemic threatens Zimbabwe with increasing instability both within and beyond its borders. The greatest immediate risk is to be found in the country's border regions, where Harare is largely powerless to control crime, smuggling, and refugees.

Eight

Responding to the Crisis

State Adaptation

Adaptive strategies employed by states to counter the effects of HIV/AIDS have taken various forms across diverse societies. However, several factors limit each sovereign state's ability to adapt and mitigate the effects of the pandemic. First and foremost, adaptive strategies are limited by endogenous state capacity, which determines the scale of endogenous adaptive resources that can be mobilized to mitigate the effects of the pandemic. Zimbabwe has a moderately low level of endogenous state capacity to combat the HIV/AIDS epidemic. Thus, it is not altogether clear at this point whether Zimbabwe has enough endogenous capacity to stop the HIV/AIDS epidemic within its own borders. As we have stressed above, the expansion of the epidemic within Zimbabwe will progressively deplete state capacity through its simultaneous destruction of the economy and erosion of the structures of governance. As a result, the epidemic simultaneously raises the "demand" for state capacity, even as it depletes its endogenous "supply." The worrisome prospect is that the epidemic will cross a threshold at which demand for state capacity will exceed supply, making it impossible for Zimbabwe to stop the epidemic using endogenous resources alone. To offset this negative spiral of state capacity depletion, then, significant levels of exogenous resources (foreign aid) will have to be provided to shore up the crumbling Zimbabwean economy and structures of governance.[73] The disinclination of the international community to deal with the corrupt Mugabe regime hinders provision of such assistance at present.

The other key to successful adaptation by the state is the mobilization of political will. Strategies employed successfully by adaptive regimes in Thailand and Uganda saw the political elites mobilize in an effort to initiate widespread behavioral change throughout their respective populations. Even countries with lower levels of state capacity may be able to contain the spread of the virus through the adoption of such low-tech strategies. Aside from diminishing state capacity, the greatest impediments to Zimbabwe's ability to gain control over the HIV/AIDS epidemic have been the persistent lack of political will on the part of ZANU-PF to mobilize the country effectively against the epidemic and the use of antiretroviral medicines as a reward to the government's political allies (see below, "Harare's Response").

One frequently asked question is: At what threshold (as a percentage of population) might HIV seroprevalence cause a society to experience the collapse of effective governance? The answer remains elusive, at least for the time being, as it depends on whether the populace has access to effective antiretroviral therapies, whether the government will provide such therapies to infected populations in a comprehensive and nonpartisan

manner, and to what extent the economy and governmental institutions and legitimacy have been damaged by the epidemic. It may also depend on regime type, as nascent democracies and authoritarian regimes will likely exhibit significant vulnerabilities to disease-induced economic and political destabilization. Established democracies would seem to be more resistant in responding to such disease-induced stresses. The effects of HIV must be understood within the framework of an attrition process—a slow and inexorable destruction of a nation's economy, institutions, and social mores. The pandemic is a process, not a temporally constrained event.

As deprivation increases to critical mass and the apparatus of coercion erodes, considerable internal political violence is likely and may culminate in the overthrow of the Mugabe regime, unless substantial reforms are enacted in the near future. The removal of Mugabe from power would probably benefit the country enormously, as it would permit a new and accountable leadership structure to be established. However, any new democratic regime would remain subject to the instability generated by the epidemic.

Harare's Response

President Mugabe recently acknowledged that the HIV/AIDS epidemic constitutes a significant threat to Zimbabwe, and he has begun to give the issue a higher priority on the regime's agenda.

In 2000, Harare responded to the epidemic by imposing a 3 percent tax on companies and individuals to raise funds for HIV/AIDS programs, amid heavy public opposition. Monies collected by the National AIDS Council have been distributed to various entities, including the Zimbabwe National Army and the Zimbabwe Republic Police, the Ministry of Health and Child Welfare, and the district AIDS action committees. However, there have been persistent accusations leveled at the ZANU-PF party that the monies raised through this levy have been distributed primarily to government supporters through the district AIDS action committees, which are aligned with the government.[74] Unfortunately, most of the monies collected through the tax have been mired in bureaucracy. According to then deputy health minister P. David Parirenyatwa, speaking in August 2001, at least $25 million was waiting to be spent, but the disbursement was held up by bureaucratic wrangling and inefficiency.[75] In November 2001, the government saw fit to suspend the disbursement of AIDS levy funds through local AIDS action committees and instead deliver such funds through ZANU-PF-affiliated district councils. Many critics subsequently charged that this approach utterly politicized the delivery of aid services to the sick, such that only supporters of the government are cared for.[76]

