

# **The impact of HIV and AIDS on Democratic Consolidation: A Comparative Assessment of Botswana and South Africa**

by  
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*Thesis presented in partial fulfilment of the requirements for the degree  
Master of Arts (Political Science) at the University of Stellenbosch*



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December 2011

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## Abstract

The purpose of this thesis is to assess the impact of HIV and AIDS on democratic consolidation in two democracies in Southern Africa: Botswana and South Africa. Mattes (2003), Barnett and Whiteside (2006) and others warned that in states with high HIV infection levels, the negative impact of the pandemic - especially in terms of socio-economic conditions, budgetary pressures and a loss of human capital in the state and the economy - was potentially so great that it may affect democracy detrimentally. In contrast, some scholars, particularly Anthony Butler (2005a) and Alex de Waal (2006), contended that although the pandemic had negative effects, democracies might survive it and that in some specific ways, democratic consolidation might even benefit from the its consequences. For instance, they argued that in South Africa, the civil society response to the government's controversial HIV and AIDS policy deepened the institutional framework of democracy.

The methodology for the above comparative analysis is based on the application of a minimalist multivariate model which, following the thinking of Bratton and Van de Walle (1997) consists of both institutional and socio-economic factors. Factors are selected for their relevance to democratic consolidation, as argued by scholars such as Linz and Stepan (1996), Przeworski, Alvarez, Cheibub and Limongi (1996), Bratton and Van de Walle (1997) and Leftwich (2000).

The chosen factors are the system of government (the relationship between the branches of government); the electoral system; political rights and civil liberties; economic indicators (affluence, economic growth and the reduction of inequality); human development (as measured by the United Nations Development Program) and civil society.

This is a descriptive, qualitative, desktop study, using secondary literature in books, as well as articles. There is no empirical component, such as fieldwork, surveys or questionnaires. As stated below, such methodology may be used for further elaboration and refining of the findings of this desktop-based comparative analysis.

The main finding is that currently, despite the cost and human implications of the disease, there are no indications that it is directly threatening to destroy the democracies of Botswana or South Africa. This finding differs from the more negative expectations of the scholars mentioned above. It is suggested that the increasing provision and effectiveness of anti-retroviral treatment (ART) enables these democracies and their economies to avoid some of the ravages of the disease that seemed inevitable a few years ago. Furthermore, it is suggested that the comparative affluence of the two states in question shields them from some negative

effects of HIV and AIDS and that this may be different in poorer Southern African states. This is an issue for further research. Such research should go beyond desktop research to include fieldwork and questionnaires.

## Opsomming

Die doel van hierdie tesis is om die impak van MIV en VIGS op demokratiese konsolidering in twee Suider-Afrikaanse demokrasieë, Botswana en Suid-Afrika, vas te stel. Mattes (2003), Barnett en Whiteside (2006) en ander het gewaarsku dat die negatiewe uitwerking van die pandemie - veral in terme van sosio-ekonomiese toestande, begrotingsdruk en 'n verlies aan menslike hulpbronne in die staat en ekonomie - potensieel so groot is dat dit demokrasie nadelig sou beïnvloed. In teenstelling hiermee het ander akademië, soos Anthony Butler (2005a) en Alex de Waal (2006), geredeneer dat demokrasieë die pandemie mag oorleef ten spyte van die negatiewe effekte wat dit wel het en dat demokrasieë selfs op sekere wyses by die gevolge daarvan mag baatvind. Byvoorbeeld, het hulle geargumenteer, in Suid-Afrika het die burgerlike samelewing se reaksie op die Mbeki-regering se kontroversiële MIV en VIGS-beleid die institusionele raamwerk van demokrasie verdiep.

Die metodologie vir hierdie vergelykende analise is gebaseer op die toepassing van 'n minimalistiese multiveranderlike model. Soos gepostuleer deur Bratton en Van de Walle (1997), wat beide institusionele en sosio-ekonomiese faktore insluit. Faktore is gekies op grond van hulle relevansie tot demokratiese konsolidering (volgens vakkundiges soos Linz en Stepan (1996), Przeworski, Alvarez, Cheibub en Limongi (1996), Bratton en Van de Walle (1997) en Leftwich (2000), asook vir dié se moontlike relevansie tot demokrasieë wat spesifiek deur MIV en VIGS geaffekteer word.

Die gekose faktore is die regeringstelsel (die verhouding tussen die uitvoerende, wetgewende en regsprekende gesag), die verkiesingstelsel, politieke regte en burgerlike vryhede, ekonomiese aanwysers (welvaart; ekonomiese groei en die vermindering van ongelikheid), menslike ontwikkeling (soos gemeet deur die Verenigde Nasies se Ontwikkelingsprogram) en die burgerlike samelewing.

Hierdie tesis is 'n literatuurstudie van 'n beskrywende, kwalitatiewe aard. Daar is gebruik gemaak van sekondêre literatuur in boeke, asook van artikels. Daar is geen empiriese komponent soos veldwerk en meningspeilings nie. Soos hieronder beklemtoon word, kan empiriese metodes in toekomstige studies gebruik word om op die bevindinge wat hierdie navorsing opgelewer het, uit te brei en dit te verfyn.

Die hoofbevinding is dat daar tans, ten spyte van die finansiële en menslike koste van MIV en VIGS, geen aanduiding is dat die siekte 'n direkte bedreiging inhou vir die voortbestaan van demokrasie in Botswana en Suid-Afrika nie. Hierdie bevinding verskil van die meer

negatiewe verwagtinge hierbo uitgespreek. Dit word voorgestel dat die toenemende voorsiening en effektiwiteit van antiretrovirale behandeling hierdie demokrasieë en hulle ekonomieë daartoe in staat stel om gedeeltelik die verwoesting van hierdie pandemie te vermy, iets wat enkele jare gelede nog as onvermydelik beskou is. Verder word die voorstel gemaak dat die impak van die pandemie op armer Suider-Afrikaanse state vergelyk behoort te word met die bevindinge wat hier aangebied word. Sulke toekomstige navorsing behoort nie net literatuurstudie in te sluit nie, maar ook veldwerk en meningsopnames.

### **Dedication**

Hierdie tesis is opgedra aan my ouma, Catharina Johanna (Hanneke) Hugo (née Moll), my “Omoes”. Sy is ‘n vrou van besondere karakter. Ek is van kleins af aangespoor deur Omoes se waardering vir my.

## Acknowledgments

I gratefully acknowledge the contributions of the following people in bringing this thesis to completion.

**Professor Willie Breytenbach**, for his excellent professional conduct and for scrutinizing my work and challenging me to produce work of the highest standard I possibly can.

**The Mandela Rhodes Foundation**, for funding my two years of study and allowing me to see myself and my work within the context of a community of inspiring young African leaders and academics.

**Stellenbosch University Postgraduate and International Office** for funding my study trip to the University of Botswana.

**Mrs Jean Cilliers** for a year and three months' administrative support as this thesis slowly took shape.

**Professor Servaas van der Berg**, who gave me advice on economic indicators.

**Dr Charles Gossett** and **Kebapetse Lotshwao** for kindly allowing me to view their draft article on by-elections in Botswana.

**Professors Bertha Osei-Hwedie, David Sebudubudu and Happy Siphambe and Mr Thabo Seleke** at the University of Botswana for each making time in their schedules to meet with me and for providing access to additional literature. Each conversation was very informative and encouraging.

**National AIDS Coordinating Agency (NACA) Library** in Gaborone.

Op 'n meer persoonlike noot bedank ek hartlik die volgende persone.

**Ryan Hartley**, the remember one. Thank you for your tremendous support, considerable editorial and conceptual input, many meals and far too many Carcasonne games.

My gesin en vriende vir hulle begrip, sin vir humor en ondersteuning. Dankie, veral, dat julle geluister het hoe ek hardop oor my tesis dink.

My oupa, **André Malan Hugo**.

**Cindy-Lee Steenekamp**, for her continued support and interest in my academic progress.

**Linsen Loots**, wat my geadviseer het oor Hoofstuk 5.

My new friend, **Colleen Barry** in Gaborone, who generously opened her home to me when I was nothing more than a friend of a friend, providing me with housing and practical advice and wonderful social time with her friends during my stay there.

Aqualung, Karen Zoid and the Twitter faves list, for keeping me company in the library.

Thank you Lord God for working through all the people above, for always being with me, and for educating me throughout.



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## List of abbreviations

ACHAP	African Comprehensive HIV/AIDS Partnership
AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
APO	African Press Organisation
ART	Antiretroviral treatment
ARVs	Antiretroviral drugs
BBCA	Botswana Business Coalition on AIDS
BCP	Botswana Congress Party
BDP	Botswana Democratic Party
BER	Bureau for Economic Research
BIDPA	Botswana Institute for Development Policy Analysis
BNF	Botswana National Front
BOCAIP	Botswana Christian AIDS Intervention Programme
BOCONGO	Botswana Council of non-governmental organisations
BONASO	Botswana Network of AIDS Service Organisations
BONELA	Botswana Network of Ethic Law and HIV and AIDS
BONEPWA	Botswana Network of People Living with HIV and AIDS
CIA	Central Intelligence Agency
COPE	Congress of the People
COSATU	Council of South African Trade Unions
CSO	Civil Society Organisation
CSSR	Center for Social Science Research
DA	Democratic Alliance
DHAPC	Department of HIV/AIDS Prevention and Care of Botswana
EISA	Electoral Institute of Southern Africa
EMB	Electoral Management Board
FPTP	First-past-the-post
GDP	Gross Domestic Product
CEGE	Center for European, Governance and Economic development research
GNP	Gross National Product
HDI	Human Development Index
HDR	Human Development Report
HRC	Human Rights Committee of the United Nations
HSRC	Human Sciences Research Council

HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Independent Electoral Commission
IFP	Inkatha Freedom Party
ILO	International Labour Organisation
ISS	Institute for Security Studies
MAP	Multi-Country HIV/AIDS Program
MDR	Multi Drug-Resistant Tuberculosis
MMP	Mixed Member Plurality
MP	Member of Parliament
MSM	Men who have Sex with Men
MTP I	First Medium Term Plan
MTP II	Second Medium Term Plan
NACA	National AIDS Coordinating Agency
NACOSA	National AIDS Convention of South Africa
NCOP	National Council of Provinces
NGO	Non-Governmental Organisation
NHI	National Health Insurance
NP	National Party
NSF I	First National Strategic Framework
NSF II	Second National Strategic Framework
OECD	Organisation for Economic Co-operation and Development
PDL	Poverty Datum Line
PEP	Post-exposure Prophylaxis
PEPFAR	United States of America's President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Purchasing Power Parity
PR	Proportional Representation
RSA	Republic of South Africa
SABC	South African Broadcasting Corporation
SACP	South African Communist Party
SADC	Southern African Development Community
SAIIA	South African Institute of International Affairs
SANAC	South African National AIDS Council

SAPA	South African Press Association
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
TRIPS	Trade-related Aspects of Intellectual Property Rights
UKZN	University of KwaZulu-Natal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Report
UNICEF	United Nations Children's Fund
UNSRID	United Nations Research Institute for Social Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation
WIDER	United Nations University World Institute for Development Economics Research
XDR	Exceptionally Drug-Resistant Tuberculosis

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## CHAPTER 1: INTRODUCTION

The advent of the African HIV pandemic coincides with the establishment of formally democratic regimes in many African states. Due to the scale and the complex institutional, economic and social impact of this pandemic, many political scientists have argued that this pandemic may have serious negative implications for the consolidation of African democracies. In contrast, some scholars, particularly Anthony Butler (2005a) and Alex de Waal (2006), contend that African democracies may survive the pandemic and that in some ways, democratic consolidation may even benefit from its effects. Robert Mattes (2003) pointed out a need for comparative cross-sectional research into this topic. Using a multivariate framework of democratic consolidation similar to those developed by Bratton and Van de Walle (1997) and others (such as Przeworski, Alvarez, Cheibub and Limongi 1996 and Leftwich 2000), this study presents a comparative assessment of the effect of HIV and AIDS on two Southern African democracies: Botswana and South Africa.

The overview of this chapter serves to introduce the research themes of this study: the prevalence and unique characteristics of HIV and AIDS in Africa and its impact on African societies, economies and democratic institutions, particularly as studied by Tony Barnett and Alan Whiteside (2002; 2006), Mattes (2003), Per Strand (2005), Butler (2005a) and De Waal (2003; 2006), as well as the work edited by Kondwani Chirambo (2008). In the problem statement, the differing scholarly arguments concerning the impact of the disease on African democratic consolidation are juxtaposed and the countries selected for comparative study are introduced. This is followed by a discussion of the purpose and significance of the study. The chapter concludes by presenting the research methodology employed in the study.

### 1.1. Overview

AIDS has, over the past fifty years, become the sixth greatest cause of death in the world (WHO 2011). Emerging as a virus capable of causing a human global epidemic by 1959 (Iliffe 2006: 8), the acquired immunodeficiency syndrome (AIDS) which is caused by the human immunodeficiency virus (HIV) had killed at least 25 million people in the world by 2008, with 33.4 million more infected with HIV (UNAIDS 2009a: 1). Botswana's prevalence rate<sup>1</sup> (25% of adults<sup>2</sup> aged 15 to 49 were estimated to have HIV in 2008) is the second

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<sup>1</sup> When studying HIV/AIDS trends, it is important to note the distinction between prevalence and incidence: *prevalence* indicates the amount of individuals that are HIV positive at a given point in time while

highest in the world (UNAIDS 2009c: 19), while in South Africa the 16.9% adult (aged 15-49) prevalence rate translates to 5.7 million infected people, making it the country with the largest number of people living with HIV and AIDS in the world (UNAIDS 2009c: 19; 27).

The main strains of HIV were carried over to humans through contact with the blood of primates that carried simian (monkey) immunodeficiency viruses in West and Central Africa in the 1930s<sup>3</sup> (Whiteside 2008: 23). The fact that the virus originated in Africa as well as its unique characteristics (discussed below), allowed the virus to spread extensively and with many loci of infection throughout Sub-Saharan Africa before it was properly identified or understood (Iliffe 2006: 58). Elsewhere in the world HIV was usually introduced within identifiable high risk subsets of the population, such as men who have sex with men (MSM), sex workers, haemophiliacs and injecting drug users (IDU). Once the major transmission routes of HIV were identified in 1986 (Quinn, Mann, Curran and Piot et al. 1986, quoted in Avert 2010b), such groups were relatively easy to target with interventions. By this time however, HIV had already infected large parts of the general heterosexual population in many African states.

Africa remains by far the worst affected area in the world, with incidence levels peaking in the mid 1990s (De Waal 2006: 2). In 2002, Sub-Saharan Africa had 28 million, or 70%, of the 40 million AIDS sufferers in the world (Pharaoh and Schönreich 2003: 2-3). By 2008, most national epidemics were apparently stabilising, but at extremely high levels, and Sub-Saharan Africa was home to 22.4 million, or 67%, of the 33.4 million infected individuals. By comparison the second and third most infected regions, South and Southeast Asia and Latin America, had 3.8 million and 2 million respectively (UNAIDS 2009a: 1). By this time, however, it had also become increasingly possible for patients in Africa to receive treatment that slow the progression of the virus into full-blown AIDS (discussed below).

Although Africa is the worst affected area in the world, there are significant regional variations. Southern and eastern Africa are much more heavily affected than West or North

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*incidence* indicates the amount of new infections over a given period. Antiretroviral treatment (ART) may *increase* prevalence because it enables people living with HIV and AIDS (PLWHA) to live longer. Declining incidence is thus a better indicator of a country's success in combating AIDS, but it is more difficult than prevalence to estimate.

<sup>2</sup> HIV prevalence and incidence rates are usually expressed as a percentage of *adult* citizens – defined by the World Health Organisation and UNAIDS as persons aged 15 and older – or if indicated as such, adults between the age of 15 and 49 (Avert.org 2010c).

<sup>3</sup> Rival theories for the origins of HIV/AIDS abound, but the abovementioned is now commonly accepted in scientific communities (Avert.org 2011b).



Africa. In 2009 the nine states in the world with adult prevalence rates of more than 10%<sup>4</sup> were all in Southern Africa: Swaziland, Botswana, Lesotho, South Africa, Zimbabwe, Namibia, Zambia, Malawi and Mozambique<sup>5</sup> (UNAIDS 2009b).

Faced with a mounting pandemic by the late 1980s, a handful of African states responded effectively, notably Senegal and Uganda (Joseph 2003: 163; Iliffe 2006: 71-2). In general, however, the responses of African governments have lacked urgency and scale (De Waal 2003: 2) and the crisis escalated to the levels discussed above. Historian John Iliffe (2006: 67) presents the following reasons for African political leaders' initial unwillingness to engage with the disease: "it questioned their competence because they had no remedy, it threatened to raise demands for assistance that they could not afford to give, it distracted them from more pressing anxieties, it was potentially divisive, its victims had as yet no political voice and it might damage their country's image and tourist industry". More pessimistically, Richard Joseph (2003: 163) argues that African governments' widespread failure to address HIV and AIDS highlights the fact that in most African states, "[w]hatever the rhetoric, the reality is that those who win governmental office concentrate on serving themselves and their narrow circles of supporters".

Although Africa bears the brunt of many widespread diseases, the specific characteristics of HIV and AIDS, scholars argue, sets it apart as particularly relevant to the study of African political systems. Firstly, in the absence of treatment, AIDS is fatal. Patients without ART usually survive an estimated 7 to 12 years after infection with HIV<sup>6</sup>. As will be discussed below, antiretroviral treatment (ART)<sup>7</sup> can now significantly prolong and improve the lives of those it reaches and ART coverage has increased dramatically over the past few years. However, there is neither cure nor vaccine for HIV and AIDS yet.

Secondly, HIV is transmitted primarily through sexual intercourse. 75%-85% of infections worldwide are sexually transmitted and most of these are through heterosexual sex

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<sup>4</sup> These prevalence rates have now stabilised in most states, albeit at such extremely high levels. Incidence seems to have peaked in all southern African states in the mid-1990s, except in rural Angola (UNAIDS 2009c: 27).

<sup>5</sup> From this list it is also clear that HIV and AIDS affect democracies and non-democracies alike: in 2010 Freedom House considered three of these nine countries Free, four Partly Free and two Not Free. This study will deal with two of the Free states as it focuses on the impact of HIV and AIDS on democratic consolidation.

<sup>6</sup> The net median survival time is estimated at 11 years (UNAIDS and WHO 2007: 10). It is probably less in resource-poor settings.

<sup>7</sup> Antiretroviral treatment, abbreviated ART, is a broad term to describe treatment regimes that entail the use of any antiretroviral drugs (ARVs), such as Nevirapine, Lamivodine and the drugs that constitute highly active antiretroviral treatment (HAART) (see, for instance, Van Dyk 2008: 91-120 and Wood 2008: 504).

(Whiteside 2008: 28). Addressing HIV and AIDS in Africa therefore necessarily means engaging with behaviour and with African sexuality and gender in particular. In a post-colonial and largely patriarchal context this has led to great controversy. As an extreme example, former South African president Thabo Mbeki considered the discourse around HIV and AIDS the “latest manifestations of a centuries-old [Western] medical discourse that pathologised Africans as near-savage in their libidinal excess” (Gevisser 2007: 739). His policy decisions, influenced by this perception, will form an important part of this study.

Thirdly, because it is usually sexually transmitted, HIV mostly infects individuals between the ages of 15 and 49 (Pharaoh and Schönteich 2003: 2). As De Waal (2006: 68) points out, it is sadly “normal” for many African children not to survive beyond the age of 5. What is abnormal, and potentially destabilising, is that where ART does not reach, *adults*’ lives are cut short before they have contributed to society as they otherwise would. In other words a disproportionate number of Africans become sick and die at the phase of their lives when they are most likely to be contributing to the economy (and supporting those who are not), participating in politics (such as voting and being active in voluntary organisations) and having children. Whiteside (2008: 92) reviews plummeting life expectancies in countries heavily affected by HIV and AIDS and argues simply: “In these settings, state collapse must be a real possibility”. Many scholars similarly argue that the “hollowing out” of these adult populations affects the sustainability of social structures, such as economic growth and democratic institutions.

Not only is HIV and AIDS lethal, usually sexually transmitted, and disproportionately prevalent among young adults, but compared to other infectious diseases HIV has an exceptionally long incubation period before it develops into symptomatic AIDS and affects the sufferer’s life. The connection between cause and effect is therefore obscured and the risk of infection often unapparent. De Waal (2006: 17) explains that it is “a disaster with few parallels, because it is so easy to make it invisible or pretend it is something else”. Particularly, the sufferer suffers few symptoms shortly after infection, yet this is when viral load is extremely high and the virus highly infectious. This makes the risk of rapid transmission high, particularly in societies where multiple concurrent sexual relationships are common, such as is the case in Southern Africa (Halperin and Epstein 2007).

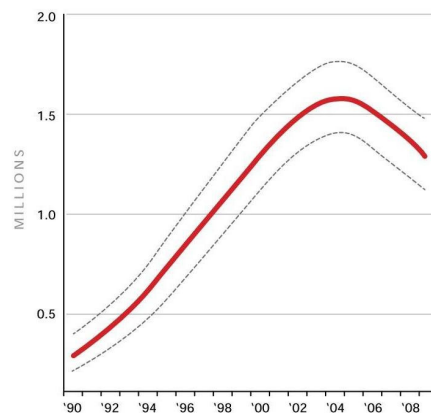
Given these characteristics of the pandemic – its deadliness; the fact that it is sexually transmitted; the fact that it affects individuals in the prime of their lives; and its long incubation period – over the past three decades the pandemic reached such magnitudes and

affected populations in such particularly destructive ways that many believed that it threatens African economies, societies and even democracies. Especially so when death could be expected to follow HIV within 12 years. Now, ART is changing these expectations.

Considered an unviable option for African policymakers until the early 2000s, ART has now become essential to any study of the African HIV and AIDS situation. While not a cure, ART inhibits the progression of HIV in the body and allows the body to recover from any damage that HIV may have caused already<sup>8</sup>. In this way, ART reduces both morbidity and mortality – in other words, it allows patients to live both healthier and longer lives. There is evidence that HIV positive patients in Africa, with appropriate ART, can live almost as long as people who are HIV negative. In a recent study, Ugandan HIV patients who initiated ART at the age of 35<sup>9</sup> increased their life expectancy by 28 years (Malan 2011). In this way, annual AIDS-related deaths are considerably reduced (see Figure 1).

