

# **The Decay of State Capacity: HIV/AIDS and South Africa's National Security**

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## **Introduction**

As the specter of apartheid fades into the past, many had hoped for an “African renaissance,” led by the nascent democracy and regional economic power of South Africa. South Africa possesses abundant natural resources, established legal, financial, transport, energy and communications infrastructure, and a major stock exchange. Despite its advantages, however, South Africa remains troubled by exceptionally high rates of unemployment, and much of its populace still does not have access to adequate education, housing, and medical care. Moreover, in recent decades the global HIV/AIDS pandemic has extended its shadow over most of southern Africa and promises increasing disruption of South Africa's society, economy, governance structures, and national security.

While it is now increasingly understood that the AIDS pandemic constitutes a threat to the security of all nations, the process by which the disease actually destabilizes societies, economies, governance structures and the national security apparatus remains opaque.<sup>1</sup> One of the greatest problems in understanding the threat posed by the pandemic emanates from the fact that studies typically

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<sup>1</sup> In prescient fashion Richard Ullman redefined national security in a manner that transcended traditional definitions that focused exclusively 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.” He redefined threats 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

concern one or another individual facet of the pandemic's effects upon a society (such as the effect of HIV/AIDS on unemployment rates). Our purpose is to demonstrate how HIV/AIDS operates across various domains (demographic, economic, and governance) to (a) destabilize states and (b) threaten their national security. In this context, it must be understood that any agent that directly threatens to destroy a significant proportion of a state's population constitutes a direct threat to that state's national security. Given that the HIV/AIDS epidemic is projected to take the lives of approximately 20 to 25 percent of the South African population over the next decade, it is reasonable and prudent to consider that the epidemic constitutes a direct threat to the national security of the South African state.

While South Africa is also beset with many other infectious diseases that promise to impede its economic development (tuberculosis in particular), it is the HIV/AIDS epidemic that threatens to destabilize South Africa in the decades to come. For South Africa, the security impact of the epidemic is already showing. From the civil service to the economy, South Africa's political and economic security has been compromised from the strain that the epidemic has placed on resources and manpower. The loss of manpower will mean that South Africa's capacity to maintain a regional hegemonic role will diminish in the short term, while in the long term the impact on South Africa will amount to a human catastrophe unseen in South African history. The long- and short-term political and economic stability of the entire southern African region will be jeopardized as South Africa becomes less capable of

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choices available to the government of a state or to private, non-governmental entities (persons, groups, corporations) within the state." This redefinition of security is useful in that it includes non-military threats, such as the destruction of a state's population by a pathogenic agent such as the human immunodeficiency virus (HIV).

coping with the fallout of the epidemic.

Not only is the nascent democracy of South Africa threatened by the proliferation of such epidemic disease, but the HIV/AIDS epidemic promises economic and social dislocation for many societies throughout the region, including Zambia, Zimbabwe, and Botswana (to name a few). This chapter examines the patterns of interaction between the HIV/AIDS epidemic and South Africa's demography, governance, and economy. The results of this examination lead us to argue that the HIV/AIDS epidemic poses an intensifying *direct* and *indirect* threat to South Africa's national security.

### **Epidemic Background**

Throughout the various manifestations of epidemics over history, significant levels of disease-induced mortality and morbidity have undercut the stability of societies (Price-Smith 2002). This phenomenon has occurred at various points in the historical record, ranging from the chaos that the plague visited upon ancient Athens during the Peloponnesian War, to the centuries of upheaval in Europe generated by the Black Death, to the smallpox-assisted conquest of Amer-Indian populations. Instability occurs in part because of the demoralization of the population due to high mortality, institutional fragility, and disease-induced poverty. Such signs have appeared in South Africa during the course of the HIV epidemic.

The first two AIDS cases in South Africa were reported in 1982. Since then, South Africa's HIV/AIDS epidemic has become one of the worst in the world. South Africa has experienced astonishing HIV prevalence increases from 1 percent of the population in 1990 to a high estimate of 26.5 percent of the population in 2002, according to South African Department of Health statistics. Based on UNAIDS data, South Africa had 1.4 million citizens infected with HIV in 1995. By 1997 approximately 2.9 million South Africans

were infected, with an adult seroprevalence rate of 12.91 percent. By 2001 more than 5 million South Africans were HIV positive with adult prevalence standing at 20.1 percent. The most recent UNAIDS/World Health Organization (WHO) Report placed the estimate of HIV infection at approximately 5.3 million South Africans, the largest population of HIV-infected people among all countries in sub-Saharan Africa. As a percentage of the total population, approximately 21.5% of South Africa's population is infected, ranking it fifth behind Swaziland, Botswana, Lesotho, and Zimbabwe. Additionally, the UNAIDS/WHO report estimated that South Africa's residual orphan problem now affected 660,000 children.

Within South Africa, some provinces are experiencing epidemics that are worse than the national average. According to government data released by the Ministry of Health, prevalence rates for some provinces exceeded the 30% level (see Appendix Table \_\_\_\_\_), while others were well below the national rate. The differential may be significant for political reasons, as highly infected regions may exhibit higher rates of lawlessness, economic dysfunction, and governance problems. Demographically, the highest areas of HIV seroprevalence concentration lie in the northern and eastern portions of the country, particularly in areas that abut other nations which exhibit high seroprevalence (notably in those areas that border Zimbabwe, Botswana, and around Lesotho and Swaziland).

