

HIV/AIDS and Governance in Africa

By the end of the 20th century, two-thirds of the countries in sub-Saharan Africa had embarked on comprehensive democratic transitions. As the 21st century begins, how will these transitions continue amidst HIV prevalence as high as 20, 30, and even 40 percent of the active population in some countries? Imagine states largely emptied of people between the ages of 15 and 49 years, the remaining population composed largely of children, older citizens, and the very sick. State systems would exist, but would be unable to fulfill their core responsibilities and functions. These “hollow states” could not provide sustained leadership across society or adequately interact with citizens through democratic institutions—and would thus be at risk for greater political instability.

Although the proximate cause of Africa’s AIDS crisis is HIV, the underlying societal causes are much broader and more familiar. Across the continent, poverty structures not only the contours of the pandemic but also the outcomes for individuals. Until poverty is reduced we will make little progress toward either reducing transmission of the virus or enhancing capacity to cope with its socio-economic consequences. It follows that sustained human development is an essential precondition for any effective response to the pandemic in Africa. Herein lies Africa’s predicament: How can we achieve the sustainable development essential for an effective response to the epidemic when the epidemic destroys the very capacities essential for the response—namely, by killing the most economically productive members of the continent?

AIDS and the African State

The disease exploits and exacerbates existing social and economic disparities and constraints in society. The ability of nations to improve the well-being of their citizens, build strong and stable societies, and expand opportunities for all is threatened by this epidemic. Women, children, and men who live in poverty and difficult circumstances are finding their conditions even more difficult, further increasing their chances of contracting the virus. The growing risk of HIV infection is especially evident among young women and girls, who comprise two-thirds of all young people with HIV/AIDS in sub-Saharan Africa (World Health Organization–Africa Region, 2005). Girls and young women are twice as likely to be infected with HIV than young men, and in some parts of the continent, they are six times more likely; in parts of eastern and southern Africa, more than one-third of teenage girls are infected with HIV (UNAIDS, 2004).

Declines in life expectancy reveal the epidemic’s immediate impact. Average life expectancy is now 49.9 years in sub-Saharan Africa; in the absence of AIDS, it would have been about 62 years (UN Department of Economic and Social Affairs [UNDESA], 2005). In Botswana, life expectancy has dropped to 34, a level not seen since before 1950. In less than 10 years, many countries in

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the region will see life expectancies fall to near 30 years—the same as at the end of the 19th century (UNDESA, 2005).

Without adequate financial and strategic support for human capacity planning, calls for greater political leadership amount to mere rhetoric. In the absence of a functional civil service of well-trained, highly skilled, and knowledgeable people, such political promises cannot be kept. A fundamental organizational principle of the state—the cadre of civil servants who assure its effective functioning—is thrown into question by incapacity due to the prolonged illnesses and early deaths of government employees.

Take Zambia: According to the United Nations Commission on HIV/AIDS and Governance in Africa (CHGA), mortality figures in the education sector from 2001 to 2004, projected to 2011, indicate that 13,000 teachers will need to be trained, instead of the 5,093 needed without AIDS. A similar study of local governments reveals that Zambia could lose 32 percent of its workforce to HIV/AIDS over the next 20 years and government agencies will need to replace an additional 1.7 percent of the staff each year over the same period to maintain current staffing levels (CHGA, 2004).

It is not, however, only the absolute levels of mortality that should concern policymakers, serious though they are. They should be particularly concerned about the broader implications of high and rising levels of morbidity and mortality for institutional knowledge formation and retention—that is, how to sustain an organization and ensure that it operates efficiently under conditions of persistent loss of human resource capacity. The impact of HIV/AIDS on the educated and professional cadres reduces their ability to pass on their accumulated knowledge and expertise to succeeding generations. As a result, younger and less experienced workers find it harder to acquire the specialized skills, expertise, and professionalism needed for their jobs. In the longer term, fewer experienced officials will be available to train younger personnel in key formal skills, or pass on more informal standard oper-

ating procedures or norms such as ministerial accountability, bureaucratic neutrality, official ethics, and institutional transparency, with negative consequences for the quality of both public and private services.

