DIE, THE BELOVED COUNTRIES: HUMAN SECURITY AND HIV/AIDS IN AFRICA

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ABSTRACT

The altered conception of "security" and the introduction of its "human" angle specifically in the post-Cold War context implies cogent reassessments of issues pertaining to sustainable development and international politics. HIV/AIDS is one such an issue that has and will continue to have a significant impact on the dynamics of "who gets what, where, when and how" in Southern Africa. This article addresses the socio-political impact of this disease in the region, using "human security" as the conceptual looking glass through which to ascertain the causes and effects of the unfolding disaster. This is achieved by focusing specifically on the implications for demographic, food, political and macro-economic security, and the effect this has on governments' ability to provide essential services. The article concludes by enjoining specifically political and other social scientists to redouble their intellectual efforts at analysing and addressing the origin, prevalence and social consequences of HIV/AIDS.

HUMAN SECURITY AND HIV/AIDS

Traditionally, the concept of 'security' has been interpreted in militaristic terms as the military defence of the state, involving 'structured violence manifest in state warfare' (MacLean, 1998:2; see also Bedelsky, 1999:1). Since the end of the Cold War this narrow definition of security has become less relevant (Hadingham, 2000:113).

The term 'human security' was first officially used in the 1994 Human Development Report of the United Nations (UN) Development Programme. According to the report, the intention of human security is '… to capture the post-Cold War peace dividend and redirect those resources towards the development agenda' (Axworthy, 1999:2). Hubert (1999) expands this conceptualisation, stating that

> ….in essence, human security means safety for people from both violent and non-violent threats. It is a condition of state of being characterised by freedom from pervasive threats to people's rights, their safety or even their lives… It is an alternative way of seeing the world, taking people as its point of reference, rather than focusing exclusively on the security or territory of governments. Like other security concepts – national security, economic security, food security – it is about protection. Human security entails taking preventative measures to reduce vulnerability and minimise risk, and taking remedial action where prevention fails.

HIV/AIDS does not fit into the traditional definition of security. However, as Hadingham (2000:120) argues, in terms of the post-Cold War human security regime, HIV/AIDS poses a 'pervasive and non-violent threat to the existence of individuals, as the virus significantly shortens life expectancy, undermined quality of

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life and limits participation in income-generating activities. The political, social and economic consequences are equally detrimental to the community, in turn undermining its security.'

In January 2000, the United Nations' (UN) Security Council debated the impact of AIDS on peace and security in Africa. The debate was the first in the Council's history that discussed an health issue as a threat to peace and security. UN secretary-general Kofi Annan told the Council: 'The impact of AIDS in Africa was no less destructive than that of warfare itself. By overwhelming the continent's health and social services, by creating millions of orphans, and by decimating health workers and teachers, AIDS is causing social and economic crises which in turn threaten political stability… In already unstable societies, this cocktail of disasters is a sure recipe for more conflict. And conflict, in turn, provides fertile ground for further infections' (UN press release, 2000).

At the same Security Council meeting the president of the World Bank, James Wolfensohn, said that AIDS was not just a health or development issue, but one affecting the peace and security of people in Africa. While life expectancy in Africa had increased by 24 years in the last four decades of the twentieth century, the continent's development gains were threatened by the AIDS epidemic and life expectancy gains were being wiped out. 'In AIDS, the world faced a war more debilitating than war itself… Without economic and social hope, there could not be peace, and AIDS undermined both. Not only did AIDS threaten stability, but a breakdown in peace fuelled the pandemic,' Wolfensohn said (UN press release, 2000). Unfortunately, these statements cannot be dismissed as hyperbole: HIV/AIDS is now the leading killer in Sub-Saharan Africa (SSA); its mortality rates surpassing people killed in warfare – in 1998 alone, for example, 200,000 people died from armed conflicts in Africa, compared with 2.2 million from AIDS (The Star, 12 January 2000).

Although Africa is late in reacting to the HIV/AIDS pandemic as a security threat, the United States's Central Intelligence Agency (US CIA) has been tracking the disease's impact on the human security of SSA for more than ten years: in 1990 CIA Interagency Intelligence Memorandum 91-10005 instructed the agency's analysts to track the dissolution of states all over the world by adding the effect of HIV/AIDS as one of the variables that determine which states would self-destruct (Gellman, 2000:A01). For these agencies the link between HIV/AIDS and security goes beyond the reality of AIDS as a physical killer: the CIA warns that 'the relationship between disease and political instability is indirect but real' (NIC, 2000). The UN has picked up on this point, stressing the impact of HIV/AIDS on states' developmental progress:

> [AIDS] is present in a number of countries already facing conflict, food scarcity and poverty, and poses real threats to social and political stability where it is most concentrated – in Africa. The Security Council redefined security as an issue going well beyond the presence or absence of armed conflict, one which affects health and social services, family composition and social structure, economies and food security.
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> There is now broad acknowledgement that AIDS has become a global development crisis, potentially affecting national security in some countries. Armed conflict and associated population movements provide fertile ground for the spread of AIDS, while the epidemic itself can be seen as a risk factor in the breakdown of social cohesion and in social and political instability, in addition to a threat to security forces (UN, 2001:9).

Malan (2001:53) accuses African governments of extreme negligence in their response to the human security aspects of HIV/AIDS – it was only at the Organisation of African Unity (OAU) summit as recent as May 1999 that an African government minister *for the first time* called the disease a major threat to economic and social development. Holzhausen (2001:17) echoes this sentiment, enjoining African governments to go beyond an admission of the dire impact of AIDS on African communities. He underlines the importance of the South African White Paper on Defence in a Democracy's insistence that '[a] common [i.e. regional, cross-national] approach to security in Southern Africa is necessary'.

