Fall-out

There is an abiding fiction that disasters do not discriminate – that they crush with a kind of democratic disregard for status, power and means. This is not so. Typically, the toll disasters take is concentrated among the poor, among those forced to juggle limited options in ways that often put them in the path of peril. Epidemics like AIDS do not buck this trend. And yet the customary picture is of AIDS as an undifferentiating scourge; 'we're all in this together' is the rousing claim.

The US National Intelligence Council (2000), for example, has warned that the economic and demographic impact of AIDS would 'undermine civil society, hamper the evolution of sound political and economic institutions, and intensify the struggle for power and resources'.[i] Youde (2001) warns that AIDS will weaken democracy in heavily affected countries by undermining the capacity to manage and administer election processes, slowing economic growth and eroding civil society. Focusing on southern Africa, Fourie and Schonteich (2001) envisage AIDS meshing with other destabilizing factors and, in Manning's summary (2002:12), spurring:

> heightened competition for limited resources and exacerbat[ing] inter-group tensions, and also weaken[ing] the capacity of government and governing institutions, especially on delivery of social services, by sapping human and financial resources. In addition, if the government is perceived to [be] poorly addressing HIV/AIDS-related issues, the epidemic could 'produce a heightened sense of marginalization amongst affected populations and a stronger sense of deprivation and resentment towards the government' which may result in spontaneous violence or the manipulation of dissatisfied groups to contribute to partisan violence.[ii]

The claims sometimes veer toward opportunist punditry, as when US presidential candidate John Kerry in 2004 reportedly warned that countries heavily affected by AIDS 'could well become the home base for terrorists or criminal elements looking for a safe haven, or even for those trading in weapons of mass destruction'.[iii] Another comment (Neilson, 2005) points to the possibly emergence of a 'disturbing new formula': 'AIDS creates economic devastation. Economic devastation creates an atmosphere where stable government can't function. When stable government can't effectively function, terrorism thrives.'[1]

This highlighting of AIDS as a (state) security threat is relatively new. More prominent in the late 1990s and early 2000s was the tendency to couch AIDS impact in terms of its anticipated effects on development – with the epidemic customarily (and hyperbolically) fingered as the 'greatest threat' to Africa's development. That discourse has shifted toward an emphasis on the alleged *security* dimensions of AIDS.[2] Frequently aired now are claims such as this:

> The war on terrorism has drawn attention to non-conventional threats to security, even as it led to conventional warfare in the case of the attack on Iraq. HIV/AIDS is arguably an even greater threat to security, with the effect of destabilizing the social and economic order to the extent that the very survival of entire nations is at stake (Altman, 2003).

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1 Trevor Neilson was also quoted as urging that the 'AIDS orphan issue' be regarded not as 'just another "humanitarian" issue, but rather as a legitimate security concern'. The quote is drawn from a media release for Neilson's discussion paper (2005), published by the Global Coalition on AIDS. The media release is available at http://www.businessfightsaids.org/site/apps/nl/content2.asp?c=gwKXJfNVJtF&b=1009023&ct=1366101. The full paper is available at http://www.businessfightsaids.org/atf/cf/%7B4AF0E874-E9A0-4D86-BA28-96C3BC31180A%7D/AIDS%20Econ%20Terror%20Final.pdf

2 Thus, the UN Security Council in July 2000 adopted Resolution 1308 which fingered AIDS as a potential threat to peace and security, especially in the context of peacekeeping operations. UNAIDS has tried to finesse the shift by deeming AIDS to be a 'a security issue, whether one is looking at the more traditional meaning of security (threats to defence of the state, with those threats emanating from other states) or the newer concept of "human security"'; see 'HIV/AIDS and security', available at http://www.unaids.org/en/in+focus/hiv_aids_security+and+humanitarian+response/hiv_aids+and+security.asp. The International Crisis Group has declared AIDS a threat to 'personal, economic, communal, national and international security'; see http://www.crisisgroup.org/home/index.cfm?id=1831&l=1.

The gradual 'securitization' of development discourse generally dates back to the 1990s already, but the process accelerated after the terror attacks of September 11, 2001, with reality increasingly viewed through a cognitive screen of 'security'. AIDS has followed that drift. This subtext of AIDS discourse does not, in itself, invalidate the forecasts as to what might unfold. But it does call attention to the ways in which dominant understandings of the epidemic and its impact are constructed, and how AIDS has become discursively located 'in the broader context of global neo-liberal economic and political restructuring' (O'Manique, 2004).[3] The popularized thinking about what AIDS holds in store for a society such as South Africa (and how its impact is framed) also bears the imprint of broader political-economic contests and concerns.

Lacking substantive empirical evidence, the scenarios are as panoramic as they are generic. There is little evident regard for the specifics of societies, for the inequitable manner in which misfortune hits home, or for the interplay of AIDS-related effects with other social, economic and political dynamics.

An epidemic that threatens to prematurely bring to an end the lives of one fifth or more of a country's population will change that society. But, as the earlier discussion of other shocks on this scale in history suggests (see the Introduction), the nature of such change and its extent are not easily forecast. One of the most far-reaching outcomes of the 'Black Death' in England, for example, was its reorganizing of social relations, which eventually erupted in the form of peasant uprisings that reconfigured society. That sequence of outcomes, however, was neither automatic nor inevitable. It required a combination of insulated hubris and tactical buffoonery (on the part of the ruling elites), and vibrant self-awareness of prospect and need (on the part of the peasantry) to achieve combustion. The consequences were historically and socially specific; different histories unfolded in those parts of Italy that were as hard-hit by the epidemic, as they did in the Netherlands and in the countries of the Middle East affected by Plague. Even epidemics of such ferocity, it seems, do not lend themselves to grand overarching punch-lines. It's at the more parochial levels that the likely effects come into much sharper focus.

Shaking the foundations

Especially vulnerable, it seems, are those sectors of the state most closely involved in the reproduction of 'human' and 'social capital', such as the education and health systems. Much research has focused on how the epidemic will affect those sectors, as well as the ministries responsible for policing and agricultural services; oddly, the effects on social welfare and social services have attracted less attention. Nevertheless, a jolting impact is expected overall.

At the institutional level, South Africa's epidemic will leave its mark as higher morbidity and mortality rates cause increased absenteeism and personnel losses – in line with trends observed elsewhere in the region. In Malawian ministries, for example, total annual attrition in 1990-2000 rose almost six fold from 347 at the start of the period under review to more than 2 000 in the final year.[4] Death was the highest cause of attrition, accounting for 40-58% of staff losses, depending on the specific ministry (Cohen, 2002). Across the public service as a whole, mortality increased by a factor of 10 during the period of the study, with deaths 'disproportionately high among young adults of both sexes' – a strong indication that AIDS was largely responsible (Cohen, 2002:9).

Similar trends are under way in South Africa's public sector. The public health care system is expected to be overburdened by AIDS, with both the demand for and cost of health services likely to increase, and health workers coming under greater strain. According to HSRC research, an estimated 13% of deaths among health workers in 1997-2001 were due to AIDS, a toll that is almost certain to rise (Shisana et al., 2003). It has

3 See O'Manique C (2004). *The 'securitization' of HIV/AIDS in sub-Saharan Africa: A critical feminist lens*. Paper prepared for the annual meeting of the International Studies Association. 17-20 March. Montreal. The shift also forms part of a deeper discursive process, as explored by Mark Duffield in his 2002 book *Global governance and the new wars: The merging of development and security.* Zed Books. London. For a critique of the methodology used to hitch AIDS to security (whilst affirming the validity of the link), see Youde J (2004). *Enter the fourth horseman: Health security and international relations theory*. Paper prepared for the 44th Annual International Studies Association Convention. 17-20 March. Montreal.

4 Ministries surveyed were the Ministry of Education, Science and Technology; the Ministry of Agriculture and Irrigation; the Ministry of Health and Population; Malawi Police Service; and the Ministry of Water Development. Together, they accounted for about 80% of public sector employment.

been projected that a country with stable 15% prevalence could expect to see 1.6-3.3% of its health-care personnel die of AIDS each year – a cumulative mortality rate over five years of 8-16% (Tawfik & Kinoti, 2003). A 2002 survey of health-care personnel in private and public facilities found HIV prevalence of 16%, which matched the adult HIV prevalence reported in the Nelson Mandela/HSRC (2002) household survey of the same year (Shisana et al., 2003).[5] Nursing staff are likely to be hit hardest, with AIDS joining emigration and a shortage of new trainee nurses as the factors thinning the ranks. Although apparently less at risk of HIV infection, doctors have also been voting with their feet. Increased illness-related absenteeism and attrition will aggravate the effects of the ongoing drain of health-care personnel. Longer work hours, deteriorating working conditions, lower morale and, as a consequence, poorer quality of health care are likely to be some of the consequences. Yet the need for well-trained health personnel arguably has never been greater in South Africa: according to the Health Systems Trust, complete roll-out of the government's antiretroviral treatment programme would require an additional 3 200 doctors, 2 400 nurses, 765 social workers, 765 dieticians, 112 pharmacists and 2 000 data capturers in the public health system by 2009 (Ijumba, Day, Ntuli, 2004).[6] Need outstrips supply. Since 1995, the number of nurses in the public sector has grown by only 7%, half the rate of population growth.

While staff capacity ebbs, care needs surge. The HSRC survey of public and private healthcare facilities found that an estimated 28% of patients in medical and paediatric wards were HIV positive (46% in public hospitals), and their hospital stays were almost twice as long as those of non-AIDS patients (13.7 days compared with 8.2 days). A much greater number of AIDS patients were being admitted in 2000, compared with 1995 (Shisana et al., 2003).[7] Total bed occupancy rates have stayed roughly stable, which suggests that AIDS patients were 'crowding out' non-AIDS patients in the public sector.[8] Earlier studies in the Hlabisa district of KwaZulu-Natal found clinic visits had increased by 88% in 1991-2001 and hospital admissions by 81% (Dedicoat M et al., 2003; Floyd et al., 1999). Both workloads and stress were growing, with almost three in four health-care workers reporting an increase in their workloads. About one third of them said their workloads had increased by 75% or more in the previous year (Shisana et al., 2003).

All this, though, is overlaid with broader inequity. South Africa devotes a significant share of its gross domestic product – approximately 9% – to health care. However, the spending occurs in a two-tier system: some 60% of those funds are devoted to paying for the health care of the 15% of the population that has private medical insurance.[9] By way of comparison, in the 1970s, during the heyday of apartheid, roughly one third of all health care expenditures were funneled toward the 20% of the population that carried private health insurance (Benatar, 2003). Annual per capita expenditure on health care in the private sector is almost six times larger than that in the public sector.[10] There have been attempts to temper these trends, but to limited effect: as a general rule, income determines access to health care, its use and its quality:

> Household data indicate the continuing influence of barriers to access on health-care demand. These include distance to the nearest health-care facility and cost of care, medication and transportation, especially given that many lack a basic income to cover food and other essential non-food spending requirements. Lower socio-economic groups seek care less frequently than other groups, despite their generally worse health status, even though primary health-care is free. There is a growing burden of chronic illness, including HIV/AIDS, and

5 The HIV prevalence range was 12.2%-19.9%. The survey was conducted in the Free State, Mpumalanga, KwaZulu-Natal and North West.

6 Astonishingly, Shisana et al. (2003) reported that four in five managers of the 220 surveyed health facilities had not seen the 2000-2005 National HIV/AIDS Plan (a strategy they are meant to help implement). About half the public hospital managers and just 8% of private health sector managers said they had seen the document.

7 2000 was relatively early in South Africa's *AIDS* epidemic: people succumbing to AIDS-related illness will have acquired HIV up to eight or more years earlier, just as the HIV infection levels were beginning to soar.

8 In the public sector, bed occupancy rates had stayed between 85% and 95%. If more AIDS patients are being admitted and their hospital stays are longer than average then, all else being equal, other patients in need of hospital-based treatment and care are not receiving it.

9 Benatar (2003) states that 18% of South Africans have medical insurance. That figure appears to date back to 1995; more recent Statistics SA data (in the 2004 General Household Survey) suggest that the proportion has shrunk to 15%; see Fewer people on medical aid. *Health-e*. 16 July 2005. Almost 70% of whites belong to medical schemes, compared with just 7.2% of Africans (and 18% of coloureds and 36% of Indians).