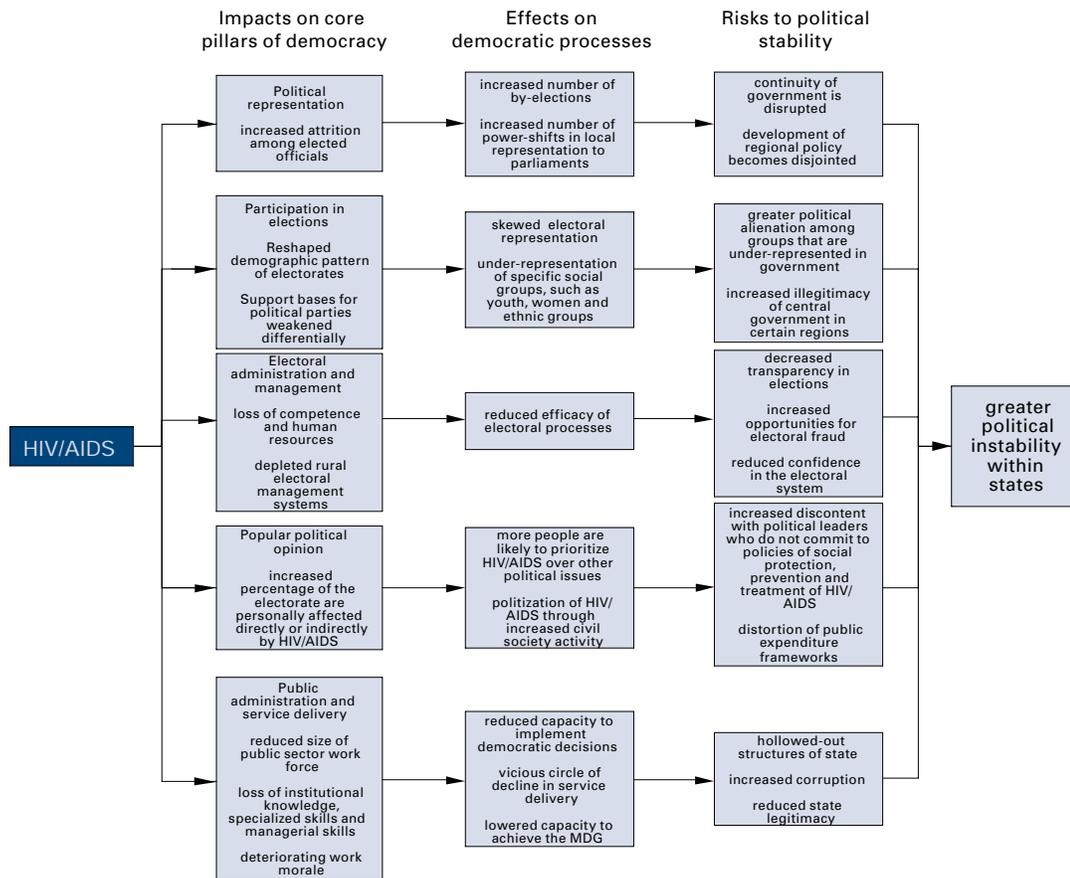
AIDS and Economic Development

The problem is particularly acute for people in rural areas. HIV/AIDS is significantly reshaping the indigenous transfer of knowledge of local agro-ecology, farming practices, and farm management. These changes in rural knowledge structures are, in turn, restructuring rural livelihoods at several levels. At the household level in some countries, chronically ill heads of households reduced the area of land they cultivated by as much as half, resulting in decreased crop production and lower food availability (Drimie, 2002). In rural Zimbabwe, maize output by households that experienced a death due to HIV/AIDS declined by nearly half, more in some households (Kwaramba, 1997).