At long last, the African continent's leaders seem to have – ostensibly at least – woken up to the human security challenge of HIV/AIDS. A UN Economic Commission for Africa (UNECA) discussion document referring to 'key areas for joint African-international action' states that '[HIV/AIDS] is Africa's number one survival issue. Without an effective effort to overcome HIV/AIDS, all of Africa's progress in terms of development and governance will be reversed' (UNECA, 2001:11).

QUANTIFYING THE FUSS: HIV/AIDS IN AFRICA

The global HIV/AIDS epidemic is far more extensive than initially anticipated. The number of people living with HIV/AIDS at the end of the last century was more than 50 percent higher than had been predicted in 1991 by the World Health Organisation (WHO) (WHO, 2000). As the Worldwatch Institute points out, the HIV epidemic raging across Sub-Saharan Africa is a tragedy of epic proportions; one that is altering the region's demographic future. It is reducing life expectancy, raising mortality, lowering fertility, creating an excess of men over women, and leaving millions of orphans in its wake (Brown, 2000:1).

Due to the long period between infection with HIV and eventual death due to AIDS-related diseases, many Africans remain sceptical about the demographic impact of the disease; AIDS remains distant and unreal, perpetuating denial and stigmatisation. In an effort to make the disease more 'real' – to give it greater visual impact – we include the following two figures:

According to UNAIDS (SAIRR, 2001:226), at the end of 1999 the HIV-infection rates in various African countries for people between the ages of 15 and 49 years were as follows:

HIV-infection rates in various African countries 1999

Country	*HIV-infection rate*
Botswana	**35.8%**
Burundi	11.32%
Central African Republic	**13.84%**
Djibouti	11.75%
Ethiopia	**10.63%**
Ivory Coast	10.76%
Kenya	**13.95%**
Lesotho	23.57%
Malawi	**15.96%**
Mozambique	13.22%
Namibia	**19.54%**
Rwanda	11.21%
South Africa	**19.94%**
Swaziland	25.25%
Zambia	**19.95%**
Zimbabwe	25.06%

The figure below gives projections of life expectancy and population growth in South Africa and six other African countries for 2010:

Life expectancy and population growth 2010 (SAIRR, 2001:226)

Country	*Life expectancy*			*Population growth*	
	Without AIDS	*With AIDS*	*Years lost*	*Without AIDS*	*With AIDS*
Namibia	**70.1**	**38.9**	**31.2**	**2.8%**	**1.2%**
Botswana	66.3	37.8	28.5	1.9%	0.2%
Swaziland	**63.2**	**37.1**	**26.1**	**3.1%**	**1.7%**
Zambia	60.1	37.8	22.3	3.1%	2.0%
Kenya	**69.2**	**43.7**	**25.5**	**1.8%**	**0.6%**
Malawi	56.8	34.8	22.0	2.2%	0.7%
South Africa	**68.2**	**48.0**	**20.2**	**1.4%**	**0.4%**

Keep in mind that the majority of the people cited in the first figure are not yet sick with the effects of HIV/AIDS. They will only start dying within the next five to ten years. The 15- to 49-year old age group is where the leaders of society is: the governing elite, the moneyed youth, the economically active, the mothers, teachers, agricultural labourers, miners, and so on. What will the effect of their initial morbidity and eventual premature mortality be on the social cohesion, economies and military security of their countries as a whole?

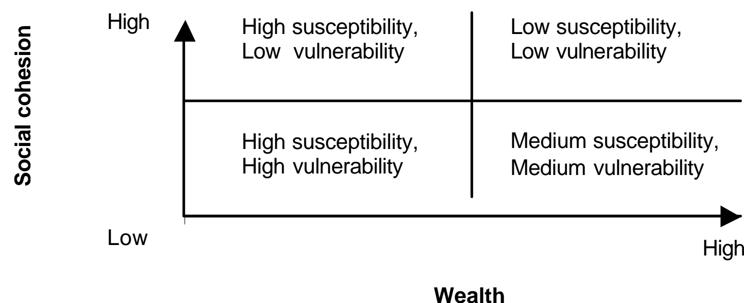
Explicitly linking the disease to security, the UN report continues to say the following:

- The epidemic destabilises societies in profound ways. As parents and workers succumb to AIDS-related illnesses, the structures and divisions of labour in households, families, workplaces and communities are disrupted, with women bearing an especially heavy burden. From there, the effects cascade across society, reducing income levels, weakening economies and undermining the social fabric.
- The economic and developmental impact can be especially dramatic. It is estimated that gross domestic product (GDP) growth shrinks by as much as 1-2 percent annually in countries with an HIV prevalence rate of more than 20 percent. Over several years, the loss of economic output accumulates alarmingly. Calculations show that heavily affected countries could lose more than 20 percent of GDP by 2020.
- The epidemic increases the strain on state institutions and resources, while undermining social systems that enable people to cope with adversity. In badly affected countries, education and health systems are compromised, economic output shrinks and state institutions such as the judiciary and police are undermined. In some societies, increased social and political instability can result.
- AIDS thrives in settings already marked by high degrees of socio-economic insecurity, social exclusion and political instability. Individuals subjected to those conditions – migrant workers, displaced people, refugees and ostracised minorities worldwide – face much higher risk of infection.
- Similarly, it is often the absence of economic security that propels people into sex work for a living, and many end up in prison where they face a higher risk of infection.
- In the past decade, HIV/AIDS has emerged as a major threat in emergency settings. Humanitarian operations can place both relief workers and local populations at greater risk of infection, with children and young people being especially vulnerable. The increased likelihood of sexual violence and prostitution among refugee populations broadens and accelerates the spread of HIV.