**Figure 1. Annual AIDS-related deaths in Sub-Saharan Africa, 1990-2009**

*Source: UNAIDS 2010c.*



ART is reaching more and more Africans, at a lower cost. It was formerly assumed that most Africans would not be able to access ART because antiretroviral drugs were “prohibitively

<sup>8</sup> There is also proof that ART can be used in HIV negative individuals to reduce (but not eliminate) their risk of contracting the virus. It thus adds to a set of measures that reduce the risk of infection: among them abstinence, male and female condoms, male circumcision, vaginal microbicides and post-exposure prophylaxis (PEP). None of these are foolproof, but ART is an important addition to the prevention “toolkit” (Hall 2011).

<sup>9</sup> Most countries follow World Health Organisation (WHO) guidelines to determine at which point during the progression of HIV patients should commence ART (Avert 2011c). The WHO adopted new guidelines in 2010, recommending that ART is commenced when a patient’s CD4 count declines to 350, instead of only when the patient’s CD4 count declines to less than 200. In other words, these guidelines have recently become stricter, making more individuals officially eligible for treatment.

expensive” in the 1990’s (Chirambo 2008: 34). For example, Youde (2001: 30) discusses the cost of ART in 2001 and concludes that few individuals in African states would have the means to benefit from such expensive medicine. First-line ART would cost a person \$12 000 to \$14 000 per year in the 1990’s. That figure fell to about \$100 per person per year by 2008 (Coriat 2008: 9). Africans access ART either through private medical schemes (including those provided by employers) or through public health systems. Public funding for ART comes from governments’ budgets as well as major international sources of funding such as the World Bank’s Multi-Country HIV/AIDS Program (MAP) created in 2000, the Global Fund against Tuberculosis, Malaria and HIV/AIDS (Global Fund) created in 2002 and the United States of America’s President’s Emergency Plan for AIDS Relief (PEPFAR) launched in 2004 (Coriat 2008: 3-9). The combination of increased organisational support, lowering cost and increased funding has vastly improved ART access, with Africa benefiting the most. From less than 2% six years earlier (UNAIDS 2009c: 25), by the end of 2009 37% of Africans who needed treatment were receiving it (UNAIDS 2010c: 29).

Because people living with HIV and AIDS (PLWHA) who adhere to appropriate ART can live longer, productive lives, it is hoped that some of the severe economic and social impacts of losing them can be diminished and the “hollowing out” of societies referred to above, therefore slowed. These impacts may now be assessed. Thereafter, the relevance of these effects to the future of democratic politics in Africa will be discussed.

One of the most cited effects of AIDS-induced adult mortality is an unprecedented increase in orphans. An estimated 16.6 million children aged 0-17 have lost one or both their parents to AIDS and 90% of them live in Sub-Saharan Africa (UNAIDS 2010:112). Children orphaned by AIDS can grow up in particularly difficult social and economic circumstances, suffering stigmatisation, trauma and neglect long before they are orphaned (Avert 2010a; Whiteside 2008: 74). An increase in orphans is expected to affect the quality of African children’s development and education – especially that of AIDS orphans, but also that of the children who must share resources with them and come to terms with the strain that increasing amounts of orphans place on schools and communities. HIV and AIDS may therefore affect African children’s employability and opportunities in adulthood. According to one South African study (Bell, Devarajan and Gersbach et al. 2006) the economic disadvantage of AIDS orphans may impact on their societies for generations to come if nothing is done, but can be substantially reduced by implementing expensive intervention programmes.

Because of their difficult circumstances, it was initially argued that AIDS orphans may be more prone to developing antisocial tendencies and engaging in crime, or may contribute to political instability (Fourie and Schönsteich 2001: 38-40; Barnett and Whiteside 2002: 210-213; Pharaoh and Schönsteich 2003: 10-11). These arguments have been disputed (Bray 2003; Pharaoh and Weiss 2005), but Youde (2001: 9) points to another source of political instability around the pandemic. He argues that, because HIV is a behaviourally transmitted disease, the pandemic may exacerbate social cleavages as groups in divided societies may blame each other for behaving in ways that spread the disease. This scholar considers this especially likely because of the diversity of historically antagonistic groups that live together in postcolonial African states.

Another oft-discussed effect of HIV and AIDS is a widening of inequality between households in the upper and lower social strata (Piot, Greener and Russell 2007: 1572). Whereas risk of infection is not always greatest among the poorest citizens<sup>10</sup>, scholars agree that poorer households that are affected by HIV and AIDS are exceptionally vulnerable to decreases in their standard of living. In order to cover the costs associated with providing for members with HIV and AIDS, such households are more likely than other classes to cut into savings, liquidate assets and/or reduce regular expenditure (Smit and Ellis 2009: 258). When it is the economically active family members that are infected with HIV and AIDS (which, as has already been pointed out, is often the case), the burden of providing for elderly relatives and the young will fall on the remaining productive adults, further reducing household income and personal savings (Mattes 2003: 4). Those middle class households that are affected by HIV and AIDS may be better placed to afford ART or to access it through private medical schemes and to cope with the additional financial pressures brought on by the disease, but this class will probably still suffer more than the upper classes because of the disease. De Waal (2003: 14) suggests that the property-owning middle class as a whole (including those who are not infected) could be negatively affected as HIV and AIDS could shift the structure of national economies away from the industries in which the middle class is typically employed, towards less skill-intensive activities such as mining and the informal sector. Price-Smith and Daly (2004: 19) also argue that not only the lower class (the poor), but also the middle class bear a disproportionate share of the AIDS burden.

In terms of the effect of HIV and AIDS on business, a loss of precious human capital is an oft-cited challenge (De Waal 2006: 93). High unemployment rates (such as in South Africa) soften the impact of a loss of unskilled labour, but the loss of skilled labour may prove

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<sup>10</sup> In some regions other factors, including expendable income in poor environments, weigh heavier.

seriously debilitating. Even if new employees can be found, high staff turnover in business means a loss of institutional memory (Price-Smith and Daly 2004: 19) and that money is spent on recruitment and training (Smit and Ellis 2009: 257). Thus companies can bear great financial burdens because of HIV and AIDS. Standard Bank estimated in 2010 that for every year a senior staff member remains productive, it saves about R300 000, an estimate which rises to R750 000 for middle managers (Jacks and Khanyile 2010). Therefore losing staff is highly undesirable.

In an effort to avoid losing staff to AIDS, companies in areas heavily affected by HIV consider it necessary to spend money managing the disease through wellness programmes, voluntary counselling and testing (VCT), prevention, awareness campaigns and support structures (Jacks and Khanyile 2010). Companies also cope with increasing absenteeism and lower productivity, especially where no support is offered to infected employees. It is expected that the additional costs incurred by companies due to HIV and AIDS will be partly paid for by consumers (by an increase in prices) but probably, for the most part, will reduce companies' profits (Smit and Ellis 2009: 257).

Governments, like households and businesses, suffer the debilitating effects of HIV and AIDS. Scholars emphasise two challenges: governments must deal with the effect of AIDS on government employees and on the populations they serve (in other words, they must develop an AIDS policy).<sup>11</sup>

To begin with, scholars have drawn attention to vulnerability of government employees to HIV and AIDS. Like businesses, government structures that lose employees to AIDS will also become less effective due to falling productivity, a loss of institutional memory and lower morale (Youde 2001: 9; Mattes 2003: 6-7; Strand 2005: 2; Pharaoh and Schönteich 2003: 6). Barnett and Whiteside (2006: 323-324) expect the effect on governments to be even more pronounced than on business, because compared to the private sector, civil servants are given a high degree of job security and are particularly difficult to dismiss. "The result is that, as levels of illness and death rise, government departments, educational establishments and health facilities face situations where absenteeism increases, productivity falls and little can be done." This precipitates what Butler (2005: 6) calls a "double crisis of administrators and delivery actors", in other words productivity will be affected both among those bureaucrats who sustain the executive branch, legislatures, judiciary and independent offices,

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<sup>11</sup> Of course, politicians themselves are also affected by HIV and AIDS. That will be discussed along with the potential effect of the pandemic on elections.

as well as among members of the civil service. Similarly, Mattes (2003:6) writes that the “pandemic is likely to devastate large portions of policy-makers, national legislators, local councillors, election officials, soldiers and civil servants – including doctors, nurses, teachers, ambulance drivers, fire fighters and the police”.

Supporting these arguments, scholars (Birdsall and Hamoudi 2006: 139; Chirambo 2008: 37-38) argue that HIV and AIDS may severely impact on the Southern African public sector, especially teachers. In Southern Africa, 200 000 of the region’s 650 000 teachers are projected to die from AIDS, while about half the teaching positions in the region are vacant already (Chirambo 2008: 37-38). This has critical implications for education and therefore for human development in the region. With regards to militaries, Heinecken (2001; 2003) argues that, should unrest ensue because of the social and economic effects of HIV and AIDS, the very armed forces and police that may be called in to maintain law and order will also be weakened physically and organisationally because of the disease.

Besides the challenges of managing a civil service affected by HIV and AIDS, governments face the challenge of coping with it in the population as a whole by developing effective policy. Governmental health sectors particularly need to cater increasingly for prevention initiatives, as well as HIV and AIDS-related health care and welfare expenditure. In South Africa, access to health care and welfare are constitutional rights (RSA 1996: S27). The problem is exacerbated by the lack of skilled health professionals in Africa and the fact that doctors and nurses, too, become infected with HIV. Government support of orphans is also set to become a new massive expenditure. Governments need to find a way to meet these new demands. Increased HIV and AIDS-related expenditure through limited deficit spending may be affordable for the richer states, but many African states face a choice between allowing this imperative to crowd out other spending priorities, increasing taxes for the shrinking productive part of the population, or increasing their reliance on foreign assistance (Mattes 2003: 5).

The latter option, namely increased reliance on international assistance, has become very common and has received increased attention in political science (Mattes 2003: 6). International assistance, notably the programmes mentioned earlier – MAP, the Global Fund and PEPFAR – have overshadowed government HIV and AIDS expenditure in many African states (Mukotsanjera 2008: 35). Although external funding has provided a great boost to the funding of HIV and AIDS policy, its sustainability is questionable – for instance, the aggregate amount spent per annum flattened for the first time in 2009 amid global financial

instability (UNAIDS 2010c: 96). Furthermore, donors' perspectives, priorities and interests may differ from those of African citizens; it may also come with explicit conditionalities (Mattes 2003: 6). In 2006, De Waal (2006: 114) speculated that, with more than 80% of HIV and AIDS programmes funded from international sources, African governments and NGOs could become primarily mechanisms for processing donor funds to provide ART to keep people alive.

Taking into account the effect of the pandemic on households, business and governments, economists who study the macroeconomic impact of AIDS on African states agree that HIV and AIDS tend to reduce GDP growth<sup>12</sup> (Piot, et al. 2006). Because they employ divergent methodologies and assumptions, scholars' estimates of this loss differs between 0.1 and 4.4 percent annually in the next 10-20 years (Smit and Ellis 2009: 252; Bonnel 2000, quoted in Rajaraman, Russell and Heymann 2006). While some scholars expect the growth of national affluence, measured as annual gains in GDP *per capita*, to be smaller than it otherwise would have been, there is also a suggestion that annual GDP *per capita* may actually *increase*, if an AIDS-induced decline in population growth should outweigh an AIDS-induced decline in GDP growth. However, as already mentioned, AIDS is also expected to increase inequality because of worsening skills shortages and the disproportionate financial effect of HIV and AIDS on poorer households. AIDS is thus likely to reduce GDP growth and aggravate inequality, while its impact on aggregate GDP *per capita* is uncertain (Mattes 2003: 4; Natrass, quoted in Butler 2005a: 4).

It is also argued that African civil society, like African households, business and government, may become less effective because of HIV and AIDS. Mattes (2003: 9) argues that many of the kind of citizens that are most active in civil society organisations are also particularly susceptible to HIV infection, because they tend to be younger, more mobile and spend more time away from the office during the course of their work. There are also suggestions that civil society organisations do not lose only those who have AIDS themselves, but also those who drop out of organisations where they previously volunteered because of responsibilities such as caring for the sick or coping with the financial implications of the disease (Mattes 2003: 9; De Waal 2003: 13).

Strand (2005: 3) and De Waal (2006: 41-42) cite these arguments, but then both mention that HIV and AIDS may also motivate people to get involved in public life. There are accounts of

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<sup>12</sup> For a brief review of studies on the macroeconomic impact of AIDS on different African countries, and a comparison of their results, see Smit and Ellis 2009: 248-253.



HIV and AIDS motivating citizens to become engaged members of society, mobilising them to promote awareness and HIV and AIDS literacy, care for those affected by AIDS and lobby government for policy change (De Waal 2006: 42). Especially a more political engaged civil society, and not just a larger one in terms of citizen participation, would be regarded as beneficial to democratic consolidation. The Treatment Action Campaign (TAC) of South Africa is a case in point that was studied by Butler (2005a) and Vandormael (2007) and will be elaborated upon in Chapter 4, when the effect of AIDS on South Africa is examined. If “citizens affected by AIDS” are defined only as those providing home based care to AIDS patients and then survey data (Afrobarometer, quoted in De Waal 2006: 42) shows that both the positive and negative expectations hold true in different African states.

Strand (2005) and researchers led by Chirambo (see Chirambo 2008: 31-44) investigated the impact of AIDS on Southern African electoral systems. Strand (2005: 4) sees AIDS as affecting both electoral *governance*, defined as “the wider set of activities that creates and maintains the broad institutional framework in which voting and elections take place”, and electoral *systems*, “a set of rules that defines how parties’ support in the voting population gets transferred into a distribution of seats in the legislative assembly through a general election”. The main electoral systems are first-past-the-post (FPTP) and proportional representation (PR).

With regards to different types of electoral systems, the abovementioned sources argue that PR electoral systems are preferable to FPTP systems in an era of AIDS<sup>13</sup> (Strand 2005: 7; Chirambo 2008: 31). If a member of parliament (MP) dies in a state that employs a PR system, his or her political party can simply nominate the next person on the list to parliament. In contrast, the FPTP system necessitates a by-election every time an MP dies. According to Strand (2005), an increase in by-elections has three main disadvantages that can affect democratic consolidation. Firstly, it can become expensive, even unaffordable in some contexts (Strand 2005: 8), secondly, by-elections tend to attract a reduced voter turnout because it is difficult to motivate voters to vote outside the general elections, meaning that the newly elected representative enjoys less democratic legitimacy (Strand 2005: 10), and thirdly, they may tip the balance of power in favour of large (ruling) parties, who have the capacity to contest repeated elections successfully (Strand 2005: 10).

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<sup>13</sup> Strand, Chirambo, Strode and Matlosa (2005: 78) also report on a study of the influence on AIDS on elections in South Africa specifically. They point out that although South Africa has a PR system at national and regional level, South Africans elect their local government through a hybrid system that combines FPTP and PR. Therefore the country’s “local government system has not spared it from the ravages of the epidemic by and large” (Strand, et al. 2005: 78).

With regards to electoral governance, firstly it was noted that electoral management boards (EMBs) could run into many of the same problems as businesses, government and civil society, such as a loss of human capital, linked to a potential decline in efficiency and institutional memory. This was a concern both in terms of potential losses of full-time staff and in terms of part-time staff and volunteers. The fact that teachers form the core of volunteers in electoral processes, and that their attrition rate was considered particularly high in Southern Africa (as mentioned earlier), was expected to impact on the quality of elections and raise training costs (Chirambo 2008: 37). EMBs were also expected to face challenges because of the effect of HIV and AIDS on voters. First, it was reported that unprecedented mortality levels posed serious administrative challenges especially in states without institutionalised citizen and voter registration systems, such as Malawi, where “ghost voters” inflate the voting roll and affect the credibility of elected leaders (Chirambo 2008: 38). Second, the disease has been highlighted as an impediment to the political participation of PLWHA, both structurally and attitudinally (Chirambo 2008: 43).

To conclude, HIV and AIDS is a unique pandemic that is disproportionately prevalent in Africa. Although ART contributes to ameliorating its effects, it does not yet reach half of Africans who need it to keep living productive lives. The effects of the pandemic thus continue: longevity is reduced; Africa must care for unprecedented numbers of orphans; the divide between social strata is widened; business and government face new demands and reduced productivity; and economic growth is believed to be hampered. Scholars have expressed divergent arguments with regards to the impact of the pandemic on affluence (GDP *per capita*) and civil society. Furthermore, scholars have pointed to the preferability of PR over FPTP electoral systems in the context of AIDS and the potential challenges associated with running elections in heavily affected areas.

These effects, scholars have argued, could affect democratic consolidation. They point out that democracies do not necessarily live forever: democratic systems of government, once established, can “break down” and governments can revert to authoritarianism, or the quality of democracy can be “eroded” (Schedler 1998). Whether the negative effects of HIV and AIDS erode democracies to the point of breakdown or not is the central question asked in this study. On the other hand, it may be that HIV and AIDS affects certain sectors, particularly civil society, in such a way as to deepen democratic politics (Butler 2005a). As will now be explained, this study aims to engage with these possible positive and negative effects of the pandemic for democratic consolidation by means of a comparative analysis.

## 1.2. Problem Statement

This section presents the “where”, “what” and “why” of this study to the reader. The geographic focus (the “where”) of the study is Botswana and South Africa, the relationship to be examined (the “what”) is the influence of AIDS on the variables of a multivariate model of democratic consolidation and the main rationale (the “why”) of the study is the lack of consensus among scholars about whether AIDS only negatively affects democratic consolidation in Africa, or whether it also has a positive influence as argued by Butler (2005a: 21-22).

South Africa and Botswana have been selected for comparative study because a study of the influence of AIDS on the two states may yield results that differ in illuminating ways. South Africa and Botswana have some important variables in common: they both have high HIV prevalence rates, are among the wealthiest states in Africa and are considered by Freedom House to be democracies.

Both Botswana and South Africa today have exceptionally high HIV prevalence rates. The virus was first detected in these countries in the early 1980s, but under very different circumstances. In Botswana, the first diagnosis of HIV occurred in 1985 in the mining town of Selebi-Phikwe (Molatole and Thaga 2006: 23), whereafter migrant labourers and long-distance truck drivers probably spread infection into the country. Iliffe (2006: 42) suggests that a high degree of cultural homogeneity probably helped to facilitate the spread of the disease as social interaction occurs easily among most citizens. In contrast, the South African population was deliberately kept apart. In 1982, a white, homosexual man was consequently diagnosed with the same strain of virus as American homosexuals and the epidemic was quickly contained among the white, homosexual, South African population. The black heterosexual population’s infection (the first case was diagnosed in 1986) was remarkably devoid of a core group. It was not, for instance, sex workers or miners that initially spread HIV, but rather a “diffusion across a long, much-permeated northern frontier and through individual contacts in many sectors of a mobile, commercialised environment” (Iliffe 2006: 44).

The governments of South Africa and Botswana, especially in the initial phase, responded differently to the epidemic. Fourie (2006: 50-64) argues that the South African political situation under Apartheid was a perfect environment for AIDS to flourish. It was further neglected because of the political turmoil and transformation of the late 1980s and early

1990s, and arguably both the pre- and post-Apartheid governments missed the window of opportunity for preventing a massive epidemic (Campbell and Williams 1999: 1630-1). Thereafter the South African government's alleged mismanagement of AIDS was dramatically exacerbated by the denialism of president Thabo Mbeki (this will be discussed in Chapter 4). The initial failure of the South African government to address AIDS affected its legitimacy and, Butler (2005a) argues, indirectly created an opportunity for strengthening the institutions of democracy in the country. At the same time, of course, this failure exacerbated the problem. In 2008, South Africa's adult (aged 15-49) prevalence was estimated at 16.9% (UNAIDS 2009c: 19). The country has recently intensified efforts to achieve universal HIV prevention, treatment, care and support and allocates increasing fiscal funds to the AIDS response, with some significant success in reducing infection rates among young people and from mothers to children (UNAIDS 2010a).

The government of Botswana, in contrast, was not in denial. Botswana's authorities took HIV and AIDS seriously shortly after the first heterosexual infections were reported, but whether its (Western-influenced) policies were the best choice, can be disputed (Allen and Heald 2004; Heald 2006). Despite government efforts, HIV spread exceptionally rapidly into both urban and rural Botswana in the late 1980's and early 1990's (Ilfie 2006: 38). Some adaptations to AIDS policy, including the first introduction in Africa of routine HIV testing, as well as the formation of national AIDS committees and an increasingly multi-sectoral approach, demonstrate a continued effort to increase policy effectiveness. The achievement of more than 80% ART coverage mentioned earlier is further proof of this government's commitment. Afrobarometer data indicated that citizens of Botswana are the only African citizens that overwhelmingly consider AIDS a priority *and* are positive about their government's efforts to address it (Strand, quoted in De Waal 2006: 43). Still, HIV prevalence remains exceptionally high. By 2008 Botswana had an adult prevalence rate of 25%, which is second only to Swaziland (UNAIDS 2009c: 19).

The second commonality is that South Africa and Botswana are among the wealthiest states in Africa: South Africa's GNI *per capita* (PPP) was estimated at \$10 060 and Botswana's at \$12 860 in 2009 (World Bank 2010a). Later, the implications of this in terms of Przeworski, et al.'s (1996) assessments of "impregnable", "fragile" and "extremely fragile" states will be considered. Of course, relative wealth does not necessarily translate into good conditions or opportunities for all their citizens: South Africa has one of the highest GINI coefficients<sup>14</sup> in

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<sup>14</sup> The GINI coefficient (or index) indicates the extent to which the distribution of income within an economy deviates from equal distribution (World Bank 2011e). It ranges from 0 (complete equality) to 1.

the world and in Botswana citizens spoke of their country as “a rich country of poor people” (Ilfie 2006: 42). Both are considered to have “medium” levels of human development, but lost “points” as life expectancies plummeted from highs of over 60 years of life expectancy in the early 1990s.

The effective rollout of ART has only recently begun to make inroads against this decline, with Botswana’s success with ART demonstrated vividly in the statistics: Life expectancy in South Africa was higher than in Botswana from 1995 to 2005, but between 2005 and 2006 life expectancy in South Africa dropped to a lower level (from 51.8 to 51.5) than that in Botswana (50.8 to 52) for the first time since 1994. Life expectancy in South Africa began to increase slightly again by 2008, for the first time since 1993 (World Bank 2011c). The Human Development Report 2010 indicates that life expectancy at birth is at 55.5 for Botswana and 52.0 for South Africa. At present both South Africa and Botswana have high school enrolment: the mean years of schooling that adults in Botswana have undergone is 8.9 and those in school are expected to undergo 12.4 years of education; the corresponding figures are 8.2 and 13.4 years respectively for South Africa. Taking into account *per capita* income, life expectancy and school enrolment, South Africa’s Human Development Index (HDI) has declined slightly since 1990, now standing at 0.597, 110th in the world. Over the same period Botswana’s HDI has risen significantly, now standing at 0.633, 98th in the world in 2010 (UNDP 2010: 142; 144-5; 149-150).