Lowered production due to the loss of household labor often continues for at least one year after a death occurs. Some households, especially those already short of household labor, may never return to previous production levels, and families severely impacted by the loss of income may be forced to disperse to survive. At the community level, the epidemic is shifting the composition of agricultural output from commercial crops toward food for consumption, with adverse effects on incomes and employment. While this may ensure household food supplies in the short term, it has long-term effects on the growth of outputs, incomes, and foreign exchange earnings, and therefore on development.

A highly publicized World Bank study argues that after allowing for intergenerational losses of human capital (and knowledge), the projected macroeconomic effects of HIV/AIDS will be severe (Bell, Devarajan, & Gersbach, 2003). These intergenerational effects have already been widely noted, especially on agriculture (McPherson, 2002). The impact is further aggravated by existing weaknesses in state capacity, such as a lack of civil service reforms,

Figure 1: The Impacts of HIV/AIDS on Political Systems and Processes



Source: Adapted from Poku (2006).

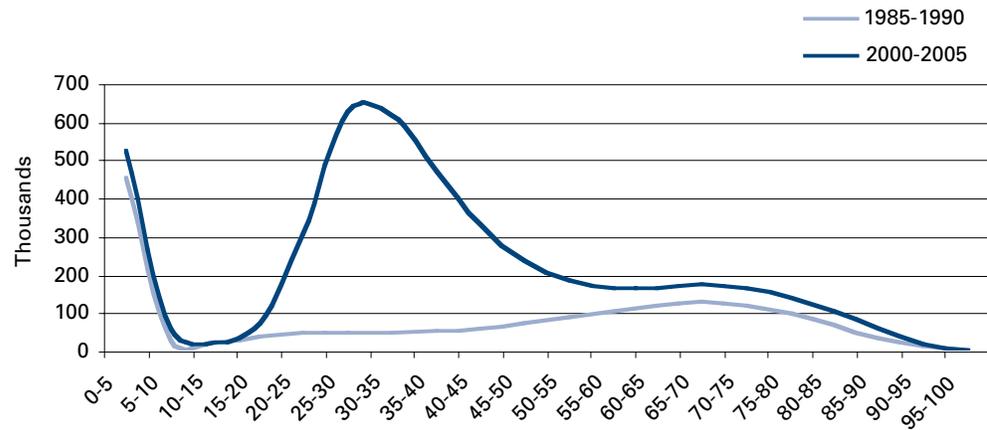
“brain drain” (staff leaving for the private sector or other countries), and financial constraints requested by international agencies such as the International Monetary Fund. In the most affected countries, the epidemic has already decreased institutional robustness and vitality, reshaped governmental structures, and restructured state-society relations.

Malcolm McPherson (2003) rightly argues that HIV/AIDS strips time out of the decision horizons of those who are infected or affected. Individuals who are HIV-positive (or think they are) concentrate on the present and immediate future. Many activities that used to be attractive when life expectancies were “normal” lose their appeal, and even their relevance. Consequently, HIV/AIDS changes economic behavior, often dramatically. The act of saving, for example, requires individuals to forego consumption.

With time at a premium, the incentive to save diminishes. Investment, which involves the commitment of current resources in the expectation of some future benefit, becomes less attractive. At the macro level, these trends are self-reinforcing. The decline in savings reduces the resources available for investment. As investment falls, the rate of economic growth can decline, reducing savings.

As a result, we can expect national revenues to diminish in comparative terms and the productivity and profitability of businesses to fall. As production and service delivery is disrupted, income is also likely to fall. These are no longer projections; evidence suggests that families and businesses are shifting spending from productive activities to medical care and related services, reducing both savings and government revenues (CHGA, 2005). At the same time, the costs asso-

Figure 2: Adults 24–50 Are Hardest Hit by AIDS-Related Deaths



Note: Figure shows number of deaths in Botswana, Lesotho, Namibia, South Africa, and Swaziland by age.