An estimated 22 million orphans in Sub-Saharan Africa by 2010 are expected to comprise a 'lost orphaned generation' with little hope of educational or employment opportunities. Such societies will be at risk of increased crime and political instability as these young people become radicalised or are exploited by various political groups for their own ends – the child soldier phenomenon may be one example (NIC, 2000). The increase in crime and political instability, moreover, will be accompanied by a probable increased availability in illicit small arms and increased operations of organised criminal organisations in Sub-Saharan Africa.

What drives this disease at such a horrific pace in Africa? Are Africans particularly vulnerable to HIV? The answer to the last question is 'yes' – given the socio-economic factors referred to above. Africans are not more sexually promiscuous than people in the West or in the greater global North, but the poverty, geographical displacement and regional conflicts have become the societal determinants that are fanning HIV infection on the continent.

The Jaipur Paradigm has been devised to serve as an econometric model to illustrate the interaction between HIV and society. Analysts praise the paradigm for its simplicity – its central premise is that in relation to HIV, societies are distinct in two parameters distributed on a continuum: susceptibility and vulnerability. Susceptibility is defined as 'those aspects of a society which make it more or less likely that an epidemic will develop', and vulnerability refers to 'those aspects of a society which make it more or less likely that an epidemic will have a serious impact on social and economic organisations' (Decosas, 1999:111). According to the Jaipur Paradigm, two factors modulate the level of susceptibility and vulnerability of a society: the level and distribution of wealth and income, and the degree of social cohesion. The latter concept is, of course, difficult to quantify, but easy to identify intuitively.[2] Visually, the Paradigm operates on two axes, as follows:



This is all good and well on a theoretical level, but what were the vectors of HIV/AIDS in Africa on the ground? Which specific variables contributed to and continue to compound the rapid spread of HIV on the continent? Analysts (Decosas, 1999:167; Shell, 2000:12-15) point to the following key factors in explaining the epidemic proportions of the disease in SSA:

1. Labour migration

Studies have shown that mobile workers such as long-distance truck drivers have a higher probability of being HIV-infected than their communities of origin. Migrant

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[2] Decosas explains social cohesion by way of analogy: Fascist Germany was a highly cohesive society and the state actively increased cohesion by murdering those who did not conform to the Aryan ideal. Cohesion may refer to the cultural homogeneity of a society, the product of good governance and a strong civil society, related to a prescriptive religious culture, or the result of a controlling authoritarian political system or military dictatorship. In this manner, cohesion may be a deciding factor in determining a society's susceptibility to HIV infection.

labourers are separated from their families for a long periods of time, are prone to visit prostitutes or have multiple sexual partners, become HIV-positive, and then return to their primary sexual partners to spread the virus in those home communities. Decosas (1999:167) demonstrates that the profile of HIV infection in West and Southern Africa is directly related to the regional pattern of labour migration:

> Widening the focus to the entire continent reveals a crescent-shaped distribution of high HIV prevalence extending from Namibia in the south-west along the east coast to Kenya, then via Southern Sudan into the Central African Republic. As in the West African region, the southern horn of this crescent coincides with a zone of intense labour migration to a single destination, South Africa. The northern horn is less clearly related to a single migration focus. Population movements above the region of the Great Lakes are more likely due to displacement caused by war.

Ironically then, HIV/AIDS has become the Frankenstein of Africans' dream for a better life: the search for greater economic security (jobs, money, housing) is one of the direct causes of the spread of the disease.

2. HIV/AIDS, the military, war and peacekeeping

War is an instrument for the spread of HIV/AIDS. 'History has revealed time and time again that the Three Horsemen of the Apocalypse – Famine, Pestilence and War – often gallop together' (Chalk, 2000:103). With over a dozen violent conflicts, tens of thousands of troops and guerrilla fighters in the field, and some eight million refugees and internally displaced persons, conflict has become a major factor in the spread of HIV in Africa.

Military conflict brings economic and social dislocation, warns the Joint UN Programme on AIDS (UNAIDS), including the forced movement of refugees and internally displaced persons, and resulting in a loss of livelihoods, separation of families, collapse of health services, and dramatically increased instances of rape and prostitution. All this creates conditions for the rapid spread of HIV and other infectious diseases (Fleshman, 2001:16).

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

Rape and other forms of sexual violence – such as forced prostitution – are frequently used in war for a number of reasons. 'Rape is an outlet for the sexual aggression of combatants and it is related to the idea that women are war booty; it is used to spread terror and loss of morale; and it is used to undermine women's ability to sustain their communities during times of conflict' (Matthews, 2000:18).

Refugee populations – many of which are single women and unaccompanied children – are particularly vulnerable to being pressured into having sex or being raped. In the early stages of conflict situations, when a large number of refugees are on the move, their need for food and other basic necessities can be acute. Exchanging sex for money or food can therefore be commonplace. Women, for example, are six times more likely to contract HIV in a refugee camp than the general outside population (Gardiner, 2001:2). 'Among refugee and displaced people it is common for the number of commercial sex workers to increase because women feel

they have no other way to keep their families alive,' according to Dr Christen Halle, the head of the UN department of peacekeeping operations. Over time established refugee camps also attract prostitutes from surrounding communities to cater for the many male refugees without partners.

Young adolescents, with little to do in refugee camps, will often start to experiment with sex earlier than young people in other more stable situations. Moreover, amid the chaos and deprivations of the conflict that is the cause of the mass movement of people, materials for HIV prevention such as condoms are in limited supply. Refugees are also likely to have inadequate access to basic health care services, including care for sexually transmitted diseases, thereby further increasing their risk of acquiring HIV through unprotected sex (UNAIDS, 1997:4-5).