In May 2002, Justice Minister Patrick Chinimasa declared, "In view of the rapid spread of HIV/AIDS among the population of Zimbabwe, the minister hereby declares an emergency period of six months, with effect from the promulgation of this notice for the purpose of enabling the state or a person authorized . . . to make or use any patented drug."[77] Although it has been derided by many and has had a negative impact on civil liberties, this edict allowed the government to satisfy World Trade Organization regulations governing the import or manufacture of generic versions of patented pharmaceuticals—in this case, cheaper versions of antiretroviral (ARV) medication. (Zimbabwe's declaration may also have been prompted by a calculation that the existence of a state of emergency

might make Western donors readier to fund AIDS prevention and treatment.) Zimbabwe, however, will likely face significant difficulties in distributing such drugs on a large scale in rural areas.

Harare began to improve its record on delivering ARV therapies to recipients in 2003. In January 2004, Parirenyatwa, now minister of health and child welfare, told Zimbabwe's parliament that the AIDS levy had amassed approximately $15 billion for the National AIDS Trust Fund, of which $8.9 billion had been distributed to those in need. Typical beneficiaries include service organizations, tertiary institutions, and government ministries. The monies are administered by the National Aids Council, which recently decentralized the distribution of funds in order to improve the transparency of the process and to address concerns that the funds were not reaching the intended beneficiaries. Parirenyatwa admitted that certain AIDS service organizations had previously abused their positions of power. He stated that "the Zimbabwe National Network for People Living with HIV and AIDS abused $96 million allocated to it and part of the money was used to buy property." The government has been successful in recovering much of these misappropriated funds, but this case illustrates the continuing problem of corruption within the service providers and the need for improved government oversight of levy expenditures.[78]

Nine

Policy Recommendations

HIV/AIDS will continue to proliferate and to undermine Zimbabwean stability, prosperity, and security until the government exhibits stronger leadership in the fight against the epidemic and institutes more effective programs to contain and treat the disease. For this to happen, various domestic and international actors need to collaborate much more closely. As laid out in this concluding chapter, our recommendations call principally for improved partnerships between the international community, Washington policymakers, and Zimbabwean nongovernmental health providers and community service agencies, all of whom will have to display both creativity and flexibility. Unfortunately, although one would hope to see Zimbabwe's government cooperating fully with these various actors, the regime is unlikely to exhibit greater leadership in the fight against HIV/AIDS unless pressured to do so from both inside and outside the country. Thus, both Zimbabwe's AIDS-related organizations and the international community must continually press the national government to do more.

Recommendations for Zimbabwean AIDS-Related NGOs

1. *Press government for stronger political leadership.* Zimbabwean nongovernmental organizations (NGOs) must press the government to meet its obligation to tackle the nation's HIV/AIDS crisis. Zimbabwean NGOs should push for increased budget allocations, stronger measures to discourage discrimination against HIV-infected persons, the institution of administratively effective and accessible HIV-testing centers, and the equitable distribution of antiretroviral medicines for all citizens seeking assistance. Furthermore, these NGOs must educate government about the benefits of a greater financial commitment to stem the growth of HIV and tuberculosis infection. This report has demonstrated that the epidemic is eroding state capacity and requires the infusion of significant exogenous fiscal resources from multilateral donors to shore up Zimbabwe's state capacity; this point should be emphasized to the government in Harare.
2. *Improve educational awareness about the disease and its victims through strengthened collaboration.* Zimbabwe's formal sector (both government and business), its educational system, and its community-based health NGOs must form stronger alliances designed to reduce the level of confusion within Zimbabwean society regarding the causes of HIV and how to prevent infection. They must dispel societal myths that promote violence against women, children, and the infected and guarantee the physical safety (and continued employment) of those who test positive for HIV. Systems that have been successful in other nations require strong and committed leadership and the support of the national government.