Within South Africa itself, cities that exhibit adult seroprevalence levels in excess of 20 percent include Johannesburg, Durban, Messina and Bloemfontain, with the city of Kimberley exhibiting levels in excess of 15 percent. Given that these cities are major metropolitan centers it suggests that the epidemic is now thoroughly entrenched throughout the northern, eastern and central provinces.

It is important to understand that the principal activities that foster the spread of HIV include polygamous sexual relations in

South African society, prostitution along major transportation arteries, a societal aversion to the use of condoms, and some intravenous drug use in major urban centers. With these factors working simultaneously, the epidemic continues to expand throughout the South African populace, with no empirical evidence of abatement.<sup>2</sup>

Several demographic models employed to project estimated HIV-induced mortality in South Africa and those used by the US Bureau of the Census estimate that nearly 25 percent of the *total* South African population will be HIV positive by the year 2010. Over 50 percent of those in the 30-55 age range will be HIV positive, while over 8 million South Africans will have died from the disease, and life expectancy will be reduced to a dismal 35 years. A more conservative estimate by the Actuarial Society of South Africa predicts 6.5 million deaths from AIDS by 2010, with a marginally higher life expectancy of 40 in the year 2010. Robert Shell has estimated that AIDS will drastically reduce life expectancy in South Africa to an astonishing 40 years in the year 2010 compared to 60 years in 1985. As a result of the dramatic winnowing of the adult population, the population distribution is expected to transform

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<sup>2</sup> Data on the extent of South Africa's epidemic are conflicting, though all underscore the severity of the problem. The South African Actuarial Society had estimated the number of infected people in 2002 at 6.5 million people. Typically, data on HIV seroprevalence in South Africa are drawn from "sentinel sites," which in this case are prenatal clinics where prospective mothers are tested for the presence of the virus. While not ideal, the data do provide a consistent method for assessing the epidemic. Other problems that complicate the process of accurate seroprevalence estimation include chronic underreporting of HIV due to a number of factors such as the lack of adequate testing infrastructure in rural areas of the country, or in areas wherein the majority of the population is black. The concentration of national medical capacity within white-dominated urban areas may in fact contribute to underreporting of HIV infection on a national level, resulting in excessively conservative estimates of aggregate societal seroprevalence. The obvious implication is that true levels of infection may be significantly higher than official South African government figures.

from a pyramidal shape to that of a chimney-type form perched on a large base of children and adolescents. Of course, this will have ramifications for societal stability, which we detail later in this chapter.

The subsequent problems associated with AIDS have begun to appear in full force. Opportunistic infections associated with HIV-positive status, such as tuberculosis, have increased since the onslaught of the HIV/AIDS pandemic. Tuberculosis (TB) infections and mortality rates increased dramatically as AIDS patients became more susceptible to infection and disease with the weakening of their immune systems. From 1994 to 1995, for example, TB mortality rates rose from 38 to 53 per 100,000 males and from 15 to 23 per 100,000 females, with the highest incidents of death being recorded in provinces that have the highest incidents of HIV prevalence among women (Kwazulu-Natal and North West) (Kleinschmidt 1999). Overall, the epidemic in South Africa presents one of the greatest humanitarian crises ever faced by the government.

### **Domestic Security: States, Institutional Fragility, and the Bureaucracy**

After the struggle against apartheid, the African National Congress (ANC) took the reins of power through free and democratic elections in 1994. The issue of how the ANC would rule quickly blossomed as South African society transformed from decades of racist oppression to a new period of democratic reforms. While the change in government went smoothly, the change in society lagged, partly because of the strength of the ANC itself and the resulting over-centralization of the national government. The ANC was not only able to garner significant national electoral strength, but it was also able to capture control of the nine provincial governments. The ANC became the dominant national party, similar to the circumstances of other parties such as the Kuomintang in Taiwan, the Institutional Revolutionary Party in Mexico and the United Malays National Organization in Malaysia (Giliomee 1998).

Based on the final constitution of 1996, a weak form of federalism emerged, which helped the ANC to consolidate power and the national decision-making process. The strength of its national appeal allowed the ANC to centralize much of the decision-making process without significant input from provincial leadership. While this may have been a strong political move for the ANC in the short term, it may ultimately be a political liability in the long term. When the ANC took control of the national government, local and provincial governments barely stayed afloat as their ability to deliver services declined and their authority within their territories eroded. According to Giliomee, "...of the approximately seven hundred local governments, about a third can manage, another third are salvageable, and the remaining third are collapsing to one degree or another" (Giliomee, 1998: 139-140).

Provincial and local institutional decay and the decline in public confidence in those institutions have significant political effects. The inability of provincial and local institutions to provide services to citizens may place additional strain on national services as the national government attempts to fill the services gap at these levels. An important sign of public confidence in the national government will be in how well the government is able to provide needed services to its people. To this effect, the ANC has not met the challenge, with the strains of such problems showing even within the ANC among national and provincial leaders.

In early 1999, South Africa's Health Minister Nkosazana Zuma removed state funding for a program to distribute the anti-viral drug Zidovudine (AZT) to pregnant HIV-infected women, arguing that the scarce resources may be better allocated in prevention programs (Baleta 1999: 908). The political fallout reached international levels, with boycotts of the July 2000 World AIDS Conference in Durban, South Africa. Domestically, the Western Cape province broke with national policy, supplying the drug as needed to pregnant women. Zuma later accused the Western Cape's New National Party of using AZT to buy votes in elections

(Baleta 1999: 908).