3. Bad blood

The South African blood transfusion services started testing the donor blood as late as 1985. The military, like the university- and church-going populations, were considered excellent donor populations. The military at their own request stopped donating blood for 'security reasons'. Be that as it may, notes Shell (2000:13), one could not wish for a better blueprint for initiating a pandemic than the map of personnel living on South African military bases.

4. Regional transport infrastructure

Shell (2000:13) furthermore points out that HIV is not only a camp follower of military campaigns but also travels in style on civilian aircraft, railroads, highways, roads and also spreads humbly by bicycle and on foot. Ironically, Southern Africa's well-developed transport infrastructure – well-utilised after the demise of Apartheid and the abolition of 'influx control'; and given the stress on economic regionalism and economic integration – has become excellent corridors for accelerating infection.

5. A free-riding disease

Tuberculosis and sexually-transmitted diseases are endemic to Southern Africa. According to Shell (2000:14), up to half of the population of SSA has had TB. HIV-positive people provide an open window for the opportunistic invasion of TB. With increasing use of antibiotics – and South Africa has one of the highest usages in the world, one may expect increasingly resistant variants of TB appearing in the general population.

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If one couples factors 1-5 with the dire implications of the socio-economic indigence described in the Jaipur Paradigm, it becomes clear that HIV/AIDS in Southern Africa is the result of different levels of human insecurity; the latter creating a downward spiral or vicious circle of ensuing military and social insecurities that compound the whole problem. To paraphrase: HIV/AIDS in Africa is not merely a health problem anchored in the sexual behaviour of individuals. Rather, it is the cause and result of human insecurity – the confluence of socio-political variables on a systemic, regional level that should be viewed through a more circumspect developmental lens.

In the following section we regard the impact of HIV/AIDS on the security of people's public and private spaces – the former referring to the sphere of socio-economic

interaction (macro-economic, governance, as well as the functions intra-state justice), and the latter denoting the household levels of social interaction.

HIV/AIDS at the macro-economic level

HIV/AIDS already has a huge and detrimental impact on the economy of South and Southern Africa. Both the production and the consumption levels of economies are affected, and this has dire implications for foreign investors' willingness to make any long-term investments in SSA. In fact, it is becoming increasingly apparent that different sectors within the broader Southern African economy will have to completely restructure to ensure self-preservation.

Economists have identified several major areas of macro-economic vulnerability. These include effects on the labour supply and productivity, remuneration cost increases, demand changes among households, higher government expenditure, as well as instances of severe risk exposure in key sectors of the economy.

In probably the most encompassing study of the impact of HIV/AIDS on the macro-economy of South Africa, Quattek (2000:33-4) found that '[t]he infection rate among the economically active population peaks at about 25.5 percent by 2006, well above the 16.7 percent peak for the total population'. Not only will HIV/AIDS affect the day-to-day quality of life of HIV-positive individuals and their families; the disease will remove these people from their places of work while they are ill, leading to increased absenteeism also on the side of spouses. Where spouses had already died, children will have to be taken from schools in order to look after sick adults/parents. Household spending power will decrease, labour productivity will suffer, the corporate memory or skills base within companies will literally die out, and the economy as a while, the state and the private sector will have to pick up the tab for training new workers, paying health bills and so on, which will drain the fiscus from any capacity to expend moneys on other essential services.

Some South African states already simply do not have the monetary and physical capacity to deal with the sheer amount of people sick with AIDS-related illnesses: Mabuza and Masuku (2000) report that 'AIDS patients in Swaziland are flocking to neighbouring South African clinics after being turned away from hospitals in their hometowns. At least 22 percent of residents in the small kingdom are HIV-positive and hospitals have begun sending AIDS patients home in an attempt to reserve meagre resources for uninfected people'.

An ING Barings study (Quattek, 2000:49 & 50) quantifies the sectoral impact of HIV/AIDS in South Africa as follows:

The sectoral impact of HIV/AIDS in South Africa

Sector	*HIV+ per 100 workers (2005)*	*AIDS deaths per 100 normal deaths (2015)*
Agriculture, forestry and fishing	23.2	503.9
Mining	29.3	759.2
Consumer manufacturing	23.0	867.2
Forestry products	20.2	636.6
Chemicals	21.6	632.5
Metals	19.9	658.4
Machinery	21.2	563.6
Construction	23.9	694.6
Retail	21.3	876.4
Catering and accommodation	23.0	601.9
Transport and storage	23.5	652.6
Communication	16.5	528.4
Finance and administration	12.4	479.6
Business services	15.6	788.8
Health	20.0	471.9
General government	24.5	229.1

Again, it is useful to separate the these figures for their illustrated effect on morbidity (by 2005) and mortality (by 2015). For example, by 2005 just under a third of all workers in South African mines will be HIV-positive – these workers will be absent from work regularly, leading to decreased productivity on mines. Mining companies will have to provide pecuniary resources to cope with the health status on mines, individual households will have decreased income, less spending power, and extended family members will have to stop work in order to look after the sick. By 2015 this seminal sector of the South African economy will look like a war-zone: almost eight mine workers will be dead or dying due to AIDS-related disease compared with one 'normal' death. And this is but a single sector of the economy.

The effect will be felt throughout the economy. Quattek (2000:52) projects that 'the average annual trend rate of GDP growth over the next 15 years is likely to be 0.3-0.5 percentage points below the rate in a no-AIDS scenario'. The savings constraint on both the macro-economic and household levels will be severe, and only the most brave or ignorant foreign companies will want to invest in South Africa. As DaimlerCrysler South Africa's chief executive stated in June 2001, 'AIDS is definitely one f the factors inhibiting foreign investments – on top of all the structural issues. When I try to persuade foreign suppliers to invest here, they ask about four things – trade unions, cost of capital, crime and AIDS' (Innocenti, 2001).