10 Fully 80% of specialists and at least 60% of general practitioners now work in the private sector (Ijumba, Day, Ntuli, 2004). Benatar (2003) estimates the percentage of physicians working in the private health sector at 66%, up from roughly 40% in the 1970s.

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> injuries, even whilst poverty-related illness persists. As a consequence, poor African households in particular have had to cope with the triple burdens of health system restructuring, increased levels of chronic illness and broader economic shocks over the last decade. (Roberts, 2005:489)

The Health Systems Trust estimated that just 12-13% of South Africans in need of antiretroviral (ARV) treatment were receiving it in 2004; by mid-2005 as many as 870 000 people in need of treatment were not receiving it (Ijumba, Day, Ntuli, 2004; Ijumba & Barron, 2005; WHO/UNAIDS, 2005).[11] The shortfall is particularly acute in poorly resourced provinces where health systems are malfunctioning due to human resource and infrastructure shortages, as well as inadequate management capacity (Ijumba, Day, Ntuli, 2004).

In the education sector, according to an HSRC cross-sectional study, as many as one in eight teachers are living with HIV (Shisana et al., 2005).[12] HIV prevalence was almost 13% overall but varied by age, income level, race and area. Among educators in KwaZulu-Natal participating in the survey, and among those aged 25-34 years nationally, one in five was HIV positive.[13] Extrapolations from the HSRC survey suggest that at least 10 000 South African educators would be eligible for immediate ARV treatment.[14] Rapid treatment roll-out will make a difference, but it will not be a panacea for the school system. ARV coverage of 60% would reduce by 18% the number of deaths by 2015 among educators younger than 45 years; 90% coverage could cut AIDS-related deaths by half.[iv]

Along with contract termination and resignations, mortality now ranks among the top causes of staff losses. The total number of in-service deaths among educators rose by 30% between 1997/98 and 2003/04. In KwaZulu-Natal, 790 educators died in 2002/03, an 80% increase over the 441 deaths in 1997/98. It's likely that a large share of the increase in deaths is associated with the worsening AIDS epidemic. Other corrosive factors, meanwhile, persist. According to the HSRC study, more than half the educators polled said they intended to leave the profession. Even more worrying was the fact that the educators most keen to abandon the profession were those with the highest qualifications, and that two thirds of technology, natural sciences, economics and management teachers said they wanted to leave. Most commonly cited as reasons were low job satisfaction, job stress and violence at schools (Shisana et al., 2005).[15] Those are not idle threats. By 2002/2003, approximately 21 000 educators were leaving the public school system each year, about half of whom had resigned (which suggests they moved to other employment). About one third of those who left returned to the public school system after six or more months.[v] It has been estimated that about 30 000 educators would need to be trained annually to maintain current staffing levels and ensure swift replacement. But training college cutbacks and other restructuring in the sector have left training capacity lagging behind need. Management and administrative skills are especially in short supply. In addition, the profession is not attracting newcomers in sufficient numbers, partly due to concerns about employment insecurity (Vass, 2003a).[16] On such trends, AIDS will exacerbate dysfunction in the public school system.

As absenteeism and personnel shortages in the public school system worsen, educators' morale and job satisfaction are likely to dip further. At the same time, the demand for their skills in the private education system and in other sectors will rise

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11 Estimates range between 750 000 and 840 00 at the end of 2004, while WHO provided an estimate of 870 000 for mid-2005.

12 The response rate in this survey was relatively high, with 83% of participants having agreed to have an HIV test..

13 Highest HIV prevalence was among African educators (16%), while among other racial groups it was much lower (less than 1%). For a discussion of possible sampling and statistical factors influencing that finding, see Shisana et al. (2005:117). Educators with low socio-economic status had much higher HIV prevalence than did their better-off counterparts: among those earning R132 000 or more a year, HIV prevalence was 5.4%, but among those earning less than R60 000 a year, prevalence was 17.5% (Shisana et al., 2005:118). Interestingly, HIV prevalence was higher among educators in rural areas than in urban areas – a pattern that runs counter to that observed in the general population. The authors surmise that this could be because educators in rural areas would tend to have higher disposable income compared to other adults, and because they might be less likely to have moved with their spouses or regular partners.

14 If a CD4 cell count of below 200 was used as the guideline to commence treatment, 10 000 teachers would require antiretroviral therapy; while if a CD4 cell count of 350 or lower were used, more than 23 000 would require treatment.

15 Seemingly illustrating the pervasiveness of job-related stress was the finding that the most frequently reported diagnoses in the previous five years among educators were high blood pressure (16%) and stomach ulcers (9%). The burden of absenteeism among educators was most closely linked to high blood pressure, tobacco use, being HIV positive, stomach ulcers, arthritis or rheumatism, and high-risk drinking (Shisana et al., 2005).

16 See also Akoojee S & McGrath S (2003), where the authors locate restructuring in the education sector both within the need to restructure the inherited apartheid education system and the government's accommodation to neo-liberal policy strictures. They note, for example, that one of the consequences of such 'rationalization' in the late 1990s was a 40% decline in enrolments for teacher training courses in 1998-1999.

– increasing the odds of educators being lured out of the public school system.[17] Compounded attrition can be expected. In the longer term, such effects will spill into the wider labour market (Vass, 2003a). If the education sector's capacity to provide basic education suffers, the springboard for higher education and skills training weakens – to unhappy effect in an economy that has been geared to rely much more heavily on top-end skills. Channels for quality educational advancement will, of course, be available but they would be largely in private hands, limited in number, restrictive in access, and expensive – a dual and discriminatory system, in other words. What might this mean for inter-generational social mobility? If the quality of public school education deteriorates further against a backdrop of continuing marginalization of the poorest households – and of overall polarization – social mobility will be hobbled, deepening the mire of chronic poverty. Whether South Africa can avert these kinds of trigger effects will help decide what kind of society coming generations will inherit.

It is generally assumed that AIDS will reduce school enrolment. Much of that effect would occur as increased infant mortality limits the number of children who reach schoolgoing-age. Effective programmes aimed at preventing mother-to-child transmission of HIV could reduce this effect substantially. There is also the expectation that school enrolment will shrink as families withdraw children from school in order to compensate for labour losses caused by AIDS (UNAIDS, 2004). There is very little evidence currently about the extent to which this might be happening in South Africa. However, analysis of evidence from elsewhere on the continent suggests that the direct effects of AIDS on school enrolment might be exaggerated at the expense of attention to other, often policy-related, variables – ranging from school and related fees, to livelihood security, employment opportunities and broader macro-economic strategies. After reviewing literature and modeling evidence on the impact of HIV/AIDS on schooling in Tanzania and Uganda, Gould and Huber (2002:1), for example concluded that:

> Enrolments in primary and secondary schools in the past and in projections to 2010 are more likely to be affected by policy variables (notably financial support for expansion in the education and health sectors) and by constraints associated with rising poverty (including increasing differentiation of HIV and non-HIV households) than by direct demographic demand.

Educational attainment was strongly associated with household wealth in KwaZulu-Natal, too, according to a recent study that also identified pregnancy as a major cause of educational underachievement in women, especially poor women (Hallman & Grant, 2004). The upshot is self-evident: the temptation of what Gould and Huber (2002) have termed 'demographic determinism' should be resisted and AIDS impact needs to be analyzed and responded to alongside the other factors that blight the public education system. The damaging role of AIDS is not easily – nor necessarily fruitfully – detached from the complex circuitry of cause and effect in which it is entangled.

Already saddled with hulking workloads and compromised capacity, the police and the correctional and judicial services are especially vulnerable to additional debilities. According to South Africa's Public Service Commission, teachers and police appear to be worst affected by AIDS, although as late as February 2005 the Commission did not yet have a strategic plan for dealing with the epidemic. AIDS could also dent South Africa's peacemaking and peacekeeping ambitions. HIV prevalence among members of the South African National Defence Force (SANDF) has been estimated at 17-23%--high enough to compromise the prominent role South Africa hopes to play in regional peacekeeping efforts. According to SANDF testimony to Parliament in 2004, HIV status was one of the factors that caused almost one third of soldiers to fail the physical standards requirements for deployment on foreign peacekeeping missions.[18]

Public and political institutions probably will be affected by other, less obvious factors as well. It's likely that the need for, demand for and uptake of some services could become more

17 Badcock-Walters et al. (2003) came to a similar conclusion when examining educator mortality in KwaZulu-Natal.

18 According to a briefing by General Pieter Oelofse of the SANDF to the National Assembly's defence portfolio committee in August 2004; see HIV/AIDS in military given as 23 percent. *SouthScan*, 19(17). 20 August 2004. Recall that the epiphany that reportedly stung Uganda's president Yoweni Museveni into action against AIDS was the realization that the epidemic was weakening the army. Uganda's military became aware of HIV spread in army ranks when the Cuban authorities insisted that Ugandan soldiers earmarked for training in Cuba first be screened for HIV (Amrith, 2001).

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unpredictable. In some respects, the scale of such changes could be anticipated: the demand for hospital beds or antiretroviral treatment in a particular district, for example, could be estimated on the basis of HIV prevalence data in that area.[19] But it would be harder to predict the possible effects on, say, housing and housing subsidy programmes.[20] In such respects, AIDS will very likely contribute to a gradual grinding-down of institutional capacities and performance, undermining the ability to deliver services – and, according to some of the more florid predictions, even precipitating a pervasive melt-down:

> If a ministry of finance fails to develop the correct models for revenue, expenditure, and economic growth (or decline), the wrong policies will be instituted, with dire outcomes. If the ministry of education fails to train enough teachers, allocate them efficiently to schools, and to pay them on time, the nation's educational system will go into decline, with important consequences for the future of the country [...] The paralysis of a police or judicial system can contribute to a crime wave [...] In turn, these governmental failures can contribute to popular discontent and unrest [...] The breakdown of discipline and authority in an army will have far-reaching consequences for national security [...] [T]he weakening of state capacity combined with its decreasing legitimacy would be a recipe for popular pressure for democratization [...] it seems unlikely that regimes' capacity for self-preservation will be undermined significantly [...] (De Waal, 2003b:18-21)

A disabling effect on the democratic process is also foreseen by some observers, with Robert Mattes (2003:5), for example, warning that:

> [T]he pandemic is likely to devastate large portions of policy-makers, national legislators, local councilors, election officials, soldiers and civil servants [...] A shrinking proportion of civil servants, policy-makers and legislators will be at their jobs long enough to develop the specialized skills, expertise and professionalism needed to do their jobs. It will be increasingly difficult for legislatures, ministries and government agencies to pass on the skills that they do have. There will be fewer experienced officials available to train younger personnel in key formal skills (such as programme design, budgeting, cost/benefit analysis, monitoring and evaluation, and personnel management), or pass on more informal standard operating procedures or norms such as ministerial accountability, bureaucratic neutrality and official ethics.

According to Idasa research, almost 1.5 million registered voters died between 1999 and 2003, with the annual number of deaths among voters having risen by 66% in that period.[21] It's impossible to say whether or how this could be affecting voting outcomes, although Idasa does not expect AIDS to badly impair the technical administration of elections in South Africa.[vi] Is the epidemic likely to weaken political institutions and elected bodies? Again, the substantive evidence is scarce. One of the few enquiries on this front found sharp increases in councilor absenteeism in the eThekwini (Durban) Metropolitan Council in 2001-2002 (Manning, 2002), but the causes were fuzzy. Meanwhile, Idasa has pointed out that the 102 by-elections held in Zambia between 1985 and 2003 were more than double the 46 staged between 1964 and 1984. The suggestion is that the increase was largely due to AIDS. In the 1964-1984 period, 14 (or 30%) of the 46 by-elections were related to deaths, as were 39 (or 38%) of the 102 by-elections in the 1985-2003 period – an 8% increase, which will have been caused by a variety of factors, probably including, but certainly not limited to, AIDS.[vii]

Though it would be foolhardy to dismiss them out of hand, the 'collapse' scenarios require more cautious interpretation. At face value plausible, they often are at least partly the fruit of fanciful intuition, draw on slight empirical evidence and

19 Even here accuracy might prove elusive. It's not known how AIDS is affecting population movements, especially in a country with such complex, circular migration patterns as South Africa. With respect to antiretroviral treatment, another complexity enters the picture. If treatment roll-out is highly uneven, 'treatment migration' might occur, as some people move to areas where treatment access is believed to be easier, more reliable or more affordable.