Source: UNDESA Population Division (2005); courtesy CHGA.

ciated with dealing with the epidemic are increasing. Government agencies are diverting funds from planned development activities to pay for the costs of ill and dead employees. These declines in economic activity are reducing tax revenues, thus lowering the capacity of the public sector to function just when demand for public health, education, and training is increasing.

While all of the macroeconomic impacts are not immediately clear, we can anticipate that reductions in skilled human capacity due to declining life expectancy will eventually adversely affect economic output—which will be compounded by reduced efficiency. In high HIV-prevalence countries, we can also expect a non-linear impact of HIV/AIDS on economic growth: the longer the high HIV prevalence persists, the more difficult and costly the recovery will be. We are already seeing this in southern Africa.

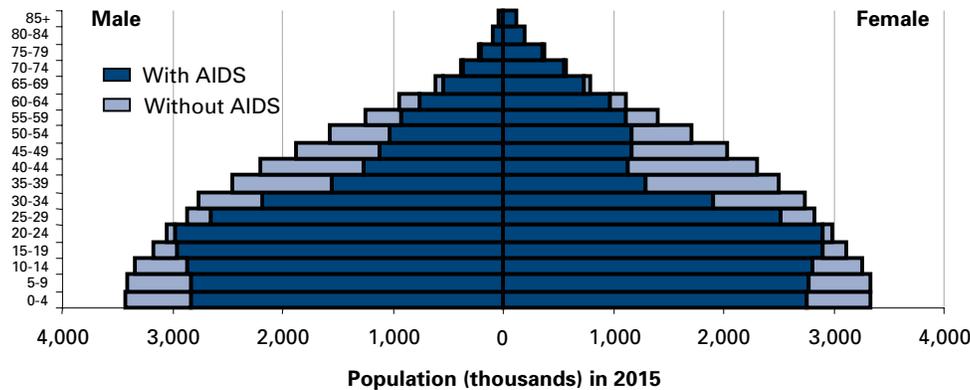
The decline in economic activity takes place against a background of rising social service expenditures, both private and public, which further strains government budgets as well as increases poverty. According to CHGA findings, in countries with consistently low prevalence rates (below 4 percent), we can expect GDP to be only slightly affected (CHGA,

2005). But if nothing changes in countries where the prevalence is 10 percent or more, their economies could be 18 percent smaller by 2020. Even with conservative assumptions, the commission concluded that HIV/AIDS-related mortality and morbidity cost Africa about 15 percent of its GDP in 2000. This translates into a decline in income of 1.7 percent per year between 1990 and 2000, an amount greater than previous estimates based solely on the loss of output due to the epidemic.

Institutional Fragility and Political Instability

The net effect of HIV/AIDS on the African state may be institutional fragility, thus compromising its overall capacity to deal effectively with national emergencies, while increasing political instability (see Figure 1). The effect is circular: The epidemic weakens government institutions, rendering the government increasingly ineffective at stopping the very agent that is weakening it. The result is a downward spiral wherein the epidemic relentlessly reduces state capacity, even as the state requires ever-increasing capacity to stop the growing epidemic. The structures of govern-

Figure 3: By 2015 AIDS Will Have Reduced the Size of All But the Oldest Age Cohort in Southern Africa



Note: Figure shows data for Botswana, Lesotho, Namibia, South Africa, and Swaziland. Source: UNDESA Population Division (2005); courtesy CHGA.

ment remain, but the ability to govern is diminished. The process is insidious because over the long term, sustained loss of human capacity is likely to leave states incapable of protecting and providing for their citizens.

“Hollow states” may suffer from decision-making that is inconsistent at best, or paralyzed at worst, which creates problems in formulating and implementing policy. As the impact of HIV/AIDS runs its course over the next decades, the key question is how to maintain and expand the ability of the state to supply essential goods and services, and also maintain security and stability. One of the biggest political challenges will be preventing the hollowing out of state structures due to staff losses and reduced resources. It will require minimizing the current and future losses of human resources, especially in key development and security sectors; and it will require new approaches to supporting both rural and urban livelihoods.