More recently, a chasm opened between national and provincial government policy over the distribution of Nevirapine to pregnant women. While the national government has refused to sanction the use of Nevirapine in curtailing mother-child transmission, provincial governments have begun to defect from the policy. In two of nine provinces where the national governing African National Congress is in local coalitions, its partners have announced a break from the national government's Nevirapine policy. Provinces and local doctors have defied the government by issuing Nevirapine doses to patients beyond those that were accepted into a pilot study on the drug. In effect provincial and local leaders have broken with national policy, recognizing that the national government's policies may not provide the care and services needed to their constituents. The relationship between national institutions and provincial institutions has eroded as provincial leaders distance themselves from unpopular, over-centralized national HIV health policies.

Such schisms within the ANC lend credence to the theoretical proposition that states facing severe infectious disease outbreaks may be vulnerable to declining legitimacy in the eyes of both the populace and political opposition groups (Price-Smith 2002). Resistance from South Africa's civil society and opposition political parties to the ruling ANC's HIV/AIDS policies and to President Thabo Mbeki's denial that HIV induces AIDS has mounted. So great are civil society's frustrations with the ANC's lack of effective leadership on the issue that groups have mounted legal challenges to pressure the government to provide anti-retroviral therapy to the infected. The opposition Pan African Congress party went so far as to charge the ANC with genocide for the government's inept response to the deepening AIDS crisis. PAC health secretary Costa Gazi has said,

Only the dim-witted and those consumed by misguided loyalty or ideology will fail to realize that South Africa, and

Africa's greatest challenge is the HIV/AIDS epidemic....Rather than continue to stand on the sideline, and remain prisoners of hope, we intend...to bring charges of genocide, alternatively culpable homicide, against the President and the government of South Africa.

Such rhetoric leaves little doubt that opposition parties see the ANC's controversial response to the epidemic as a means to challenge the government's eroding political support in the general population. Over the long term, the government may continue to face challenges from both societal groups, and from competing political elites who could use the crisis to wrestle power from the ANC. In fact Nelson Mandela noted that the AIDS crisis has generated increasing levels of social and political pressure on Mbeki to design and implement effective policy solutions to the epidemic. But the government's capacity to carry out such policies may be in jeopardy as well.

The epidemic's potential impact on government services is significant, but extends far beyond the national political configurations that evolved from the post-apartheid transition. The essence of government services, the bureaucracy, is jeopardized by the onslaught of the HIV/AIDS pandemic. The pandemic is affecting civil servants, which could further cripple the national government's ability to deliver services that maintain civil order and promote public confidence in political institutions. The problem is likely to affect provincial and local governmental institutions first, given locally high prevalence and infection rates (see Table \_\_\_\_). In South Africa, it has been estimated that as many as one in seven civil workers (150,000 or more) are HIV positive (ICG 2001; Canadian Development Agency) with educators, health care workers, and the police most affected. South Africa has been able to cope

with the problem for now, but the long-term situation may provide a greater challenge.

In the long term, what may be termed *institutional memory* will decline, diminishing institutions' efficacy and responsiveness to societal demands and limiting their ability to deal with "stressors" such as the HIV/AIDS epidemic. Hence, the increasing infection of society will debilitate and kill senior members of government institutions, diminishing the guidance, consistency and direction passed on to younger members of the bureaucracy. The net effect may be to generate *institutional fragility*, compromising the overall capacity of the state to deal effectively with national emergencies. The effect is then circular; the epidemic weakens government institutions, rendering the government increasingly ineffective in stopping the very agent that is weakening it. The result is a downward spiral wherein the epidemic is relentlessly reducing state capacity, even as the state requires ever-increasing capacity to stop the growing epidemic.

All forms of services are affected by the HIV/AIDS pandemic, but some are burdened more than others. Two service areas affected most in the long term by the pandemic are health care and police services. Strains on the health care system are obvious in that the health care system in South Africa will be pressured to deal with the epidemic as it progresses. However, the health care system may not be able to cope with potentially the most drastic fallout of the epidemic. The number of orphans in South Africa is increasing with the spread of the epidemic. Sadly, the increase in orphans may result in an increased propensity toward what could best be termed "extended suicide." One ethnographic study of inner-city Detroit residents clinically diagnosed with AIDS and their families revealed a horrific trend toward "survivor terror" (Tourigny 1998). Children of parents diagnosed with AIDS may adopt self-destructive rationales—deeply rooted in the conditions they face, such as poverty, crime, fear, depression and hopelessness—and seek

intentionally to expose themselves to the HIV virus. In a similar vein, HIV infection may also produce a sense of despair causing people who are infected with the virus to engage in reckless behavior that may promote its transmission to others. In both cases, such behavior may be an extreme reaction, but it can hardly be ruled out as a potential outcome of the desperate conditions the epidemic creates. The manifestation of this form of behavior would only serve to extend the epidemic in South Africa while creating additional stress on medical and psychiatric services that would be needed to deter orphaned children from pursuing such a drastic course of action.