Of course South Africa is not the only country in SSA that are experiencing such odds in its economy: According to Forsythe and Roberts (1994) the average company (in heavy industry, transportation, wood processing and in the sugar industry) in Kenya was expected to incur HIV/AIDS-related costs at an average annual loss of US$150,000 in 1992, and by 2005 the annual cost would average US$403,000 per business. Health-care costs, HIV-absenteeism and training alone will account for over 60 percent of all AIDS-related company costs in that country.

Southern Africa also has a large informal economy – conceptualised as 'those businesses that were unregistered and did not have a value added tax (VAT) number' (SAIRR, 2001:355), the enterprises (excluding a significant amount of domestic workers) within this sector provided an income for an estimated 2,705,000 South Africans in 1999. In 1996, the informal sector accounted for 15 percent of the

total amount of economically active South Africans (SAIRR, 2001:405). Wilkins (1999:223) cautions that informal enterprise operators and workers tend to belong to groups (women and young people) who are at a high risk of infection with HIV. Due to the structure and social determinants inherent to its operation, the informal sector is hard hit by HIV/AIDS: 'when the operator of an informal enterprise, and probably one or two other family members develop AIDS-related illnesses, can no longer work and eventually die, the enterprise will die with them' (Wilkins, 1999:223). Also, due to their insular existence, it is exceedingly difficult to reach the informal sector with orthodox anti-HIV/AIDS interventions and programmes. Again, the poorest and most isolated sectors of society are at the greatest risk to be infected and affected by the disease.

HIV/AIDS and food security

In August 1999, the Zimbabwean Commercial Farmers' Union put figures reflecting the decline of the country's agricultural food output at the following: maize by 60 percent, cotton by 47 percent and vegetables by 49 percent (Sayagues, 1999). Why? Because of the loss of workers and workdays due to HIV/AIDS. In northern Uganda millet and sorghum are left overgrown because labour goes into caring for the sick and in the east of that country pastoralists are dying before they can transmit skills in herd care. In Namibia – a country dependent on water-purification plants for a consistent supply of fresh water – NamWater (the country's largest water purification company) says that HIV/AIDS is crippling its operations and the company is experiencing loss of productive hours increasing absenteeism (IRIN, 2001). In Malawi it was reported that the death of the primary male in a farm household will lead to a loss of income for that household of over 50 percent (Norse, 1991). The UN's Food and Agricultural Organisation's (FAO) Committee on World Food Security notes that in the 27 most HIV/AIDS-affected countries in Africa, seven million agricultural workers have already died from AIDS since 1985. Sixteen million more deaths are likely by 2020. The FAO (2001) provides the following table reflecting labour force decreases in the ten most heavily-affected countries:

Impact of HIV/AIDS on agricultural labour force in the most infected African countries
(Projected losses in percentages)

Country	*2000*	*2020*
Namibia	3.0	26.0
Botswana	6.6	23.2
Zimbabwe	9.6	22.7
Mozambique	2.3	20.0
South Africa	3.9	19.9
Kenya	3.9	16.8
Malawi	5.8	13.8
Uganda	12.8	13.7
Tanzania	5.8	12.7
Central African Republic	6.3	12.6
Ivory Coast	5.6	11.4
Cameroon	2.9	10.7

Bearing in mind that the farm household is the primary production unit in large sectors of Southern African economies, the impact of HIV/AIDS on these units has to be seen within the context that these household units represent a complex system dependent on human capital and remittances. The impact of HIV/AIDS on the human security aspects of this system are manifold: the area of land under cultivation becomes smaller (land is often allocated by community authorities to families on the basis of their size), agricultural output declines, the crop variety decreases as cash crops are abandoned owing to the inability to maintain enough

labour for both cash and subsistence crops, and livestock production declines due to medical costs (the latter often requires the sale of livestock) – Shell (2000:17) reminds us that the cost of treating a single terminal case of AIDS with an AZT cocktail per month is equivalent to placing 19 schoolchildren in primary school for a month. Also, agricultural skills are lost – as Du Guerny (1999:15) points out, the oral tradition of passing on skills of the trade will die with parents – 'owing to the gender division of labour and knowledge, the surviving parent is not always able to transfer the skills of the deceased one'.

When parents die, older children are left to fend for younger ones (whilst caring for sick and dying adults). In addition to the factors noted in the previous paragraph, the FAO (2001) also warns that agricultural post-production, food storage and processing are impaired. Thus, the security of food and other raw materials between harvests are at risk, including the availability of seed for subsequent cropping. The FAO report concludes by underlining the systemic impact of HIV/AIDS on agriculture and food security: 'HIV/AIDS does not merely affect certain agriculture and rural development sub-sectoral components, leaving others unaffected. If one component of the system is affected, it is likely that others will also be affected, either directly or indirectly'. The irony is – as noted earlier – that decreased food production and subsequent hunger might logically lead to the movement of large quantities of indigent populations – not only within their own countries, but across porous Southern Africa borders. This will exacerbate the movement of people caused by military conflicts elsewhere, again leading to increased vulnerability to HIV-infection on the continent as a whole.