20 One attempt to gauge the likely effects concluded that a drop in demand was most likely; see Kayamandi Consulting (2002). *Impact of HIV/AIDS on the demand for low-cost housing*. Kayamandi Consulting. Johannesburg. However, it's also conceivable that population movement patterns and splintering households could increase demand in some areas.

21 That increase was in line with the 62% rise in the annual number of death notifications for people aged 15 years and older between 1997 and 2002, as documented by Statistics SA (2005).

seldom express a solid analytical method. Highlighted is the need for more-rigorous examination and analysis of the sociological fall-out of a severe AIDS epidemic. One of the most telling shortcoming of current prognoses is their neglect of the ways in which AIDS impact is tempered or aggravated by unequal access to resources and services. A substantial proportion of public servants and politicians is, by virtue of their skills and status, likely to have quality medical insurance coverage, to receive regular medical check-ups and to be able to afford antiretroviral therapy. In such cases, an HIV-positive status does not necessarily equal a 'death sentence'. The extent of AIDS-related absenteeism and personnel losses in these higher tiers almost certainly will be lower than among their less-privileged colleagues.

A new wave of mobilization?

Aired occasionally is an expectation that AIDS will intensify sheer, desperate need and enflame challenges aimed at the state. Indications from elsewhere in southern and East Africa are that such needs-driven or entitlement-driven mobilization and activism is relatively rare. However, South Africa's more-recent history of large-scale and diffuse political activism might position it in a special category – as the dramatic emergence of the Treatment Action Campaign (TAC) in the late 1990s would seem to suggest.

An independent association of organizations and individuals, the TAC has used the discourse of human and socioeconomic rights– and thus, by implication, also the discourse of the South African liberation struggle – to successfully challenge government policy, raise public awareness of AIDS and AIDS treatment, and initiate alternative grassroots projects. An early breakthrough came when the TAC (as a 'friend of the court') joined a court case brought by 39 pharmaceutical corporations against the South African government. By helping mobilize an impressive gallery of legal and health expertise domestically, by tapping into international networks of 'anti-globalization' and AIDS activism, and by highlighting the ferocious profiteering of the pharmaceutical industry, the TAC helped shame the corporations into withdrawing their court challenge. This sort of tactical craft became a hallmark of TAC activism. Combining court-based thrusts with direct action and grassroots mobilization, and forging tactical alliances with other social formations (especially the trade union movement and organized religion), the TAC conjured up the most successful adaptation of liberation struggle traditions seen since 1994. Especially astute was the ambivalent relationship it initially struck with the government, with the TAC positioning itself simultaneously as critic, watchdog and supporter. By 2003, however, that tactical agility was waning as the government's intransigence (first on the roll-out of a prevention of mother-to-child transmission plan, then on a national antiretroviral treatment strategy) forced the battle-lines to be drawn more emphatically. Still, a programme that brought together grassroots training and mobilization, tactical activism, canny use of the media and a strong policy research and analysis capacity has reaped several major victories-not least the mid-2003 decision of the South African government to expand considerably treatment and care provision through the public health system.

Does this herald a wave of wider radical mobilization and organization in pursuit of social change, with AIDS acting as a kind of prism for wider-ranging grievances and unmet needs? Possibly, but not very likely. No doubt, the TAC helped legitimize and validate progressive rights-based criticism, protest actions and policy interventions at a time when these had been routinely demonized from within government as the gestures of reactionary, wrecking tendencies. Largely due to the TAC, health (and specifically AIDS) has become the only arena in which the state's monopoly on policymaking authority has been visibly and successfully challenged in a sustained way since 1994, as Greenstein (2003) has observed. But it remains to be seen whether the TAC can adjust *strategically* to current realities as adroitly as it adapted *tactically* to opportunities in its early years. And, although the TAC itself cannot be blamed for the relish with which many observers in the early 2000s eyed it as a new social movement in-the-making, the fact remains that that expectation has not (yet) been realized.

There are other reasons, too, why AIDS might, in sociopolitical terms, prove to be less combustive than some anticipate. Many of the hardships and grievances most obviously and explicitly associated with AIDS tend to be experienced not as a communal issues but as 'private', 'domestic' ones – to which AIDS, in addition, attaches a premium of stigma and shame. As well, in Loewenson's (2004:31) view:

Activities within the extended family sector are often not brought into the social or public domain unless this is organized by community leaders, civil society or the state. In fact, there is some evidence that such demands are more likely to be made by middle- and higher-income households than by low-income households.

In a context of pervasive poverty and social violence, many NGOs and CBOs fulfill vital welfarist roles at community level, with religious and cultural organizations especially prominent. Both manifest need and the surge of AIDS-related development funding has spurred the emergence of new layers of support organizations, many of them trying to manage some of the consequences of ineffective or absent state policy and provision. Generally, however, such association-based support mechanisms tend to focus on mutual support and are not necessarily amenable to radical social mobilization. In addition, they contain motley interests, are inflected with the inequalities that pervade the communities they emerge from, and often are entangled in local patronage networks. Their utility as autonomous nodes of grassroot sociopolitical activism and challenge should not be exaggerated (Pieterse, 2003). These organizations are also very vulnerable to attrition. Destabilization brought on by staff losses has been a familiar part of CBO and NGO life for the past decade.[22] AIDS now looks set to compound those difficulties. Even in the best of circumstances, NGOs and CBOs tend to rely heavily on a few, key individuals. The past decade has seen this sort of dependency reinforced – with organizational knowledge, networks and experience ever more concentrated around a handful of individuals. Losing these organizational 'pillars' could be disastrous for NGOs and CBOs, and for the communities that rely on their services. Yet, these kinds of effects on civil society have not attracted nearly as much research attention as the anticipated impact on the economy.

Pounding the economy

It seems indisputable that an epidemic as severe as South Africa's will affect the economy – but how and to what extent is less easily gauged (Barnett & Whiteside, 2000). Some projections seem almost to trivialize AIDS impact, suggesting that even rampant epidemics would have a negligible effect on economic output.[23] ING Barings (2000), for example, estimated that South Africa's gross domestic product (GDP) would be just 2.8% smaller in 2015 than it would have been in the absence of an AIDS epidemic, while the Bureau for Economic Research (BER) concluded that real GDP growth would be 0.3-0.6% less *per annum* in the AIDS scenario (BER, 2001). Other exercises point towards much greater economic impact. Financial analysis by ABSA Bank has forecast that GDP would be 9.6% smaller in 2015, while Arndt and Lewis (2000) concluded that GDP would be 17% lower in 2010.

Nattrass' (2002) review of three modeling exercises (ING Barings, Arndt & Lewis, and BER) illustrates how contingent and rickety economic impact estimates can be. The estimates diverge mainly because they emerge out of models that employ different assumptions about the epidemic's demographic impact, about the channels along which AIDS is likely to affect the economy, and about the nature of the effects themselves. For example, it's safe to assume that AIDS will alter the size and efficiency of the labour force in South Africa, and that it will also reshape consumption patterns. Beyond that, though, the consensus more or less dissolves. The BER model, for example, assumes that wages for higher-skilled workers will rise (as increased scarcity and demand converge) and that this would roughly cancel out the effect of reduced employment on aggregate household income. The ING Barings model, on the other hand, sees lower household incomes draining consumption,

22 From 1994 onward, hundreds of key NGO staff were lured into post-apartheid government departments and parastatal institutions and, later, the private sector. Along with funding difficulties, this dimmed the effectiveness and even accelerated the demise of many progressive NGOs and CBOs. Those that survived soon encountered another trend. Large companies, keen to advertise their acquiescence to the 'new South Africa' (and under pressure to heed affirmative action requirements), began courting (black) NGO staff and snatching newly graduated talent.

23 Most models used to estimate the economic impact of AIDS counterpoise 'with-AIDS' and 'without-AIDS' scenarios, in line with the *ceteris paribus* ('all else remaining equal') principle. The principle is applied for methodological reasons, but it yields a plainly distorting abstraction: other factors affecting the economy do not freeze in place, and their largely unpredictable undulations affect one another as well as the overall system in a complex interplay of kick-on and feedback effects. 'With AIDS' and 'without AIDS' scenarios have important illustrative value and can broadly indicate the scale and dynamics of epidemic's impact, but should not be used as literal 'forecasts' of, say, gross domestic product growth in 2010, or the exact number of orphans in 2015.

which cuts into demand that, in turn, causes lower growth (Nattrass, 2002).[24] Each assumption meanwhile rests on additional layers of conjecture that draw on particular (sometimes ideologically inflected) interpretations of empirical evidence. Just under half the drag on GDP growth in the Arndt and Lewis (2000) estimate was attributed to a 'crowding out' effect, which ostensibly sees greater government spending (mostly on health) inflating the budget deficit and discouraging private investment.[25] Economists of Keynesian bent, on the other hand, take a different view; the ING Barings and the BER scenarios predict that increased government spending would boost consumption and spur economic growth. There, the punch-line is that tight fiscal policy would further choke demand and bring growth to a halt once the AIDS epidemic is in full-swing.[viii]

The assumptions also differ with respect to how firms react to higher AIDS-related costs: do they pass the costs onto consumers, or do they absorb some of them (thus cutting into profit margins and possibly reducing future investments), or do they attempt to mechanize more of their operations (and reduce their labour dependency), or outsource more of their labour requirements, or cap or reduce wages, or cut back on worker benefits, or introduce various combinations of those options? Whether it incorporates all such variables or not, each model implies answers to such questions – but on the basis of very little empirical data.[ix] Ultimately, grand economic impact estimates pack illustrative punch, but add little substantive insight; enquiries into the likely economic effects of the epidemic tend to be more rewarding when they zero in on the details.[26]

Ducking the blows

In theory, the direct costs of AIDS to businesses will arrive in the form of higher health-care costs and more expensive workers' benefits, while the indirect costs will occur in the shape of reduced productivity, loss of skills, experience and institutional memory, and (re)training and recruitment time and expenses. Indirect costs are significantly higher for skilled workers, compared with their less-skilled counterparts, while employee benefit costs tend also to be higher for skilled workers (Whiteside & O'Grady, 2003). Ultimately, these costs add up to a kind of hidden employment or payroll tax (De Waal, 2003b).[27] However, companies have a great deal of scope for averting or deflecting such costs (see below). As a result, the impact is likely to be felt most sharply by those companies that are vulnerable to substantial drops in consumer demand.

By slashing the working and income-earning lives of millions of people, AIDS could squeeze consumer markets and cramp economic growth. A small proportion of companies already claim to be feeling that pinch. In one of the largest HIV/AIDS surveys conducted to date among South African companies, less than 12% of them (mostly in the financial services and retail sectors) reported that the epidemic was affecting demand for their products and services (BER, 2004). This should not surprise us. An epidemic that discriminates, as AIDS does, un-leashes uneven effects that will tend to cluster among particular sectors and ventures. Overall, it's the retail

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24 The ING Barings model also assumed that HIV susceptibility is spread evenly across all sectors and skills levels in the economy. Available evidence suggests this is not the case (see below). Increasingly, studies find HIV prevalence to be higher among lower-skilled workers than among their better-skilled counterparts, and prevalence in some sectors (notably mining) appears to be considerably higher than in others (such as financial services). Anglo American estimated that about 23% of its workforce was HIV positive in 2002, while telecommunications and financial companies have reported HIV prevalence of 7% and 5% respectively. See Vass J (2003a). The impact of HIV/AIDS, in HSRC. *Human Resources Development Review 2003*. HRSC. Pretoria, p 191-192.

25 The 'crowding out' argument is a favourite saw of neoliberal economics, and was used to strong effect in promoting and, later, defending the 1996 Growth, Employment and Redistribution strategy in South Africa. See Bond (2005) and Marais (2001a).