UNAIDS estimates the number of South African children who have lost one or both parents to AIDS under the age of 17 in 2003 at an astonishing 1.1 million, an increase in the cumulative number of AIDS orphans by approximately 440,000 from 1999. Whiteside et al., estimate that in the province of Natal alone there may be anywhere from 759,700 to 833,520 AIDS orphans by the year 2010. The US NIC report concludes,

With as much as a third of the children under fifteen in hardest-hit countries (such as SA) 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.

It is likely that the projected expense of orphaned populations to total state expenditure will become onerous in the years to

come and has the capacity to strain South Africa's already tenuous budget. The other portion of the burden will fall upon extended family members to care for the children, which will put additional strains on declining household incomes and savings. AIDS orphans will most likely grow up impoverished, poorly educated, prone to criminal behavior, and disenchanting with society, increasing the likelihood that they will be easily recruited to radical political causes. The overall impact is that governance problems for South Africa may increase in the years to come.

A related issue that has had little attention paid to it has been the epidemic's impact on crime. Schönteich (1999) draws attention to the long-term impact that the HIV/AIDS pandemic may have on South Africa's violent crime rates. Because of the increasing orphan population and the breakdown of the family structure, which occurs when parents die from the virus, orphans may resort to crime to survive under conditions of poor supervision and upbringing. Ashraf Grimwood of the National AIDS Coalition of South Africa has said that "Crime 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." Schönteich has argued that as the orphan population increases as a result of the AIDS epidemic, the frequency and severity of crime in South Africa will also increase in the decades to come.

In less than a decade's time every fourth South African will be aged between 15 and 24. It is at this age that a person's propensity to commit crime is at its highest. At about the same time there will be a boom in South Africa's orphan population as the AIDS epidemic takes its toll. 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.

Of course, sex crimes (prostitution) may increase as a way for orphans to survive while sex victimization (rape) may also increase because of the social vulnerability of the orphan population. Given the historical trend to lawlessness evident in plague-ridden societies, one might expect to observe a similar trend toward lawlessness within South Africa as HIV/AIDS prevalence intensifies over the coming decade. Indeed, such manifestations of increasing lawlessness are already evident in the dramatic increase of sexual violence throughout South African society.

Unfortunately, South Africa has, in recent years, come to exhibit one of the highest rates of sexual assault in the world. Tables \_\_\_ and \_\_\_ present data on the number of rapes, attempted rapes and indecent assaults nationally and provincially. In all cases, the number of rapes and indecent assaults grew substantially over the 1994-2002 period. In 1994 there were 42,429 cases of rape and attempted rape; by 1997 this figure had increased to 52,159 assaults with further increases to 52,875 in 2000-1 and 54,293 in 2001-2. The latest official government statistics for the 2002 period placed the number of rapes at 52,107 and the number of indecent assaults at 8,469, though these numbers are not without controversy.<sup>3</sup> Shockingly, of the number of rape cases reported in the 2002-3 SAPS

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<sup>3</sup> Controversy has been raised in the past two years about the actual number of rapes that occur in South Africa. The government has challenged claims that official government statistics severely understate the problem, though it does admit that not all rapes and indecent assaults are reported. Independent researchers have placed the actual number of rapes in South Africa at around 1.8 million during the 2002-3 period, a claim that the government has called "...absolute fiction in search of sensation" (South African Police Service 2003, Part 6). Leggett (2003) notes that changes in legislation designed to encourage reporting of sex crimes and to reclassify certain sex crimes may ultimately increase the number of reported rape cases while some cases of rape may be masked by the reclassification.

Annual Report, 14.2 percent of the rape victims were between the ages of 0-12 while 39.3 percent of the offenders were under the age of 19 (SAPS 2003).

Preliminary analysis presented in Table \_\_\_ suggests that the number of rapes and indecent assaults correlates significantly with the HIV prevalence rates.<sup>4</sup> At the national level, HIV prevalence rates correlated significantly with rape ( $r=.798$ ) and indecent assault ( $r=.809$ ). An important distinction should be made between rapes and indecent assaults. Under the reporting system, attempted rapes of children and infants (0-12) are not reported as attempted rapes or rapes if penetration could not be achieved (SAPS 2003). Instead, these crimes are reported as indecent assaults. When correlations are examined across the provincial level, the correlation between HIV prevalence rates and rapes was statistically significant in only five of the nine provinces. However, the correlation between HIV prevalence rates and indecent assaults was statistically significant in eight of the nine provinces. The implication of these results is that the increasing incidence of child rape may be closely associated with increasing HIV prevalence, but less strongly associated with rape in general. A potential reason for this is that many South African men now mistakenly believe that having sex with a virgin will rid them of the affliction. This thinking has led to a high incidence of child rape as HIV-positive males seek to cure themselves of AIDS. Such attacks consequently have led to increasingly frequent reprisals against the accused by mobs intent on carrying out vigilante justice.

Aside from increases in rape and indecent assaults, South Africa has also experienced increases in other areas of criminal

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<sup>4</sup> It is important to note that correlation does not translate into causation. The high correlations between the variables suggest that there is a solid basis for greater study of the relationship between HIV prevalence and the number of sex-related crimes reported in South Africa.

activity. Following the transition from apartheid, crime rates overall in South Africa skyrocketed, with 2000 having the highest crime rates on record. According to Schönteich and Louw (2001), between 1994 and 2000, violent crime rose 34% and property crime increased by 23%. In 2000, 825,000 violent crimes were reported, up from 618,000 in 1994.