3. *Prevent the spread of HIV through enhanced health strategies.* Zimbabwe must continue to emphasize educational awareness and prevention strategies in its communities, businesses, and schools. Progress in boosting awareness and bolstering prevention can best be accomplished by coordinating initiatives with Zimbabwe's media, by educational programming at local schools, and by distributing informational materials through community churches and religious organizations. International religious, commercial, and educational organizations should be encouraged to support improved prevention and awareness programming through donations of financial resources and expertise.
4. *Call for the mandatory testing of Zimbabwean military and peacekeeping forces.* Pressure must be placed on government to initiate strategies for limiting the scope of infection in the Zimbabwean military and peacekeeping forces. Policies requiring mandatory testing of all military and other peacekeeping personnel (e.g., law enforcement) should be instituted. Those individuals testing positive should be placed in assignments where they are less likely to contribute to the spread of HIV.
5. *Emphasize increased protection of human rights in Zimbabwean society.* Emphasis must also be given to the development of public policies and educational initiatives that preserve and protect Zimbabwean human rights. A key element of this effort should be to protect more vulnerable segments of society (e.g., women, children, and the poor) from abuses associated with the spread of HIV/AIDS and other communicable diseases. AIDS-related NGOs should work closely with human rights organizations (e.g., Women and Law in Southern Africa) and the international community to identify abuses, promote awareness, and develop policies that provide greater protection of basic human rights.

Recommendations for the International Community

1. *Provide greater support to the Global Fund to Fight AIDS.* The UN Declaration of Commitment on HIV/AIDS, issued by the UN General Assembly Special Session on AIDS (UNGASS) of June 2001, is a solid step toward long-term international mobilization to stem the pandemic. UNGASS's decision to establish the Global Fund to Fight AIDS, tuberculosis, and malaria is an excellent first step toward creating multilateral fiscal mechanisms to slow the spread of the disease. Given the increasing severity of the expanding pandemic, the developed nations of the world should increase the amount of money available through the Global Fund from 2002 levels of U.S.$700–$800 million to at least $3 billion by the year 2007. Given the magnitude of the HIV/AIDS pandemic, resources on this scale are necessary to mount an effective global response.
2. *Press for greater rights and educational opportunities for women.* Women in developing nations suffer disproportionately the consequences of poverty. The spillover effects of poverty result in poor health and a higher probability of contracting communicable diseases such as HIV/AIDS. The creation by the World Health Organization of its Commission on Macroeconomics and Health is a timely move. Launched in January 2000, this commission's purpose is to analyze the impact of health on development and to determine health strategies for minimizing poverty in developing nations. However, in recognition of the growing understanding of the relationship between health and governance, the WHO should swiftly establish a commission on international

governance and health. Such a commission should be designed to address methods that enhance health provisions through improved governance systems and structures in developing nations. It should also focus on identifying methods for increasing the legislative representation of women, which in turn would encourage efforts to meet the special health needs of females in developing societies. Working alongside, and in concert with, the Commission on Macroeconomics and Health, this new commission could better address issues of health and gender equity.

In many regions of the developing world, women tend to have fewer rights than men when it comes to the selection of sexual partners. They acquire less education and earn less money than men. Some women are driven by harsh economic conditions into prostitution. Women are also biologically more prone to infection. All of these factors contribute to the spread of HIV among women. On a global scale, women now exhibit slightly higher HIV seroprevalence levels than do males.

The linkage between poverty, gender, and AIDS is well established. Better-educated women typically find better-paying work, which lessens their likelihood of becoming infected and spreading the infection to their children. They are also less likely to suffer sexual coercion and rape, which also promote the spread of the disease. Hence, it is important in the fight against the epidemic to improve respect for the rights of women as well as to identify methods to increase educational opportunities. The two WHO commissions (one extant, the other proposed) mentioned above should assign a high priority to research into the linkages between health and governance and the advancement of women's rights and education opportunities in developing systems .

Recommendations for Washington

1. *Rally the international community.* The United States should use its diplomatic power in the UN Security Council and G-8 to spur other developed nations to increase the level of international aid they commit to the fight against the AIDS pandemic. A concerted multilateral effort by donor countries is needed to provide the massive levels of foreign assistance necessary to shore up declining endogenous capacities in deeply affected nations.
2. *Fully fund the President's Initiative.* The President's Emergency Plan to AIDS Relief (the "President's Initiative"), announced in January 2003, seeks to commit $15 billion in funding to slow the pandemic. It is an excellent step and should be emulated by other members of the international community. This initiative provides humanitarian relief to extend the lives of those who are infected and provides antiretroviral therapy to reduce viral loads so that a treated individual will be less likely to infect others. If successful, the initiative will generate a decline in the debilitation and mortality rates associated with the onset of AIDS and, as a result, will likely enhance societal productivity and stability. As of January 2004, the U.S. Congress has authorized only 51 percent of the administration's budgeted request for the provision of antiretroviral therapies. Members of Congress should come together in a bipartisan show of support for efforts to curb the pandemic by authorizing the appropriation of the remaining 49 percent.