26 The models suffer other limitations, too. The differential ways in which the epidemic is experienced seldom feature in the scenarios, value produced in the non-market economy of the household and community (including child-care, elder care, other home-based tasks and volunteer work) is not reflected, and the potential kick-on effects of losses in one sector on others are not factored in. They also tend not to capture the possible depreciation of human and social capital, and its effect on economic output. Some modellers have sought to incorporate more elements, prompting exceptionally gloomy predictions that call to mind MacPherson's claim (2000:11, cited in Whiteside, 2003:323) that the effect of savings and efficiency losses would be akin to 'running Adam Smith in reverse'. One recent exercise attempted to incorporate and quantify the effects of AIDS on both human capital and on the stock of experience, skills and education that help prime an economy's growth potential. Applying the model to South Africa, the authors concluded that, within a few generations, AIDS could bring the South African economy to near collapse (Bell, Devarajan, Gersbach, 2003). The forecast is not widely regarded as credible.

27 The outlines of such a 'tax' have emerged in a few studies, among them Rosen et al. (2003), which focused on six Botswana and South African companies where HIV prevalence among workers ranged from 8% to 25%. Applying a conservative set of assumptions, the authors concluded that an 'AIDS tax' of 1-6% of labour costs per year was being incurred.

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sector – and especially those enterprises that rely on products and services aimed at mass consumer markets or markets that are close to saturation – which seem most vulnerable (BER, 2004).

Studies among poor households show that the bulk of household expenditures are on food, energy and debt. De Swardt's research (2003) in Mount Frere, Ceres and Langa (Cape Town), for example, found that between 37% and 44% of monthly income was reserved for buying food; 4-11% went towards paying for energy, and 5-12% was spent servicing debts. Goods purchases comprised only 5% of monthly household income in Mount Frere, 8% in Langa and 10% in Ceres. These households have very little latitude for shuffling their expenditures when their finances come under additional strain; something has to give. Food expenditures tend to be protected, but once under pressure these, too, are cut back to bare essentials.[28] Enterprises that rely heavily on sales to the poorest two, perhaps three, quintiles of society therefore are likely to be hit hardest. Most vulnerable will be informal retailers and spaza shops that depend on sales of food and other basic goods (including cigarettes, personal care products and beverages) in largely poor communities.[29] One effect would be to cut further into the already-feeble livelihood strategies of households that rely on so-called 'micro-enterprise' retail efforts.

Shrinking or unstable incomes would further prevent poor households from purchasing durable goods, as well discourage purchases of clothing, shoes and other semi-durables.[30] A significant share of durable and semi-durable goods purchases in South Africa involve hire purchase arrangements or some other form of credit provided by the retailer. Many of these include an insurance component which either writes off or settles outstanding payments in the event of the customer dying. Higher mortality rates renders these forms of credit more costly (since more debtors are likely to die before settling their debts), and firms are having to decide whether to absorb part of the additional cost themselves or to pass it on entirely to consumers (at the risk of surrendering price competitiveness in a tight market).

While some producers and retailers will suffer, others will be able to take evasive action, and some might even gain.[31] Vulnerable companies that can expand operations abroad (especially elsewhere in Africa where markets for their products and services are not yet saturated) will be tempted to do so. Other companies seem to be adapting their product lines to appeal more to the wealthier market segments which they assume are less affected by the epidemic (Whiteside & O'Grady, 2003). Indeed, if wages and salaries for the top skills levels increase (and income inequality widens), the durable and luxury goods market overall might not be that badly affected. The effects will cluster elsewhere. If firms react to AIDS by continuing to reduce their reliance on unskilled labour and by moving out of economic sectors with customer bases comprising lower-income consumers, then poor households will find themselves 'doubly disadvantaged': not only will their access to the labour market be reduced further, but the products they purchase may become more costly (Nattrass, 2002).

Deflecting the impact

In tackling the epidemic's effects on workforces, companies have four basic strategic options, according to Rosen and Simon

28 In the Free State study, AIDS-affected households spent less on food than their unaffected neighbours. Other research suggests that food expenses are often reduced by avoiding more expensive and protein-rich items (such as meat, eggs and milk)—which could further compromise nutritional status.

29 Michael (1999) briefly touched on this aspect, which has attracted surprisingly little research attention.

30 The possible impact on the cellular phone industry tempts speculation. Since erupting onto the scene in the early-1990s, the industry has had a presumably major (though poorly researched) effect on personal expenditure decisions in poorer households. People using contract systems spent an average of R384 per month and those using pre-paid systems spent R134 per month on their cellular phones, according to the 2005 study *The impact of mobile technologies on the South African consumer* (see 'South Africans love their cells', *Mail & Guardian*, 9 June 2005). It is likely that cellular phone costs currently absorb a small but significant share of income in poorer households in urban areas, where the phones often substitute for inaccessible landline services.

31 An 1998 assessment of AIDS impact on the market share of a major southern African furniture and household company, for example, forecast that its customer base would shrink by almost one fifth by 2015. The company has diversified its operations into other regions. It's not clear whether or to what extent the expansion of its operations into the Czech Republic, Hungary, Poland and Slovakia was triggered by the study findings, although Whiteside & O'Grady (2003) have suggested a link. See also 'JD, Ellerine aim to convince skeptics', *Sunday Times*, 14 May 2000; and 'AIDS threat sparks business into action', *Sunday Times*, 11 November 2001.

(2003). They can invest in HIV prevention programmes; they can provide treatment, care and support to AIDS-affected workers and their families; they can invest more in sustaining and extending their human capital base; and they can change the terms on which they hire labour. Some are experimenting with a combination of these options; many, though, seem to prefer the last one.

South Africa has long had a very stratified labour pool, marked by shortages of highly skilled workers and a large reserve of poorly skilled and poorly educated labour.[32] Amid the tilt toward export orientation and the attempts to encourage growth in the services and knowledge-intensive sectors (e.g. finance, business services and infotech), the demand for skilled and highly skilled labour has risen at a faster rate than for semi- and un-skilled labour (Vass, 2003b). Attempts have been made to adjust the education and training systems, both to reduce inequalities in human resource development and to align the range and mix of available skills more closely to labour market demand. Progress, though, has been tardy and uneven. Wage and salary gaps have widened and a real decline in formal employment has occurred. In Miriam Altman's summary:

> The shift has been from formal to informal, with fewer returns to education, low wages, and fewer contractual obligations or benefits. If both the formal and informal sectors were growing and drawing in the unemployed, that could be a positive scenario. Instead, the experience is the opposite. From the perspective of households, this would indicate that there is a vicious downward cycle, not an upward virtuous development cycle: this is not a sustainable growth path in a middle-income economy (2004:174).

Until the early 2000s, the reactions of most South African firms – and worker organizations – to the AIDS epidemic ranged from lethargy to indifference. The mining industry, whose historical reliance on migrant labour had helped shape the template of social relations on which the epidemic would eventually erupt, became one of the early, high-profile exceptions. It and a handful of manufacturing and financial services firms have introduced high-profile antiretroviral treatment programmes for some of their employees, in addition to HIV prevention activities. But three quarters of the firms surveyed in 2003 lacked even an HIV/AIDS policy, even though a third of them reported experiencing lower productivity and higher absentee rates due to AIDS (Bureau for Economic Research, 2004). Such behaviour need not surprise us: private-sector companies have a substantial degree of leeway for avoiding and deflecting many of the AIDS-related costs described here – and they are using it.

Practices include pre-employment screening, the adopting of labour-saving methods and technologies (especially mechanization and automatization), outsourcing jobs (including to off-shore units or suppliers), cutting worker benefits, and restructuring employment contracts (Rosen & Simon, 2003). Mining, agribusiness, building and construction firms have shown an especially strong penchant for contracting 'independent' workers, who receive few, if any, benefits. When questioned in 2004, almost one quarter of mining companies and almost one fifth of manufacturing companies reported that they were investing in machinery and equipment in order to reduce their labour dependency because of AIDS (BER, 2004).[33] Substituting machines and technologies for less-skilled workers reduces overall labour requirements but also creates a need for higher-skilled workers. Though fewer in number and apparently less at risk of HIV infection, the epidemic does not leave them unscathed; companies will

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32 'Skills' usually refer to formal education and training levels, a definition which devalues the skills and experience acquired on the job and elsewhere. Thus, low-skilled workers might lack formal qualifications, but in the course of their working lives they accumulate skills and experience that are not quickly replaced. The notion that unskilled and low-skilled labour losses are overcome easily and seamlessly ignores the varied textures of 'skills'. Even 'soft skills' - such as workplace socialization, a familiarity with organizational culture and work ethics - often have to be nurtured afresh, especially in a labour market like South Africa's, where a large proportion of unemployed men and women younger than 30 years have never had a formal job.

33 Interestingly, 10% of building and construction firms offered the same reply, despite the sector's manifest shift over the past two decades towards using 'casual' semi- and 'un'-skilled workers. More than 60% of the mining companies and over 40% of the manufacturing companies participating in the survey reported that AIDS had already reduced labour productivity, increased absenteeism and caused a rise in worker benefit costs (BER, 2004). Generally, by far the biggest share of fixed capital investment generally goes towards 'machinery and other equipment' - and that share has grown larger, from an average 40% in 1990-1994 to 49% in 1995-2002 (UNDP, 2004). Most tax codes are designed to encourage investment in physical capital, for example via generous depreciation terms and other discounts; South Africa is no exception.

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still need the ability to fast-track skills acquisition and training, which is costly. Poaching or importing skills might be the easy way out (Vass, 2003b).

Meanwhile regressive changes to workers' health-care benefits and pensions continue to be made. Many of these manoeuvres form part of wider, ongoing restructuring efforts; AIDS is providing additional impetus to them. According to a World Bank survey, the shifts toward casual labour and mechanization, for example, accelerated in the mid-1990s partly in reaction to new, progressive labour legislation.[x] Medical benefits are now customarily capped at levels (or even replaced with fixed cash pay-outs) far too low to cover the costs of serious ill health or injury. In 1997-1999 already, more than two thirds of major South African companies either cut workers' health care benefits or increased workers' contributions to medical schemes (Rosen & Simon, 2003).[34] When surveyed in the late 1990s, more than three quarters of 56 randomly sampled large South African companies were cutting back death and disability benefits, limiting employer contributions, and requiring that workers pay a larger share of the premiums for the same benefits. On average, more than one third of the workers with access to such medical schemes had withdrawn from them because of the costs they entailed.[xi] In addition, most large companies have replaced defined-benefit retirement funds with defined-contribution funds, often with the support (and in some cases the encouragement) of trade unions who believed that defined-contribution funds were in their members' interests (Barchiesi, 2004; Van den Heever, 1998). The former variant provides long-term support for the spouses of deceased workers (at significant cost to companies). The latter comprises a one-off pay-out equal to the combined amounts contributed by the employer and the worker up to the last day of employment. It is of scant value to younger workers and provides little longer-term help to families – but it shields companies against future obligations. By 2000, almost three quarters of 800 retirement funds had defined-contribution funds, compared with just over one quarter in 1992.[xii]

These kinds of adjustments betray the fundamental tension between private profit and the public good. Their net effect is a constant whittling of real wages and benefits for those South Africans with formal employment – at a time when they and their families are at increased risk of severe illness and premature death. Much more worse off are 'casual' or 'non-permanent' workers, who have access to feeble or no retirement, death and disability benefits, who earn much lower wages, and who work on terms weighted inordinately in the favour of employers.

In this context, AIDS could affect the labour market in several ways. It probably will contribute to other pressures to cap or reduce real wages for non-unionized workers, and hoist wages and salaries of skilled and highly skilled workers. AIDS risk might inhibit private-sector investment in training and education, with companies more inclined to poach or lure top skills from elsewhere in the world, especially from other African countries (Vass, 2003b). This would reinforce the barriers that block mobility into higher-skilled employment, with Africans (especially women) worst affected:

> [I]f current training continues to relegate the historically disadvantaged to low-skilled, low-paid occupations, HIV/AIDS-induced constraints on training may entrench this trend further. It will also become even more difficult for women to accumulate the skills and experience needed to break through the 'glass ceiling' at the skilled and highly-skilled levels of traditionally male-dominated occupations (Vass, 2003b:64).