Some positive results have come from South Africa's battle against crime. The most recent SAPS Annual Report for 2002-3 indicates that the murder rate in South Africa has declined slightly, putting it at around the same level as the murder rate in Washington DC and out of contention with Columbia for the title of "murder capital" of the world (Leggett 2003). Also the number of car and truck hijackings declined by 20 percent. Despite some successes, South Africa's police forces confront conditions that currently make some areas of South Africa as dangerous as a war zone. If Schönteich (1999) is correct, the potential exists for South Africa to experience an even larger jump in crime rates than what has occurred already in the post-apartheid era.

Already, the crime problem in South Africa has extended beyond the capacity of the police forces to control it. In 1996, a white paper on National Defense for the Republic of South Africa concluded that while policing of crime is predominantly a responsibility of the South African Police Service (SAPS), there is a clear need for assistance from the South African National Defense Forces (SANDF)—i.e. the military. Constitutionally, the SANDF shares an auxiliary law enforcement role with the SAPS, an unusual role for the military in a democracy. While there is tremendous reluctance to involve the SANDF in policing affairs, the extensive crime problems have necessitated it (Winkates 2000; National Defense for the Republic of South Africa 1996). The lack of an overt external threat to South Africa means that the domestic policing role may increase for the SANDF. However, they are not allowed to conduct normal police functions, investigations, suspect arrests or actual involvement in the criminal justice system.

Despite these restrictions, the deployment of the SANDF in cases of “serious crime” has been done. These crimes include armed attacks on farms, stock theft, arms trafficking, and car hijackings. The SANDF and SAPS have shared scarce equipment, supplies, and services, but both forces also share the same problem: the HIV/AIDS epidemic.

Data are scarce and contested, but estimates of HIV infection among the SAPS and the SANDF show a blossoming crisis that will affect South Africa’s domestic and international security. For the SAPS, reports by the South African Health Department have placed HIV infection among the police at between 20 percent and 25 percent, though that figure is strongly contested by the SAPS (The Star 1998; South African Press Association 1998). According to the Department, the highest infection rates were among those police serving in the Caprivi Strip in Namibia or in exile.

Both the South African Police Union (SAPU) and the Police and Prison Civil Rights Union (POPCRU) have warned that the deepening of the epidemic will lead to serious shortages of trained personnel in the police forces. Given the problem of increasing crime rates throughout South Africa, the demand for additional SAPS personnel may increase precisely as the capacity of the police and legal institutions is being diminished by the epidemic. Thus, just as the epidemic is creating increasing demands on the institutional capacity of the state’s coercive apparatus, it is simultaneously undercutting the supply of such capacity. The probable result will be serious governance problems that may only worsen as the police forces are inexorably depleted by the epidemic.

Infection rate estimates among members of the SANDF have also been controversial. While some have estimated that as much as 40 percent of the SANDF are HIV positive, the SANDF itself has acknowledged an infection rate of approximately 17 percent (Magardie 1999; Beresford 2001). The latter figure is based on a survey of military personnel in three of South Africa’s provinces,

though the army says that infection rates most likely resemble overall provincial infection rates throughout South Africa (Beresford 2001). The former figure exceeds government estimates, yet it is free of the bias that government sources may exhibit in their efforts to reduce perceptions of insecurity in South Africa. It may be the case that political pressure within the government and military has downplayed infection levels so as not to erode the perception of South African military power. Doubts remain as to whether the SANDF would release accurate data indicating high levels of HIV prevalence among their forces, fearing that this would be a sign of weakness to their regional competitors. Local media have reported that actual infection rates in the SANDF range from 50 to 70 percent, with several units showing an astonishing 90 percent rate of infection. However, it is important to note that high rates in several units may not mean similarly elevated rates in the rest of military units throughout the country. Despite these assertions, there is no concrete and comprehensive evidence to back such claims, although it is probable that certain units are exhibiting rates of HIV infection that exceed those across the military and even those in the general population.

The reported rates of infection in the military have brought strident accusations from the political opponents who claim that the nation's defense forces have now been seriously compromised by the HIV epidemic. According to Greg Mills of Wits University, less than 50 percent of the SANDF is considered combat-ready due to a variety of reasons including insufficient training, a lack of equipment, and increasing illness. Another problem is the increasing reluctance of officers to enter into combat situations alongside soldiers that are HIV positive, given that warfare results in bloodletting and possible exposure to the virus. This only serves to further undermine the SANDF's levels of morale, combat readiness, and efficacy. Strategic implications of the burgeoning HIV/AIDS epidemic include increasing institutional fragility of the military through the mortality of those in command and specialized posts.

Additionally, some also question whether the military has enough capacity within its hospitals to deal adequately with the proliferation of HIV throughout its ranks, given that the military must supply its soldiers with free medical treatment. The Surgeon General concludes that due to high levels of HIV prevalence,

the military can expect a loss of continuity at command level and within the ranks, increased costs with regard to recruitment and training for replacements, a reduction in military preparedness, increased costs with regard to health care, loss in productivity and a reduction of internal stability and external security. In this sense, HIV/AIDS can easily become a regional destabilizer and a potential war-starter.