Finally, Larry Diamond’s (1996) system of classification would identify both South Africa and Botswana as “liberal democracies” according to their 2010 Freedom House ratings<sup>15</sup>, although neither are fully consolidated democracies (Afrobarometer 2009b). South Africa received a rating of 2 for both political rights and civil liberties since 2007. Its political rights rating had been 1 from 1995 until Freedom House changed it to 2 in 2007 “due to the ruling ANC’s growing monopoly on policy making and its increasingly technocratic nature” (Freedom House 2007). Botswana scores 2 for political rights and 3 for civil liberties, scoring 2 for both categories since 1995 and regressing from 2 to 3 in 2010 due to “decreased transparency and accountability in the executive branch” (Freedom House 2010a).

Botswana and South Africa differ in terms of their electoral systems as well as the size and diversity of their populations. Botswana’s electoral system is FPTP while South Africa uses

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<sup>15</sup> Diamond (1996: 24) considered states with Freedom House ratings of 1.0 to 2.5 the best available empirical indicator of “liberal democracies”. Later he narrowed this classification only to include states with ratings of up to 2.0, classifying as “electoral democracies” states with scores of 2.5 (Diamond 2002: 30-31).

PR for national government. It may therefore be expected that, based on research mentioned earlier (especially the research led by Chirambo 2008), Botswana's national electoral system may become expensive if many parliamentarians must be replaced because of AIDS. At the local level, both states run the risk of increased costs as both employ Mixed-Member Plurality (MMP) systems at the local level.

Another important difference is that South Africans are vastly more populous than the citizens of Botswana. The 16.9% of the South African adult (aged 15-49) population translates to 5.7 million infected people, making it the country with the largest number of people living with HIV in the world (UNAIDS 2009c: 27). In contrast Botswana's population totals only 1.9 million but it has a 25% adult (aged 15-49) prevalence rate (UNAIDS 2009c: 19). The AIDS challenge in South Africa, in real terms, is therefore much greater and will require considerably more funding. Finally, South Africa is ethnically highly diverse, potentially "locking" the disease into separate social groups, especially black Africans (see Chapter 4), as opposed to Botswana where a great majority are black African and Setswana-speaking people.

To understand in which way AIDS can affect the health of these democracies, this study turns to theories of democratic consolidation. Democratic consolidation, according to Larry Diamond (1996: 33), is "the process of achieving broad and deep legitimation, such that all significant political actors, at both elite and mass levels, believe that the democratic regime is better for their society than any other realistic alternative they can imagine". This will be expanded upon in Chapter 2.

Political scientists have developed theories of what promotes democratic consolidation and what makes it less likely to be obtained. Some scholars have focused predominantly on the socio-economic factors that are empirically associated with democratic consolidation (e.g. Joseph Schumpeter and Seymour Martin Lipset), while others have focused on the institutional characteristics of consolidated democracies (e.g. Linz and Stepan). These factors can be encapsulated in a "multivariate model" of democratic consolidation, similar to the models that Michael Bratton and Nicolas van de Walle (1997) developed to study such phenomena as the extent of transition and democratization in Africa between 1988 and 1994. Such a model will be developed in Chapter 2 and, based on the assumptions of Bratton and Van de Walle, will include both institutional and socio-economic variables (or factors), very similar to the studies of Przeworski, et al. (1996) and Leftwich (2000). The influence of HIV and AIDS on these variables in South Africa and Botswana is the "what" of the study.

The majority of scholars reach negative conclusions about the effects of HIV and AIDS on democratic consolidation. Mattes (2003: 11) concludes his article on the topic by arguing that HIV and AIDS threatened “to block and even reverse democratic development across the [Southern African] region”. Other prominent scholars echo this conclusion (Fourie and Schönteich 2001: 11; Whiteside, Barnett, George and Van Niekerk 2003: 3; Price-Smith and Daly 2004; Youde 2009: 220). Shell (2000) even titles his work “Halfway to the Holocaust”, emphasising how much destruction he expected the pandemic to sow by 2010. Their reasoning, as well as the contradicting arguments of Butler (2005a) and others, will now briefly be linked to the effects of HIV and AIDS as mentioned in the previous section. In Chapter 2, their arguments will be considered in the selection of some (but not all) of these factors for comparative analysis. (See methodology, below.)

A key democratic institution which, scholars have argued, may be negatively affected by HIV and AIDS, is the institution of elections. As mentioned, electoral *governance* is expected to be affected in any state with high prevalence of HIV and AIDS, while when it comes to electoral *systems*, FPTP systems are expected to be more vulnerable than PR systems. This is an obvious concern, considering that free, fair and regular elections are generally considered a prerequisite for democracy (see Dahl 2005, in Chapter 2).

Butler (2005) also points out that the politics around HIV and AIDS policy in South Africa has had positive outcomes for the legitimacy of accountability-protecting institutions, such as the judiciary, in the context of what he considers the “anti-democratic trajectory” of the executive. This is significant if South Africa is to avoid becoming stuck in a “dominant power politics” syndrome which, Carothers (2001) points out, is not always a stepping stone to consolidated democracy.

Besides those mentioned above, most arguments are centred around socio-economic factors that are considered relevant to democratic consolidation. To begin with, Przeworski, et al. (1996) demonstrated the relevance of certain macroeconomic indicators – national affluence (measured in terms of *per capita* income), economic growth and trends in inequality (measured in terms of GINI coefficients) – for the survival of democratic regimes from one year to the next. In this they concurred with the work of Lipset (1959). As discussed earlier, scholars generally expected HIV and AIDS to affect economic growth and inequality detrimentally, while there are conflicting theories concerning the impact of the disease on affluence. On these three counts (affluence, economic growth and the reduction of

inequality), Mattes (2003) and others are not very optimistic about the effect of the pandemic on African democratic consolidation.

Furthermore, Bratton and Van de Walle (1997: 237-239), Leftwich (2003) and before them, Barrington Moore (1966) pointed out that a sizable middle class (bourgeoisie) correlates well with consolidated democracy. This class emerges in the context of urbanisation, high literacy levels and above average incomes. For this reason, although middle class households have greater access to ART, De Waal's (2003: 14) projection of decreased opportunities for the middle class as a whole is important.

Besides the effect of AIDS on economic indicators and the middle class, scholars express their concern about its effects on other measures of human development which are also considered important for the consolidation of democracy. Bratton and Van de Walle (1997: 238) consider it valuable to consider literacy rates in order to understand the socio-economic characteristics of population when assessing its chances at democratic consolidation. Inglehart and Welzel (2005) find empirical evidence that human development precedes and enables political liberalisation (See Chapter 2). For this reason the projected increase in AIDS orphans and the resultant developmental challenges for them and their peers (mentioned above) is cause for concern. So too is Chirambo's (2008: 38) assertion that teachers are at great risk of HIV infection. The effect on life expectancy, as stated above, has been extremely negative in heavily affected countries but is now slowly being alleviated by ART. In short, scholars argue that in AIDS-stricken countries across Africa, the disease is "imposing a steady decline in the key indicators of human development" (Boutayeb 2009: 1) and therefore poses a threat to democratic consolidation.

The opposing views of the impact of AIDS on the robustness of civil society, as discussed above, is central to this study. Linz and Stepan (1996: 17), Leftwich (2000: 146) and Bratton and Van de Walle (1997: 253-255) all argue that a strong civil society is significant for endurance and consolidation. Mattes (2003) and Butler (2005a) both make the link between this impact and democratic consolidation, with Mattes expressing concern about its potential negative effects in Southern Africa, such as potential weakening of this sector associated with a loss of human capital, and Butler pointing at what he considers the unforeseen positive impact of the pandemic on civil society in South Africa.

A final socio-economic factor that contributes to democratic consolidation is the provision for the differing interests of a heterogeneous society. Linz and Stepan (1996: 25-28) and



Leftwich (2000: 147) argue that, where deep ethnic or cultural cleavages exist, provision must be made for peaceful coexistence. For this reason Youde (2001: 9) is concerned about the potential exacerbation of social cleavages because of HIV and AIDS, as mentioned earlier.

To conclude, authors that argue that HIV and AIDS has a potentially detrimental effect on democratic endurance and consolidation because it could affect economic indicators, middle class, human development, civil society and peaceful coexistence in a heterogeneous society negatively. Most of these considerations are socio-economic. On the other hand, others, especially Butler (2005a), argue that the disease may also affect democratic consolidation positively, especially through a positive impact on civil society and the legitimacy of democratic institutions.

The rationale behind this study – the “why” – lies in this lack of consensus among political scientists with regards to the question: How has HIV and AIDS affected the consolidation of African democracies and how can we expect it to do so from here onwards? Is the impact positive or negative, and to what extent is it significant? Despite the negative predictions of Mattes (2003) and others, there has in fact been remarkably little visible political upheaval associated with HIV and AIDS so far. Joseph (2003) remarks on the ability of democratically elected governments to retain legitimacy while failing in AIDS service delivery. If AIDS is pushing African states towards authoritarianism, it is not yet obvious at first glance, suggesting that the arguments of Butler (2005a) and De Waal (2006), although challenging the then prevailing views, have some validity. These contrasting arguments will be considered in the comparative analysis of the pandemic’s impact on Botswana and South Africa.

The “where”, “what” and “why” of this study may yield results that differ in illuminating ways. Did AIDS only strengthen South African civil society because it was already vibrant and was faced with an overtly denialist government, or can it spur on a historically weaker civil society culture such as that in Botswana? Is a culturally homogenous population better placed to confront the democratic challenges posed by AIDS or can ART be targeted best in heterogeneous societies by focusing on groups more exposed to infection? To what extent does near-universal ART rollout ameliorate the projected socio-economic and institutional damages of AIDS? Ultimately, such questions can offer a nuanced answer as to what extent HIV and AIDS impacts on the consolidation of democracy.

### 1.3. Purpose and Significance

The purpose of this study is to ask how HIV and AIDS impacts on democratic consolidation in Africa. Critical engagement with existing theories of democratic consolidation, combined with analyses of democracies with high AIDS figures in Southern Africa is crucial to a real understanding of how the African AIDS story will play out economically, socially and especially politically. It will examine how South Africa and Botswana in particular will be affected by AIDS. By comparing the impact of AIDS on *several variables* of democratic consolidation in *only two states*, it hopes to complement existing studies that focus on the impact of HIV and AIDS.

In order to do so, the purpose of Chapter 2 is to analyse literature on democratic consolidation, defining the concept and developing a multivariate model of democratic consolidation similar to those used by Bratton and Van de Walle (1997), Przeworski, et al. (1996) and Leftwich (2000) to examine processes of democratization in African democracies. The socio-economic and institutional factors of consolidation identified by them will then be elaborated upon. Chapter 2 thus aims to create a theoretical framework of variables that may be applied in the studies of Botswana and South Africa.

The purposes of Chapters 3 and 4 will be to describe the prevalence of HIV and AIDS in Botswana and South Africa in turn, focusing on the particular impact it has on socio-economic and institutional factors of consolidation identified in Chapter 2. In line with Leftwich's thinking, distinctions are made between survival and the endurance, or consolidation, of democracy.

In Chapter 5, the study aims to assess comparative dimensions, evaluating similarities and differences in Botswana and South Africa. It is hoped that it will be illuminating to compare these two relatively affluent, but unequal and parliamentary democracies with their extremely high incidences of HIV. The obvious differences are that they have different electoral systems, vastly differing histories of HIV and AIDS policies, populations that differ in terms of size, cultural homogeneity and strength of civil society, and Botswana also had an earlier start with the rollout of ART. To conclude the study, Chapter 6 will consider the relevance of the findings of the study to other African democracies and suggest problems for further research.

## 1.4. Research Methodology

This will be a descriptive, qualitative, desktop study, analysing academic journals and books, as well as other secondary sources and the official documents of governments, non-governmental organisations (NGOs) and the media. Although these will include quantitative data, the conclusions drawn will be qualitative. The methodology is confined to desktop work and does not include fieldwork or questionnaires.

The characteristics of HIV and AIDS are introduced in Chapter 1. The second chapter is a literary study devoted to conceptualising and operationalising the concept of democratic consolidation. In order to operationalise democratic consolidation, a multivariate model like those of Bratton and Van de Walle (1997), Przeworski, et al. (1996) and Leftwich (2000) will be developed, consisting of both institutional and socio-economic variables. Informed as it is by a review of existing scholarship, the multivariate model incorporates variables (or factors) of which the relevance to democratic consolidation has been established by scholars mentioned above. However, in Southern Africa there are rival assumptions: those of Mattes (2003) pertaining to negative consequences for consolidation, and Butler (2005a), postulating more positive outcomes. Once the multivariate model of democratic consolidation is developed, the effect of AIDS can be examined and compared in terms of the factors chosen.

The comparative approach is an approach employed to discover correlations among variables. This study takes two states, South Africa and Botswana, as main units of comparative analysis and investigates the relationship between the independent variable, HIV and AIDS, and the dependent variable, democratic consolidation, within these states. Choosing to compare two units has benefits and disadvantages. The fact that only two states are selected, does limit the representivity of the study. The findings of a study of two Southern African democracies cannot be said to describe the general experience of all African democracies. However, it must be taken into account that due to the time limitations of this study, a cross-unit analysis would necessarily have been more cursory and may deserve Butler's criticism (2005: 8-9) of African comparativists' democratic theory for skimming over important validity considerations. The fact that only two cases have been selected makes it possible to engage them in their (desktop) variations, leading to insights that may not have been possible in a broad sample of states.

By selecting these states as main units of comparative analysis, this study takes Przeworski and Teune's "most similar systems" approach to comparative inquiry (quoted in Mahler 2003: 8). According to this approach, units of analysis are selected for their similarities in order to highlight the importance of their differences on the relationship between their dependent and independent variables. The important similarities between Botswana and South Africa are that both are electoral democracies in Africa; both are relatively affluent; and have extremely high levels of HIV prevalence. The question is: Do their democracies suffer under the impacts of HIV and AIDS?

Differences found between South Africa and Botswana will less likely be attributable to their current level of democratic development or HIV prevalence and more likely be attributable to other aspects in which they differ, such as the robustness of civil society or their electoral systems. As Ian Taylor (2004: 151) points out about Botswana, the combination of "a burgeoning economy and burgeoning infection rate, make[s] the country of profound interest to any discussion of the political implications that the AIDS pandemic might have in Africa". If a great HIV and AIDS burden can harm democracy, Botswana may be one of the first African countries to show this (Mukhara 2004: 30). The same reasoning is true for South Africa.

Chapters 3 and 4 are each mostly concerned with longitudinal comparison – it examines HIV and AIDS-related changes in the attributes of the variables (such as institutions and human development indicators as well as the robustness of civil society), over time (longitudinally). With regards to time frame, this study will analyse applicable sources from the beginning of the (heterosexual) epidemic to the present (August 2011) in each state. For Botswana, an epidemic was perceived to threaten the population by 1986 (Ilfie 2006: 38) and in South Africa the epidemic was rapidly spreading by 1987 (Ilfie 2006: 43). The processes identified in the study will, of course, have implications for the future effects of HIV and AIDS on democratic consolidation.

## CHAPTER 2: CONCEPTS

### 2.1. Definition of Democratic Consolidation

This chapter defines the concept of democratic endurance or consolidation, discusses institutional and socio-economic factors that are considered important to the process, and uses a minimalist set of variables possibly impacted by HIV and AIDS that will be assessed and compared in Botswana and South Africa.

The first basic prerequisite for democracy, as the term will be employed in this thesis, is the existence of a state. Linz and Stepan (1996: 14) state simply: “[n]o state, no democracy”. Where there is a state, one may turn to the influential work of Robert A. Dahl to determine whether or not the system of government is democratic. Democracy, or what Dahl (1971:1) prefers to call *polyarchy*, is characterised by the continuing responsiveness of the government to the preferences of its citizens, considered as political equals. For such a system to exist over a period of time, citizens must have unimpaired opportunity to formulate their preferences; to signify their preferences to their fellow citizens and the government; and to have their preferences weighted equally with no discrimination because of the content or source of the preference (Dahl 1971: 2).

These characteristics, in modern democracies, are embodied in a set of political institutions that can be identified in order to classify regimes (Dahl 1971: 3; 1989: 221; 2005: 188). Dahl (2005: 188) holds six institutions up as the minimal requirements for a democratic country. These are:

1. Elected officials.
2. Free, fair and frequent elections.
3. Freedom of expression.
4. Alternative sources of information.
5. Associational autonomy (i.e. civil society).
6. Inclusive citizenship.

To summarize these requirements, arguably the most important characteristics of democracy are participation and opposition (or contestation) (Dahl 1971: 4). Schedler (1998: 92) summarises them as “civil and political rights plus fair, competitive and inclusive elections”.

A distinction must also be drawn between democratic and authoritarian (undemocratic) regimes (Schedler 1998: 92). For example, since 1974, there has been a great increase in democratization across (almost) the whole world. By 2003, 63 percent of states, home to 70 percent of the world's population, exhibited some key features of democracy (Heywood 2007: 35). This expansion of democratic features is what Huntington (1991: 3) called the "Third Wave" of democratisation.

The Third Wave also swept through Africa, where there was a considerable increase in multiparty elections in African states (Van de Walle 2002: 67). Initially this created great optimism that fully-fledged democracy was taking hold in Africa. Indeed, some African states have now acquired the institutional trappings of democracies (Van de Walle 2002: 68). But some of these countries, while moving away from dictatorship, were not necessarily in transition to democracy (Carothers 2002: 14). There also were, and continue to be, many states that hold regular, relatively free and fair elections and yet do not meet all the minimal requirements for democracy as set out by Dahl above. As this demonstrates, elections are a necessary, but not sufficient, criterion for democracies (Schmitter and Karl 1991: 81; Schedler 2002: 37). Although not completely authoritarian, such regimes cannot be considered fully democratic (and therefore democracy cannot be said to be enduring or consolidating).

It is therefore necessary to speak of levels of democraticness. Schedler (1998: 92-3) distinguishes three levels of democraticness, apart from authoritarian regimes, which are simply undemocratic. What Schedler calls electoral democracy is any "diminished subtype" of democracy that fulfils some, but not all, of Dahl's minimal requirements for a democracy (all of them have some form of elections). The other two levels are liberal democracies and "advanced democracies". The distinction between liberal democracies and advanced democracies is that liberal democracies merely fulfil Dahl's minimal requirements (they demonstrate Leftwich's "survival", explained below) while advanced democracies "presumptively possess some positive traits over and above the minimal defining criteria of liberal democracy" (Schedler 1998: 93) and are, presumably, consolidated.

Having established this system of classification, Schedler (1998: 93-94) discusses scholars' awareness that democracies may move either "back" towards authoritarianism or "forward" towards advanced democracy. Democracies do not, in other words, necessarily live forever: they may "erode" or "break down".

Similarly, Thomas Carothers (2002: 6) points out in his article “The end of the transition paradigm” that new democracies do not move inevitably towards higher levels of democracy, as the “transition paradigm” (inspired by O’Donnell and Schmitter’s early work on “transitology”) assumed. Many new democracies “have not achieved relatively well-functioning democracy or do not seem to be deepening or advancing whatever democratic progress they have made” (Carothers 2002: 9). Instead, most of them in fact operate in a “grey zone”, which is broadly synonymous with Schedler’s electoral democracy. Two political syndromes Carothers identifies as common in this zone, are “feckless pluralism” (Carothers 2002: 10-11) and “dominant-power politics” (Carothers 2002: 11-13). He also disputes the “no preconditions” assumption implicit in the transition paradigm, pointing out that the more successful recent cases of democratization demonstrated the value of both socio-economic factors and institutional legacies (Carothers 2002: 8; 16). This study makes similar assumptions.

Given the understanding that there are levels of democraticness and that progression over time, from lower to higher levels of democraticness, is not guaranteed, the phenomenon of democratic consolidation has received increasing attention.

Schedler defines a consolidated democracy as “a democratic regime that the relevant observers expect to last well into the future” (Schedler 1998: 103) – one that is considered safe from democratic erosion (a slow regression in the quality of democracy) and democratic breakdown (an overt reversion to authoritarianism). Diamond’s (1994) definition may be considered complementary. He emphasises legitimation. To him, democratic consolidation is “the process by which democracy becomes so broadly and profoundly legitimate among its citizens that it is very unlikely to break down.”

The emphasis upon legitimation is elaborated by Linz and Stepan (1996: 15), who define a consolidated democracy as one in which democracy becomes “the only game in town”. As mentioned in Chapter 1, they argue that democracy is consolidated behaviourally, when violent overthrow is never contemplated; attitudinally, when even in crises democratic procedures are upheld; and constitutionally, when political conflicts are dealt with within established norms (Linz and Stepan 1996: 15-16). They emphasise the role of civil society and institutions in the consolidation of democracy.

The simplest operationalisation of democratic consolidation is Huntington’s two-turnover test (1991: 267). According to Huntington, a democracy may be expected to last well into the

future if the incumbent political party accepts losing an election and hands over to the winners peacefully, and this party then accepts defeat in a subsequent future election. Huntington argues that such turnovers demonstrate “the heart of democracy”, the ability to elect rulers – or if things go wrong, “the unique democratic remedy of ‘peacefully dismissing the government’” (Giliomee and Simkins 1999: xv). Bratton (2003) finds that in terms of public opinion, alternations of power can re-establish the legitimacy of democracy where it is often declining in Africa (Bratton 2003: 156).

For Huntington, as long as a state fails the two-turnover test it is not yet consolidated; as soon as it passes the test, it is considered consolidated. If one applies this minimalist test, one may withhold the label of consolidation in enduring democracies (Beetham 1994: 160). For instance, the two-turnover test alone cannot explain the consolidation of democracy in Japan, in which democracy has endured since 1947 without any turnovers (Garcia-Rivero, Kotzé and Du Toit 2002: 166). Still, no scholars dispute the consolidation of democracies that have seen two turnovers. In Southern Africa, only Mauritius meets this requirement.