HIV/AIDS and governance

The possible impact that HIV/AIDS will have on issues related to so-called 'good governance' and sustainable democracy in SSA have not really been examined in any great depth. The few pieces of analysis on this topic echo the CIA's mentioned focus on AIDS' impact on the dissolution of states. Of course quite a bit has been written on the disease's implications for governments' ability to expend resources on essential services with AIDS draining the fiscus, but Willan (2000:14) is one of the few analysts who have attempted to address the potential of HIV/AIDS to undermine democratic governance itself. She highlights a few areas that together might lead to the breakdown in democracy – HIV/AIDS can, in her view, cripple a country's attempts to establish and maintain democracy and equity because:

- The next generation of political and economic leaders is being wiped out.
- Women are bearing the brunt of the disease – they are the primary caregivers and are subsequently removed from the public sphere, from political participation.
- As mentioned below, a magnitude of orphans pose a long-term threat to stability and development.
- Family structures and social society are breaking down due to their inability to cope.
- The increase in the budgetary demand on governments are projected to increase to the nth degree – cutting down on delivery in other sectors of society.
- A crucial tax base is being lost.
- This might lead to decreased respect for government, leading to social unrest in light of non-delivery and ensuing frustration.

- Citizen support and participation in democratic governance will wane, as more people develop terminal diseases and are removed from the public sphere. This will also affect civil society's capacity to take part in public debates, translating into a loss in society's ability to build a sense of national cohesion.
- The inclination and ability to pay debts such as rates and health bills often dwindles when there is an increase in personal and family illness.

Although the causal link between these factors and a collapse in governance capacity and democratic social values are speculative at best, these analysts are of the opinion that the future of democracy in South and Southern Africa – infantile and already tenuous – will be adversely affected by HIV/AIDS. Willan (2000:14) argues that, unless HIV/AIDS is regarded by governments and civil society as more than 'mere' health and economic issues, 'democracy itself is threatened'.

Goyer (2001:13) agrees, noting with dismay that the 'relationship between HIV/AIDS and politics is only just beginning to be examined. In addition to the factors mentioned by Willan, he points out that the demographic impact of the disease is almost sure to change future voting patterns and political activity – we simply do not know what to expect. Of particular concern is the link between conflict and the epidemic. As noted above, AIDS and military conflict go hand-in-hand in Southern Africa – the one feeding the other. And if – according to Goyer (2001:13) – the link between cross-national military violence and HIV/AIDS is already so easy to prove and quantify, why should the disease not have a detrimental impact on security and issues related to governance within states? After all, the disease can well be personified as an abusive husband; as an invading military force: it penetrates societies and kills off the economically viable sectors of society.

A US National Intelligence Council report concludes that there is a definite link between infectious disease epidemics (in particular HIV/AIDS) and security (NIC, 2000). For example, the report found that:

- The impact of HIV/AIDS is likely to aggravate and even provoke social fragmentation and political polarisation in the hardest hit countries in the developing world.
- The relationship between disease and political instability is indirect but real. Infant mortality (likely to more than double in a number of Southern African states because of HIV/AIDS by 2010) correlates strongly with political instability, particularly in countries that have achieved a measure of democratisation.
- The severe social and economic impact of HIV/AIDS, and the infiltration of the epidemic into the ruling political and military elites and middle classes of developing countries are likely to intensify the struggle for political power to control scarce state resources. This will hamper the development of a civil society and other underpinnings of democracy, and will increase pressure on democratic transitions in SSA.

HIV/AIDS and crime

Orphans

In contrast to most infectious diseases (which take their heaviest toll among the elderly and the very young) HIV/AIDS takes its greatest toll among young adults. The wholesale death of young adults in Africa is producing orphans on a scale

unprecedented in world history. Historically, large-scale orphaning has been a sporadic, short-term problem caused by war, famine or disease. However, the HIV/AIDS epidemic has transformed orphaning into a long-term chronic problem that will extend at least through the first third of the twenty-first century (Hunter & Williamson, 2000:1). This is because the increase in orphan rates lags behind HIV-infection levels by about ten years (the time it takes the average person who contracts the virus to die from full-blown AIDS).

In 2000, 90 percent of the 11 million orphans left by the global AIDS epidemic were children living in SSA, even though only a tenth of the world's population lives in the region. According to USAID, Southern Africa had 2.9 million maternal of double orphans (8 percent of all children under the age of 15 years) in 2000, of which 65 percent were orphaned because of AIDS. By 2010 the region is expected to have 5.5 million maternal of double orphans (16 percent of all children under the age of 15 years), of which 87 percent will be orphaned because of AIDS. Some countries in the region will be worse affected than others. In Botswana, for example, every fifth child is expected to be an orphan by 2010 – 96 percent of these children will be AIDS orphans (Hunter & Williamson, 2000). To place these percentages into context, it is sobering to point out that before AIDS only approximately two percent of children in developing countries were orphaned (UNICEF, 1999:3).

As the AIDS epidemic progresses, there will be fewer adults of normal parenting age to care for the children they leave behind. The burden of care will increasingly fall on other children or upon the growing proportion of elderly people. In Zimbabwe, for example, 43 percent of orphan households are headed by a grandmother (Myslic et al, 1997:6). However, the large number of anticipated AIDS orphans has led the United Nations Children's Fund (UNICEF) to conclude that Africa's age-old social safety net for such children – in the form of deep-rooted kinship systems and extended-family networks – is unable to cope with the strain of AIDS and soaring numbers of orphans in the most affected countries: '[c]apacity and resources are stretched to breaking point, and those providing the necessary care in many cases are already impoverished, often elderly and might themselves have depended financially and physically on the support of the very son or daughter who has died' (UNICEF, 1999:3).

A number of studies have been conducted on the plight of orphans and their caretakers in various African countries. It has been shown that families that foster children in Kenya usually live below the poverty line, and that orphan households in Tanzania have more children, are larger, and have less favourable dependency ratios (Myslik et al, 1997:6). Orphans run greater risk of being malnourished and growth-stunted than children who have parents to look after them (Confronting AIDS, 1999:223-24). They are also the first to be denied education when extended families cannot afford to educate all the children of the household. This lack of schooling (often combined with a lack of proper nutrition) makes it particularly difficult for orphans to escape poverty (Confronting AIDS, 1999:225-27).