The levels of HIV infection within the military create special circumstances that warrant attention to the behavior of military personnel both in and out of conflict zones. As Elbe and Ostergard detail in Chapter \_\_\_\_\_, from a behavioral perspective, the general conduct of military personnel has been linked to behavior that is conducive to the transmission of the HIV virus (Carballo, Mansfield and Prokop 2000; UNAIDS 1998; United States Institute of Peace 2001; Heinecken 2001; Goyer 2001). When military demographics are combined with the social pressures of the military, the conditions for behavior conducive to viral spread emerge.<sup>5</sup>

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<sup>5</sup> For instance, while the problem of civilian rape by military personnel has been most prevalent in Africa's post-Cold War civil conflicts (such as Sierra Leone, the Democratic Republic of the Congo, and most recently in the Darfur region of Sudan), South Africa has had to confront the problem of soldier rape on a much more limited scale. In its 1998 peacekeeping operations in Lesotho, massive public demonstrations against the presence of SANDF appeared in Maseru after allegations that SANDF soldiers had raped three young girls at Ha Leqele village near Makoanyane Barracks. In another incident the military levied accusations against seven SANDF soldiers who allegedly raped a married woman at gun point in front of her husband.

## **HIV/AIDS and South Africa's Economic Security**

Researchers and scholars have examined the long-run economic impact of the HIV/AIDS pandemic in a number of studies that indicate the pandemic will have tremendous consequences for Africa (Barnett and Whiteside 2000; Cross and Whiteside 1993; Nevin 1998; Over 1992; Tbaijuka 1997; Topouzis 1998). South Africa's current economic condition reflects these basic conclusions. Since the transition from the apartheid government in 1994, South Africa's general economic conditions have declined. Unemployment in South Africa jumped dramatically between 1994-2000, with current unemployment hovering between twenty-five per cent and thirty per cent. The unemployment problem has been compounded by a lack of incentive for domestic investment. Inflation in South Africa's economy is running at close to forty per cent annually, while the central bank has increased interest rates to between fourteen and eighteen per cent in order to control the high levels of inflation. Annual economic growth has stagnated at under two per cent, while per capita gross domestic product has declined in recent years. Current economic conditions paint a clear picture of an ailing South African economy and the future impact of HIV may only exacerbate the problems.

For instance, in their macro-analysis of the epidemic's projected impact on the South African economy, Arndt and Lewis argue that AIDS will result in a GDP level in 2010 that is significantly lower than that of a 'non-AIDS' scenario. They also project that per capita GDP will decline by 8 percent relative to the non-AIDS scenario. Using an alternate quantitative model, Quattek concurs that the AIDS epidemic will exert a profound negative impact on South Africa's national GDP:

In 2006-2010, constant price GDP in the AIDS scenario will be an annual 3.1% lower than in the no-AIDS baseline; in

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2011-2015, it is expected to be 4.7% lower on an average annual basis. In constant 1995 terms, GDP would be R12.5 billion below its no-AIDS level by 2005 and R41 billion by 2015. GDP growth rates are expected to be 0.4 percentage points lower in 2006-10 and 0.3 percentage points in 2011-2015. In constant 1995 rand terms, this would also mean that real disposable income would be R20 billion lower by 2005 and R40 billion lower by 2015 than in the no-AIDS scenario.

Arndt and Lewis conclude that the major portion of the projected deterioration in growth results from the shift in government spending towards the health sector, which in turn inflates the budget deficit and results in a decline in total investment. Arndt and Lewis further find that in the year 2010, real GDP will be approximately 20 percent below the level that would have been attained in the counterfactual 'no-AIDS' scenario. This bleak assessment is confirmed by a Stellenbosch Bureau of Economic Research (BER) model that shows that the AIDS epidemic will lower South African real gross domestic product by 1.5 percent in 2010, and by 5.7 percent in 2015. Moreover, the BER predicts that the average annual growth rate will decline by 0.1% (from 2002-05), 0.3% (2006-2010) and by 0.9% (2011-2015). "The net effect of the AIDS epidemic will be negative for growth...the average annual trend over the next 15 years is likely to be 0.3-0.4 percentage points below the rate in a no-AIDS scenario."

However, McPherson et al. argue that previous analyses which plot 'no-AIDS' vs AIDS scenarios are likely to understate the problem, given that AIDS has actually been exerting a negative effect on African economies for several decades. This point is well-taken, and economic models would do well to consider it in future analyses. Using regression models McPherson comes to the

following conclusions.

The rising prevalence of HIV/AIDS lowers worker efficiency, raises costs, and reduces individual savings and firms' profits. Individuals who are HIV-positive increase their consumption, in part to combat the effects of disease, and in part, because the prospect of a premature death raises the opportunity cost of time. These changes lower the supply of investable resources, at both the individual and national levels, and reduce the efficiency with which the existing stock of productive assets is used. Those effects, in turn, lower the rate of growth of per capita incomes, setting off a further cycle of declining savings and investment.

Skeptics frequently speculate that such massive and abrupt mortality resulting from the epidemic might actually improve per capita GDP for those that remain, increasing individual wealth. Ardnt and Lewis invalidate this line of reasoning, by demonstrating that in the year 2010, South African per capita GDP will in fact be 8 percent lower in the "AIDS" scenario relative to the "no-AIDS" scenario. Given that the HIV/AIDS epidemic is expected to generate significant constraints upon macroeconomic performance in South Africa over the coming decades, the government will find that current tax revenues will correspondingly decline. As a result, the epidemic will contribute towards the emergence of pronounced budget deficits as a direct result of lower revenues coupled with dramatically increasing health and other social services expenditures (such as care for orphans).