Such a sequence of reactions need not even show up as a drag on economic growth in specific sectors; it could appear to boost productivity and cut costs for some enterprises, widening profit margins, and buoying equities. The adjustments amount to a large-scale redistribution of risk and an abdication of responsibility for social reproduction – with the costs socialized, that is to say deflected into the 'domestic' sphere and, to a lesser extent, those zones of the state and civil society active in social development and welfare activities. It defies any notion of a social contract and strips bare the pretences of corporate

34 Some of the changes to health care benefits are AIDS-specific. Rosen and Simon (2003), for example, report instances elsewhere in Africa where HIV infection has been classified a 'self-inflicted condition' in some medical schemes and therefore is not covered. A South African company reportedly also lowered its ceiling for HIV-related claims per family from R100 000 (roughly US$20 000) in 1997 to R15 000 (US$2 500) in 1999; see Center for International Health. The cost of HIV/AIDS to business in Africa (forthcoming), cited in Rosen & Simon (2003:132).

social responsibility. From every vantage point besides the bottom line, the outcome is nefarious. Companies enjoy considerable scope to reduce their social obligations, and they will continue to exploit those opportunities until prevented from doing so:

> The private sector has a clear incentive, and some ability, to shift the burden unless governments take action to prevent it. Deliberate decisions on social policy must be made, and enforced, if the ultimate allocation of the burden is to be socially desirable (Rosen & Simon, 2003:135).

The sum effect would be to increase inequality and trap more people in poverty. Firms could continue to reduce their dependency on an unstable supply of labour by mechanizing more of their operations (thus increasing unemployment), cutting the wages of un- and semi-skilled workers, restructuring and trimming job benefits, and/or out-sourcing more of the their labour requirements. Young people and older women who try to enter the labour market (but who lack sought-after skills and attributes, including physical strength) will not only find work difficult to find but will probably end up competing heavily on the lowest rungs of the market for exceptionally low wages. At the same time, increased demand for an already-limited pool of skilled and highly skilled labour would push up wages and salaries at that end of the labour market. Skilled workers could benefit from an increase in demand for their labour, with a potentially profound effect on the fortunes of trade unions. Those representing less-skilled workers, especially in sectors where labour requirements are being adjusted radically, will come under greater pressure. But unions representing the more-skilled sections of the work force probably could see their bargaining hands strengthen. Meanwhile, in both the public and private sectors, we are likely to see work increasingly contracted out to consultants.

More broadly, for the poorest sections of society, access to and the quality of essential services (such as education and health) are likely to be compromised even further, as the epidemic takes its toll in the public sector. Beyond this, current trends suggest that it is the poorest South Africans who are least likely to receive antiretroviral and other life-prolonging treatment. AIDS will entrench existing inequalities; very likely, it will deepen them substantially.[35]

Worlds apart

The demographics and pervasiveness of poverty in South Africa, where a majority of Africans live below any acceptable minimum poverty line, means that even if HIV infections were distributed evenly between the five income quintiles, the vast majority of infected people would be poor, and a large part of them would be extremely poor. As it is, AIDS does not threaten and afflict all and sundry alike or in equal measure; it feeds off and aggravates existing inequalities.[36] The epidemic affects South African society differentially. These patterns reflect embedded, structural vulnerabilities and social relations forged over the past 150 years. Rooted in the colonial and apartheid era, the ongoing, severely-unequal distribution of economic opportunity, social power, resources and livelihood options provides the epidemic with a great deal of its dynamism and helps generate the patterns of HIV transmission in society.

A welter of sector- and workplace-level studies show HIV prevalence tends to be higher among people with fewer skills, lower incomes and poorer access to basic services. Among health workers in private and public health facilities in four provinces, for example, HIV prevalence was just under 14%

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35 Oddly, except for some rare attempts, the impact of AIDS on income *inequalities* has not been carefully examined. Greener et al. (2000) projected that in Botswana household per capita income would decrease by 8-10% and the percentage of households in poverty would increase by 6-8% as a result of AIDS over the next decade. Despite this, the authors concluded that income inequality, as measured by the Gini coefficient, was unlikely to be affected by AIDS.

36 Just how unequal is South Africa? According to the government, South Africa's Gini coefficient was 0.59 in 2000 (Government of South Africa, 2005) – although Leibrandt et al. (2004) calculated it at 0.72 and the HSRC (2004) put it at 0.77, making South Africa one of the most unequal societies in the world. Inequality among Africans widened from 0.62 in 1991 to 0.72 in 2001 (HSRC, 2004). However, according to Van der Berg (2002), if social grants and services are factored in, the coefficient eases considerably, to 0.44%; according to the government, it declines to 0.35. Yet, even the more conservative calculations evoke a shocking reality: in 2000 the poorest 20% of households accounted for 2.8% of total expenditure, while the wealthiest 20% accounted for 64.5% (Government of South Africa, 2005). See Leibbrandt M et al. (2004). *Measuring changes in South African inequality and poverty using 1996 and 2001 census data*. Working Paper No. 84. Centre for Social Science Research. University of Cape Town, and Van der Berg, S (2002). *Poverty, fiscal incidence and social outcomes*. Paper commissioned by the German Agency for Technical Cooperation, both cited in Friedman S (2004). 'Understanding poverty: the limits of data'. In Brown S & Folscher A (eds.) *2004 Transformation Audit*. Institute for Justice and Reconciliation. Cape Town.

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among professionals and over 20% among non-professional staff (Shisana et al., 2003). An HIV prevalence study among employees of the Buffalo City Municipality in 2004 found higher prevalence among temporary than permanent staff, with infection levels highest in the lowest skills levels (Thomas et al., 2005). The gold mining company Harmony stated in 2004 that 34% of its labour force was infected with HIV, while Anglo American reported that approximately 24% of its workers were infected.[xiii] Meanwhile, the mainly white-collar employees in the financial services sector appear to be much less affected; a survey in 2003 of workers at four major banks (ABSA, FirstRand, Nedcor and Standard Bank) found HIV prevalence of 3.4%.[xiv] Among South African workers participating in a three-country seroprevalence survey of 34 major companies in 2000-2001, HIV prevalence was 15% for unskilled workers, 18% for their semi-skilled counterparts and 20% for contract employees – compared with 7% for skilled workers and 4% for management staff (Evian et al., 2004).

For the majority of households affected by the epidemic, AIDS arrives alongside ongoing dispossession and hardship. According to the Human Sciences Research Council, in 2001, 57% of South African households were living in poverty (unchanged from 1996) (HSRC, 2004).[37] In mainly African townships around Cape Town, research conducted by the Programme for Land and Agrarian Studies (PLAAS) found that three quarters of households lived below the poverty line and that 52% of them lacked regular wage incomes. Levels of education did not appear to influence significantly people's chances of finding paid work.[xv] In 1999, there was no-one with a job in 38% of households nationally; in the poorest quintile, 83% of households had no-one in formal employment (Everatt, 2003). The gender and racial contours of poverty remain shocking: approximately 57% of Africans are poor, compared with 1% of whites, and the poverty rate among female-headed households is twice that of male-headed households (Committee of inquiry into a comprehensive system of social security for South Africa, 2002). Surveys consistently uncover scandalously high proportions of people admitting that they lack the money to buy food for themselves and their kin. In 1999, 22% of South African households said members went hungry because they could not afford to buy food (Everatt, 2003).[xvi] A 2001 survey of 500 poor households in Limpopo (then Northern province) found that 51% of the households had lacked enough food to eat for up to 6 days in the previous month, and 5% said they had gone hungry continually for most of that month (Van den Ruit et al., 2001).

What is to be done?

It is obvious that households' abilities to guard food security, care for and protect children, and achieve secure livelihoods are in urgent need of bolstering. At an elemental level, this means preventing more effectively the spread of HIV, and keeping those persons who are infected with HIV alive and healthy for as long as possible. This implies expanded programmes to prevent the transmission of HIV from mother to child, universal and affordable access to antiretroviral (ARV) therapy, and ensuring that vulnerable households have food security. Given that AIDS-related death rates are upward of 90% in the absence of antiretroviral treatment, the extent of the epidemic's impact will be shaped also by the speed and extent to which ARV treatment is made available, and the degree to which treatment is adhered to. It doesn't mean that ARV treatment will *prevent* HIV-positive people from dying of AIDS, but it can extend their lives for an indefinite period. (Less than a decade after the widespread introduction of effective ARV therapy in industrialized countries, we don't yet know for how long ARVs can prolong people's lives.) Progress on this front has been sluggish. By mid-2005, according to WHO estimates, between 97 000 and 138 000 persons were being treated with antiretrovirals in South Africa (10-14% coverage)

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37 In the Limpopo and Eastern Cape provinces, roughly three quarters of the population was living in poverty in 2001. The HSRC calculations used a poverty income of R1 290 per month (in constant 2001 prices) for a household of four; the poverty line obviously varies according to household size (HSRC, 2004). Leibrandt et al. (2004:77) calculated that 58% of South Africans were living in poverty in 2001 (compared with 50% in 1996). They note that 'access to basic services has improved, suggesting some increases in well-being [...] even though the poorest quintiles are most deprived, it is generally these households that are experiencing the greatest gains'. 'Gains', it should be added, off an extremely low base, and often on market terms that limit affordability and sustainability. Meanwhile HSRC statistics show that the poverty gap has grown - from an equivalent to 6.7% of gross domestic product (GDP) in 1996, to 8.3% in 2001. This indicates that the poor have not shared in the benefits of economic growth (HSRC, 2004). (The 'poverty gap' is the total income needed to lift the households living in poverty above the poverty line.)

(WHO/UNAIDS, 2005). According to the Health ministry, 61 000 people were receiving antiretroviral treatment in the public health sector by June 2005 (the Health Systems Trust had estimated 50 000 by April 2005), which implies that roughly half the people on treatment were receiving it through the private health sector (Ministry of Health, 2005; Ijumba & Barron, 2005). Approximately 870 000 people in need of antiretroviral treatment were not receiving it in mid-2005 (WHO/UNAIDS, 2005).[38] The roll-out has been especially slow in KwaZulu-Natal (largely due to the massive burden of disease there) and in the Free State, Limpopo and Mpumalanga provinces.

Alongside much more effective prevention strategies, a drastically expanded treatment effort represents the 'emergency' aspect of what must be done. However, AIDS is also deepening and hardening a structural crisis which, in turn, is providing the epidemic with much of its momentum. Overcoming the epidemic therefore coincides with the overarching need to bring about a much more just society, one in which all South Africans have at least the basic means to a secure livelihood and the realistic prospect of improving their lives and those of their children.

All that is solid, melts into air

Access to paid employment is among the most important factors affecting the poverty status of households; joblessness accounts to a large degree for the extent of impoverishment in South Africa. The official (narrow) unemployment rate was 26.5% in March 2005, down slightly from 27.9% in March 2004, according to the March 2005 *Labour Force Survey*.[39] Among Africans, the official unemployment rate was 31.6%, compared with 5.1% among whites; 37.6% of African women were jobless. When workers who have given up on looking for jobs are tallied, the unemployment rate reaches 40.5%: 8.1 million people (Statistics SA, 2005a).[40] For most of the employed, not having a job is not a temporary circumstance: almost three quarters of the unemployed had never had a job, and among those who had been employed previously, 41% had been jobless for three or more years, according to the 1999 *October Household Survey*.[xvii] The fact that 34% of the unemployed (official definition) have completed high school suggests that the school system currently does not add much to the upward mobility of the poor in the labour market either (Statistics SA, 2005a; Van der Berg, 2002). [xviii]

However, the binary perspective that equates unemployment with poverty and employment with relative well-being matches reality less and less, even if it continues to underpin the jobs 'debate' (Barchiesi, 2004).[41] The majority of wage-earners in South Africa are low-skilled and low-paid. Their wages are vital, but they're earned on such insecure terms and so often without attendant benefits that earning a wage does not, in itself, guarantee a relatively secure livelihood or serve as a barrier against privation when misfortune strikes. Of the 11.9 million workers officially classified as *employed*, almost 18% (2.1 million people) work in the informal sector, just over 7% (850 000 people) are domestic workers, and more than 4% (514 000) are engaged in small-scale subsistence farming – insecure, low-paying work typically lacking in benefits and rights protection.[xix] Among domestic workers, 43% earn less than R500 a month (US$77), as do 33% of workers employed in the informal sector. Approximately two thirds of workers with jobs are employed in the formal sector (7.8 million). Almost one in five of those workers (18%) earn less than R1 000 a month (Statistics SA, 2005a).[xx] Between 1995 and 2002 real wages were stagnant or they declined (depending on the skills level), which translates into a welfare loss for poor households (Altman, 2005).