3. *Emphasize the importance of prevention.* While the President's Initiative is a positive first step, because infected persons can still transmit the virus to the uninfected while undergoing antiretroviral therapy, the U.S. government must place a high priority on prevention through the initiation of behavioral change. While the provision of antiretroviral therapies is an important step, it will not by itself stop the spread of the pandemic; infected individuals will still eventually sicken and die, and there is growing evidence that HIV is capable of evolving resistance to antiretroviral therapies.

4. *Reexamine development priorities.* As noted above, certain development projects (notably, large construction projects) frequently take men away from their families, leading to widespread demand and opportunities for commercial sex. A pilot project in Cameroon created special camps where workers could live with their families, reducing the incentive to engage in risky behavior. USAID and others should include similar practices within their major construction project proposals (e.g., for dams, road construction, and other major infrastructure improvements). Moreover, U.S. development aid to regions where HIV/AIDS is flourishing should include specific strategies to reduce risky sexual behavior.

5. *Invest in education.* The United States should provide targeted assistance to reduce school fees, which will help families who have lost a breadwinner to keep their children in school. The education of AIDS orphans is vital to prevent future criminality and radicalization and to foster a productive and hopeful future for these dispossessed youth. Targeted assistance programs should be created to provide the basic necessities of life and develop human capital within orphan cohorts.

6. *Preservation of smallholder agriculture.* Indigent farms in rural sectors of southern Africa serve as the primary food source for their households. In the early years of this century, families in Zimbabwe and other southern African nations have had to contend with the consequences not only of the HIV/AIDS epidemic but also of drought. HIV/AIDS denudes household resources (both financial and labor) and inhibits house members from planting, tending to, and harvesting their crops. The catastrophic effects of the HIV/AIDS epidemic on subsistence families have been compounded by climatic conditions, with the result that the Zimbabwean countryside is fast becoming populated by widows and orphans. The United States and its allies should advocate the extensive revision of land-tenure arrangements to help protect these families. Donor countries should also emphasize crop diversification and improved access to essential production factors, such as land, labor, capital, management skills, and draft animals. The U.S. government can also offer direct assistance through the Peace Corps and through U.S. Department of Agriculture programs designed to help these families.

7. *Promote sustainable distribution of resources within Zimbabwean society.* The magnitude of the HIV/AIDS epidemic is likely to further widen class divisions within Zimbabwe and intensify deprivation for the lower and middle classes, who bear the greatest burden of the disease. As the severity of the disease increases and suffering grows more widespread, society as a whole may adopt an attitude of living for today and neglecting the future. Such an atmosphere breeds lawlessness and a loss of respect for the

interests of others, which in turn encourages societal breakdown. If further erosion of the cohesion of Zimbabwean society is to be avoided, the United States and other donor countries must advocate greater distribution of economic resources to offset the growing sense of hopelessness and injustice. Highly skewed distributions of basic resources (e.g., food, shelter, education, and medical care) seriously undermine the stability of the social order. Moreover, recent research suggests that increasing equity in the national distribution of income will slow the further spread of disease throughout affected societies.[80]

8. *Develop improved partnerships within the private sector.* Zimbabwean NGOs and community health service organizations should be encouraged to collaborate more closely with Zimbabwe's business community. NGO-business partnerships can be designed to promote greater educational awareness about HIV/AIDS, to provide a mechanism for victim and family counseling, and to encourage destigmatization of individuals infected with the disease. The United States can take the lead in this area by encouraging U.S. corporations active in southern Africa (e.g., Kellogg, Coca-Cola, and Microsoft) to continue sharing their resources and expertise to help promote administrative efficiencies and improved program service delivery within the business sector. Zimbabwean businesses stand to benefit from these partnerships by maintaining a more productive workforce, reducing the costs to themselves and their employees of health care, and improving planning for the eventual outplacement and replacement of employees in declining health.