Most prominent among the economic problems South Africa faces is the increased government expenditures needed to combat the pandemic. Increased expenses arise in two areas, government prevention programs and government health care expenses for those

already infected. Government prevention programs become a fundamental necessity in trying to stem the pandemic from doing further population damage. Government health care expenses increase through two factors: the number of people infected (more people needing assistance) and the basic costs of assisting those people (drugs and other medical supplies).

While these increased costs are necessitated by the nature of the pandemic, the expected increase in health related expenditures by the central government has not fully materialized. In fact, from 1993-1998, health expenditures per capita have actually declined more than six per cent. This fact alone calls into question a number of studies that have projected the impact of the HIV/AIDS pandemic on increased government expenditures for health care. For instance, Quattek (2000) has estimated that government health care expenditures per capita would remain constant, with the number of AIDS patients rising, indicating that overall government expenditures would quadruple by 2010. However, even over this brief time series declining economic conditions could actually *decrease* health expenditures per patient, drastically hindering the government's effort in stemming the HIV/AIDS pandemic.

South Africa's domestic economy presents a distinct problem in combating the pandemic: how to maintain economic growth which is needed to fight the pandemic while maintaining a healthy work force which will drive the economy? To answer this question, the South African government must pay attention to two aspects: cutting the incident of HIV/AIDS transmission while at the same time decreasing the overall death rate due to the pandemic. The former is a matter of education (and possibly vaccination, though this approach seems unlikely in the near future); the latter is a matter of politics and economics. As Christopher May discusses in Chapter \_\_\_\_, the latter issue manifests itself in the inability to produce domestically pharmaceuticals that could extend peoples' lives, a problem that originates in the global intellectual property rights regime that prevents South Africa from manufacturing patented

pharmaceuticals.

### **Conclusion**

The HIV/AIDS epidemic continues to generate catastrophic numbers of human deaths in South Africa, and will continue to do so for many years to come. In relative terms, the absolute mortality that AIDS has induced within the South African population vastly exceeds deaths resulting from any armed conflict in the recorded history of that nation. Thus, HIV/AIDS has a *direct* negative effect on South African security through its generation of massive mortality in the South African populace.

However, the epidemic also poses an indirect threat to the national security and stability of South Africa. The balance of evidence suggests that the epidemic will have a significant long-term negative effect on the prosperity and quality of life of the majority of the South African people, generating increasing levels of relative deprivation throughout the populace. Ted Gurr has argued that increasing deprivation generates increasing frustration and aggression by both individuals and collectivities, and that such increasing deprivation increases the probability of social and political violence. However, if deprivation were the sole sufficient and necessary condition to generate political violence, then the majority of states in the world would be perpetually consumed with the fires of internal rebellion. The strength or weakness of the state apparatus itself is a key factor in the outbreak of political and social violence. Thus, the notion of state capacity (the ability of the state to govern effectively) is a concept of high utility. When increasing deprivation is combined with declining state capacity, the probability of collective violence against the state increases.

The state weakness thesis suggests that collective violence against the state tends to occur when stressor variables (such as the HIV/AIDS epidemic) create both the incentive and the opportunity for citizens to engage in violent collective action against the status

quo. The AIDS epidemic has most certainly placed rapidly increasing demands on the South African government to provide additional services to its population, even as the government's capacity to provide such additional services is simultaneously reduced by the epidemic. Furthermore, the federal government may have to significantly increase taxation of the populace to restore depleted government coffers. Reduction of services and increasing taxation in a climate of increasing deprivation is likely to erode further the government's legitimacy.

Hence, the overall threat to South Africa's stability should not be perceived as being at its end. Rather, the threat to South Africa's political and economic stability is in its infancy. As the epidemic winds its way through South African society, the government's capacity to cope with the epidemic's extent and impact will diminish, with the effects appearing in three forms.

First, at the domestic level, the government's ability to provide needed services (e.g. health care) will dwindle in the face of an overwhelming demand for resources. As a result, the division between the central government and the provisional governments will continue to grow, challenging the central government and further illustrating the inability of the government to cope with the impending crisis.

Second, South Africa's ability to be the bedrock of regional stability will continue to diminish as resources and manpower are drained from the foreign policy and military institutions needed to carry out such expectations. While South Africa has managed to keep out of severe conflict, its desire to enter the DRC conflict may prove to be a catastrophic foreign policy decision based on its inability to sustain a long-term peacekeeping operation. The failed operation in the tiny country of Lesotho is only a precursor to the disaster that may await South Africa in the DRC if it is unable to dedicate appropriate resources to peacekeeping efforts.

Finally, South Africa's economic stability is compromised by long-term exposure to the epidemic's impact. From macroeconomic problems to microeconomic incapacity the South African economy will falter under the long-term impact of the epidemic. Corporations will need to close the gap where the government fails to provide services, which provides a serious problem for state security and for the political development of South Africa. The drain on corporate performance and long-term corporate profits will generate detrimental macroeconomic problems such as chronic unemployment and possible forms of hyperinflation as costs increase and are passed to the consumer.

These three areas pose the greatest short-term and long-term threats to South Africa's security. Without adequate attention to the consequences of the HIV/AIDS epidemic in South Africa, the very existence of the state is jeopardized.