Some scholars (Diamond 1996: 35; Dahl 1980: 315) suggest that consolidation is partly a process of habituation and that the passage of time is instrumental. Others analyse mass support for democracy. Afrobarometer (2009b), for instance, suggest that a democracy is consolidated when, over some time, more than 70% of citizens both express support for democracy and believe that they live in a democracy<sup>16</sup>.

However a consolidated democracy is operationalised, scholars put forward conditions and factors to explain why some democracies (which start out as minimally democratic in Dahl’s terms) erode or break down, while others consolidate. For instance, Linz and Stepan (1996) list five mutually reinforcing conditions for democratic consolidation. They emphasise institutions, while Przeworski, et al. (1996) emphasise socio-economics.

Other scholars distinguish between democratic “survival” and “consolidation”. For instance, for Bratton and Van de Walle (1997: 237) the key question is which of the new African democracies will “survive at all, thus beginning the arduous process of long-term consolidation”. They distinguish between “short-term survival” and “long-term consolidation” – “emerging democracies may survive, in the sense of enduring without reversal to authoritarianism, without making much progress on the difficult process of consolidation” (Bratton and Van de Walle 1997: 235). Still, there is a relationship between

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<sup>16</sup> See also: Garcia-Rivero, et al. 2002: 165-166.



the two processes: the longer democracy survives, the likelier is consolidation (Bratton and Van de Walle 1997: 236).

Leftwich (2000) presents two separate sets of factors which may both be considered important for this study. First, Leftwich (2000: 136) offers five “conditions for democratic survival” which he paraphrases “conditions for democratic consolidation”. He argues that these are “critical structural conditions that make for democratic stability” (Leftwich 2000:145). Without at least some of them (Leftwich 2000: 147), a democracy may fulfil Dahl’s minimal criteria but might not do so for very long. They are geographical, constitutional and political legitimacy; adherence to the rules of the game; policy restraint by the winning parties; overcoming the obstacle of widespread poverty where it is present; and overcoming the difficulties of sharp ethnic, cultural or religious cleavages where they are present (Leftwich 2000: 136-145).

Under the heading “Democratic Endurance” Leftwich (2000: 145) then lists a separate set of “wider factors” that enable the aforementioned conditions to take hold. The factors he then lists correlate with those that promote more than democratic “survival” according to Przeworski, et al. (1996). Thus Leftwich uses the word “survive” when discussing factors for democratic “endurance”, but has separate “conditions for democratic survival/consolidation” and “wider factors for endurance”. He also argues that “democracies need to be consolidated if they are to endure” (Leftwich 2000: 147). Przeworski, et al. (1996) also use the word “endure” to describe long-term survival (see Przeworski, et al. 1996: 41; 49), but consider “consolidation” an empty term, although the meanings are almost synonymous.

To summarize, Bratton and Van de Walle (1997) distinguish between survival and consolidation; Leftwich (2000) separates conditions for survival/consolidation from factors for endurance, while Przeworski, et al. (1996) separate survival/endurance from consolidation. For the purpose of this study consolidation and endurance will be used as synonyms. Survival will be considered a prerequisite for endurance/consolidation and therefore factors that affect it will also be deemed relevant.

Two different schools of thought, the institutionalists and the so-called modernization theorists, focus on institutional and socio-economic factors respectively when studying democratic consolidation. Recently most scholars have considered both. For instance, Linz and Stepan (1996) who are institutionalists, list five conditions for democratic consolidation,

of which four are institutional. The non-institutional condition, which they list first, is civil society. Similarly, Leftwich (2000: 145-146) lists factors for endurance, mainly of a socio-economic nature, but he includes parliamentary systems as well. Following these scholars, as well as such scholars as Przeworski, et al. (1996), Bratton and Van de Walle (1997) and Schedler (1998), this study will include *both* institutional and socio-economic variables that are considered important for the endurance/consolidation of democracy. An overview of the literature considering institutional factors will now be presented; followed by an overview of socio-economic factors. Because of its constraints, this study omits the international and regional context and focuses on domestic factors.

## **2.2. Factors for Democratic Consolidation**

### **2.2.1. Institutions**

#### **2.2.1.1. Presidential and parliamentary systems of government**

A theme in the literature on the Third Wave (i.e. literature around transitions, democratization, democracy, survival and endurance/consolidation) is a comparison of parliamentary systems and presidential ones. These systems of government represent different relationships between the legislature and the executive. In a parliamentary system (such as the British system) the executive is drawn from, and accountable to, parliament – in other words, there is a degree of fusion between the legislative and executive arms. Such a government by definition has the confidence of parliament and retains power only as long as it retains this support. In contrast, presidential systems (such as the American one) are based on a strict separation of powers between the legislature and the executive, which are separately elected and relate to each other through a system of checks and balances (Heywood 2007: 239-340).

When it comes to the influence of different systems of government upon democratic consolidation, Linz (1990) discussed the “perils of presidentialism”, arguing that parliamentary systems had proven more conducive to a stable democracy than presidential systems and that they were so for several reasons. In 1991, Arend Lijphart suggested the same; as did Riggs (1994: 72), who suggested that presidentialism as a political formula is “seriously flawed”, because of the frequent collapse of presidentialist Third Wave democracies.

Counterarguments abound, but Mainwaring (1993) and Przeworski, et al. (1996) confirmed the superiority of parliamentarianism for the endurance of democracy in empirical studies. The latter study found that, over 135 countries, for the period 1950-1990, presidential systems were considerably less likely to survive from one year to the next than were parliamentary systems: democracies under presidential systems tended to last less than 20 years, while under parliamentary systems they lasted 71 years (Przeworski, et al. 1996: 44-7). Three oft-cited explanations for this finding will be listed here.

First, presidential systems are prone to legislative-executive deadlock. Because the president and legislature are elected separately, both the president and the parliament can claim democratic legitimacy. In contrast, in a parliamentary system, the only democratically elected institution is the parliament. The prime minister has the ability to dissolve parliament and call for re-elections, but except for this drastic move the prime minister cannot “appeal to the people over the heads of their representatives” in parliament (Linz 1990: 52). Linz therefore argues that the presidential system creates a tension between the legislature and chief executive, and especially when the opposition wins a majority in the legislature, a deadlock can emerge. This argument was supported by Stepan and Skatch (1993: 18), who highlighted the lack of a constitutionally legitimate “impasse-breaking device”. Mainwaring (1993) agreed, arguing that presidentialism combined with multipartism (as opposed to a two-party democracy) is especially likely to create such a deadlock. Przeworski, et al. (1996: 45) found that the conditions for executive-legislative deadlock were common under presidentialism.

Secondly, Linz argues that the stakes are very high in presidential elections, because of the great amount of power vested in the president (especially compared to the leader of the opposition). Opposition groups may perceive elections as a zero-sum game<sup>17</sup>, which grants this system greater potential for conflict and polarization than a parliamentary system and is therefore particularly dangerous for democracies in the transition or consolidation phase (Linz 1990: 56-7; 60). Furthermore the president, as representative of both the population as a whole and the ruling party specifically, may conflate the will of the ruling party with that of the people and make the policies of the opposition out as “the selfish designs of narrow interests”, leading to indifference or even outright hostility to the opposition (Linz 1990: 61).

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<sup>17</sup> A zero-sum game is a contest in which one person’s loss is equal to another person’s gain. The implication, in politics, is that there is no scope for long-run cooperation between the players; mutual increase of gain is impossible (Concise Oxford dictionary of politics 1996: 537).

The third issue is the president's fixed term in office. Linz argues that it breaks political life, for all political actors, into rigid presidential terms, and in the case of death or incapacity of the president, may result in the appointment of someone the electorate would not have voted for (Linz 1990: 54). The time limitation on his or her presidential term may also result in a sense of urgency in the president's policies; or for the sake of continuity the removal of the limitation or appointment of an agreeable but unsuitable "yes-man" as successor (Linz 1990: 66-67).

One can conclude that parliamentary systems are more likely to consolidate and that democracies with presidential systems must make every effort to recognize and safeguard against the "perils of presidentialism". In Africa, many presidents usurp their constitutional powers, undermine parliament and make the executive dominant. (This was, almost always, the precursor to the establishment of one-party states in Africa, prior to the emergence of "Third Wave" democracies.)

#### **2.2.1.2. Electoral system: First-past-the-post and Proportional Representation**

Dahl (2005: 195) lists regular, free and fair elections as a requirement for democracy. The need for a fair electoral system is taken for granted in literature, he writes. Yet there is a fair amount of debate about what kind of voting system best ensures such freeness and fairness.

The main options are first-past-the-post (FPTP) systems (also called plurality or constituency systems) and proportional representation (PR) systems. The FPTP system entails the election of the legislature by (at the national level, usually single-member) voting constituencies. PR models vary greatly, but the PR list model treats the whole country as a single constituency and parties are allocated seats in direct proportion to the votes they gain in the election (except if there is a threshold) (Heywood 2007: 263).

It is widely accepted that the FPTP system is associated with the emergence of two large political parties, a one-party cabinet and the dominance of the legislature (through a strong ruling party) over the executive branch of government. In contrast, the PR system is associated with multiparty systems, coalition governments and greater equality between the legislature and the executive (Lijphart 1991: 72-73). Because of the concentration of power in the hands of the ruling party in the FPTP system, Lijphart (1991: 73) labels it the majoritarian model of democracy, while PR, which encourages broad coalitions, he labels the consensus model.

Most scholars are willing to discuss the benefits and disadvantages of both electoral systems. Because PR grants smaller parties a place in the legislature, it is a more inclusive model. It provides a means of including ethnic or religious minorities and for new democratic forces to share power with old antidemocratic elites (Lijphart 1991: 75). It is therefore often adopted as a means to promote unity in new, heterogeneous democracies, lessening the threat to democratic consolidation (Reynolds 1995: 120). Its focus is on representivity. In contrast, FPTP tends to magnify the gains of the winning party, even when this party does not have an absolute majority of the popular vote. Many votes are thus “wasted” and electoral preferences are distorted (Heywood 2007: 257). Losing parties may feel excluded from politics and less motivated to cooperate democratically.

On the other hand, proponents of FPTP claim that it is the only system in which clear accountability for government policy can be achieved (Lijphart 1991: 76). Put differently, the proponents argue that FPTP promotes the “vertical” dimension of democracy, namely a representative relationship between elites and non-elites with a common political interest (Reynolds 1995: 117). This is achieved because voting districts vote specific individuals into parliament, who then become accountable to their constituencies. Importantly for the purpose of this study, ministers and members of parliament (MPs) who cannot complete their term, must be replaced in by-elections in order to keep their voting district represented in parliament.

Supporters of FPTP also argue that more effective government can be achieved by a one-party cabinet, which is a common result of this system (England and some members of the British Commonwealth are cases in point). However, the experience of effective government in continental Europe disproves this claim (Beetham 1994: 170). The fact that this system tends to produce a two-party system and that coalition government is therefore not necessary, may limit the power of small extremist parties and promote stable government (Heywood 2007: 257).

South Africa uses a PR system and Botswana an FPTP system at national level. Whatever model a state adopts, Leftwich (2000: 138) argues that popular confidence in elections is a necessary condition for the consolidation of democracy (he goes on to advocate adherence to the rules of the game and policy restraint by the winning parties). This includes confidence in both the process and the outcome of elections; in other words, not only must the public deem PR or FPTP a legitimate system, but they must also consider elections legitimately free and fair. It is particularly in the latter sense that the effect of AIDS will be studied.

### 2.2.1.3. Political rights and civil liberties

Political rights, according to Freedom House (2011), “enable people to participate freely in the political process through the right to vote, compete for public office and elect representatives who have a decisive impact on public policies and are accountable to the electorate”. These are distinguished from civil liberties, which “allow for the freedoms of expression and belief, associational and organizational rights, rule of law and personal autonomy without interference from the state”. These are relatively narrow definitions, in particular, the definition of civil liberties has to do mostly with non-interference and does not imply that a democracy must provide in all positive rights of citizens (which may vary and may be very extensive in some states) before it is considered “free”.

Political rights and civil liberties are an essential part of democracy and therefore of democratic consolidation. This is obvious in Schedler’s (1992: 92) definition of democracy. Bratton and Van de Walle’s (1997: 236) conception is similar; and Linz and Stepan (1996: 20) argue simply: “[d]emocracy is a form of government in which the rights of citizens are guaranteed and protected”. Quite often, levels of democraticness relate to either an increase or an erosion of these rights (see Schedler 1998; Van de Walle 1997; Diamond 1996 and Carothers 2002).

Diamond (1996: 34) argues that the less respect political actors have for political rights and civil liberties, the more democratic consolidation is obstructed, in two ways. Firstly, where these ratings deteriorate below a certain level, democracy cannot, by definition, consolidate because the procedural underpinning that defines the democratic nature of the regime is drawn into question. Secondly, to the extent that a regime is or becomes “shallow, exclusive, unaccountable, and abusive of individual and group rights,” it loses legitimacy in the eyes of citizens and lowers the perceived costs of reverting to authoritarianism, thereby making democratic breakdown more likely. For Leftwich (2000: 135-145) legitimacy is the most important condition for the survival of democracy. Afrobarometer data analysed by Bratton and Mattes (2001) supports these arguments about legitimacy: they found that citizens’ approval of democracy hinges to a considerable extent on its ability to guarantee their political rights (see also, Youde 2009). Disrespect for political rights and civil liberties thus obstruct democratic consolidation both by definition and causally.

Given the centrality of political rights and civil liberties to democracy, any development that affects a state’s respect for political rights and civil liberties directly, can be considered a

threat for democratic consolidation. Conversely, developments that affirm political rights and civil liberties support democratic consolidation by implication. This includes forces that affect the rule of law (Linz and Stepan 1996: 18-19), because the judiciary is critical to the survival of these rights (Bratton and Van de Walle 1997: 248).

For this reason Diamond and others (e.g. Breytenbach 2005) consider Freedom House ratings important in the evaluation of democratic consolidation. Freedom House is an organisation that releases an annual survey of the “progress and decline of freedom” (Freedom House 2011e: 30). Freedom House measures political rights and civil liberties on separate scales of 1 to 7, with 1 indicating the highest degree of freedom and 7 the lowest. When these two scores produce a combined average of 2.5 or less, the state is rated “free”. From 3.0 to 5.0, the state is rated “partly free” and states with ratings from 5.5 to 7 are rated “not free”. Breytenbach (2005: 51-52) points out that prominent democratization theorists consider Freedom House’s annual ratings a useful operationalisation of levels of democracy. This operationalisation is measurable and therefore comparable.

## **2.2.2. Socio-economic factors**

### **2.2.2.1. Affluence**

As stated above, democracies are formed on the basis of institutions. For modernisation theorists, these are necessary for the mere survival of democracies, but not necessarily sufficient. What makes for sufficiency?

It is generally accepted that affluence is conducive to democratic survival. The correlation was initially suggested by Seymour Martin Lipset, who argued “[t]he more well-to-do a nation, the greater chances that it will sustain democracy” (1959: 56). In line with this suggestion, Przeworski, et al. (1996: 40) operationalised affluence by linking it to annual *per capita* incomes and found that, at above \$6 000 democracies are “impregnable”; poorer democracies, between \$6 000 and \$1 000, are “fragile” and those with *per capita* incomes below \$1 000, are “extremely fragile”. These were data for 1950-1990. Huntington (1991: 272), using 1987 data, draws the same conclusion about the influence of affluence on democratic consolidation, finding that by 1990, India was the only extremely poor Third Wave democracy that had survived (of course, many poor democracies were born thereafter, but not all survived. Ghana and India are the exceptions in Africa and Asia). Leftwich (2000: 145) as well as Bratton and Van de Walle (1997: 237-8) also allude to *per capita* incomes.

Leftwich (2000: 143) suggests that it is the struggle for scarce resources and the comparatively enormous benefits of political power that makes incumbents in poor democracies more inclined to suspend democracy and remain in power.

Much of the initial theorizing around the relationship between affluence and democracy was part of modernisation theory, a school that holds that democratization is a result of economic growth. However, the work by Przeworski, et al. (1996) disproves this. They find that transitions to democracy are random with regard to the level of economic development, but that the affluence of democracies, once established, is relevant to their survival, as stated above (Przeworski, et al. 1996: 40). In the Third Wave especially, many poor nations have adopted democracy – but once they have done so, their chances at survival are significantly slimmer than those of affluent democracies.

Przeworski, et al.'s (1996: 81) income figures are based on 1985 constant purchasing power parity (PPP) dollars. Following Diamond (2003: 18), this figure may be adjusted for inflation. The affluence line of \$6 000 would be equivalent to \$12 195.78 in 2010 (US Bureau of Labour Statistics 2010). Above this level, democracies may be considered impregnable according to this thinking. The threshold for “fragile” democracies was between \$12 195 and \$2 032 and for “extremely fragile” systems, lower than \$2 032 (US Bureau of Labour Statistics 2010).

#### **2.2.2.2. GDP growth and low levels of inflation**

It is important to note the weight of the previous point before continuing. Przeworski, et al. (1996) found that affluent democratic nations were “impregnable”: “once democracy is in place, affluence is a sufficient condition for it to survive regardless of anything else” (Przeworski, et al. 1996: 42). No other factor was found to have such explanatory power.

Przeworski, et al. (1996) also found correlations between democratic survival and economic growth; and democratic survival and the reduction of inequality. Economic growth can to some extent compensate for poverty in ensuring democratic survival (Przeworski, et al. 1996: 42; Leftwich 2000: 145). In times of economic downturn, democracy is more likely to break down. The same is true for inflation: poor democracies that succeed in sustaining moderate levels of inflation also have better chances of survival (at inflation rates of under 6 percent, an average life span of 44 years) than those with high inflation (at inflation rates of over 30 percent, an average life span of 16 years) (Przeworski, et al. 1996: 42). Although the



Leftwich (2000) study came four years after the Przeworski, et al. (1996) study, it fully underwrites their conclusions about affluence and endurance.

Bratton and Van de Walle (1997: 240) explain the relationship between economic performance and democratic consolidation as follows: “[i]n a consolidated democracy, economic grievances are expressed through the ballot box and can lead to the replacement of one elected government by another; in a nonconsolidated democracy, however, the penalty for poor performance may well be the end of democratic rule itself and a return to authoritarianism”.

Although economic performance is crucially important for democratic endurance (Przeworski, et al. 1996: 42), no scholars argue that economic growth alone is a sufficient condition for democracy (as some argue affluence is). As Diamond (2008) points out, Kenya demonstrates this point. Despite at the time registering significant economic growth for the first time in many years, much of Kenya’s democratic gains were reversed by the wave of ethnic violence that followed its 2007 elections. Events and circumstances that promote economic performance, especially in poor democracies, promote democratic consolidation indirectly; and events and circumstances that make it more difficult, threaten democratic endurance and consolidation indirectly.

### **2.2.2.3. Inequality reduction**

A third socio-economic factor studied by Przeworski, et al. (quoted by Leftwich 2000: 145), is income inequality. The Gini coefficient can be used to measure income inequality and can range from 0 (complete equality) to 1 (one person has all the income). Przeworski, et al. (1996: 43) found that, although there is no proof that democracies with high socio-economic inequalities are more prone to failure than more egalitarian societies, the phenomenon of rising inequality is detrimental to democratic survival, with an average democratic “life span” of only 22 years in such countries. On the other hand, democracies that manage to reduce socio-economic inequalities can expect to live, on average, 84 years. “People expect democracy to reduce inequality,” the authors explain, “and democracies are more likely to survive when they do” (Przeworski, et al. 1996: 43).

Diamond (1990: 57) argues that the necessity of reducing inequality is a difficult paradox of democracy. On the one hand, deep class cleavages may lead to bitter political polarization and democratic instability. On the other, socio-economic reforms that attempt to address

inequality could meet with bitter resistance from “entrenched elites” such as large landowners and the employers of cheap labour (Diamond 1990: 57), who may resort to undemocratic means to secure their interests if they consider the costs of such action low enough. Thus both addressing inequality and a failure to address it are likely to lead to some measure of democratic instability. He (Diamond 1990: 57) also connects economic growth and the reduction of inequality, arguing that “only in the context of economic growth can inequality be reduced in a way that brings an enduring reduction in poverty”.

From the above discussion it follows that the prospects for democratic consolidation increase when there is reduction in inequality. What matters in this study, is whether HIV and AIDS impact on the reduction of inequality in Botswana and South Africa.

#### **2.2.2.4. Trends in Human Development**

##### *Using the UN Development Report*

For modernisation theorists, human development, measured in a variety of ways, has gained importance as a factor of endurance, often used in conjunction with measurement of income levels.

Bratton and Van de Walle (1997: 238), acknowledging that *per capita* income may not accurately reflect citizens’ circumstances and opportunities where national economies are dependent on oil or mineral resources, suggest using literacy scores in conjunction with income *per capita* to measure the socio-economic characteristics of a given state. Leftwich (2000: 53) defines the major components of human development as “a long and healthy life, education and access to resources that provide a decent standard of living”. Similarly, Diamond (2003: 6) indicates that socio-economic realities could be measured by referring to the United Nations Human Development Index (UN HDI) and Breytenbach (2005: 52) operationalised development as a combination of economic development (*per capita* income) and UN HDI. He then juxtaposed this with Freedom House’s classifications and found that freer nations correlated with higher HDI levels and that unfree nations also correlated with poorer ones in Southern Africa.

Welzel, Inglehart and Klingemann (2003) use the World Values Surveys to identify a causal relationship between human development and democratization: socio-economic development (which is defined not as GDP *per capita* but more broadly as “growing

individual resources”) tends to shift society’s values toward a greater emphasis on human emancipation and choice, which in turn stimulates the demand for democratization as it provides legal guarantees of choice by institutionalizing “freedom rights”. Welzel, et al. (2003) thus confirm the assumptions implicit in the abovementioned (mostly earlier) works. Inglehart and Welzel (2005) expanded upon these findings, demonstrating that human development leads to a replacement of survival values with self-expression values, which are causally prior to sustainable and effective democratic institutions (Inglehart and Welzel 2005: 288-289). Unfortunately, neither study tests the effect of *declining* human development (such as declining levels of health and longevity). Their study does at least suggest that in the event of a decline, the human development trend in a country can no longer be said to promote democratization.

Berg-Schlusser (2008) also tests for the explanatory strength of variables related to human development in explaining democratic success and finds significant bivariate correlations between democratic success and human development factors. In his step-wise regression of these human development factors, declining infant mortality emerged as the single factor that correlates most strongly with democratic success (Berg-Schlusser 2008: 289). He does not establish causation.