Looking to the Future

How can African states remain functional in the coming years, even as the worst of the epidemic lies ahead? Two actions may provide the answer:

First, antiretroviral therapy (ART) increases the quality of life of people living with HIV/AIDS, in addition to easing the burden of their care on families and health systems. ART reduces mortality by up to 90 percent and cuts the risk of major opportunistic infections by 55-80 percent in the first years of treatment.

The reduction in the cost of antiretroviral drugs has significantly increased the potential for treatment. As treatment sustains health and prolongs lives, increased access to treatment could reduce the socio-economic costs of the epidemic. ART also enhances prevention as it both reduces the infectivity of people and creates incentives for individuals to get tested. In this sense, treatment and prevention are linked in effectiveness (Solomon et al., 2005). Increasing access to treatment can transform the effectiveness of prevention activities, in part by widening access to counseling and testing, and in part by mobilizing civil society organizations and communities (see, e.g., Katzenstein, Laga, & Moatti, 2003). And in the case of pregnant women, HIV transmission can be reduced substantially by ART programs that seek to prevent mother-to-child-transmission.

The costs of weak access to treatment are



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much greater than the UNAIDS estimate of losses of 2.6 percent of GDP annually, once all of the direct and indirect costs of the epidemic are factored into the analysis. The benefits are, of course, not confined to the direct beneficiaries but also accrue to society as a whole. Thus in most sub-Saharan countries, even with the present costs of antiretroviral drugs, the total benefits of increasing access to treatment undoubtedly exceed costs.

The second element is human capacity planning. National policymakers must sustain and improve the pool of human resources in the face of HIV/AIDS. In most sub-Saharan countries most workers are free of HIV infection and are productively employed. Keeping this labor force free of HIV infection by expanding prevention activities must be a priority. National planning policy must not assume that public services can continue to be supported by the present establishment. Innovative, less-intensive ways of delivering education, health, and other services must be developed. Responding to losses by expanding existing training programs will quickly become too costly for national budgets. Both new ways of delivering essential public services must be developed and implemented, and less costly ways of meeting the needs for skilled and professionally qualified labor need to be identified and delivered.

Responding to the new and emerging conditions of labor markets—both internally and externally—will not be easy but it is essential that countries plan for the future rather than simply respond to market outcomes. The loss or movement of qualified personnel—from public to private, rural to urban, national to international sectors—requires that the public sector undertake salary and other reforms to ensure that it retains key human resources. To match and improve skills the educational sector must adapt its programs to meet the needs of other sectors as well as its own. Managers must ensure that workplace training and skills developed on the job are not lost.

Losses of labor are not of course confined to the public sector but are common throughout the economy. Many international firms have already responded to the threats posed by

HIV/AIDS with comprehensive workplace programs that ensure access to care, support, and treatment for staff (and sometimes their families). There are some similar workplace programs in the public sector, but they are far too limited in number and in coverage. Support from international organizations and bilateral donors—both financial and technical—is required to rapidly scale up these activities.

Note: This article draws on research prepared for and by the Commission on HIV/AIDS and Governance in Africa (CHGA), which was created in 2003 by then-UN Secretary-General Kofi Annan under the leadership of Wilson Center Distinguished African Scholar K.Y. Amoako, then the executive secretary of the UN Economic Commission for Africa. The final report advances current scholarship in HIV/AIDS policy and governance, and is the culmination of a unique consultation by CHGA commissioners with a wide constituency in Africa and beyond. The findings and recommendations not only embody deep analytical insights derived from the commission's own research, but also reflect the views of the more than 1,000 Africans—including senior policymakers, advocacy groups, nongovernmental organizations, community-based organizations, people living with HIV/AIDS, research organizations, and UN agencies—who took part in the consultation process.

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Members of the Nigeria Police promote condoms during an HIV/AIDS awareness and education campaign in Lagos, Nigeria (© 2005 Kunle Ajayi, courtesy of Photoshare).