Growing up without a parent or parents, and badly supervised by relatives and welfare organisations, Southern Africa's burgeoning orphan population will be at greater than average risk to engage in criminal activity. The many orphaned African children who will grow up under extreme levels of poverty will be sorely tempted – or even obliged for the sake of their physical survival – to commit a range of property related crimes. These crimes would include the theft of food and clothing by shoplifting and residential burglary, or the theft of other items that can be sold or

traded for the necessities of life. Older orphans in their early teenage years might resort to mugging and robbery to make ends meet.

The forced migration of children because of high rural unemployment and poverty levels has long been observed in developing countries. Studies in Ghana and Uganda found that girls are increasingly being sent away to relatives in urban areas, or else to agents who placed them as domestic workers (Michael, 2001:25). This trend is likely to increase as the epidemic escalates and leaves large numbers of orphans in its wake. A significant number of child migrants flocking to the cities will increase the already high numbers of street children in Africa (Brown, 2000). Street children are both the cause and victims of a range of crimes. Petty thefts, muggings and theft out of motor vehicles are crimes commonly associated with street children. Many such children are assaulted, abused, raped and drawn into prostitution rings.

A large influx of orphaned children into the urban slums surrounding many African cities will exacerbate socio-economic conditions, thereby creating a vibrant breeding ground for a variety of social ills such as crime. Moreover, the frequency of certain types of crime – such as gang related crimes, vehicle thefts, robberies and burglaries – is higher in cities than in rural areas, with the rate generally increasing according to city size. Most factors associated with high crime rates characterise cities to a greater extent than small towns or rural villages. Population density, for example, is thought to be associated with crime, in that greater concentrations of people lead to competition for limited resources, greater stress and increased conflict. Factors such as overcrowding and increased consumer demands and expectations that characterise urbanisation are themselves believed to be associated with high crime rates. High levels of gang activity and the availability of firearms are also mainly evident in urban areas and are known to be related to criminal activity (Glanz, 1995:17).

Children who lose a parent to AIDS suffer loss and grief like any other orphan. However, their loss is exacerbated by prejudice and social exclusion, and can lead to the loss of education and health care (Breaking the Vicious Cycle, 1997). That is, the shame, fear and rejection that often surrounds people affected by HIV/AIDS can create additional stress for and isolation of children – both before and after the death of their parent or parents. The psychological impact on a child who witnesses his or her parent dying of AIDS can be more intense than for children whose parents die from more sudden causes. 'HIV ultimately makes people ill but it runs an unpredictable course. There are typically months or years of stress, suffering or depression before a patient dies. And in developing countries, where the epidemic is concentrated, effective pain or symptom relief is often unavailable to alleviate a parent's suffering' (Children Orphaned by AIDS, 1997).

Moreover, for a child living with a parent who has AIDS, the disease is especially cruel as HIV is sexually transmitted. Consequently, once one parent is infected, he or she is likely to pass it on to the other parent. Children who loose a parent to AIDS are thus at considerable risk of losing their remaining parent as well. Consequently, these children have to take on the role of mother, father or both, do housework, farm and care for their siblings and their ill or dying parents, 'bringing on stress that would exhaust even adults' (UNICEF, 1999:5).

A report prepared for UNICEF identifies a set of experiences commonly affecting most AIDS orphans:

- trauma associated with losing a parent, which is in most cases exacerbated by the threat of losing the second parent;
- witnessing the parent's physical deterioration, pain and death;
- having cared for the parent in their terminal phase and often being blamed for causing pain; and
- anxiety about their source of livelihood and their ability to retain the family home after the parent's death (Loening-Voysey & Wilson, 2001).

Reviewing the impact of AIDS in South Africa, a department of health publication predicts that children orphaned because of AIDS could be at risk to engage in delinquent behaviour. 'As [orphaned] children under stress grow up without adequate parenting and support, they are at greater risk of developing antisocial behaviour and of being less productive members of society' (Kinghorn & Steinberg, 2001:15).

Ashraf Grimwood of the National Aids Coalition in South Africa argues that the increasing number of AIDS orphans, who grow up without parental support and supervision, will turn to crime: '[c]rime will increase because of the disintegration of the fabric of our society. It will be made worse by the lack of guidance, care and support for HIV-positive people, including children. Children orphaned by AIDS will have no role models in the future and they will resort to crime to survive' (Mackay, 1999).

Research commissioned by the Nelson Mandela Children's Fund found that South African AIDS orphans are being ostracised by their communities and exploited financially by relatives who had taken them in, primarily to receive a state grant. Emotionally, the orphans were found to be suffering as a result of the deprivation of parental guidance, emotional trauma as a result of loss, and the problem of having to cope with adult responsibilities prematurely. Orphans were also vulnerable to physical and sexual abuse by neighbours and relatives (Thompson, 2001). A USAID research report came to a similar conclusion: '[d]enied the basic closeness of family life, children lack love, attention and affection… they are often harshly treated or abused by step- or foster parents' (Hunter & Williamson, 2000:4).

A review of the backgrounds of a large sample of children who have killed or committed other grave (usually violent) crimes in the United Kingdom found that 57 percent had experienced the death, or loss of contact, of someone important such as a parent.

A 1998 interview study of young men serving jail sentences, or involved in crime, by the Centre for the Study of Violence and Reconciliation (South Africa) found that most of the interviewees were 'abandoned or kicked out of their homes, or… had to live with a stepfather or mother who rejected them. Many expressed feelings of being unloved' (Segal et al, 1999:24).