**Table\_\_\_ Estimated HIV prevalence rates for women aged 15-49 years, 1990-2002**

<b>Year</b>	<b>Eastern Cape</b>	<b>Free State</b>	<b>Gauteng</b>	<b>Kwazulu- Natal</b>	<b>Limpopo</b>	<b>Mpuma langa</b>	<b>North West</b>	<b>Northern Cape</b>	<b>Western Cape</b>	<b>RSA</b>
1990	0.44	0.59	0.66	1.61	0.26	0.38	1.05	0.20	0.06	0.70
1991	0.58	1.50	1.12	2.86	0.48	1.21	6.54	0.12	0.08	1.70
1992	0.96	2.86	2.53	4.50	1.05	2.23	0.94	0.65	0.25	2.20
1993	1.94	4.12	4.13	9.53	1.79	2.40	2.19	1.07	0.56	4.00
1994	4.52	9.19	6.44	14.35	3.04	12.16	6.71	1.81	1.16	7.60
1995	6.00	11.03	12.03	18.23	4.89	16.18	8.30	5.34	1.66	10.40
1996	8.10	17.50	15.50	19.90	7.90	15.80	25.10	6.47	3.10	14.20
1997	12.60	19.60	17.10	26.90	8.20	22.60	18.10	8.60	6.30	17.00
1998	15.90	22.80	22.50	32.50	11.50	30.00	21.30	9.90	5.20	22.80
1999	18.00	27.90	23.90	32.50	11.40	27.30	23.00	10.10	7.10	22.40
2000	20.20	27.90	29.40	36.20	13.20	29.70	22.20	11.20	8.70	24.50
2001	21.70	30.10	29.80	33.50	14.50	29.20	25.20	15.90	8.60	24.80
2002	23.60	28.80	31.60	36.50	15.60	28.60	26.20	15.10	12.40	26.50

**Table \_\_\_\_ Indecent assault in the RSA for the period January to December 1994-2002, Reported Crime Figures**

	Eastern Cape	Free State	Gauteng	KwaZulu -Natal	Limpopo	Mpuma langa	North West	Northern Cape	Western Cape	<b>RSA Total</b>
<b>1994</b>	417	213	998	585	108	154	150	115	1,134	<b>3,874</b>
<b>1995</b>	433	340	1,144	835	159	185	263	120	1,394	<b>4,873</b>
<b>1996</b>	569	336	1,083	692	168	441	330	139	1,462	<b>5,220</b>
<b>1997</b>	593	306	966	753	208	221	276	138	1,592	<b>5,053</b>
<b>1998</b>	518	279	894	806	145	183	252	167	1,607	<b>4,851</b>
<b>1999</b>	674	319	1,055	855	167	197	319	215	1,961	<b>5,762</b>
<b>2000</b>	725	391	1,269	1,030	200	233	326	245	2,183	<b>6,602</b>
<b>2001</b>	735	437	1,553	1,146	218	257	451	259	2,362	<b>7,418</b>
<b>2002</b>	814	542	1,782	1,357	278	295	438	333	2,630	<b>8,469</b>

**Table \_\_\_\_ Rape and Attempted Rape in the RSA for the period January to December 1994-2002,  
Reported Crime Figures**

	Eastern Cape	Free State	Gauteng	KwaZulu- Natal	Limpopo	Mpuma langa	North West	Northern Cape	Western Cape	<b>RSA Total</b>
<b>1994</b>	5,558	3,637	11,030	7,131	2,643	2,495	3,806	1,358	5,558	<b>43,216</b>
<b>1995</b>	6,096	3,859	12,142	8,114	3,051	2,892	4,613	1,541	5,864	<b>48,172</b>
<b>1996</b>	6,523	3,886	13,026	8,756	3,262	3,250	4,460	1,476	6,422	<b>51,061</b>
<b>1997</b>	7,237	3,909	12,765	8,708	3,711	3,143	4,863	1,541	6,819	<b>52,696</b>
<b>1998</b>	6,587	3,536	11,866	8,628	3,831	3,049	4,483	1,456	6,318	<b>49,754</b>
<b>1999</b>	6,914	3,511	12,188	8,990	3,932	3,297	4,611	1,496	6,799	<b>51,738</b>
<b>2000</b>	6,958	3,572	12,513	9,447	4,195	3,520	4,707	1,554	6,917	<b>53,383</b>
<b>2001</b>	6,840	3,815	12,713	9,307	4,802	3,702	5,011	1,485	6,818	<b>54,493</b>
<b>2002</b>	6,025	3,704	12,107	9,382	4,433	3,499	5,013	1,455	6,489	<b>52,107</b>

Table \_\_\_\_ Correlation analysis between HIV Prevalence Rates and Rape and Indecent Assaults by Region

<b>Region</b>	<b>Rape</b>	<b>Indecent Assault</b>
National	0.798 (**)	0.809 (**)
Limpopo	.962(**)	.766(*)
Eastern Cape	0.448	.925(**)
Free State	-0.332	.676(*)
Gauteng	0.397	.679(*)
Kwazulu	.878(**)	.772(*)
Mpumalanga	.760(*)	-0.073
Northern Cape	0.306	.892(**)
North West	0.659	.806(**)
Western Cape	.725(*)	.962(**)

\*p<.05

\*\*p<.01