9. *Foster peace in sub-Saharan Africa.* Conflict often serves as a disease amplifier, with deployed troops acting as vectors for disease transmission. Certainly, the myriad conflicts now being fought in Africa foster the expansion of the HIV/AIDS epidemic. The United States should increase its mediatory efforts to bring peace to the region. Such a strategy would not only promote stability and democracy in southern Africa but also facilitate the containment of the epidemic by reducing the need for troop deployments. At the same time, the United States should expand its collaborative programs with African military forces to educate soldiers about HIV transmission and safe-sex practices, and should promote mandatory testing for all members of the armed forces. Although UN legislation prohibits HIV-infected forces from serving as UN peacekeepers, this rule is often ignored, and thus peacekeeping forces often serve as vectors of transmission. The United States should do all it can (e.g., through the provision of technical support and support for further research) to ensure that all participants in multilateral peacekeeping operations are free of HIV/AIDS and other communicable diseases.

10. *Support debt relief.* Endogenous efforts to bring the HIV/AIDS epidemic under control are severely inhibited by the high levels of international indebtedness plaguing developing countries in general and sub-Saharan African countries in particular. Servicing those debts draws monies away from programs and institutional sectors—such as education and health—that can alleviate the spread of HIV/AIDS. The U.S. government should make a high priority of a strategy of debt relief for seriously affected countries (which might be defined as nations with HIV seroprevalence levels above 5 percent). Such relief should be contingent on the redirection of funds toward HIV/AIDS sup-

pression—in essence, swapping debt relief for AIDS relief. Similar strategies have been used to encourage countries to protect endangered ecosystems. In the case of Zimbabwe, debt relief should be contingent on government reforms to bring Zimbabwe in line with accepted international democratic practices (e.g., freedom of speech and association, adherence to international human rights standards, and transparency in the use of government resources). Offers of debt relief should continue to be communicated through unofficial and secondary lines of communication (e.g., through other southern African governments) and should stress that the price of debt relief is political reform.

11. *Foster political leadership in Zimbabwe in the war against HIV/AIDS.* Preliminary evidence suggests that the advocacy of prevention by endogenous political elites is extremely successful in reducing HIV infection rates. The most successful models for the developing world are presently Uganda and Thailand, where political elites have used their power to educate the population and have encouraged an environment to support initiatives that control the spread of HIV without violating individual rights. The United States and its allies should encourage the Mugabe regime to adopt the Ugandan model of HIV suppression, which seems to be highly effective in societies of moderate to low state capacity. This would involve the mobilization of political elites (both ZANU-PF and MDC) to spread the word throughout the country about how to lower transmission rates through behavioral modification. Requisite programs would include education, voluntary counseling and testing, promotion of safe-sex practices, treatment of other STDs that act as gateways for HIV transmission, and increased efforts to destigmatize the disease and to promote basic human rights.

12. *Step up a dialogue between the political opposition and military leaders.* Given that the Mugabe administration seems incapable of effective governance on a broad spectrum of issues, and given, too, that the aging Mugabe is unlikely to remain in power for more than another five years, the United States should anticipate regime change in Zimbabwe. Consequently, the U.S. government should position itself to create dialogue with individuals likely to play leading roles in Zimbabwe's future, such as the leaders of the MDC and prominent military figures. The latter, conscious that the HIV/AIDS epidemic is eroding their power base by decimating the troops under their command, have a strong incentive to limit the spread of HIV. The United States should work with MDC leaders to assist them in developing strategies to reduce the transmission of HIV within their communities. Resources might be channeled to MDC leaders through NGOs to facilitate this process, thereby not only helping to combat the epidemic but also boosting the perceived legitimacy and viability of the MDC in the eyes of the electorate and enabling it to expand its power base vis-à-vis the increasingly delegitimized ZANU-PF regime.

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Our recommendations will not be easily implemented or likely welcomed by Zimbabwe's current government. Clearly, the implementation of many of these components requires courage on the part of policy implementers, especially those individuals residing in Zimbabwe. Unless those risks are taken, however, Zimbabwean society will suffer further degradation.

For the international community, the HIV/AIDS pandemic in Zimbabwe is certain to be a more formidable and enduring concern than Robert Mugabe or his government. The international community and policymakers in Washington must view the problems in Zimbabwe beyond the immediate political horizon. They must not turn away from the task of addressing Zimbabwe's humanitarian crisis because of a distaste for the country's present government. Acting on the recommendations outlined in this report would notify the political leadership in Harare—and elsewhere—that the international community expects Zimbabwe's leaders to address the needs of the country's people as a whole.