The United Nations Development Programme proposes a composite of three variables with their Human Development Index, updated annually in the United Nations Human Development Report. The Report (1990) was an answer to calls for a broader measurement of “development” than standard economic measurements. Its Human Development Index was explicitly devised as a usable rival to pure GDP *per capita* (Sen 2010: IV). It combines three indicators: health (life expectancy at birth), education (literacy rates) and income (GDP *per capita*). The methodology changed somewhat in 2010. A rating between 0 and 1 (with 1 being the most developed and 0 being the least developed) is annually assigned to each state. States are also ranked from highest to lowest levels of human development. Botswana and South Africa rank in the medium categories, with Botswana ranking higher than South Africa.

Welzel, et al. (2003: 356) prefer the more complex Vanhanen Index to the UN HDI<sup>18</sup>. However, the UN HDI is well-known, easily available and presents a snapshot of socio-

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<sup>18</sup> Welzel, et al. (2003: 356) explain that the Vanhanen index (Vanhanen 1997) includes both physical and intellectual resources and measures not only levels but also the distribution of these resources. It also includes a measure of social complexity.

economic conditions that is comparable across states. In the 2010 rankings (UNDP 2010) Botswana was rated 98th and South Africa 110th in the world.

#### **2.2.2.5. Heterogeneity**

As early as the 1860s, John Stuart Mill (1861, quoted in Beetham 1994: 169) wrote that “free institutions are next to impossible in a country made up of different nationalities” because “each fears more injury to itself from the other nationalities than from the common arbiter, the state”. Although no longer considered “next to impossible”, the existence of deep social cleavages in Third Wave democracies has been flagged as an impediment to their endurance and consolidation. The majority of African democracies are heterogeneous (whether their fault lines run along cultural, ethnic, linguistic or religious lines or a combination of these) and the presence of settler societies added a racial element to some of them (Breytenbach 1996: 10). They are by no means nation-states, like the older democracies of Germany, Japan and France.

Beetham (1994: 169) summarized the heterogeneity hypothesis in question as follows: “societies divided by clearly defined and historically antagonistic groups will have great difficulty in sustaining democracy”. He writes that the reasons why heterogeneity is considered detrimental to democratic consolidation are twofold: firstly, because democracy relies on popular consent in conditions of free expression and association and there is no democratic solution to a society that refuses to consent to living together. Secondly, electoral competition is itself a very divisive process, which in the absence of cross-cutting loyalties may exacerbate social divisions.

Similarly, Leftwich (2000: 143-145) also discusses sharp “national”, ethnic, cultural or religious differences as “obstacles” to democratic consolidation and argues that they must be provided for carefully if democracies are to survive. Linz and Stepan (1996: 23-27) call heterogeneity a “surmountable obstacle”. They argue that prospects for democratic consolidation in a heterogeneous context can be improved by inclusive and equal citizenship and a state-mandated and state-enforced set of individual rights. Crafters of democracy may also consider nonmajoritarian measures such as federalism, publicly supported communal institutions and proportional representation (Linz and Stepan 1996: 26).

In a similar vein, Berg-Schlosser (2008: 276) operationalises heterogeneity. He proposes that the ethnic/linguistic constellation in a state may be more or less conflict-prone. Particularly,

he suggests that populations in which one group is clearly numerically dominant but where other significant groups exist, are considered the most at risk of conflict. But he, too, emphasizes that “it is not ethnic or religious affiliation or identity as such, but the way these are translated into the political processes that determined the potential conflict of these groups” (Berg-Schlusser 2008: 289).

Conflict and democratic breakdown in heterogeneous states is thus not inevitable, but if democracies are to endure and consolidate, heterogeneity should be borne in mind and carefully provided for in institutional design. This is particularly important in Africa, where postcolonial states are often home to diverse and/or antagonistic groups. It is not heterogeneity as such, but the political polarization along social fault lines that it may produce, that obstructs democratic endurance and consolidation. Botswana is more homogeneous than South Africa, as will be explained later.

#### **2.2.2.6. Middle Class**

The notion that a large middle class is important for the consolidation of democracy was postulated by modernization theorists such as Barrington Moore (1959). Moore considered a large middle class not only a beneficial factor but an essential prerequisite for democratisation. Therefore the statement: “No bourgeois, no democracy” (Moore 1966: 418). This class, “a vigorous and independent class of town dwellers” in Moore’s (1996: 418) phrasing, was to Moore an independent variable upon which the dependent variable, democracy, depended (Breytenbach 2005: 53).

The implication of Moore’s statement is that democratic consolidation requires not merely affluence or economic growth, but (the development of) an economic structure that creates and sustains a socio-economic class with an interest in, and the means to, support democracy (Beetham 1994: 166). This essentially implies a diversified capitalist economy. Linz and Stepan (1996: 21-23) also discuss the importance of capitalist development for the consolidation of democracy. According to Rueschemeyer, Stevens and Stevens (1992, quoted in Beetham 1994: 166-167), capitalism is conducive to the survival of democracy inasmuch as it has two effects: a reduction of the power of large landowners on the one hand and the development of a substantial urbanized working class on the other. It is in the context of urbanisation that civil society arises as voluntary associations separate from the state.

Rueschemeyer, Stevens and Stevens (1992, quoted in Beetham 1994: 166-167) differ from Moore by including urban workers in their definition of the middle class and excluding “capital”, or big business (Breytenbach 1996: 21-22). This results in some conceptual confusion, but it is clear that the middle class does not constitute the very poor or the top elites. With regards to the inclusion of workers and big business, Breytenbach (1996: 21-22) suggests that the class of big business might be good consolidators because of their vested interest in the status quo (i.e. stability – whether democratic or not), while the smaller middle classes and the workers may play an important role in democratization itself, perhaps through the workings of civil society. Since both groups will expect government to serve their interests, a democracy must possess two further attributes if it is to consolidate. The first is sufficient national wealth to satisfy the demands of both capital and labour, and the second is a democratic political system in which both groups can be represented (Rueschemeyer, Stevens and Stevens 1992, quoted in Beetham 1994: 167). In the absence of such conditions, one of the classes may be alienated and be tempted to support authoritarian alternatives.

Beetham (1994: 167) ends his discussion by pointing out that the organised working class in developing democracies are generally relatively small. Therefore, it is important to pay attention to members of all economic strata “whose conditions of social activity incline them to defend the freedoms of association, expression, and so on” that democracy promises, and not only organised economic interests. In the absence of a strong middle class, a democratic coalition between class interests and such groups may be essential, hence the importance of “civil society”, which can now be discussed.

#### **2.2.2.7. Civil Society**

Civil society is defined as associations that are independent from government and organized by individuals in pursuit of their own ends (Heywood 2007: 8). Diamond (1999: 221) adds some more attributes. For him, civil society is “the realm of organized social life that is open, voluntary, self-generating, at least partially self-supporting [...]. It is distinct from “society” in general in that it involves citizens acting collectively in a public sphere” (Diamond 1999: 221). Civil society operates within the rule of law and forms an intermediary level between the state and the private sphere.

Leftwich (2000: 146-147), Diamond (1999: 218-260), Linz and Stepan (1996: 17) and Bratton and Van de Walle (1997:254) stress the importance of a rich and pluralistic civil society for

the survival of democracy. Berg-Schlosser (2008: 290) finds that the correlation between democratic survival and press freedom is highly significant. However, Chazan (1992: 282) speaks of the “missing middle” and Bayart (1993) of the “bourgeois illusion” in African democracies, pointing to the fact that civil society is often worryingly absent.

Civil society is usually organised in urban environments and mostly draws its members from the middle and working classes, but certain civil society organisations can also encompass all classes. Churches are a good example (Breytenbach 1996: 22). Other examples include youth groups, trade unions, the independent media and interest groups (Leftwich 2000: 145).

The value of civil society is that it both pressures the state and restrains an over-active state, “thereby strengthen[ing] the assumptions and practices of democratic self-management in complex societies” (Leftwich 2000: 146). Scholars discuss several ways in which civil society influences democratic consolidation; four will be listed here. The first is that civil society adopts the role of checking, monitoring and restraining state power and keeping it accountable (Linz and Stepan 1996: 18; Diamond 1999: 240; Chazan 1992: 283). This is possible because through membership of civil society organisations, “citizens acquire a source of power which does not derive directly from [the state] and is not dependant [sic] on it” (Friedman 2003: 10). In this way civil society organizations can play an especially important role in checking corruption in young democracies (Diamond 1999: 240). Second, civil society does not only contain state power but also legitimates state authority (Chazan 1992: 283; Linz and Stepan 1996: 18), because by definition, their purpose is neither to seize government nor to dispute the legitimacy of the democratic regime. In fact, they often take it upon themselves to educate citizens for democracy (Diamond 1999: 243). Third, civil society contributes to the consolidation of democracy by stimulating political participation, increasing the political efficacy and skill of democratic citizens and promoting an appreciation of the obligations as well as rights of democratic citizens (Diamond 1999: 242). In short, civil society groups can act as “large free schools” of democracy (Tocqueville, quoted in Diamond 1999: 242). Finally, civil society groups provide multiple channels, in addition to political parties, for political engagement, which is of particular value for marginalized groups (Diamond 1999: 243).

However, Steven Friedman (2003) warns that it is inappropriate to elevate civil society to a “repository of unquestioned virtue”. Because civil society derives its independence from freedom of association, subjective observers will see civil society to comprise the “virtuous and the vicious, the progressive and the retrogressive, the enlightened and the misguided”.

Therefore he argues that, instead of considering civil society, its constituent elements (such as the media, churches and trade unions) or members (individuals or organizations) of these groups virtuous in any specific way, it is more correct to argue that its existence has virtuous effects (as listed in the previous paragraph). Furthermore, he emphasizes that representivity is not a property of civil society and that civil society organizations are not necessarily internally democratic (Friedman 2003: 9). The democratic state, through general elections, remains the only body with a proven mandate to decide for entire societies (Friedman 2003: 10-11). It must therefore also “check” the power of civil society.

As the above discussion demonstrates, the relationship between civil society and the state is an important one. For Linz and Stepan (1996: 17-18) it is especially important that civil society and political society do not oppose each other, but that their complementary roles are recognised by state and civil society alike. On the other hand, they must not cooperate so well as to become indistinguishable. State and civil society are not alternatives to each other – “beneficial outcomes are possible only if both elements of the equation are capacitated” (Friedman 2003: 8). Leftwich (2000: 147) emphasises that the co-optation of civil society groups by dominant one-party states is a dangerous trend in Third Wave democracies. In South Africa, powerful trade unions as a component of civil society are partners in the ruling “tripartite alliance”, which raises questions about its co-optation by the state. Maundeni (2004) also argues that the BDP has managed to co-opt several key civil society members and groups, thus undermining their authority.

### **2.3. The Multivariate Model of a minimalist kind**

Bratton and Van de Walle (1997: 221-225) construct multivariate models to explain the extent of transitions and democratization in African regimes from independence to 1989. They find that democratization can be explained to a great extent with reference to only a minimal set of variables. The four variables most significant to explaining democratic transition were all institutional (these were, during the pre-democratization phase: the number of military interventions, the number of elections, the frequency of political protest and the percentage of seats in the legislature (Bratton and Van de Walle 1997: 224). However, the authors expect that socio-structural factors gain greater explanatory power with regards to democratic consolidation (Bratton and Van de Walle 1997: 237). The model used in this study is therefore not an adoption of theirs, but also accepts a modest, minimalist set of variables, including both institutional and socio-economic variables of the kind used by Przeworski, et al. (1996) and Leftwich (2000).



This chapter has discussed the concept of democratic consolidation, describing it as a process of legitimation and safeguarding against breakdown and erosion. In terms of a *direct* effect on democratic consolidation, scholars do not argue that AIDS is directly effecting an outright reversion to autocracy in either state. Furthermore, neither Botswana nor South Africa is likely to pass Huntington's two-turnover test soon and the ruling parties remain dominant despite HIV and AIDS. We must therefore choose more indirect *factors* of democratic endurance/consolidation upon which the pandemic has an impact. Taken together, its impact on these factors may rather contribute to democratic *erosion*, a slow death of democracy.

The first institutional factor that was discussed is the legislative system. When it comes to presidentialism and parliamentarianism, parliamentarianism is generally considered preferable. South Africa and Botswana both have parliamentary systems in which a president is elected by parliament (RSA 1996: S86 (1); Botswana: 1966: S32 (3)). These presidents are heads of state and of the executive (RSA 1996: S83; S85; Botswana 1966: S30; S47), but they and their cabinets are formally accountable to parliament (RSA 1996: S92; Botswana 1966: S50 (1)). Butler (2005: 16) points to an absence of multiple impediments to prolonged abuse of executive power in South Africa. In other words, although parliamentary, the South African governmental system allows its president executive power greater than that commonly vested in the prime minister and therefore some of the "perils of presidentialism" (such as a divisive succession contest, or a weakened cabinet) may arguably still emerge.

Another institution to consider is choice of electoral system. As mentioned in Chapter 1, Strand (2005), Strand, et al. (2005) and the study led and edited by Chirambo (2008) underscore the effect of AIDS on electoral processes. This is one of the most explicit and extensively investigated detrimental effects of HIV and AIDS on democracy, and since South Africa uses a PR system and Botswana an FPTP system, comparison of the effect of the pandemic on these two electoral systems is a key aspect of this study.

It may also be fruitful to look at political rights and civil liberties, especially since South Africans relied on their civil liberties of freedom of expression, organisation and association in order to demand their constitutional right to life-saving ART. De Waal's argument that international donors may develop inordinate influence on public policy, and that African governments could become primarily mechanisms for processing donor funds to provide ART to keep people alive, is also relevant to citizens' political rights.

When it comes to socio-economic factors, a review of the literature in Chapter 1 concluded that AIDS is expected to reduce GDP growth and increase inequality, while there is disagreement about whether it will increase or decrease the growth of *per capita* incomes. All three factors (affluence, economic growth and inequality reduction) will be assessed to present a full picture of the impact of HIV and AIDS on economic trends in Botswana and South Africa. The impact of the pandemic inequality is also likely to impact the size and composition of the middle class, but this factor will not be studied in its entirety.

As demonstrated in UN HDI ratings, human development is being profoundly affected by HIV and AIDS and should be assessed. Heterogeneity is a reality in both South Africa and Botswana, but a preliminary study of the relevant literature did not reveal expectations that the disease will affect the heterogeneous composition of these states in any significant way, or directly exacerbate tensions along social cleavages.

Chapter 1 also discussed the different arguments of scholars with regards to the impact of HIV and AIDS on civil society in Africa. The effect of the pandemic on civil society in Botswana and South Africa will be studied and compared.

The multivariate model of democratic consolidation will thus consist of 1) systems of parliamentary or presidential governance, 2) electoral systems, 3) political and civil liberties, 4) affluence, economic growth and inequality reduction, 5) UN HDI and 6) civil society.

## CHAPTER 3: BOTSWANA

### 3.1. Background: HIV and AIDS in Botswana

Botswana is a democracy whose political stability since independence is unparalleled in Sub-Saharan Africa (Tsie 1996: 600). It is relatively affluent – the *per capita* income is high enough for its democratic form of government to be “impregnable” according to Przeworski, et al. (1996) rankings. HIV has spread through the population since the mid-1980s. Driven to a great extent by population mobility linked to trade and trucking routes (Molatole and Thaga 2006: 26; 60), prevalence reached extremely high levels, especially in northern and (initially) urban areas, despite government’s extensive efforts to combat it. Prevalence has begun to decline slightly since the mid-2000s, but serious policy challenges remain.

Botswana is a landlocked state with a population of 1.95 million in 2009 (World Bank 2011a). About 80% of the population speak Setswana and claim membership of one of eight Tswana tribes<sup>19</sup>. The Kgalakgadi desert covers a large part of the country.

The area was declared the Protectorate of Bechuanaland under the British crown in 1885. Having declared the Protectorate mostly to prevent colonization or expansion into the area by others<sup>20</sup>, the British did not take an active interest in governing or developing the area. The Tswana chiefs were recognized as rulers<sup>21</sup> with only a handful of new constraints (Holm 1988: 183).

Following the first parliamentary elections in 1965, which the Botswana Democratic Party (BDP) under Seretse Khama won by a landslide, Botswana peacefully gained independence from Britain in 1966. The BDP has been in power ever since and all elections have been declared free and fair by observers. The presidency has changed hands thrice: Khama was succeeded upon his death in office by Quett Ketumile Masire in 1980, who was succeeded by Festus Mogae in 1998, followed by Ian Khama (the son of Seretse Khama) in 2008. Support

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<sup>19</sup> For a list of the eight Tswana tribes and the regions where they are dominant, see Robinson (2009: 1).

<sup>20</sup> The British perceived Germany in the west, Portugal in the east, and the northward expansion of the Afrikaners from the south as potential threats to road access between South Africa to areas of British interest further north; some Tswana chiefs also expressed the desire for protection (Colclough and McCarthy 1980: 12).

<sup>21</sup> The other ethnic groups of the region were thus denied separate ethnic representation. In independent Botswana the House of Chiefs also initially consisted only of Tswana chiefs, and “struggles for representation by [minority ethnic groups] have been countered by majoritarian efforts to maintain the status quo of an inherited colonial hierarchy of ethnic groupings” (Nyamnjoh 2003: 107).

for democracy is consistently high among the population of Botswana and has resurged in 2008 after a gradual decline over the preceding decade (Afrobarometer 2009c).

A mostly agricultural economy at independence in 1966, diamonds and other minerals were discovered in Botswana shortly after independence. Under the leadership of Seretse Khama, a profitable long-term partnership was established between the government and Debswana (the Botswana branch of the De Beers mining corporation). A regime of fiscal and monetary discipline created an attractive environment for foreign investment, so that Botswana managed to achieve sustained economic growth, boasting an average annual growth rate of 5.9% for the period 1975-2005 (Robinson 2009: 2; Leith 2005: 120-122). The government continues to receive substantial diamond revenues, which it has spent on public priorities such as health, education and welfare provision (Thomson 2004: 102). To a lesser extent, the economy also features beef exports and tourism, but it remains largely undiversified, rendering it vulnerable to shocks in the diamond market. This vulnerability was recently demonstrated as the country's diamond production fell by 90 percent amid the global financial crisis of 2008 and 2009 and the government ran a deficit of 14 percent (Gaothlobogwe 2011). Thereafter diamond sales have reached historically unprecedented levels (Mguni 2011). Diamond and mineral production, although still lucrative for some decades, is expected to decline as reserves are depleted.

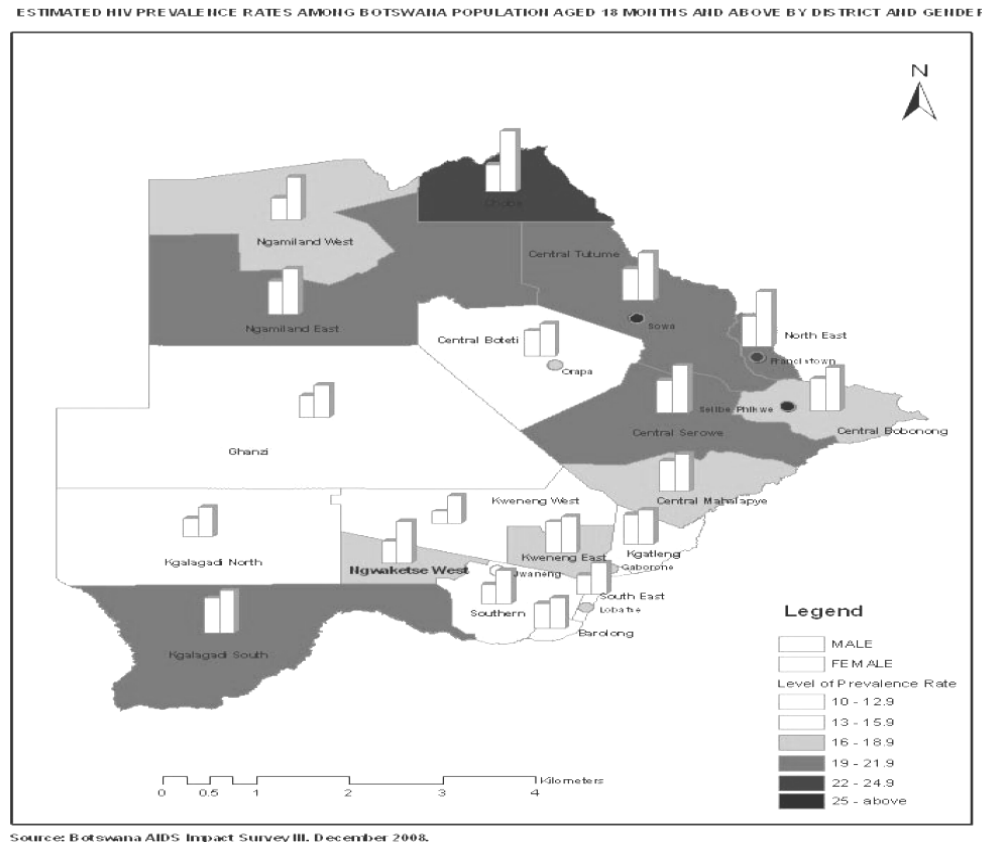
In this relatively stable and prosperous democracy, the first case of HIV was reported in the mining town of Selebi-Phikwe in 1985 (Molatole and Thaga 2006: 23). Thereafter, incidence escalated rapidly in the late 1980s and early 1990s to stabilize at an adult prevalence level second only to Swaziland (see Figure 3). Barnett and Whiteside (2008: 137) find some explanation for this in the fact that Botswana was and remains characterized by rapid economic growth, an expanding transport network, population mobility, urbanisation, cross-border trade and inequality, all of which are characteristics of a risk environment for the spread of HIV. Molatole and Thaga (2006: 27-29) echo most of these points and also emphasise stigma and denial, the subordination of women and the influx of refugees from neighbouring states. Stegling (2004: 230) suggests that most answers offered for the rapid spread of the virus through Botswana provides only a partial explanation and that further analysis of this topic is needed.

Today, prevalence is higher in northern and northeastern areas than in southern and western areas – demonstrating that the pandemic spread to Botswana from the north, through trade and trucking routes – and in urban rather than more traditional and sparsely populated rural

areas (Barnett and Whiteside 2006: 132; Molatole and Thaga 2006: 25-26). Prevalence levels were significantly higher in urban than in rural areas until recently, but today, the distinction between rural and urban prevalence levels is not clear anymore (Dorrington, Moultrie and Daniel 2006: 36; Mookodi, Ntshebe and Taylor 2011). The difference in infection between rural and urban areas narrowed significantly between 2004 and 2008, and is now, on the whole, within one percentage point from one another (17.1% in rural and 17.9% in urban areas) (UNAIDS 2010b: 11). As Figure 2 below demonstrates, HIV prevalence remains higher in major tourist destinations like Chobe and migrant labour centers like Selebi-Phikwe (Molatole and Thaga 2006: 26).