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38 This is an area where women do appear to be gaining greater benefit than men: statistics from Free State and KwaZulu-Natal provinces show approximately two thirds of people receiving antiretrovirals through the public health system were women. The figures are line with general under-utilization of health services by men (Ijumba & Barron, 2005).

39 The *official* (narrow) definition unemployment refers only to those economically active persons who sought employment in the four weeks prior to the survey. The *expanded* definition includes economically active persons who are deemed to have been discouraged from seeking work. Note that informal sector employment estimates in the Labour Force Survey (LFS) tend to be higher than those in the October Household Survey. As Charles Simkins (2004) has pointed out, 'the LFS criterion for counting as employed is very lenient: just one hour of work in the past week, which can be spent on a range of non-market activities as well as work for pay or family businesses'.

40 As with AIDS, so with unemployment. In May 2005 President Mbeki questioned the official joblessness statistics, saying they would imply 'at least four million South Africans walking about in our villages, our towns and cities'. Earlier, Finance Minister Trevor Manuel had chimed in with similar reservations: 'If you look at the surge in expenditure [on] consumer durables or the white goods sector and take that as a proxy for a series of things ... I think the story that comes out is that this is not a country with unemployment at 32% or 40%'. Trevor Manuel quoted in Paul Stober. 'SA's four-letter word: JOBS. Employment isn't what it used to be'. *Sunday Times*. 12 December 2004.

41 The irony is that South Africa historically has offered little basis for such a viewpoint; until the ascendancy of the trades union movement from the early 1980s onward, wage incomes and benefits provided a paltry barrier against impoverishment.

While official discourse prefers to treat employment creation as a 'down-stream' effect of economic growth, critical discourse tends to regard poverty reduction and improvement in livelihoods largely as functions of formal-sector employment. Both, in a sense, fetishize formal-sector employment, even though it has become increasingly insecure, wage- and benefit-poor, and less easily distinguishable from informal-sector employment. It's not that job creation is not desperately needed – it is – nor that joblessness doesn't constitute a national crisis – it does. But given the surfeit of working poor, the porous division between formal and informal employment, and the resolute grab-back of workers' benefits by employers, a job often does not ensure the rudiments of well-being – a secure living income, affordable access to essential services and insurance, food security, etc. As the AIDS epidemic peaks, our perspective needs to broaden to take in the entirety of the challenge. The jobs 'debate' has become something of a proxy for what should be a debate about social rights and about the various ways of realizing them in a society in which millions are impoverished in the midst of abundance.

Breaking the fall – social transfers

Generous compared with many other countries of the South, South Africa's state social security net rests on the assumption that able-bodied adults can earn a living through wage labour (Nattrass, 2004). State assistance therefore is available mainly to those who cannot be expected to fend for themselves – disabled persons, the elderly and children.[42] Imbedded in the system, in other words, is a double fiction: the idea that employment is available to those who seek it, and the notion that wage incomes guarantee well-being.

Poor households rely heavily on social transfers – all the more so those affected by health crises, according to a Free State study (Booysen & Bachmann, 2002). Almost three quarters of households with an HIV-infected member were receiving government grants, compared with under a half of those without an HIV-infected member, according to one pilot study in Soweto (Naidu, 2003).[43] Overall, by the end of 2004, approximately eight million South Africans were receiving some form of social assistance (up from 2.6 million in 1994, according to government figures), a number that could exceed 10 million once eligibility for the child support grant is extended from 11 to 14 years (Government of South Africa, 2005).[44] Welfare spending in 2005 absorbed 14% of non-interest budget expenditure, and more than 3% of gross domestic product.[xxi] According to the Finance Ministry, continued expansion is fiscally unsustainable; grant provision and take-up would need to slow down again and track population growth.[xxii]

Four types of social transfers can have a direct bearing on the destinies of poor households in general and on the recovery prospects of those affected by shocks such as AIDS: the old-age pension, foster care grant, child support grant, and the disability grant.

The *old-age pension* often serves as a lifeline for entire households. Frequently described as a poverty alleviation tool, the pension (worth R780 per month) enables many households which otherwise might have sunk into destitution to remain afloat – as long as the recipient is alive. About 2 million pensioners were receiving the pension in early 2005. Yet, significant numbers of the poorest South Africans live in households *without* any access to pensions; it is the relatively better-off among the poor who are most likely to be receiving pensions (Leibbrandt, Bhorat & Woolard, 1998; Sender, 2000). The challenge is to consolidate and extend the kinds of benefits this grant provides, bearing in mind the main trends that have to be contended

42 The fact that the disability grant, for example, explicitly targets adults who cannot work, irrespective of whether work is available or not, betrays this underlying assumption of full employment. See Simchowitz B (2004). *Social security and HIV/AIDS: Assessing 'disability' in the context of ARV treatment*. Draft paper presented at the Centre for Social Science Research. 29 July. University of Cape Town, cited by Nattrass (2004:6).

43 Remittances were also found to be a more common source of income in households affected by AIDS, compared with those not affected, in the Free State and the Soweto studies (Booysen et al., 2002; Naidu, 2003).

44 Since its introduction in 1998, child support grant eligibility criteria have been steadily broadened; the initial cut-off age of seven years was first extended to 11 years, then to 14 years (in 2005). The latter extension entails an additional R9.8 billion expenditure – or, to put it in perspective, two thirds as much as the R15 billion in tax cuts the Finance Ministry announced in 2003 (Idasa, 2003). The number of beneficiaries of the disability and foster care grants have doubled since 2001 – from 700 000 to 1.4 million.

with. Firstly, the numbers of South African living in poverty are not decreasing; in some places, including some cities, they are increasing. Secondly, rising numbers of old persons are taking on care, fostering and child-rearing duties. Thirdly, far more women than men are assuming these roles. Fourthly, as the AIDS epidemic approaches its most intense phase, the elderly will lose more of the financial and other support younger relatives used to provide. The need for the old-age pension is growing, not diminishing. Given the overall dearth of income-earning opportunities for women, and the burdens they bear, lowering the eligibility age for women to 55 years should be considered (Legido-Quigley, 2003). There is a hitch, though. A disproportionate reliance on the pension could backfire because of the demographic distortions that are being generated. Over the next 20-30 years, proportionally fewer households in need will be benefiting from pensions – because proportionally fewer adults will be reaching pension age. Clearly, while the epidemic lasts, welfare needs will keep growing.

What about the other grant instruments?

In early 2005, about 5.5 million children were benefiting from the *child support grant*.[45] However, its potential benefit is diminished by its size (at R180 a month, it hardly approaches minimum child-care costs) and by its premature cut-off point. Eligibility ends when a child reaches 11 years, though this was due to be extended to 14 years in 2005. Still, terminating grant eligibility at the point when schooling and other expenses burgeon defies all but fiscal reasoning.

About 200 000 people were receiving the *foster care grant* in mid-2004, more than double the number two years earlier.[xxiii] That trend looks set to continue for the next decade at least, as the orphan crisis worsens. Already social workers are being swamped by the volume of applications and cases crossing their desks, which often prevents them from performing other key tasks (such as monitoring the well-being of children placed in foster care and probing cases of alleged abuse). With AIDS sapping administrative capacity in the public sector and simultaneously increasing the need for foster care, the management of this grant – and of child protection services in general – will come under extreme strain. Meanwhile, many eligible households are either unaware of this grant or encounter huge difficulties in accessing it. In northern KwaZulu-Natal, for example, fewer than 10% of double orphans were benefiting from any sort of social grant, and just 2% were benefiting from a foster-care grant, according to Case et al. (2005). The grant (which is available until an orphan reaches 18 years of age) can be accessed only if the child has been placed in the care of foster parents by the children's court after a cumbersome and protracted process. Acquiring the requisite documentation is a routine problem for applicants. Persistent grumbling from officialdom about 'welfare fraud' probably means those requirements will be tightened rather than relaxed.

The grant is entangled in a bigger conundrum, though. Worth three times as much as the child support grant (R530 per month), the foster care grant is being used by social workers to assist poor households that care for orphans. Its original role – protecting children in distress – is being eclipsed by this broader welfare function.[46] Demand and eligibility for the grant will keep increasing, but the laborious procedures it entails will limit the number of beneficiaries and quickly overload capacity. A significant share of welfare resources is being funneled into a grant channel which can benefit a very limited number of children (Meintjies et al., 2003; Desmond & Gow, 2002). It is not an efficient social security mechanism.[47] Meanwhile, neglect and abuse of children (including orphans) are widespread enough to demand a child protection system, a role the grant no longer performs effectively (Meintjies et al., 2003).

45 Take-up rates can improve further, though. A significant proportion of needy and eligible children have not been benefiting from this grant: by one estimate, between 28% and 39% of poor children younger than nine years were not accessing the grant in 2003 (Foster, 2004). Part of the problem lies with the documentation requirements, which include the birth certificate of the child and the care-givers' bar-coded ID document. Ignorance about the availability of the grant seems widespread, too (Desmond & Gow, 2002).

46 Recall that the foster care grant was designed specifically to aid those orphans who are bereft of any support, or are subject to abuse and constant neglect - hence the intensive screening and the legalistic placement process.

47 Financial grants can serve as powerful incentives for the fostering of orphans. However, they can also lead to situations where applicants provide minimal, nominal care for orphans in order to access financial support that can be used to sustain families that are already in distress; see Loening-Voysey H (2002). HIV/AIDS in South Africa: Caring for Vulnerable Children. *African Journal of AIDS Research*, 1, cited in Stein (2003).

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There are ways around this logjam. One option would be to release the foster care grant from its happenstance poverty relief function, and revert to its original, specialized task of protecting children in distress. This could be achieved by equalizing the amounts of the child support and foster care grants (thus reducing the incentive to opt for the latter over the former), and by boosting the ranks of social workers and improving their resources (Idasa, 2003). Another option would be to shift away from targeting orphans and instead adopt a universalist approach that can benefit all children in need. This would entail providing a child support grant to all children and dropping the current means test – a variant, in other words, of the Basic Income Grant proposal (see below) (Meintjies et al., 2003).[48] The goal would be to provide some form of social security to many more South African children, vast numbers of who live in dire circumstances. The overriding ethic would be one of universalism and equity.

Meanwhile, demand for the *disability grant* (worth a maximum R780 a month) has ballooned to such an extent that the Treasury has voiced concerns about its fiscal implications. Strictly speaking, the grant is available to 'severely physically and mentally disabled persons' between the ages 18 and 65 years. The estimated number of South Africans meeting the varying criteria rose to 1.28 million by mid-2004 (up from 954 000 in 2003, and double the 627 000 in 2001).[xxiv] AIDS is responsible for a significant part of that trend, though not all.[49] There are no AIDS-specific eligibility criteria for the grant, but some provinces, including the Western Cape, have set a CD4 count of under 200 as the threshold, while others opt for a diagnosis of Clinical Stages 3 or 4. In the meantime, many AIDS-sick beneficiaries are encountering an odious dilemma (Nattrass, 2004). Those who opt for and receive ARV treatment are likely to see their CD4 counts rise beyond the 200 mark, thus rendering them ineligible for this grant once their eligibility status is reviewed. Yet, it is the grant that often enables them to afford the treatment (and better nutrition), and that helps sustain their households.[50] One survey in Khayelitsha, Cape Town, found that disability grants contributed 40-50% of total income in those households receiving the grant (Nattrass, 2004). There is a fear that some people might opt to discontinue ARV treatment in order to retain their disability grants – exercising a literal, pitiless choice between 'the money or your life'.[51] Besides compromising health, this would also boost the chances that drug-resistant HIV strains could become prevalent enough to undermine the ARV treatment programme.