Notes

1. For an intriguing analysis of the increasingly despotic behavior of the Mugabe administration, see Sandra J. Maclean, "Mugabe at War: The Political Economy of Conflict in Zimbabwe," *Third World Quarterly* 23, no. 3 (2002): 513–528.

2. This figure comes from the UNAIDS epidemiological fact sheet for Zimbabwe. Similar data are available for other countries; see www.unaids.org.

3. For a detailed discussion of health and security concerns and their relationship to the concept of state capacity, see Andrew T. Price-Smith, *The Health of Nations: Infectious Disease, Environmental Change and Their Effects on National Security and Development* (Cambridge, Mass.: MIT Press, 2002); and Andrew T. Price-Smith, ed., *Plagues and Politics: Infectious Disease and International Policy* (Houndmills, UK: Palgrave/Macmillan Press, 2001).

4. Almost 75 percent of HIV-positive individuals in Zimbabwe are coinfected with tuberculosis.

5. See Jared Diamond, *Guns, Germs, and Steel: The Fates of Human Societies* (New York: Norton, 1999).

6. Thucydides, *History of the Peloponnesian War* (New York: Penguin, 1980), 155.

7. Edward Gibbon, *The Decline and Fall of the Roman Empire,* quoted in Hans Zinsser, *Rats, Lice, and History* (New York: Little, Brown, 1934), 147.

8. See William McNeill, *Plagues and Peoples* (New York: Doubleday, 1976).

9. Alfred W. Crosby, *Ecological Imperialism: The Biological Expansion of Europe, 900–1900* (New York: Cambridge University Press, 1986), 200. Also see William Denevan, ed., *The Native Population of the Americas in 1492* (Madison: University of Wisconsin Press, 1976).

10. Theda Skocpol, "Bringing the State Back In: Strategies of Analysis in Current Research," in *Bringing the State Back In,* ed. Peter B. Evans et al., 3–43 (New York: Cambridge University Press, 1985).

11. Joel S. Migdal, *Strong Societies and Weak States* (Princeton, N.J.: Princeton University Press, 1988).

12. Pierre Engelbert, *State Legitimacy and Development in Africa* (Boulder, Colo.: Lynne Rienner, 2000).

13. See Price-Smith, *Health of Nations,* 25.

14. State capacity can be empirically measured according to the index developed in ibid., 25–29.

15. Robert Ostergard, "Politics in the Hot Zone: AIDS and National Security in Africa," *Third World Quarterly* 23, no. 2 (2002): 334.

16. Barry Buzan, *People, States, and Fear: The National Security Problem in International Relations* (Brighton, UK: Wheatsheaf Books, 1983).

17. Richard Ullman, "Redefining Security," *International Security* 8, no. 1 (1983): 129.

18. Ibid., 123.

19. See Andrew T. Price-Smith, "Ghosts of Kigali: Infectious Disease and Global Stability in the Coming Century," *International Journal* 54, no. 3 (1999): 426–442; David Gordon, *The Global Infectious Disease Threat and Its Implications for the United States,* Report NIE 99-17D (Washington, D.C.:

National Intelligence Council, January 2000), available at www.odci.gov/cia/publications/nie/report/nie99-17d.html; Patrick W. Kelley, "Transnational Contagion and Global Security," *Military Review* 80, no. 3 (May-June 2000): 59–64, available at www-cgsc.army.mil/milrev/English/MayJun00/kelley.pdf; and Laurie Garrett "The Return of Infectious Disease," *Foreign Affairs* 75, no. 1 (1996) 66–79.

We concur with Roland Paris's assertions that definitions of human security are "slippery by design" and therefore prone to "cultivated ambiguity" (Roland Paris, "Human Security: Paradigm Shift or Hot Air?" *International Security* 26, no. 2. [fall 2001]: 88). Paris holds that human security is too nebulous a concept to provide much analytical traction, and so the concept of human security is best applied as a "label for a broad category of research—a distinct branch of security studies that explores the particular conditions that affect the survival of individuals, groups, and societies" (ibid., 102). Among the better analyses from the school of human security are those conducted by Peter Fourie and Martin Schonteich in their evaluation of the threat that HIV poses to the society of the Republic of South Africa—see Peter Fourie and Martin Schonteich, "Africa's New Security Threat: HIV/AIDS and Human Security in Southern Africa," *African Security Review* 10, no. 4 (2001): 29–57.