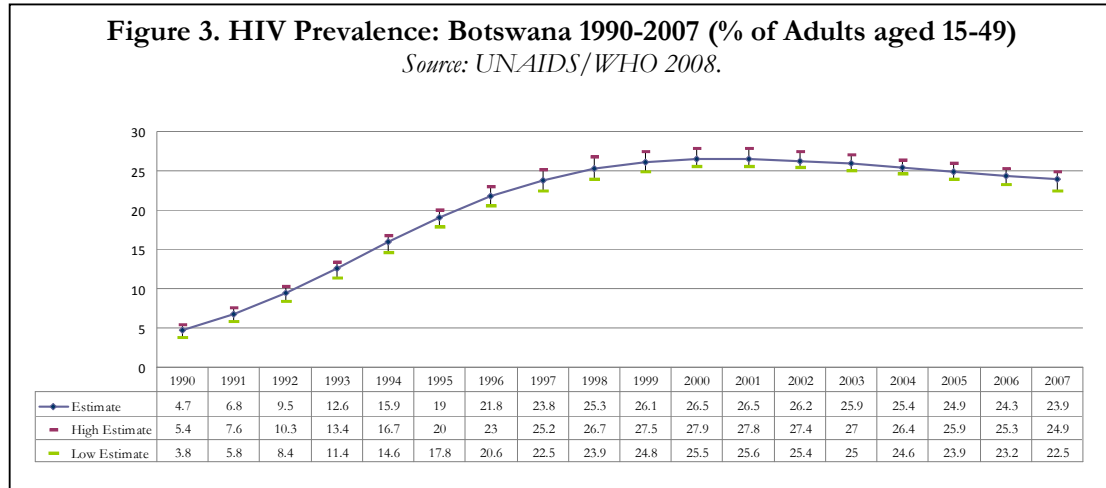
**Figure 2. HIV prevalence by district, Botswana, 2008**

*Source: UNAIDS 2010b.*



Unlike many others in Africa, the government of Botswana was never in denial about HIV and AIDS. After the first AIDS case was reported, the government responded (though on a small scale) in 1986, by establishing the National AIDS Control Programme, followed by the development of a one-year Short Term Plan in 1987 and the initiation of the first broad-

based Medium Term Plan (MTP I, 1987-1993). This plan was successful in educating a large percentage of the population about HIV transmission, but did not seem to make any impact on the alarmingly escalating incidence<sup>22</sup> (UNDP 2000: 42).



By 1995, adult HIV prevalence was estimated at 19% (see Figure 3). Recognizing the multi-sectoral nature of the problem, the second Medium Term Plan (MTP II) which ran from 1997 to 2003 was developed through broader consultation with stakeholders such as NGOs and private firms, and established many of the multi-sectoral coordination structures in operation today, including the National AIDS Coordinating Agency (NACA). During this period, in 1998, Botswana pioneered the rollout of Prevention of Mother-to-Child Transmission (PMTCT) treatment; and in 2002 it launched a large-scale ART rollout programme called Masa (“new dawn” in Setswana). Mostly because of increased access to these medicines, in 2003 life expectancy began to increase for the first time since 1989 (as will be discussed in 3.3.2). The weaknesses of MTP II included a lack of clarity concerning the implementation responsibilities of different stakeholders.

Thereafter followed the National Strategic Framework (NSF I) for 2003-2009. NSF I saw several achievements and new developments, including the introduction of Routine HIV Testing (the first such policy in Africa) and increased voluntary counseling and testing (VCT) centers. In this period the positive effects of Masa also began to be felt. Although progress was slow at first, and although the programme continued to need more medical practitioners

<sup>22</sup> The UN Development Report for Botswana (2000: 42) explains that the authorities in Botswana came to the following realization: “It does not matter how much information on HIV and AIDS is disseminated; how attentively it is absorbed; or how many condoms are supplied; [as long as the underlying factors of] poverty, financial dependence, inequality, gender discrimination and formidably defended social and cultural norms [...] continue to exist at current levels, the epidemic will rage on.”

than are available (AIDS and Human Rights Research Unit 2007: 15), Masa has by now proven extremely successful, reaching universal access (more than 80%<sup>23</sup> of those who need it) to ART and PMTCT (Avert 2011a). Botswana therefore boasts the most extensive public ART programme in Africa (Jefferis, Kinghorn, Siphambe and Thurlow 2008: 112). The effect of this success in treatment (if not incidence) plays out in several ways. The increase in ART coverage correlates vividly with a decline in tuberculosis (TB) (UNAIDS 2010c: 108). AIDS-related deaths have already peaked (Jefferis, et al. 2008: 114) and declined by more than half between 2002 and 2009. The estimated number of children newly orphaned fell by 40% between 2002 and 2009 (UNAIDS 2010c: 29). Depending on the progression of their parents' disease, many of these children have a chance of coming of age before their parents die of AIDS. Prevalence has also decreased: by 2004, adult prevalence had risen to 25.9%, but then it began to drop slowly, reaching 23.9% in 2007 (see Figure 3). Overall, there is now evidence that during the decade 2000-2010, prevalence declined among young people (aged 15 to 24) and pregnant women presenting at antenatal clinics, while prevalence leveled off for other groups (UNAIDS 2010b: 10).

The more important figure in the long run, of course, is not prevalence but incidence: the number of new infections, which determines the burden of HIV and AIDS sufferers the country must continue to bear in the future. An important problem in this regard is that Botswana's young people (aged 15-24) lag behind their peers in other severely affected countries in their knowledge about HIV and AIDS transmission. Other prominent problems are multiple concurrency<sup>24</sup> (UNAIDS 2010: 15) and continued widespread social stigma and denial. Still, 95% of respondents in a 2008 Botswana Afrobarometer survey think that the government is doing well or fairly well in handling HIV and AIDS, which makes it the aspect of service delivery with which the population is most satisfied (APO 2009). The second National Strategic Framework (NSF II), which will run from 2010-2016, was developed through wide consultation with stakeholders and has four aims: preventing new HIV infections; systems strengthening; strategic information management; and scaling up treatment, care and support. The government and HIV and AIDS stakeholders have set the target of "no new infections by 2016".

The next section will deal with the question of how the country's institutions dealt with this pandemic. Clearly there must be lessons for others.

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<sup>23</sup> Botswana's coverage is over 95% of "those who need ART" if these individuals defined according to the WHO's older guidelines, which were in place when Masa was initiated. See footnote 9.

<sup>24</sup> Multiple concurrency means having more than one sexual relationship that overlap over the same period of time.

## 3.2. Institutions

### 3.2.1. System of government

Botswana is a bicameral parliamentary democracy similar to the English system, but features a president who is by no means a “first among equals” like the prime minister in the Westminster system. Because Botswana’s system of government combines elements of both parliamentarism and presidentialism, the possible risks to democratic consolidation posed by both systems should be considered. This section mentions the most salient features of the system in Botswana and assesses literature regarding the impact of HIV and AIDS on this system.

Section 58 of the constitution (amended 1992 and 2002) dictates that the National Assembly consist of 57 members of parliament (MPs), elected by the 57 constituencies; 4 seats co-opted by parliament; the attorney-general; and the president. The second chamber is the House of Chiefs<sup>25</sup> (Ntlo ya Dikgosi). Any National Assembly bill that is of tribal concern must be referred to the House of Chiefs for advisory (not binding) opinion (Kadima, Matlosa and Shale 2006: 10).

The constitution grants the president of Botswana extensive powers (Freedom House 2011b). From among the members of parliament the president appoints the vice president (subject to parliamentary approval) and cabinet, of which the president is the head. He (or she) is also commander in chief of the armed forces (French 2007: 5). The president alone appoints the Secretary of the Independent Electoral Commission (IEC) and has the power to determine the date and time of the elections, arrangements to which members of the opposition have, predictably, objected (Good and Taylor 2005b: 64; Lekorwe and Tshosa 2005: 52-56; Shale 2009: 64). The president also has the ability to dismiss parliament at any time.

The president is not elected by the general electorate; instead, the presidential candidate supported by more than half of the MPs is declared president (as in prime ministerial parliamentary systems). This “indirect” election of a very powerful president has been a point of some contention (Maudeni 2005: 85), but still satisfies the majority: in 2008,

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<sup>25</sup> The tradition of chieftaincy in Botswana, far from being obsolete in the democratic system, has “displayed a remarkable dynamism, adaptiveness and adaptability to new socio-economic and political developments” and remains relevant in Botswana today (see Nyamnjoh 2003: 93-114).



Afrobarometer found that 58% of citizens supported the current electoral system, as opposed to 41% who favoured direct presidential election (APO 2009).

As discussed in Chapter 2, the strongest objections against presidentialism are the high risk of legislative-executive deadlock; the high stakes of presidential elections; and the president's fixed term of office (see Chapter 2). Because, in the case of Botswana, the ruling party in parliament effectively appoints the president, there is no risk of cohabitation which could lead to deadlock. This aspect of the system is typically parliamentary. However, the amount of power vested in the president is far greater than that vested in a typical prime minister and this has shaped politics in Botswana; and the president's fixed term in office has caused controversy because all presidents have either died or retired before the end of their term, as will be discussed later. The influence of HIV and AIDS on these dynamics will now be discussed.

The president of Botswana is allegedly powerful enough that there have been instances where each president has broken the law without serious repercussions. In a work about "growing authoritarianism in Botswana", Taylor (2005: 3) argues that Seretse Khama, Masire and Mogae have not hesitated to "subordinate the law and the constitution to the political exigencies of the time" (although Freedom House ratings, which will be discussed below, indicate that they have done so within limits). Taylor lists several examples, but none of them are related to these presidents' handling of HIV and AIDS.

In fact, the powerful position of the president may have strengthened the ability of Mogae, whose term coincided with the height of HIV prevalence in the country, to become an influential "AIDS activist" himself. The beginning of his presidency in 1998 marked unprecedented governmental commitment to combating the disease. Writing the foreword to the 2000 United Nations Development Report on Botswana, the then president expressed his understanding of the disease as an unprecedented national challenge to which his government was committed, with the aim of achieving "an AIDS-Free generation in our lifetime" (Mogae 2000: V-VI). Mogae also vowed never to speak in public without mentioning HIV and AIDS and publicly took an HIV test in 2003 (Heald 2006: 11). Under his leadership, Botswana established a public-private partnership called the African Comprehensive HIV/AIDS Partnership (ACHAP) in 2001 to cooperate with international organisations and companies such as the Bill and Melinda Gates Foundation and Merck

Pharmaceuticals<sup>26</sup>. ACHAP aimed not only to channel a great amount of resources into HIV and AIDS efforts but to encourage a new openness in the place of stigma around the disease (Heald 2006: 7). Despite this external injection, in 2006, the government under Mogae funded at least 70% of the national HIV and AIDS effort (Heald 2006: 8) and Khama announced that 90% of HIV and AIDS funding in 2007 came from domestic resources (Khama 2008a). As far as the available literature indicates, the president did not use the pandemic as an excuse for marginalising the opposition or civil society groups. It was during the presidency of Mogae that the second Medium Term Plan (MTP II) saw the inclusion of hitherto excluded stakeholders such as NGOs and private firms in policy development and implementation.

Only one incident of an unlawful extension of presidential power is linked to the pandemic. The executive, in return for unspecified American HIV and AIDS funding, signed an agreement not to hand over American soldiers accused of war crimes. Parliament was not given a chance to debate this decision (Osei-Hwedie and Sebudubudu 2004: 36). This is an example of, firstly, the strength of the executive vis-à-vis the legislature, and secondly, the decreased bargaining power of an AIDS-ridden state dependent on international assistance, which Mattes (2003: 6) and De Waal (2006: 114) argued could erode state policymaking autonomy and legitimacy. Yet it seems to have been an isolated case.

Aside from this example, if HIV and AIDS exacerbated the problem of an over-powerful president, it was primarily by giving him an opportunity to demonstrate his commitment to the cause, possibly gaining legitimacy that allowed him to act forcefully in other policy areas. Even Good and Taylor (2005a; also 2007a, in a scathing article entitled “The Bitter Freedom of Festus Mogae”), do not mention HIV and AIDS in their enumeration of the president’s failings.

As for Mogae’s successor, Ian Khama demonstrates a clear understanding of the issues confronting the country in terms of HIV and AIDS. He has particularly emphasized that the next challenge is to curb incidence and not merely care for the already infected, and called on citizens to change their behaviour and heed the call of “O Icheke [check yourself], break the chain of sexual partners and HIV infection”<sup>27</sup> (Khama 2009). Although there might be

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<sup>26</sup> Other partners include the Harvard Institute, United Nations Development Programme (UNDP), the WHO, Swedish International Development Agency (SIDA) and SADC (Molatole and Thaga 2006: 33).

<sup>27</sup> The practice of having multiple concurrent partnerships is an important factor in driving the epidemic in Botswana (UNAIDS 2010c: 3).

concerns that the new president is increasingly authoritarian, it is hard to establish causality between his behaviour and the problem of HIV and AIDS.

We now turn to the dynamic of the president's fixed term of office. Linz (1990: 54) points out that "[i]t is a paradox of presidential government that while it leads to the personalization of power, its legal mechanisms may also lead, in the event of a sudden midterm succession, to the rise of someone whom the ordinary electoral process would never have made the chief of state." This, critics argue, is a core feature of politics in Botswana. Masire, Mogae and Khama all held the position of vice president and were automatically declared president at the death in office (in the case of Seretse Khama) or retirement of their predecessors, before being elected president in the subsequent elections. This, labeled the practice of "automatic elitist succession" by Good and Taylor (2005b), has come under fire since it enables the president, in appointing his deputy, also in effect to appoint his successor. It thus excludes parliament from the succession process (at least until the end of the retired president's term). No studies suggest a link between HIV and AIDS and presidential succession.

Having examined the impact of HIV and AIDS on the presidential elements of Botswana's system of government, we turn now to parliamentary elements. In parliamentary systems there is a degree of fusion between the legislature and executive: in Botswana the executive (cabinet) is drawn from, and accountable to, the legislature. In theory, these groups are dependent for their functioning upon mutual support: the constitution grants parliament the power to pass a vote of no confidence in the president and his government (Part V Section 59) and in turn also allows the president to dissolve parliament at any time (Part V Section 91). Both actions would result in new elections. The provision that the legislature may dismiss the executive is, however, rarely a practical consideration in Botswana. Members of parliament (MPs) are generally at a disadvantage vis-à-vis the executive, as they lack the necessary expertise to draft bills, and the executive is inclined rather to formulate policy based on the professional expertise and recommendations of the civil service (Sebudubudu and Osei-Hwedie 2006: 38). What is more, executive ministers are not directly called to account in parliament; instead, the permanent secretaries (who are civil servants) appear before the Public Accounts Committee (PAC) (Sebudubudu and Osei-Hwedie 2006: 39).

The president's power to dissolve the parliament, on the other hand, has been a political consideration at certain turns, such as when Mogae threatened to dissolve parliament if it opposed his controversial appointment of Khama as deputy president (Good and Taylor 2005a: 10). Scholars conclude that – as is the case almost always, and worldwide – cabinet

and the bureaucracy occupy stronger positions than parliament (Sebudubudu and Osei-Hwedie 2006: 37-38). Given the executive's relatively "spotless" effort to address HIV and AIDS, led by the president, the crisis has not afforded much opportunity for this relationship to change. One could even argue that the strength of the executive was beneficial to Botswana, as the government responded admirably to the pandemic.

### **3.2.2. Electoral system**

Botswana employs an FPTP electoral system consisting of 57 single-member constituencies. The country has since independence functioned as a multiparty democracy in which one party is dominant. The BDP has (in ten elections) consistently won decisive majorities in parliament<sup>28</sup>. Although opposition parties (led by the Botswana National Front (BNF) since 1979) are weak and prone to infighting, scholars argue that these failings are not the only reason for their consistent losses at the polls. There is reason to argue that political parties in Botswana, like those in Georgia, Malaysia and Malawi, compete on an "uneven playing field" that is skewed in the ruling party's favour (Levitsky and Way 2010). The ruling party's unequal and opaque access to resources, as well as its partisan use of state media, is important matters in this regard (Taylor 2005: 11-13; Saleshando 2009). The problem is compounded by urbanisation and the geographical division of constituencies, which grants disproportionate weight to rural constituencies (Holm 1996, quoted in Osei-Hwedie and Sebudubudu 2005: 42). Since independence the ruling BDP dominated rural constituencies with fewer voters, as opposed to opposition parties who captured many urban constituencies with more voters. This led to disproportionality of representation.

A comparison of votes cast and seats allocated may illustrate this point. The BDP's popularity was on the decline from 1984 to 2004, as it obtained a smaller and smaller percentage of the vote in each successive election: it obtained 75% in 1979, a majority which declined to only 51% in 2004. Under a proportional representation system the opposition parties would thus have come close to being able to form a ruling coalition, and potentially forcing the BDP to demonstrate the extent of its commitment to a democratic system that it does not control. Such a turnover would be regarded as an important indicator of democratic consolidation (although Huntington insists on a double turnover before a country is regarded as entirely consolidated – see Chapter 2). Under the current system, the BDP won 65% of the vote yet was awarded 91% of parliamentary seats in the 1989 election; but when it won a

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<sup>28</sup> A table of the outcomes of all parliamentary elections from 1965 to 2004 is available in Molomo (2005: 32-33).

mere 51% of the vote it was awarded 77% of seats in 2004 (Molomo 2005: 32-33). In the 2009 election the BDP's popularity increased marginally for the first time since 1974. It won 52% of the vote but 79% (45 out of 57) of the seats (IEC Botswana 2011.).

The discrepancy is largely explained by noting that, as mentioned above, the opposition draws its support mostly from urban areas while the increasingly sparsely populated rural areas are usually BDP strongholds – indeed 80% of seats in parliament represent rural areas while more than half the population is now urbanized<sup>29</sup>. Under the FPTP system, rural and urban constituencies carry the same weight regardless of the size of the population they represent, sending one MP each to parliament – even if urban constituencies include considerably more voters. The vastly disproportionate translation of votes into seats is the clearest motivation for calls for electoral reform away from disproportionate constituencies. The fact that, until recently, HIV prevalence was also considerably higher in urban than rural areas would be one more reason to argue that rural and urban constituencies need to be equally represented to parliament in terms of population size.

Calls for electoral reform have emanated from the opposition, civil society and academia (see Molomo 2005; 2007; Matlosa 2004; Sebudubudu and Osei-Hwedie 2005: 7-9). If an alternative system is suggested, it is usually Mixed Member Proportionality (MMP) (for instance, Molomo 2004 and Matlosa 2004). However, the general population is comfortable with the system: in 2008, 66% of respondents believed that the electoral process worked either well or very well in ensuring that Parliament reflected the will of the voters (APO 2009). In other words, proponents of electoral reform are so far unsuccessful in convincing a population that tends to “go with the flow when it comes to politics” (Cook and Sarkin 2010: 477), that their democracy leaves room for improvement in this regard. This may be part of the reason why civil society in Botswana remains rather weak.

Whether the issue of electoral reform enjoys attention or not, its supporters do not explicitly cite the influence of HIV and AIDS on the viability of FPTP as a motivation for their campaign. Yet Per Strand (2005: 7) made the point that proportional representation (PR) is superior to FPTP in the context of HIV and AIDS because FPTP requires holding by-elections when an MP needs to be replaced between general elections, whereas with PR, the

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<sup>29</sup> Sources vary on the rate of urbanization in Botswana. Depending on methodology and data sources, the urban population as a percentage of the total population has respectively been estimated at 48% (Barnett and Whiteside 2008: 137), 73% (Thomson 2004: 104), 57% (World Bank 2010b – data for 2005); and 60% (Unicef 2010) in the last decade. What is evident is that rapid urbanisation is occurring and that the urban population - however it is measured - can be expected to grow even larger in relation to the rural population.

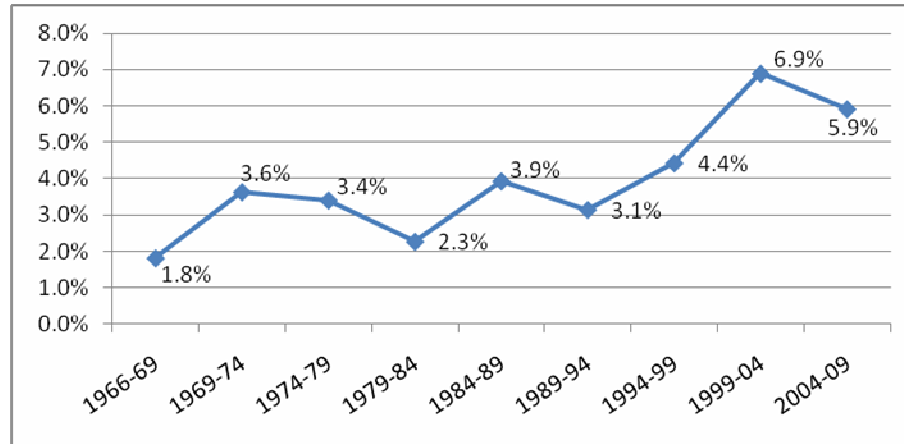
next person on the party list may simply be appointed to parliament. As stated in Chapter 1, Strand (2005) argued that the disadvantages of a (possibly AIDS-induced) increase in by-elections include increased expense for the treasury; a reduced voter turnout and weaker mandate for the winner of the by-election and a possible increase in the ruling party's power. The important study led and edited by Chirambo (2008) on the political cost of AIDS in Southern African states, which tested the abovementioned hypotheses, did however not cover Botswana. This study therefore draws upon the work of Gossett and Lotshwao (2010), who studied the impact of AIDS on electoral systems in Botswana specifically.

Strand's (2005) argument (above) about the preferability of PR over FPTP systems in the context of HIV and AIDS was based upon the expectation that the pandemic would cause the death of a significant number of elected representatives. Bearing this in mind, Gossett and Lotshwao (2010) studied the reasons why MPs in Botswana vacated their seats between 1965 and 2009. Too few parliamentary by-elections had taken place to allow patterns to emerge – 21 in the 44-year period covered. Only four of the by-elections between 1984 and 2009 (the period in which HIV was known to be present in Botswana) were due to the death of the representative. During this period only once, between 1995 and 1999, did two MPs die in the same term. Both these men had at least 20 years' experience in politics behind them and the authors suggest that their deaths could just as easily have been because of other diseases related to aging rather than because of AIDS. There is thus no evidence that a single MP has died of AIDS.