However, as Nattrass (2004) has highlighted, a moral conundrum arises if HIV-positive persons are allowed to retain their disability grants after their health has been restored by antiretroviral therapy. In essence, HIV status then functions as a criterion for access to financial support, with equally needy but HIV-negative persons (without other disabilities) not qualifying for the grant. The conundrum can be solved, Nattrass argues, by introducing a universal social assistance instrument, such as the Basic Income Grant (BIG), a device championed by trade unions, church organizations and much of the NGO sector for several years already. Such a grant would be worth approximately R100-R200 and would be available to all.[52] Although spread thinner, its benefit would extend far wider than, for instance, the expanded public works programme, which is expected to create an estimated 200 000 temporary jobs (8 million South Africans are out of work). Although the government remains opposed to a BIG, the case for such an intervention has not diminished. Financial simulations indicate that even a modest BIG of R100 per month for all South Africans could contribute

48 Amid endemic poverty, proponents argue, targeting orphans is neither equitable nor cost-efficient: it misdirects scarce and vital resources, risks scuttling the child protection system, and is based on dubious understandings of children's circumstances. Extending the child support grant to all children up to the age of 18 years would enable the removal of grants targeted at specific categories of children: a blanketing approach would spread the benefits widely enough to help reinvigorate various neighbourhood and community support networks (Meintjies et al., 2003).

49 Nattrass (2004) implies that the sharp 2002-2003 increase might be anomalous, and notes three other, possible contributing factors besides AIDS. Eligibility appears to have been more leniently assessed in the Northern Cape and Eastern Cape provinces, a court order forced the government to reinstate temporary grants that had been cancelled without following all procedures, and fraud allegedly swelled the number of recipients (2004:9). However, between 2003 and 2004 a further 300 000 recipients were added, suggesting a continuing, steep trend.

50 Bear in mind that treatment involves numerous costs besides the drugs themselves – transport, income lost when seeking health care, consultancy fees, etc.

51 Once ineligibility halts access to the grant, and the person's failing health again drives his or her CD4 count below 200, it can take six or more months before grant payments resume – a delay that could spell life or death.

52 Disabled persons could receive the BIG plus a slightly reduced disability grant of, say, R650, Nattrass suggests.

substantially to reducing poverty and inequality in South Africa.[xxv] The likely costs and various financing formulas will continue to enervate and frustrate,[53] but the debate, as Nattrass (2004: 18) reminds 'ultimately boils down to whether reasonable people can tolerate living in a society that forces people living with AIDS to choose between income and health'.

Even in their current guise, state grants not only reduce poverty but have a variety of other developmental effects (EPRI, 2004). There is evidence that poor children, especially girls, are more likely to attend school if they are living in households that receive social grants, for example. (The old-age pension has proved especially effective on this front, possibly because women outnumber men as recipients and seem more likely to prioritize children's education.) In such households, a larger share of expenditure also tends to go towards food (EPRI, 2004). More broadly, grants tend to function as minor demand-side catalysts in the food, clothing and personal care sectors of the economy (which also tend to be more labour-intensive and have higher local content).

The poverty-reducing effect of the old-age pension, though, is probably almost exhausted – mainly because take-up is already high (upward of 85%). Only a larger amount would significantly boost that effect. A 50% increase in take-up of the disability grant could, by one calculation, reduce the total rand poverty gap by almost 2%, while full take-up would narrow that gap by more than 5%.[xxvi] But it's the child support grant that appears to have the strongest effect. Extending the eligibility age to 14 years (planned for 2005) could reduce the poverty gap by more than 16%. If calls for a further extension to 18 years are heeded, the gap would be reduced by 21%. The combined effect of the child support grant (with a cut-off age 14 years), and full take-up of the old-age pension and of the disability grant would be to reduce the poverty gap by 29%, according to EPRI, which notes that:

> South Africa's system of social security substantially reduces deprivation, and the progressive extension of the magnitude, scope and reach of social grants holds the potential to dramatically diminish the prevalence of poverty in South Africa (EPRI, 2004:2).

Blaming the victim

Allegations of welfare fraud have become a recurring refrain and are likely to remain so as the Treasury tries to limit social welfare expenditures. A national social security agency is to be established (supplanting the provinces' responsibility for transfers) as part of a bid to introduce 'tighter controls', and more restrictive eligibility criteria are almost certain to follow. Fraud is doubtless part of the social transfers landscape, though it's unclear how many fraudulent applications are impelled by sheer desperation.[xxvii] For example, according to a 2003 study by the Planned Parenthood Association of South Africa, one in ten teenagers who become pregnant do so in an effort to access a child support grant (worth R180 a month).[xxviii] The heartless might interpret that as a form of 'welfare fraud'; most, though, will recognize in it the stamp of desperation.

The 'welfare cheat' refrain, though, reflects more than a quest for probity. It's part of a perspective that regards social grants as welfarist gestures which, while necessary within limits, risk fuelling an 'entitlement' culture that 'crowds out' education and health spending, threatens fiscal rectitude and can destabilize the labour market[54], thus undermining economic growth.[55]

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53 Finance Minister Trevor Manuel in late 2004 told members of the national Council of Provinces that introducing BIG would 'bankrupt the country'. Manuel claimed BIG would cost the fiscus R83 billion (US$14 billion). BIG advocates, on the other hand, claim the scheme would cost between R24 billion (US$4 billion) and R40 billion (US$6.6 billion), depending on how some of the costs were recuperated through the tax system. (By way of comparison, in late 2005 plans were afoot to construct a controversial new rail link – the Gautrain – between Johannesburg International Airport, Johannesburg, Sandton and Pretoria, at an estimated cost of R20 billion; see Linda Ensor. 'High-risk Gautrain could be white elephant'. *Business Day*, 10 November 2005.) Shortly after Manuel's comments, Archbishop Desmond Tutu was quoted as remarking that people should not allow themselves to be 'browbeaten by pontificating decrees from on high' and that 'we cannot glibly on full stomachs speak about "handouts" to those who often go to bed hungry'. See 'South Africa: Debate rages over proposed basic income grant'. UN Integrated Regional Information Networks (IRIN). 23 November 2004

54 By discouraging grant beneficiaries from entering the labour force. This concern has been leveled even against the old-age pension. The claims that social transfers distort the labour market (by discouraging participation) and thereby act as brake on economic growth are not supported by recent research; see, for example, EPRI (2004) and Nattrass (2004). However, some grants do appear to have some adverse labour market effects, chiefly among the less poor, although EPRI claims these 'stem from distortions on the social security targeting mechanisms [...] A more comprehensive system of social security provides fewer opportunities for distortions to be generated by the incentive effects created by the social grants' (2004:19).

55 Hence the mutterings that 'government now needs to stem the *damage* caused by ballooning social grants' (emphasis added); see Carol Paton. 'Social welfare spending: no end in sight.' *Financial Mail*. 25 February 2005.

Grants are seen to be justified principally for the elderly, vulnerable children and the disabled; the rest of the population in theory should be able to fend for itself. For salvation, this perspective looks toward increased employment opportunities (as a by-product of economic growth) and a surge in small-scale entrepreneurial activities.

The mirage of microfinance

Touted for their alleged poverty-alleviating potential, microfinance schemes have been gaining favour also as tools for cushioning the AIDS epidemic's impact and helping households recover. Microfinance has boomed in South Africa over the past 10 years, so much so that the number of positively indebted households more than doubled between 1995 and 2000 (Daniels, 2003). Even in rural areas, development orthodoxy emphasizes the growth of smallholder agriculture and self-employment in rural micro-enterprises as a feasible exit route from poverty (Sender, 2000).[56] Proponents argue that these schemes are easily adapted to reach women (who often are excluded from credit systems), that they can benefit people and operate in areas that are bypassed by the formal banking system, and that they can be adapted easily to specific circumstances. Schemes can also be slotted into wider, multifaceted development initiatives that transcend credit provision and extend the benefits.[xxix] Recent innovations include the provision of death insurance for terminally ill patients, flexible saving arrangements, emergency loans and special efforts to attract female clients.[57]

In settings with chronically high unemployment, limited income-earning opportunities, and pervasive ill health and early death it might seem churlish to question the optimism surrounding microfinance. Yet a tacit but fundamental premise of microfinance is that the viability of poor households depends on their becoming (greater) consumers of credit. It is unclear how deeper indebtedness is meant to boost and safeguard economic security when households are losing caregivers and workers, and when surviving members (typically widows and the elderly) often are stretched to the limit, with little time for novel income-generating ventures. In a sense, microfinance schemes distill neoliberal ideology quite pithily, by presenting a household-level analogy of international finance institution emergency loans – with deeper integration into the market economy and adherence to its strictures as the conditions for relief (Baylies, 2002).[58]

The jury is out on the benefits the very poor derive from such schemes (Baylies, 2002; Mosley & Hume, 1998; Sender, 2000). According to a USAID study of microcredit schemes in Zimbabwe, India and Peru, the programmes did help very poor households meet basic needs and protect themselves against risks. However, household incomes didn't rise in Zimbabwe, and income sources didn't diversify in India, nor did food consumption improve there. The assessment also found 'limited impact on the ability to cope after [financial] shocks had occurred' (Snodgrass & Sebstad, 2002). Research on Uganda's Women's Finance Trust found that microfinance projects were not reaching the poorest of the poor (Wright et al., 1999, cited in Hoang, 2002). Generally, the very poor appear not to invest the funds in small enterprises, but rather spend them on essential expenses (especially food) or use them to settle other, overdue debts; their extremely limited resource base tends to discourage 'risk-taking'. In such cases, the credit can tide a household over, but since it's not necessarily income generating it adds to their overall debt load and becomes an additional encumbrance. Needless to say, in such cases poverty reduction is not the outcome: research in India and Malawi has found that extremely poor borrowers ended up worse off financially.[59]

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56 This veritable cult of small enterprise has flourished also in industrialized countries, despite survey evidence from OECD countries that 'the predominant trend in self-employment is downward' and that 'increases in the proportion of self-employment appear to produce *lower* not higher GDP' (Blanchflower, 2000:12, 22; cited in Sender, 2000).

57 The latter is an especially sage approach, given the evidence that women are more likely to devote additional income to meeting their children's needs (Hunter & Williamson, 1998, cited in Mutangadura, 2000). Households benefiting from Uganda's Women's Finance Trust, for example, were found to spend more money on health and education than other households. (Wright et al., 1999, cited in Hoang, 2002).

58 In the fashionable theoretical framework, as John Sender has observed, the rural poor are seen as self-employed 'agents' struggling in imperfect markets; what they need, it's claimed, are more 'assets', purchased through access to micro-credit, to 'smooth their transition into the ranks of the petty bourgeoisie' (Sender, 2000:38).

59 See Hulme D & Mosley P 91996). *Finance against poverty*. Routledge. London, cited in Hoang (2002).

Microfinance would seem appropriate and potentially effective only when productive capacity exists and access to markets is available – conditions that cannot be assumed – and seems most appropriate for supporting existing economic activities rather than starting up new ones (MkNelly & Dunford, 1996). But in many parts of South Africa, those capacities and traditions are frail. De Swardt's (2003) study of poor households in rural areas of the Eastern and Western Cape and in Cape Town, for example, highlighted the marginal value of self-employment as a source of income. In Mount Frere, Ceres and Langa, wage labour was by far the major source of household income, followed by social grants. Similar to Sender's (2000) findings in Mpumalanga, in Mount Frere there was an evident failure of land-based livelihood strategies and subsistence agriculture, with food purchases comprising the bulk of monthly expenses.[60] In periods and places with extraordinarily high levels of morbidity and mortality, the usefulness of microcredit is open to further question. In a heavily affected poor community, participation in a such a scheme involves taking on additional debt at the same time as disposable income shrinks further and competition intensifies in that community. Often these income-generating schemes also lack distribution and marketing support – one of the reasons why craft schemes, a staple in many impoverished communities targeted with donor largesse, tend to bring scant and fleeting financial benefit to households. Emergency relief, possibly in the form of expanded access to social grants, or start-up grants would seem more suitable and potentially beneficial (Baylies, 2002; Hoang, 2002). Sender's (2000) research among poor women in rural Mpumalanga suggests that where people rely heavily on insecure waged incomes, steps to extend and protect the labour rights of casual and seasonal works would be more appropriate.[61]

Epilogue: Fragmentation, introversion, erasure

The South African struggle for liberation was a struggle against the banishment of millions into penury and sickness, against polarization and exclusion – and for a just society. It's on this template of ideals and aspirations – and rights – that the effects of the epidemic must be mapped and examined. That AIDS mangles and ruins is clear. But when it does so in a society with South Africa's characteristics, these miseries are not distributed indiscriminately. The glacial crush of the epidemic exaggerates the social relations that constitute society. In that, AIDS unmasks the world we live in and reiterates the need to transform it. In South Africa, it specifically underscores the need for an encompassing social package as part of an overarching programme of redistribution and rights-realization. Such a package would rest on several pillars, including job creation and workers' rights protection, safeguarded food security, and the affordable (and decommodified) provision of essential services. Other pillars would include pensions and other social transfers which are administered efficiently and set at levels that correspond to unfolding needs. In all this, the principle of universalism should hold sway.[62]

60 Of the six main monthly expenses in Mount Frere, food comprised 44%, education 13% and health 11%. More than 80% of the households said they had had too little food available in the previous year. Education and health fees were also major expense items, testament to the extent to which cost-recovery-based state service provision was squeezing impoverished households (De Swardt, 2003).