20. UNAIDS, "Epidemiological Fact Sheets: Zimbabwe 2002 Update" (revised) (Geneva: UNAIDS), 2, available at www.unaids.org.

21. UNAIDS, *AIDS Epidemic Update,* December 2002 (Geneva: World Health Organization, 2002).

22. Claire Bisseker, "AIDS Epidemic Runs Wild," *Financial Mail* (Zimbabwe), July 5, 2002, Health, 30.

23. See data on the PovertyNet Web site, available at www.worldbank.org/poverty/data/trends/mort.htm.

24. The data are taken from the UNAIDS Web site, at www.unaids.org, and supplemented by data at the World Bank "Data & Statistics" site, www.worldbank.org/data/dataquery.html.

25. The HIV epidemics in the former Soviet territories are fueled primarily by the use of illicit narcotics and prostitution.

26. UNAIDS, "Epidemiological Fact Sheet: Zimbabwe," 3.

27. Fourie and Schonteich, "Africa's New Security Threat."

28. Martin Schonteich, "Age and AIDS: South Africa's Crime Time Bomb?" *Africa Security Review* 18, no. 4 (1999): 57.

29. National Intelligence Council, *National Intelligence Estimate: The Global Infectious Disease Threat and Its Implications for the United States* (Washington, D.C.: National Intelligence Council, January 2000), reprinted in *Environmental Change and Security Project Report,* Report no. 6 (Washington, D.C.: Woodrow Wilson Center, summer 2000), 61.

30. Lori Bollinger et al., *The Economic Impact of AIDS in Zimbabwe* (Washington, D.C.: USAID, POLICY Project, September 1999), 3–4.

31. Ibid., 4.

32. Christopher J. L. Murray and Alan D. Lopez, *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability* (Boston: Harvard School of Public Health, 1996).

33. See Malcom F. McPherson, "Macroeconomic Models of the Impact of HIV/AIDS," 13, available at ksg.harvard.edu/cbg/hiv-aids/ksg/McPherson_Macroeconomic.models.pdf.

34. Ibid., 13.

35. John Robertson, "Zimbabwe's Economy Shipwrecked," *Times* (London), March 6, 2002, available at www.timesonline.co.uk/article/0,,3-227241,00.html.

36 Food and Agricultural Organization, *FAO/WFP Crop and Food Supply Assessment Mission to Zimbabwe,* June 1, 2001, available at www.fao.org/WAICENT/faoinfo/economic/giews/english/alertes/2001/SRZIM601.htm.

37. See P. Kwaramba, *The Socioeconomic Impact of HIV/AIDS on Communal Agricultural Systems in Zimbabwe,* Zimbabwe Farmers Union, Friedrich Ebert Stiftung Economic Advisory Project, Working Paper 19 (Harare: Zimbabwe Farmers Union, 1997).

38. Marcus Haacker, *The Economic Consequences of HIV/AIDS in Southern Africa,* IMF Working Paper WP/02/38 (Washington, D.C.: International Monetary Fund, 2002), 12.

39. See Lewis Machipisa, "At Least Two Teachers Die from AIDS Everyday," Inter-Press Service, July 10, 2002, available at www.aegis.com/news/ips/2002/IP020716.html.

40. U.S. Embassy, Tokyo, "Fact Sheet: UNAIDS Tracks Global Impact of HIV/AIDS," available at usembassy.state.gov/tokyo/wwwhg10413.html.

41. "Teacher-Pupil Sex Blamed for HIV Rise," *BBC News,* November 18, 2003, available at news.bbc.co.uk/2/hi/africa/3281619.stm.

42. U.S. Embassy, Tokyo, "Fact Sheet."

43. Haacker, *Economic Consequences,* 15.

44. See Lori Bollinger and John Stover, *The Economic Impact of AIDS* (Glastonbury, Conn.: Futures Group International, 1999).

45. "HIV/AIDS Pandemic Strains Economy," *Herald,* courtesy of Africa News Service, September 23, 2002, 1.