On the local level, in contrast, the authors found a clear trend as they studied 160 by-elections for district council and town council positions. Since 1994, deaths as a percentage of all members have reached higher levels than ever before. The period 1999 to 2004 saw an unprecedented spike in deaths as a percentage of councillors from 4.4% to 6.9% (see Figure 4). However in the period 2004 to 2009, deaths as a percentage of positions declined again (to 5.9%), but were still more than any period before 1999 (this roughly corresponds with the increasing availability of ART). Thus the FPTP system is not necessarily a threat to parliamentary democracy at national level in Botswana, but it may have a significant influence on local government, especially where prevalence is high (in mining towns, tourist destinations and on the trade routes).

Figure 4: **Deaths as a Percentage of Total Membership on Botswana District and Town Councils**

*Source: Gossett and Lotshwao (2010: 13).*



The impact of an increase in by-elections needs further investigation, but the researchers made the following points. Firstly, the government of Botswana is reportedly spending an unprecedented amount on by-elections (it was estimated in 2008 that each by-election costs the government \$18 900) (Gossett and Lotshwao 2010). In a poorer country, this could have been devastating, while no costs would be incurred in a PR system. Secondly, Gossett and Lotshwao find no evidence that by-elections advantage the ruling party; the BDP lost more seats than it won in local by-elections between 1990 and 2009, the period during which AIDS was widespread throughout the population. The researchers did not investigate whether there was lower voter turnout at by-elections (as is usually the case). Ultimately the question is whether the pandemic has reduced the legitimacy of the local government electoral system or elected candidates in the eyes of voters – such an impact could be determined using surveys.

Besides electoral system legitimacy, Leftwich (2000:138) also notes that the electorate must consider the outcome of the elections legitimately free and fair. Thinking along the same lines, Strand (2005: 4) warns that HIV and AIDS affect both electoral *systems* (as discussed above) and electoral *governance*. He anticipates, for instance, increased trouble with keeping the voters' roll up to date and higher turnover of electoral management board (EMB) staff; the related loss of continuity and the need to accommodate large numbers of sick voters (see also, Youde 2001).

We turn now to the experience of electoral governance in practice. Elections in Botswana have been held every five years since 1965 and have always been declared free and fair by observers. After complaints about the lack of an independent electoral body (Shale 2009: 63), a referendum was held in 1997 and the constitution was subsequently amended to lower the voting age from 21 to 18; to create an absentee ballot (for citizens outside Botswana at voting time); and to establish an independent electoral commission (IEC) (Molomo 2005: 34-35). The reforms of 1997 ended the most salient complaints about the transparency of electoral *governance* – but at the same time, HIV prevalence was nearing its peak, posing new challenges, particularly as it is among the 15-49 years age group that HIV infection is the most prevalent. (As mentioned, AIDS mortality has peaked, and declined dramatically after 2002.)

For one there is the problem of enabling a large percentage of voters who are sick to cast their vote. In Botswana those who are too sick to register for voting have the right to request the local registration officer to register for them, but Youde (2001: 15) expressed his doubts with regards to the practicality of this system. Those who provide care for the sick may also be excluded if multiple trips are required in order to register and vote. However, PLWHA are not a vocal pressure group in Botswana and there is no research specifically indicating the number of PLWHA who vote and whether they face particular challenges. The new IEC brought out short reports on the elections of 1999 and 2004, but these did not mention the influence of the disease. Nor has the IEC acknowledged any problems with recruitment or a loss of institutional memory.

Given little detailed research into the impact of HIV and AIDS on electoral governance, we may look at the overall legitimacy of the elections in the eyes of Botswana's voters. In 1999, at the height of the pandemic, a combined 83% of citizens of Botswana expressed confidence that the recent national elections was both free and fair, or free and fair but with some minor problems. They expressed even higher confidence in the 2004 elections, the combined total coming to 84% in 2005 and 86% in 2008 (Afrobarometer 2009c: 10). A great majority of citizens therefore consider electoral governance legitimate despite the problems discussed here – in fact, their trust in the system has recently increased.

To conclude, firstly, a study of the impact of HIV and AIDS within the FPTP system in Botswana does not present a particularly strong case for electoral reform at the national level (although disproportionate urban/rural HIV prevalence could formerly have presented such a case). It is not certain that a single MP has died of AIDS. However, local government has



been seriously affected and the legitimacy of district and town councils should be investigated. Secondly, there has been little attention paid to the challenges that Botswana faces in electoral governance in an era of AIDS. For now, the public approves of electoral governance, and the potential administrative pitfalls listed by Strand (2005: 4) and Youde (2001) have not yet come to light. With Botswana now achieving universal access to ART and mortality rates having peaked (see the introduction to this chapter), the worst may already be over.

### **3.2.3. Political Rights and Civil Liberties**

In Chapter 2 it was argued that the degree of respect afforded to political rights and civil liberties influences democratic consolidation, both by definition and causally. If HIV and AIDS influence citizens' ability to enjoy these rights, whether positively or negatively, it can be said to influence democratic consolidation in the same direction.

Because of limitations in terms of time and length, this study cannot present information on all aspects of civil rights and political liberties in Botswana. The country's Freedom House scores are presented here in order to give an overall impression of the freedoms citizens have enjoyed since independence, followed by a brief overview of current human rights issues. Thereafter the focus shifts to those rights and liberties that have reportedly been affected by HIV and AIDS.

Botswana has been rated Free since 1974 (Freedom House ratings are available from 1973) and scored 2 for both political rights and civil liberties from 1995 to 2009. Botswana's score for political rights declined in 2010 from 2 to 3 due to "decreased transparency and accountability in the executive branch under President Seretse Khama Ian Khama<sup>30</sup>" (Freedom House 2010a). Political rights related to democratic participation (such as the right to vote or to compete for public office) have not explicitly been violated (see also, the section on electoral systems above). The decreased rating is probably more related to the president's style of governance and the hand of his executive in controversial events, described below, than with HIV and AIDS directly.

Although the government of Botswana generally respects citizens' civil liberties, as enshrined in Chapter II of the constitution, a long-standing dispute over the plight of the Basarwa (also

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<sup>30</sup> Seretse Khama Ian Khama, or Ian a Sérêtsê, is the full name of the president.

called the San or Bushmen)<sup>31</sup> has clouded its civil liberties record. Further question marks over the government's otherwise relatively respectful treatment of citizens have become more common in the last decade (Good and Taylor 2007b). A recent spate of extrajudicial killings by security forces were allegedly ordered by the recent Khama administration (Freedom House 2010a). With regards to freedom of speech the private media in Botswana, although available since 1982 (Holm and Darnolf 2000: 136), has never been on equal par with state-owned media, partly due to a lack of funds. There are reports that the government occasionally has censored or restricted the public media and accused the private media, when it was critical of the government, of being unpatriotic and "rallying behind the enemy" (Reporters Without Borders 2006). A Media Practitioners Act, which requires all media workers to register with a committee that reports to the government, was passed in 2008. Furthermore, the National Security Act of 1986 has been used only against journalists and trade unionists. (This implies the silencing of civil society.) Despite these apparent infringements upon freedom of speech, a combined 83% of respondents in the 2008 Afrobarometer survey felt "completely free" to say what they think (Afrobarometer 2009c: 11). None of these matters – the plight of the Basarwa; the alleged extrajudicial killings; and the occasionally restricted media environment – have been linked directly to HIV and AIDS.

In 2007, a study (AIDS and Human Rights Research Unit 2007) highlighted legal aspects of Botswana's HIV and AIDS policy and practices. The right to privacy of PLWHA is protected, and the disease is not legally notifiable in the public health system, although record is kept of infection levels for planning purposes (AIDS and Human Rights Research Unit 2007: 16-17). In 2000, the Court of Appeal has set a precedent whereby constitutional protection from discrimination extends to PLWHA (AIDS and Human Rights Research Unit 2007: 20-21). Until recently the government has tested potential civil service employees of foreign nationality for HIV, implying that the state could discriminate on the basis of HIV status. Government-sponsored students intending to study abroad; persons convicted of rape and potential employees of some private firms (such as Debswana) were also subjected to compulsory HIV testing. Such practices were rendered illegal by recent legislation including the Employment Act of 2010 (Freedom House 2011b) and the Public Service Act (see the section on civil society below). Moreover, according to some legal scholars, the law does not sufficiently protect women from certain discriminatory customs that exacerbate

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<sup>31</sup> The Basarwa were forcibly evicted from their ancestral lands in 2002. After winning a court case, they were allowed to resettle there in 2006, but it took two more battles in court for them to be re-allowed access to a well in the vicinity, of which the government had taken control after their eviction. Five judges in the High Court (which serves as the court of appeal) unanimously ruled against the government in January 2011, stating that denying the Basarwa access to their well amounted to "degrading" treatment (Survival International 2011).

their political and economic subjugation to men and which exacerbates their risk of contracting HIV (AIDS and Human Rights Research Unit 2007: 24-26). Judged in context, Botswana has been relatively responsive to HIV and AIDS-related concerns with regards to political rights and civil liberties, as its policy initiatives and treatment interventions are the best in Africa.

The right to medicine is not a basic political right or civil liberty (see Freedom House's definition of these freedoms). The constitution does not explicitly guarantee the right to health, but it does guarantee the right to life (Part II Section 4). This, interpreted broadly, can be said to imply a governmental obligation to promote long life and eliminate epidemics (AIDS and Human Rights Research Unit 2007: 12). The government of Botswana itself established a link between the right to life and HIV and AIDS: in a report to the United Nations Human Rights Committee (HRC), the government of Botswana listed a range of health measures, including HIV and AIDS-related measures, that were implemented "[i]n order to increase life expectancy and promote the right to life" (HRC 2007: 30). It is therefore relevant that President Khama announced in 2008: "the level of [ART] response is unsustainable in the face of other competing development imperatives. At this rate, continued progress cannot be guaranteed." Freedom House (2010a) also notes that in the light of recent revenue shortfalls the government announced a cutback on HIV and AIDS spending. By then (see Jefferis, et al. 2008: 114), AIDS mortality had peaked already (but this was possibly due to the extensive provision of ART after 2002).

To conclude, political rights and civil liberties have been relatively well protected in Botswana despite HIV and AIDS. It has been argued that citizens have the right to ART based on their right to life, yet there are indications that the government's commitment to the provision of ART could wane in future. That civil society, in its present weak position (see below), or the opposition (see above) will organise against the possibility of decreased AIDS spending, seems unlikely. Instead, the focus may fall on the courts. However, so far no steps have been made to decrease funding.

### **3.3. Socio-economic factors**

#### **3.3.1. Affluence, economic growth and inequality reduction**

Chapter 1 gave an overview of the expected economic effects of HIV and AIDS in Southern African countries. It was concluded that scholars anticipated that HIV and AIDS would

reduce African states' GDP growth and increase inequality, while the impact on affluence (in terms of aggregate income *per capita*) was uncertain. Taking into account that theory (particularly that of Przeworski, et al. 1996) has linked these three macroeconomic factors to democratic consolidation, Mattes (2003) considers the economic effects of HIV and AIDS problematic for democratic consolidation, especially in poorer countries. An overview of Botswana's status in terms of these factors will be presented here, followed by an assessment of how HIV and AIDS are believed to influence them.

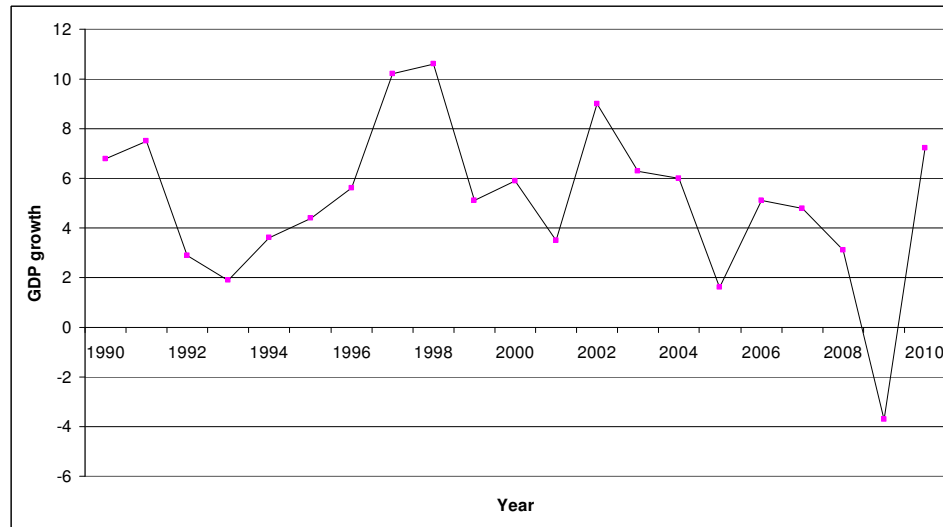
Botswana is considered an upper middle income country by the World Bank, and, in terms of this study, affluent. In 2010 it generated an estimated GDP (PPP) of \$26.6 trillion (CIA World Factbook 2011) and in 2009 its GDP *per capita* (PPP)<sup>32</sup> was estimated at \$13 384 for 2009 (World Bank 2010a). This level of *per capita* income places it above the level of \$12 195.78 beyond which democracies may, according to the Przeworski, et al. study (1996), be considered "impregnable". Of course it is not impossible that a democracy may "die"<sup>33</sup> at a higher level of affluence in the future. When considering such a possibility, the interplay between income *per capita* and other indicators of human development and institutional erosion is crucial – as will be explained hereunder.

Botswana has registered impressive levels of economic growth (see Figure 5). The past decade has however seen fluctuations, with the country registering a 3.7% contraction in 2009 due to global financial instability, followed by 7.2% growth in 2010 as the economy rebounded. These events confirm that the economy is vulnerable to external shocks, especially because it is heavily reliant on diamonds, from which analysts insist it must diversify if sustainable growth is to be attained (Siphambe 2011: 37; Benza 2011).

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<sup>32</sup> The figures used by Przeworski, et al. (1996) were drawn from version 5.5 of the Penn World Tables. This table estimated states' gross domestic product (GDP) at purchasing power parity (PPP), using 1985 as baseline. Newer versions of the Penn World Tables provide more recent data but their methodology differs from earlier versions, rendering Przeworski, et al.'s (1996) figures incomparable. However, it is assumed that the \$6 000 level provided by Przeworski, et al. (1996) was not provided as a precise figure.

<sup>33</sup> The Przeworski, et al. study (1996: 39) used a minimal definition of democracy, counting as democratic "all regimes that hold elections in which the opposition has some chance of winning and taking office". A transition to dictatorship, in which the abovementioned condition is no longer met, was treated as a democratic "death".

**Figure 5. Botswana GDP growth (% annual), 1990-2010***Source: World Bank / OECD 2011.*

Botswana has been quite unequal since independence. Holm and Darnolf (2000: 119) argue that the government has not attempted to change the distribution of income in the country and that inequality has remained at the same level since independence, or even worsened. Using Botswana's Household Income and Expenditure Surveys (HIES), Siphambe (2011: 54) produces the following Gini coefficients: 0.556 in 1985/6; 0.537 in 1993/4; and 0.573 in 2002/3. He concludes that income inequality has increased marginally since the 1985/6 study, meaning that Botswana's high levels of economic growth have not benefited the poor as much as the wealthy. The country also suffers from high, stagnant unemployment (at 17.6% in 2005/6), rooted in high population growth and slow job growth (Siphambe 2011: 32; 47).

Against this background, we may now focus on HIV and AIDS and the economy. Macroeconomic studies by BIDPA (2000), Bollinger and Stover (1999), Greener, Jefferis and Siphambe (2000), Masha (2004) and Jefferis, et al. (2008) investigate the macroeconomic impact of the pandemic in Botswana<sup>34</sup>. Of these, only the Masha (2004) and Jefferis, et al. (2008) studies are recent enough to take into account the widespread availability of ART. The Jefferis, et al. (2008) study benefits from the most recent economic and epidemiological data for Botswana.

<sup>34</sup> There are also studies on the micro-level economic impact of HIV and AIDS in Botswana. They tend to confirm that in Botswana, businesses, households and government are negatively affected by the disease, as previously suggested. Because the macroeconomic studies mentioned here attempt to take such costs into account, these studies will not be elaborated upon here.

Jefferis, et al. (2008: 118) find that in Botswana “the macroeconomic impact of HIV/AIDS is now severe enough to be affecting the economy as a whole, thereby pulling some of the uninfected population into poverty.” Methodologically they concur with the projections expressed in Chapter 1: when they consider the macroeconomic effect of the epidemic, they factor in impact channels such as lower productivity, loss of skills and experience, greater health expenditure and reduced savings and investments (Jefferis, et al. 2008: 114). They also consider two scenarios of the economic impact of the disease on government expenditure: the fiscal cost of providing treatment versus the fiscal cost of not providing treatment, but then fulfilling other obligations such as orphan support.

Jefferis, et al. (2008) find that even with the provision of ART to 80% of those who need it (which has now become a reality), the economy of Botswana will grow 1.2% less per annum than in a no-AIDS scenario. After 20 years, this means that the economy will be one fifth smaller than in the absence of HIV and AIDS.<sup>35</sup> If ART is not provided, the blow to economic growth is much greater. Siphambe (2011: 22) also mentions HIV and AIDS as a factor that has hampered economic growth in the past decade.

Like older studies (for instance, Greener, et al. 2000), Jefferis, et al. (2008: 116) find that the negative impact on economic growth outstrips the decline in population growth, pushing average incomes down to between 1.1% and 2.2% less than they would have been in the absence of the disease (but not reversing them). By 2021, average real incomes are projected to be 10-15% lower than without AIDS, but if ART is provided to 80% of those who need it, this effect can be lessened. They also find that labour-intensive industries such as agriculture will be harder hit than capital-intensive industries such as the mining sector, especially since lower skilled labourers have higher prevalence rates and less access to ART (Jefferis, et al. 2008: 116). They thus expect Botswana’s experience to contradict Pharaoh and Schönreich (2003: 7) who stated that HIV and AIDS have a particularly pronounced effect on the mining sectors of SADC states. The authors however do not discuss inequality directly. Greener, et al. (2000) did not expect the GINI coefficient to be affected by HIV and AIDS, but their model assumed that all sectors of society were equally likely to become infected with HIV. In contrast, Jefferis, et al. (2008) mention that lower skilled labourers have higher prevalence levels. No recent investigation of the impact of the pandemic on

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<sup>35</sup> Jefferis, et al. (2008: 117) also find that the total costs of HIV and AIDS to the government, should it not provide ART, is only slightly lower than if it does provide ART. This is because, should the government “save” by not providing ART, the cost of caring for the sick and dying and of supporting orphans would vastly increase; while the economy would suffer greater setbacks and the government would receive less in revenue than in the with-ART scenario.

stagnant income inequality in Botswana is forthcoming. However, they do re-affirm Greener, et al.'s (2000) finding that the macroeconomic effect of HIV and AIDS is sufficiently large to drag uninfected persons and households into poverty through its retarding impact on income and employment growth. The model used also shows that ART can prevent between one-third and one-half of AIDS-induced poverty (Jefferis, et al. 2008: 118). As such, ART mitigates against the regression of democracy.

To conclude, the three indicators (affluence, economic growth and inequality) all seem to be affected negatively by HIV and AIDS, although not as much as initially projected. Firstly, in terms of affluence, the emerging picture is contrary to expectations: whereas older models projected that populations may fall faster than national incomes, thereby pushing up GDP *per capita* (Mattes 2003: 4), recent models for Botswana suggest that the indirect effects of reduced economic growth are great enough to overshadow the decline in population growth. This means that, while Botswana is already above Przeworski, et al.'s (1996) level for "impregnable" democracies and remains on an upward trend, this figure climbs at a slower pace because of HIV and AIDS. Secondly, Botswana's experience seems consistent with Mattes's (2003: 4) expectation that economic growth will be hampered by HIV and AIDS, especially increased health costs. Thirdly, in terms of inequality, the evidence is unfortunately inconclusive. In the absence of such data, it is worth noting that studies (Greener, et al. 2000; Jefferis, et al. 2008) agree that the poor in Botswana, as elsewhere, will be the group hardest hit financially by HIV and AIDS. Jefferis, et al. (2008: 113) argue that the impact of HIV and AIDS is now severe enough to pull some of the uninfected into poverty. But whether this would erode civil society and the wealthier middle classes (who tend to have better access to ART) is conjecture at this stage.

Some important caveats remain. The studies quoted above offer projections for, at most, up to 2020. Given that HIV and AIDS is a long-wave event (Barnett 2006: 302-303), certain impacts may be felt far beyond this date. For instance, it remains to be seen whether children newly orphaned in the 2000s will be able to find employment as adults one or two decades later. The Jefferis, et al. (2008) study also assumes that the government will continue to provide ART on a wide scale to those who need it. As already mentioned, there has been mention of a possibility that the government may cut back on HIV and AIDS expenditure in the future, making the poor more vulnerable. The government, usually praised for its prudent fiscal policies, announced that instead of the surplus it predicted for 2003/4 it would run a deficit of \$396 million due to AIDS expenses (Zaba, et al. 2004: S6). The report (UNAIDS 2010b: 15) of the government to UNAIDS in 2010 projected a 60% increase in

the need for adult ART by 2016 – it is therefore worrisome that the level of fiscal expenditure on HIV and AIDS has a trade-off effect on other human development priorities (Youde 2009: 221; Molatole and Thaga 2006: 37). We turn now to a study of these priorities, as defined and measured by the United Nations.