The absence of a father figure early in the lives of young males tends to increase later delinquency.[3] Moreover, such an absence will directly affect a boy's ability to develop self-control: '[t]he secure attachment or emotional investment process [a father figure provides] facilitates the child's ability to develop and demonstrate both empathy and self-control. By extension, an insecure attachment will lead to lower levels of empathy and self-control, and to an increase in violent behaviour' (Katz, 1999).

[3] See, for example, Bowlby (1947) and Gabel (1992).

Another research group completed an exhaustive review of family factors as correlates and predictors of juvenile conduct problems and delinquency. They found that, inter alia, poor parental supervision or monitoring and low parental involvement with the child (factors present in orphaned children) compounds problems and delinquency (Loeber & Stouthamer-Loeber, 1986:29-149). Another study by the American Psychological Association on violence and youth found that 'lack of parental supervision is one of the strongest predictors of the development of conduct problems and delinquency' (American Psychological, 1993:19).

Since the early 1990s reports from government commissions, research reports, and syntheses produced by national crime prevention organisations have identified a number of common factors associated with delinquency, violence and insecurity (Crime Prevention Digest, 1999:20-21):

- poverty and unemployment deriving from social exclusion, especially for youth;
- dysfunctional families with uncaring and inconsistent parental attitudes, violence or parental conflicts;
- discrimination and exclusion deriving from one or other form of oppression;
- degradation of urban environments and social bonds;
- social valuation of a culture of violence;
- presence of facilitators (such as firearms and drugs);
- social valuation of a culture of violence.

Most of the above factors – all of them if a society is also ravaged by war or conflict – are present in a large proportion of AIDS orphans in Africa. They grow up impoverished, tend to be socially excluded, are not fully cared for because of the loss of their parent(s), are often discriminated against, and grow up in an environment where social bonds are falling apart because of the high AIDS-related mortality rates among all sectors of society.

If would appear that the kind of psychological trauma and lack of parental affection and supervision experienced by AIDS orphans is a good predictor of subsequent delinquency and violent criminal activity. Insufficient research has been done on the extent of the risk AIDS orphans face of engaging in anti-social and violent behaviour in their later lives. However, given that there will be some 5 million AIDS orphans in Southern Africa by 2010, it is conceivable that the region will experience a significant increase in violent interpersonal crime such as murder, rape and assault, violent property crime such as robbery, and violent crime against property such as malicious injury to property.

Income inequality

In households with one adult death the economic impact of AIDS is greater in poor households that in rich households, according to a World Bank research report. This is because households that experience an adult death draw on their assets to cushion the shock of the epidemic. It follows that households with lower levels of assets can be expected to have more difficulty in coping with the death than households with more assets (Confronting AIDS, 1999:221-23).

Moreover, while the prevalence of HIV is widely spread among all sectors of the population in developing countries, more educated people with higher incomes are in a better position to learn about the epidemic and alter their behaviour to avoid

infection. Consequently, even in developing countries, AIDS is taking on the pattern of other infectious diseases, in that the poor are more likely to become infected: '[u]ltimately AIDS may become most prevalent in the poorest urban slums of developing countries' (Confronting AIDS, 1999:207).

One of the consequences of the epidemic in high prevalence countries is not only that societies will end up poorer than they would have been without AIDS, but income inequalities are likely to widen. Generally, the poor in Africa are more prone to being infected by HIV, and are least likely to cope with the financial implications of the disease. As a result the gap between the poor and non-poor is likely to get bigger in many African countries in the next 10 to 20 years.

This widening gap between the very poor and the rest in society is likely to contribute to rising levels of crime in a number of African countries. It is the level of inequality, or the relative deprivation of a group or community in a society which is an important risk factor for crime frequency. According to British criminologist Jock Young, widening inequalities of income engenders 'chronic relative deprivation amongst the poor which gives rise to crime and a precarious anxiety among the better off which breeds intolerance and punitiveness towards the law-breaker' (Young, 1999:8). It is no coincidence that South Africa and Brazil – two societies with extremely high income disparities – have extraordinary high levels of property and violent crime.

CONCLUSION

We are dying. Our economy is under threat. The enemy is attacking the elite in our society, but also the children, the elderly and the infirm. Using the urge at the core of what makes us human – the will to reproduce – it has already infiltrated our schools, houses, mines, governments and churches. The threat to Southern Africa's human security is such that those of us who are not infected, dying and dead are certainly equally *affected* by the disease. This state of affairs is partly the result of our historical legacy of poverty, creating a confluence of time and space that makes this continent the Armageddon of HIV/AIDS. And we are losing.

Yet we are in denial. The Political Science community ignores the issue, and our governments ponder the causal link between HIV and AIDS whilst the latter is already affecting our food security, our livelihoods, our sense of community. What will be the social effects of the missing generation of young adults unable to raise their children? How will intra-African peacekeeping operations be affected by the epidemic which disproportionately affects military personnel? What impact will the virus have on the functioning of state departments in already poorly performing criminal justice systems in Sub-Saharan Africa? How will 30 to 40 percent of the adult population, which is HIV-positive and dying, react when their government decides to spend limited state resources on policing, education or housing instead of building more hospitals and care centres for those infected by the virus?

African Political Scientists' lethargic response to this issue up to now is an indictment of our academic community – of our 'intellectual *in*security' in dealing with this issue. As Marais (2000:55) notes,

> [t]he debate over [the social determinants and effects of HIV/AIDS] has been lively, but so often imbued with either racism or academic political correctness that the reality of the situation is so often misconstrued and invalidated … These kinds of epistemological complications render all the more difficult efforts to

mount an effective response that answers to the demands of inclusivity, empowerment and 'ownership'.

May this be a call to intellectual arms.

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