46. Haacker, *Economic Consequences,* 35.

47. R. Bonnel, *Economic Analysis of HIV/AIDS, ADF2000 Background Paper* (World Bank, 2000).

48. Data available from World Bank world data tables at www.worldbank.org.

49. Ibid.

50. Food and Agricultural Organization, *Crop and Food Supply Assessment.*

51. Data available at www.businessmap.co.za/.

52. McPherson, "Macroeconomic Models," 16–18.

53. See Maclean, "Mugabe at War."

54. John Brinkley, *Zimbabwe and the Politics of Torture,* Special Report 92 (Washington, D.C.: United States Institute of Peace, April 2002), available at www.usip.org/pubs/specialreports/sr92.html.

55. Ibid.

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57. J. M. Makumbe, "The Zimbabwe Civil Service: A Wind of Change," in *The Role of Government in Adjusting Economies, 1994–1999* (Birmingham, UK: University of Birmingham, International Development Department, 1997), available at www.idd.bham.ac.uk/research/Projects/Role_of_gov/workingpapers/paper16.htm.

58. International Monetary Fund, *Zimbabwe: Recent Economic Developments, Selected Issues and Statistical Appendix,* IMF Country Report No. 01/13 (Washington, D.C.: International Monetary Fund, January 2001), available at www.imf.org/external/pubs/ft/scr/2001/cr0113.pdf.

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61. Andrew T. Price-Smith, Steven Tauber, and Anand Bhat, "Preliminary Empirical Evidence of a Positive Association between State Capacity and HIV Incidence Reduction," in Mohsen Milani, ed., *Occasional Papers in Globalization,* vol. 11, no. 2 (Tampa: Globalization Research Center, University of South Florida, March 2004).

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63. In December 2000, for instance, Mugabe declared before a ZANU-PF congress, "Our party must continue to strike fear in the heart of the white man, our real enemy." Raymond Copson, *Zimbabwe Backgrounder* (Washington, D.C.: Library of Congress, December 27, 2001), 12.

64. See Ted Gurr, *Why Men Rebel* (Princeton, N.J.: Princeton University Press, 1970).

65. The U.S. Central Intelligence Agency's *World Factbook 2002* bluntly states: "ignoring international condemnation, Mugabe rigged the 2002 presidential election to have himself reelected." Central Intelligence Agency, "Zimbabwe," in *The World Factbook 2002,* available at www.cia.gov/cia/publications/factbook/print/zi.html.

66. See Stefan Elbe, "HIV/AIDS and the Changing Landscape of War in Africa," *International Security* 27, no. 2 (fall 2002): 159–177; and Robert L. Ostergard Jr., "Politics in the Hot Zone: AIDS and National Security in Africa," *Third World Quarterly* 23, no. 2. (2002): 333–350.

67. Elbe, "HIV/AIDS," 155–156.

68. Armando Mabuchi, "Zimbabwe: Security Information," Institute for Security Studies (South Africa), available at www.iss.co.za/AF/profiles/Zimbabwe/SecInfo.html.

69. Lindy Heinecken, "Living in Terror: The Looming Security Threat to Southern Africa," *African Security Review* 10, no. 4 (2001): 11.

70. Rodger Yeager, *Military HIV/AIDS Policy in Eastern and Southern Africa: A Seven-Country Comparison,* Occasional Paper No. 1 (Civil-Military Alliance to Combat HIV and AIDS, 1996), 2.

71. Mabuchi, "Zimbabwe."

72. Realist theory argues that shifts in the relative power often precipitate interstate conflict. See Kenneth Waltz, *Theory of International Politics* (New York: McGraw-Hill, 1979).

73. See Price-Smith, *Health of Nations,* for an advanced discussion of the relationship between infectious disease and state capacity.

74. "ZANU-PF Accused of Hijacking HIV/AIDS Fund," *Financial Gazette,* July 4, 2002.

75. Henri Cauvin, "Zimbabwe Fund for AIDS Patients Is Frozen in Bureaucracy," *New York Times,* August 19, 2001.

76. "HIV/AIDS Groups Accuse Government of 'Playing Politics,'" UN Integrated Regional Information Networks, November 15, 2001.

77. "Zimbabwe Declares AIDS Emergency," CNN.com, May 27, 2002.

78. See "AIDS Levy Rakes in $15 bn.," *Herald Reporter,* January 30, 2004, available at http://www.herald.co.zw/index.php?id=28634&pubdate=2004-01-30.

79. See Alan Whiteside, "Poverty and HIV/AIDS in Africa," *Third World Quarterly* 23, no. 2 (2002): 313–332.

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