61 Part of the problem lies with vague and slack use of the concept 'poverty', and with the tendency to ignore differentiation within communities and households classified as 'poor'. As a consequence, projects intended to assist the most vulnerable households can end up being cornered by households that are relatively better off, as Sender (2000) found in Mpumalanga. Off the agenda, meanwhile, are measures to protect seasonal agricultural labourers, migrant domestic servants and other hyper-exploited categories of workers.

62 Exempting the poor (through means testing) can bring advantages if it allows poor households access to essential services. The problem is that, in general, policies that exempt only certain categories of users from fees tend to improve access for the poor only marginally. Using free health-care services, for example, still can still entail transport costs and income losses that might discourage the poor from seeking care; see Goudge & Govender (2000). Targeting also carries a danger of further polarizing society by promoting dual structures and systems for social services – some funded by the state and aimed at the poor, the others provided chiefly by the private sector. It serves as another nail in the coffin of universalism, of an inclusive society. Targeting AIDS-affected households with specific social packages introduces additional hitches, some of them potentially harmful. Providing food and/or nutritional supplements to AIDS-sick patients (or to households with AIDS-sick members) seems, at face value, an attractive course of action. But problems abound, not least the conditionality of AIDS illness that's applied. For one, the exceptional status this accords to AIDS is discriminatory and is likely to trigger any number of perverse effects (including further stigmatizing AIDS-affected households). More obviously, the death of the AIDS-sick member of the household might discontinue its eligibility for food and nutritional support but not its need for that support. Such a conundrum has been observed in Zambia, for example; see Bond V, Tihon V, Muchimba M (1999). 'Food givers or care givers? The distribution of food to TB patients by home-based care programmes in Lusaka.' ICASA Abstract book 13BT4-3, cited in Baylies (2002).

On current trends, however, the epidemic will exacerbate inequality, worsen impoverishment, and further corrode the prospects of a better life. In its wake we can expect intensified polarization, with privilege no longer guaranteeing mere comfort and indulgence, but buying life itself and cornering the future. The very poor, the 10 million or more people who earn less than 5% of total income, will have to contend with compromised services and with the fraying of those bonds and circuits of obligation and reciprocity that should help stave off destitution.

Like many scourges, the Plague included, AIDS pits the living against the dead, and the healthy against the sick (Herlihy, 1997). That AIDS-related stigma does so in ways that diminish and wound others is not unusual, neither is the enthusiasm with which men direct it at women; what is atypical is the ferocity with which it is aimed at loved ones, kin and friends. A distillation of everyday obsessions – about trust, desire, betrayal, contamination, sex, death – stigma also derives its energy from the 'invisibility' of HIV and the license it provides for suspicion and judgment, in other words for self-definition. Stigma is a binary instrument; it's used to draw distinctions and establish boundaries. It includes and excludes, validates and condemns, affirms and obliterates. Wounding as AIDS-related stigma can be, it's hardly an aberration; it's a grotesque example of the devices we use to traverse the social terrain, to situate ourselves within society, to assign or remove status, to build bonds and assemble affinities. To pretend that AIDS-related stigma somehow can be neatly excised from this social functionality is to misunderstand how deeply embedded it is in the arrangement and exercise of social power.

There is a hope such extraordinary tribulation might spur new social arrangements, and new forms of popular organization and activism. This is possible. But the current trends are not cheering. These point to petrifying arrangements and possibly even a kind of social contraction, as the capacities of the poor to extend generosity diminish and the reciprocal arrangements that sustain social life wane further (De Waal, 2003a). Responsibilities and entitlements, it seems, are not being reallocated more equitably in households and communities; social roles seem to be ossifying, instead of growing more pliant. Rather than trigger a 're-imagining' of 'womanhood' and 'manhood', AIDS is cementing the schizoid typology of women as angels of mercy and/or sullied whores. It is women who are accused of 'bringing the disease' into homes, girls who are subjected to 'virginity testing', and women who tend the sick and the frail and the survivors. Men seem to hover along the fringes of this drama, leaving women ubiquitous yet trapped between blame and the praise they earn for the forbearance shown within the confines of domestic space and duty. AIDS lays bare the coercive subtext nestled in the notion of 'mothers of the nation'. Collectively assigned the duty of care, nurture and salvation, women oblige with stoicism and courage but at the cost of an obliterated individual autonomy. The home-based care model, so flimsily supported at present, codifies this exploitation of women's labour, financial and emotional reserves. Women's organizations, oddly, have avoided tackling this convergence of vulnerability and exploitation (Albertyn & Hassim, 2003).

A similar process of 'erasure' occurs among children who endure systematic deprivation, trauma and stigmatization. The tendency of traumatized children is less to 'explode' their hurt than to invert it, and to collapse into themselves, into a private twilight that might offer some solace (Richter, 2004; Stein, 2003). People at the mercy of pain live at the extreme limits of that experience. The necessary aversion to the phrase 'AIDS sufferers' cannot undo the reality that unthinkable numbers of people do suffer horribly, and in ways that almost literally remove them, living, from the world. Their pain, as Elaine Scarry has written (1985), erases the world and them in it:

> What from the inside is experienced as an increasingly insubstantial world may look from the outside as though the world is intact but the person is growing insubstantial, and so the experience is often represented as solid world ground on which the person no longer has a place [...] As one's world is obliterated, one's externalized self and therefore one's visibility is obliterated.[xxx]

Polarization, implosion, erasure and the dismantling of the social – all this forms the undertow of the epidemic, its secret thrust. At the core of this unfolding horror is the prospect that an epidemic this intense, layered atop a reality this unjust, imprisons vast numbers of us in a kind of eternal present, unmaking the ability and perhaps even the desire to imagine a different, better world.

Chapter endnotes

i National Intelligence Council (2000). *Global Trends 2015: A Dialogue About the Future with Nongovernment Experts*. National Intelligence Council. Washington, DC, cited in Garrett (2005:23).

ii See, for example, National Intelligence Council (2000). *Global Trends 2015: A Dialogue About the Future with Nongovernment Experts*. National Intelligence Council. Washington, DC. For similar claims, see Pharoah R & Schonteich M (2003). *AIDS, Security and Governance in Southern Africa: Exploring the impact*. January. Occasional Paper No 65. Institute for Security Studies; Altman D (2003). AIDS and Security. *International Relations*, 17(4):417-427; International Crisis Group (2004), HIV/AIDS as a Security Issue in Africa: Lessons from Uganda, ICG Issues Report No. 3. Kampala, Brussels.

iii See 'Doctors and nurses for John Kerry' (2005). 'The Kerry-Edwards Plan to Respond to the AIDS Crisis: Will Invest in Combating the AIDS Epidemic in the United States and Around the 'World. June, available at http://www.rchusid.addr.com/aids.htm, and cited in Garrett (2005:23).

iv Reported in Theo Smart. 'One in eight South African teachers may be HIV-positive'. *Aidsmap news*. 16 June 2005.

v See HSRC (2005). 'Study of the demand and supply of educators in South African public schools.' Fact Sheet No. 10. HSRC. Pretoria.

vi See 'HIV threatens elections base, says Idasa report'. *SouthScan*, 19(24). 26 November 2004.

vii *Ibid*

viii For these and other differences between the ING Barings, Arndt & Lewis, and BER scenarios, see Nattrass (2000:7-12).

ix Arndt & Lewis (2000:857) admit as much, saying that 'the parameters used in specifying the various AIDS effects are based on fairly limited empirical evidence ...'

x Chandra V et al. (2001). *Constraints to growth and employment in South Africa: Report No. 1 – Statistics from the large manufacturing firm survey*. Informal discussion papers on aspects of the economy of South Africa No. 14. World Bank. Washington, DC, cited in Rosen & Simon (2003: 133).

xi See 'Will your trustee fund survive AIDS?' *Old Mutual Trustee Times*. February 2000. Johannesburg, and Old Mutual (1999). *The Old Mutual Healthcare Survey*. Old Mutual. Johannesburg, both cited in Rosen & Simon (2003:132).

xii 'Sanlam's new system targets retirement funds'. *Business Day*. 22 March 2001. Johannesburg, cited in Rosen & Simon (2003:132).

xiii Harmony (2004). *Harmony Annual Report 2004: Sustainability Report* (available at http://www.harmony.co.za), and cited in BER (2004a).

xiv See The Banking Council of South Africa. 'Banks' HIV/AIDS prevalence survey'. Media release. 27 November 2003; cited in BER (2004a).

xv See De Swardt C & Du Toit A (2003). 'Staying poor in South Africa.' *Insights*, 45.

xvi Based on Everatt's analysis of data from the 1996 and 1999 *October Household Surveys*, and from *Transforming the Present* (Committee of Inquiry into a comprehensive system of social security for South Africa (2002).

xvii Statistics SA (2000). *October Household Survey 1999*. Statistics SA. Pretoria, cited in Aliber (2003).

xviii See 'Labour market may be showing signs of stability'. *Sapa*. 29 September 2004.

xix See Table A7 (Statistics SA, 2005a).

xx See Table 3.5 (Statistics SA, 2005a).

xxi Carol Paton. 'Social welfare spending: no end in sight.' *Financial Mail*. 25 February 2005. http://www.fm.co.za/cgi-bin/pp-print.pl

xxii Brendan Boyle. 'More support to the people.' *Sunday Times*. 27 February 2005.

xxiii Carol Paton. 'Social welfare spending: no end in sight.' *Financial Mail*. 25 February 2005.

xxiv National Treasury statistics, cited in Carol Paton. 'Social welfare spending: no end in sight.' *Financial Mail*. 25 February 2005.

xxv See, for example, Le Roux P (2003). 'Financing a Universal Income Grant in South Africa.' *Social Dynamics*, 28(2):98-121, cited in Nattrass (2004).

xxvi For a detailed exposition of the methodology used to arrive at these figures, see EPRI (2004:7).

xxvii Eastern Cape and KwaZulu-Natal provinces are regarded as the worst offenders. According to one report, a forensic audit found that 90% of disability grant applications on KwaZulu-Natal's south coast were 'fraudulent'. See Carol Paton. 'Social welfare spending: no end in sight.' Financial Mail. 25 February 2005.

xxviii Carol Paton. 'Social welfare spending: no end in sight.' *Financial Mail*. 25 February 2005.

xxix One example is the Country Womens Association of Nigeria (COWAN), which builds on traditional savings and credit systems, and has branched into health-care financing. It requires that members funnel profits into a special health development fund, which funds emergency health care (as well as monthly medical visits to rural communities). See United Nations Office of the Special Adviser on Africa (2003). *Community Realities & Responses to HIV/AIDS in Sub-Saharan Africa*. June. United Nations. New York. Available at: http://www.un.org/esa/africa/hiv_aids.pdf

xxx Scarry (1985), cited in Wright (2005).

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