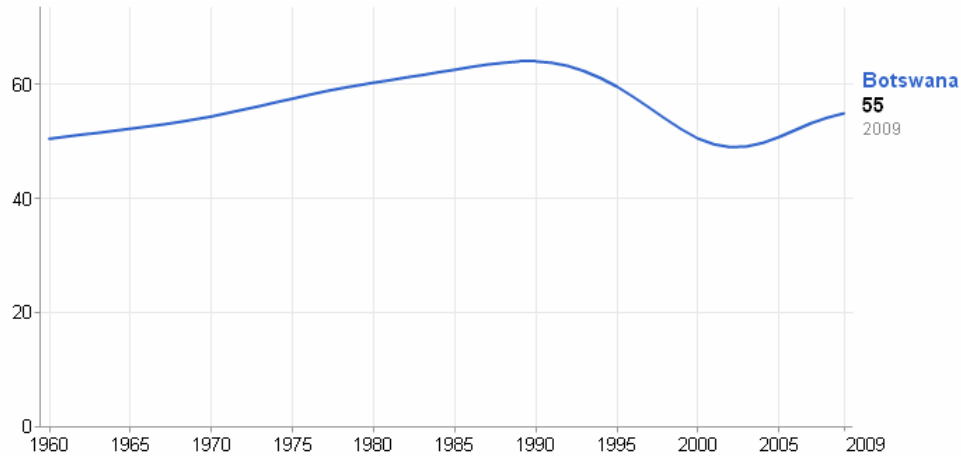
### **3.3.2. Trends in Human Development (UN HDI)**

As noted in Chapter 2, Welzel, et al. (2003) use the World Values Surveys to identify a causal relationship between human development and democratization. Human development, for them, is synonymous with “growing individual resources”, which includes income and education. Scholars of democratic consolidation such as Bratton and Van de Walle (1997) and Leftwich (2000) (quoted in Chapter 2) consider human development crucial for democratic consolidation. All these authors found that correlations existed. If the HIV and AIDS pandemic is seen as detrimental to human development, it may by the same token be detrimental to democratic consolidation.

Since independence, the government of Botswana has made a relatively rare effort to reach even its rural areas in terms of service delivery (Robinson 2009: 3). By 2000, 75% of citizens had access to basic amenities like healthcare and drinking water (UNDP 2000: 8). Reflecting successes in healthcare development, life expectancy in Botswana climbed steadily to a high of 64.1 years in 1989 (see Figure 6). However, as Mogae wrote (UNDP 2000: V): “It took us three decades to build [a good human development] record. Yet, the HIV and AIDS epidemic threatens to wipe it out in less than a decade”.

After 1989, the disease began to take its toll on life expectancy (see Figure 6). Within 13 years this figure plummeted, reaching 49.0 years in 2002. Hospital admissions doubled between 1990 and 1996, with deaths as a percentage of discharges demonstrating a steady increase over the same period (UNDP 2000: 21). There is no other explanation but HIV and AIDS for these trends. As Ian Taylor bitterly points out, Botswana is “fairly unique” in experiencing a fall in human development accompanied by high economic growth (Taylor 2005: 3). After 2002 the life expectancy curve sloped upwards again, reaching 55 years by 2009 (World Bank 2011c). These statistics demonstrate the success of universal access to PTMTC treatment and the Masa programme, discussed in the introductory section of this thesis. The disease has therefore drastically lowered health (life expectancy), but the availability of appropriate medical treatment has slowly begun to make a difference in longevity. This achievement, as described, is not cheap.



**Figure 6. Botswana Life Expectancy at birth, 1960 - 2009***Source: World Bank 2011c.*

With regards to education, as with health, Botswana has made impressive progress and it seems that its successes in this regard have not been as severely affected. 75% of adults in Botswana are literate, with literacy also high in rural areas and 96% of primary school age children are in school (Barnett and Whiteside 2008: 137). Even in the context of HIV and AIDS the UNDP's overall education index for Botswana is still on an upward trend (see Table 1). Increases in literacy have levelled off, but have not been reversed by the pandemic. Education expenditure remains quite high at 10% of GDP (World Bank 2011b).

**Table 1. Botswana Education index, selected years, 1980 - 2010***Source: UNDP 2010.*

1980	1985	1990	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
0.26	0.36	0.47	0.54	0.61	0.62	0.62	0.63	0.64	0.64	0.65	0.65	0.66	0.66	0.67

While qualitative research on the impact of HIV and AIDS on education in Botswana is not forthcoming<sup>36</sup>, one estimate in 2001 was that 35% to 40% of Botswana's teachers had HIV and AIDS, which was more than other professionals (Youde 2001: 37). One study also estimated that half of the students at the University of Botswana were HIV positive (Youde

<sup>36</sup> One more publication (Motshegwa 2003) at the University of Botswana could have helped to shed light on the qualitative impact of the disease on the education system in this country, but the researcher was unable to access it due to time constraints.

2001: 38). Given such prevalence rates, Birdsall and Hamoudi (2006: 141-143) estimated that, in order to maintain its current teacher-student ratio, Botswana would need to train almost 150% more teachers to offset the estimated teacher attrition rates due to AIDS.

However, newer empirical data contradict these estimates. Bennell (2005: 448) pointed out that in 2001, teacher turnover (transfers, study leave and mortality) in Botswana was 14%, which is more than 25 times the figure for teacher mortality in the same year. In other words, AIDS did not play a major role in the loss of teachers. In 2002-2003, similarly, teacher deaths did not exceed 1% of the total number of teachers and it has declined further thereafter as the amount of teachers accessing ART has increased<sup>37</sup> (Bennell 2006: 2). It seems that ART is also keeping teacher absenteeism relatively low, with most students and staff members surveyed not considering teacher absenteeism a “serious problem” (Bennell 2005: 449). At the time of Bennell’s (2006) update on the impact of AIDS on education, new graduates from the six teaching colleges were struggling to find work. Empirical data, therefore, suggests that the impact of AIDS on education has been exaggerated in Botswana.

HIV and AIDS have thus had a severe effect on human development, especially in terms of life expectancy and increased health care costs. The education system, which ultimately builds human capital for the future, has fortunately not been affected as severely as some studies suggested. Still, the Botswana Human Development Report 2000 is quite justified in calling HIV and AIDS “an antithesis to human development” (UNDP 2000: 2). Following Welzel (2003), one could argue that reduced levels of human development mean that the population of Botswana will be less inclined to attach value to freedom of choice – including, ultimately, choice of government.

### **3.3.3. Civil Society**

As discussed in Chapter 2, a rich and pluralistic civil society is considered essential for democratic consolidation. Butler’s (2005) argument is that in South Africa, HIV and AIDS politics has had a positive impact on civil society and by extension, on democratic consolidation. Mattes (2003: 9), on the other hand, is concerned with the loss of human capital within voluntary organisations due to AIDS. De Waal (2006: 42) finds proof of both processes in different countries.

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<sup>37</sup> Botswana’s public sector teachers were the first in Africa to receive ART, with about 62 teachers receiving treatment through the government’s medical scheme by 1999 and 474 by 2002 (Bennell 2006: 2).

A robust civil society has historically been lacking in Botswana (Holm 1996; Osei-Hwedie and Sebudubudu 2004; Carroll and Carroll 2004). A variety of reasons account for this, including the specific experience of Botswana as a Protectorate. Ian Taylor (2005: 2) puts it, “the experience of popular struggle was wholly absent” in the process of decolonization. Political parties only emerged in the last 15 years leading up to independence and the Botswana Democratic Party, which came to power at independence and has been in power ever since, received support from the colonial government (Mokopakgosi and Molomo 2000: 5).

In the past two decades, however, a range of voluntary associations have emerged in Botswana. Carroll and Carroll (2004: 334) investigated this “rapid growth” of civil society organisations (CSOs) in the 1990’s. They found that this sector grew from “only the most rudimentary beginnings of a civil society” in 1989 to “literally hundreds of functioning indigenous non-governmental organisations”, of which many frequently gave input in government policy, a mere ten years later. This growth has continued in the 2000’s. Business associations developed as the amount of small to medium business owners grew in the late 1980’s (Carroll and Carroll 2004: 340-341). A national women’s group, Emang Basadi, was founded in 1986 in response to the government’s refusal to change discriminatory citizenship laws, and subsequently managed to win their case against this law in the Court of Appeal and place gender issues on the political agenda (Maudeni 2004: 45; Carroll and Carroll 2004: 341-343).

This proliferation of CSOs, over the past 20 years, has coincided with the spread of HIV through the population. In identifying the core factors that contributed to this process, Carroll and Carroll do not mention the pandemic. If it can be demonstrated that citizens who became involved in these civil society organisations would not have done so had it not been for the disease, the line of causation between HIV and AIDS and the encouragement of political participation, in terms of *numerical growth*, could be established. This relationship is not explicitly stated, but many of the new groups are HIV and AIDS-related<sup>38</sup>.

There is a more obvious relationship between AIDS and the *attitude of government* toward civil society (Carroll and Carroll 2004: 351). Before the mid-1990s, government was hostile to

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<sup>38</sup> Prominent organisations include the Botswana Network of People Living with HIV and AIDS (BONEPWA); the Botswana Network of Ethic Law and HIV and AIDS (BONELA); Botswana Christian AIDS Intervention Program (BOCAIP) and the Botswana Business Coalition on AIDS (BBCA). Like most in Botswana, these HIV and AIDS-related CSOs fall under an umbrella body, the Botswana Network of AIDS Service Organisations (BONASO).

interventions by fledgling civil society, unless they were carrying out entirely uncontroversial activities (such as the Red Cross). This was especially true of foreign NGOs (Carroll and Carroll 2004: 339). By the mid-1990s, however, the government had accepted the input of CSOs and began to consult with them on policy issues, including HIV and AIDS. Umbrella bodies were formed with international and governmental assistance, the main one being the Botswana Council of non-governmental organisations (BOCONGO), under which BONASO resorts. The government is in the habit of consulting with them.

Carroll and Carroll (2004: 349) speculate that the government's change in attitude (lead at the time by Masire and Mogae) was motivated, among other things, by the continued pressure of international organisations and donors to include civil society in policy making processes. Since this change coincided with Botswana's increasing cooperation with foreign donors for HIV and AIDS funding, there is a correlation with the hypothesis of De Waal (2006: 114, see Chapter 1) that, amid increased reliance on international assistance, governments may become less able to resist outside pressures. At the same time the change in policy could have stemmed from simple executive pragmatism. The government states that HIV and AIDS-related community organisations were encouraged in the early 1990s as the size of the pandemic exceeded government capacity (DCHAP 2011), and because the government and civil society "[e]ach brings major strengths that can complement the gaps and weaknesses of the other" (Rau 2006: 293). In other words, HIV and AIDS may have motivated the government to be more welcoming towards the input from civil society, indirectly (through decreased bargaining power vis-à-vis the pressures of international community) and/or directly (through a need for CSOs' assistance in fighting the pandemic).

For whatever reason, the government of Botswana has a well-established relationship with HIV and AIDS-related CSOs. It calls them the "Health Support Network" and acknowledges them as "the major stakeholders in implementation of HIV and AIDS programmes". Among the roles that CSOs fulfill, the government lists "reaching marginalized vulnerable and underserved communities with ease"; "monitoring and advocacy for quality of health services" and "mobilizing material and financial support" (DHAPC 2011). President Ian Khama thanks civil society (including the private sector) for their part in HIV and AIDS efforts, saying that "Government cannot win this war alone" (Khama 2008b: 10).

The positive working relationship between government and civil society seems encouraging in terms of the country's fight against HIV and AIDS. But civil society that is in effect

merely an extension of government cannot contribute to democratic consolidation as it needs to (Friedman 2003). It must be evident that civil society provides citizens with a source of power that is not dependent on the state, and/or that it encourages political participation among citizens. But most scholars agree that this is not the case (Mogalakwe and Sebudubudu 2006: 211). Taylor (2003: 81) asserted that “civil society in Botswana is readily co-opted into state structures, lacks a strong grassroots base and is prepared to work within the parameters deemed permissible by the state – and not beyond.” As late as during the 2004 elections, Sebudubudu and Osei-Hwedie (2005: 28-29) describe the vigorous separation of political and civil matters, a separation maintained apparently by political parties as well as civil society organisations. Indeed, the inclusion of the word “Service” in the BONASO acronym is perhaps indicative of the non-political orientation of most of these groups. Many NGOs are partly funded by government or entirely funded by donors, rendering them unable to define their own priorities. Recently donor support for civil society groups has declined (Osei-Hwedie and Sebudubudu 2005: 2), so that groups that turn down government funding and are not membership-based are found not to be “mobilising material and financial support” but rather to be ill-resourced.

On the other hand, Maundeni (2004: 10) argues that the portrayal of Botswana’s civil society as “weak” is Eurocentric. In the context of Botswana politics, “lengthy debates are common and confrontations are unusual”. Deborah Durham (1999: 196) similarly argues that if scholars consider civil society in Botswana weak, it is because of “a lack of familiarity with everyday life in villages and towns on the part of those Western social scientists who have been most vocal in dissecting the public sphere in this African context”. Instead, Maundeni (2004: 16-17) argues that in Botswana, civil society organisations’ strength can be measured in their ability to secure the attendance of relevant government ministers at their events, where there is the opportunity for “mutual criticism in each other’s presence”. “Street encounters”, such as verbal attacks and industrial strikes, are frowned upon and less effective (Maundeni 2004: 18-20).

But civil society that, whether for cultural or other reasons, is only influential as long as it does not fall out of favour with the government, simply cannot provide citizens with an effective counterweight to state power. There is a lack of evidence that civil society has been willing to challenge the government with regards to HIV and AIDS policy. This lack may be rooted either in a continued subservience of the population to the leadership and authority of the government; or it may indicate a specific policy failure, namely, that the government has led the HIV and AIDS response in a “top-down, bureaucratic and patronising” manner,

leaving little room for a grassroots activism to develop (Molutsi and Badade 1999, quoted in Stegling 2004: 240). Stegling (2004: 240) points to studies that indicate that the disease has been “desexualised” through public discussion, while few citizens have yet internalised HIV messages.

Carroll and Carroll (2004: 351) recognise that initially, HIV and AIDS had the effect of strengthening civil society's position in Botswana as the demands of the pandemic rendered the government of Botswana more open to civil society assistance. However, they fear that in the long term civil society organisations are losing human capital. As mentioned in Chapter 1, Mattes (2003: 9), De Waal (2003: 13) and Whiteside (2008: 8) also speculate that African CSOs may weaken as they lose PLWHA and their caregivers.

Trade unions, similar to CSOs, have as mentioned historically been subservient to government and reluctant to engage with politicians. Two interviewees representing trade unions said that MPs were “shy” and “suspicious” about representing labour associations and that labour associations in turn are reluctant to associate with opposition MPs for fear of being sidelined by the government (Osei-Hwedie and Sebudubudu 2005: 38). Furthermore, Mogalakwe and Sebudubudu (2006: 214-216) point out that Botswana has been a member of the International Labour Organisation (ILO) since 1978, yet it only ratified the conventions considered essential to trade union rights and freedoms in 1997 and only began to process the amendment of the relevant laws in 2003. On 1 May 2010 the Public Service Act (number 30 of 2008) was finally launched, for the first time granting thousands of civil servants the right to join trade unions. The first major strike the country has seen since independence – an eight week long public service workers’ strike – followed in May and June 2011, and ended with no substantial victories for workers (SAPA 2011). No research on the impact of HIV and AIDS on trade unions was forthcoming.

In short, civil society in Botswana is rather weak. Despite its now much greater inclusion in the policy making process and its important role in addressing HIV and AIDS, there is no literature claiming that the disease is affecting civil society in a way that contributes to, or damages, the consolidation of democracy. It is therefore plausible that the challenge compelled the government to initiate cooperation with civil society in policy formulation and execution, but this relationship is still highly unbalanced. In other words, Butler's (2005) argument that the politics around HIV and AIDS in South Africa has energized civil society, legitimized conflictual relations with government and opened up fresh space for policy

contestation, does not (yet) apply in the case of Botswana. There is no evidence that the disease has deepened the institutional framework for democratic politics.

### **3.4. Assessment**

It was stated that the rationale behind this study – the “why” – lies in the lack of consensus among political scientists with regards to the question: how will HIV and AIDS affect the consolidation of African democracies: positively or negatively? Ultimately, therefore, the findings in this chapter must be compared to the points raised by Mattes (2003), Strand (2005) and Chirambo and his colleagues (2008), who expect the disease to impact negatively on democratic consolidation in Southern Africa; as well as the article by Butler (2005a) who emphasises the positive effect of HIV and AIDS in activating civil society and deepening institutions in South Africa (especially through the use of courts) and the study by De Waal (2006), who makes the point that the pandemic has not resulted in any political crises yet.

Looking at the first variable, HIV and AIDS have not seriously influenced the balance of power between the executive and the legislature: it is still skewed in favour of the executive, and this continues to pose questions about the democratic nature of the system. Secondly, with regards to electoral systems, the FPTP system does not seem to be severely affected by AIDS at a national level (this is contrary to the findings in other Southern African states of the researchers led Chirambo 2008). On a local government level, however, there are indications that the disease caused an unprecedented amount of by-elections, necessitating the cost and organisation associated with their administration. This impact lessened towards 2009 and it is possible that with increasing access to ART the amount of by-elections may return to more typical figures, but more research could shed light on these developments. More research is also needed on Botswana’s electoral governance amid high HIV infection levels (here the problems encountered by the Chirambo study in other states may still be identified) – but for now, national elections continue to enjoy overwhelming legitimacy despite HIV and AIDS. It is possible that Botswana has ART to thank for this, too. Third, De Waal (2006: 119-120) seems justified in his argument that political and civil rights are not dramatically affected by HIV and AIDS. The erosion of political rights, which is ominous for democratic consolidation (Schedler 1998: 103), cannot be linked directly to the pandemic in question. If in the light of recent economic hardship the government cuts its expenditure on ART, despite studies that demonstrated that providing ART makes fiscal sense (see above), civil society and the courts can and should play meaningful roles, which is not yet the case in Botswana.

Socio-economically, the effect of HIV and AIDS is more evident. Firstly, it is likely to have some detrimental effect on all three economic variables, which means that Mattes's (2003) arguments were partly correct. The magnitude of these effects will determine the severity of the threat to democratic consolidation. Low levels of economic growth and a slower increase in income *per capita* is a new phenomenon for the citizens of Botswana, but they are known for their remarkable political stability and may bear such a change with patience. Importantly, Przeworski, et al. (1996) do not offer a deep analysis of *how* the abovementioned economic factors contribute to the survival or death of democracies. It stands to be seen to what extent Przeworski, et al.'s (1996) findings about democratic survival will hold for this country in the future. Secondly, in terms of human development, Botswana has suffered a serious blow, especially in terms of health/life expectancy. An inversion of Welzel's (2003) finding about the positive influence of human development upon the demand for constitutionally protected liberties would suggest that, given a blow to health, the citizens of Botswana may revert back to intolerance and a focus on survival: Mattes's (2003: 9) "uncivil society". The fact that education levels have not deteriorated, may offset this process, as may rebounding health levels under a well-administered and continuous ART regime. Thirdly, and finally, civil society seems relatively unaffected by HIV and AIDS, except for a numerical proliferation of (politically weak) CSOs and, possibly, the greater cooperation between (weak) civil society and (strong) government. Neither of these developments necessarily promotes democratic consolidation. This means that Butler's (2005) key argument about the positive effect of HIV and AIDS on democratic consolidation in South Africa does not apply to Botswana.

It is possible that Botswana has its success in achieving universal access to ART to thank for much of its apparent functionality in spite of high HIV prevalence. This has not offset all negative effects of the pandemic – as Jefferis, et al. (2008: 113) concluded, the impact of HIV and AIDS is now severe enough to be affecting the economy as a whole. But where the reach of ART is less extensive, such as in South Africa, the effects foreseen by scholars may be more obvious. It is to South Africa that we turn now.



## CHAPTER 4: SOUTH AFRICA

### 4.1. Background: HIV and AIDS in South Africa

HIV and AIDS policy in South Africa has been highly controversial, especially during the first term of former president Thabo Mbeki. This section briefly provides background about the country; the spread of HIV and AIDS through the population and government HIV and AIDS policy to date. The sections thereafter assess whether and in what way this disease impacted on democratic consolidation. The focus will be on institutions and socio-economic factors.

South Africa is the southernmost African state. It had a population of 49.99 million by mid-2010 (Statistics South Africa 2010: 3) and reached 50.58 million in July 2011, consisting of a majority of black Africans (80%) as well as smaller groups of whites (of European descent), people of Indian descent, people of mixed race, as well as smaller minorities. As the richest nation in Africa with GDP valued at \$460 billion in 2009 (PPP constant 2005 prices) (World Bank 2011d), the state is sometimes described as a regional hegemon (for example, Adebajo and Landsberg 2003; Alden and Soko 2005) and has been grouped as an emerging economy along with such states as Brazil, Russia, India and China (for instance, see Cooper, Anthkiewicz and Shaw 2007). It plays an influential role in international diplomacy, serving as a non-permanent member of the United Nations Security Council in 2007-2008 and 2011-2012.

Historically inhabited by San and Khoikhoi peoples and later by Bantu-speaking African groups who migrated from the north, South Africa was colonised in 1652, initially by the Dutch, followed by Britain (see Ross 2008: 5-58). Following four decades of active racial discrimination under the rule of the Afrikaner-nationalist National Party (NP) under policies known as Apartheid and Separate Development, the country made a transition in the 1990s from white minority rule to an inclusive democracy (see Ross 2008: 122-213). The first democratic election was held on 27 April 1994, in which the African National Congress (ANC) won 62.3% of the national vote and Nelson Mandela became president. Since then, three more general elections have taken place and the ANC has established its position as the dominant party, with never less than 62% of the vote.

The HIV and AIDS pandemic arrived in South Africa during the politically tumultuous decade leading up to the demise of Apartheid (Fourie 2006: 55). The first known South African AIDS victim was a white homosexual air steward, who died in 1982. The epidemic spread mostly among white homosexual men, but was contained, reaching 308 reported cases. Prevalence declined by 1990. It did not spread to the general heterosexual population and because initially it did not appear to be a serious threat to society, the pre-1994 government did not draft a comprehensive policy to address it. The main sufferers of the disease, homosexuals as well as some commercial sex workers and injecting drug users, had already been criminalised (Fourie 2006: 97). In 1986 the first AIDS cases in heterosexual members of the population were detected among male black mineworkers (Ilfiffe 2006: 43-44). Thereafter, HIV spread exponentially through the black population (Ilfiffe 2006: 44). In South Africa, there was no particular core group spreading HIV (such as sex workers or truck drivers). Rather, infection occurred “by diffusion across a long, much-permeated northern frontier and through individual contacts in many sectors of a mobile, commercialised environment” (Ilfiffe 2006: 44).

Not only did the country face an epidemic from multiple neighbouring states, but additionally, Fourie (2006: 50-64) argues that the political situation under Apartheid was a perfect environment for AIDS to flourish. Shula Marks (2008) agrees, basing her argument on the work of Zwi and Cabral (1991, quoted in Marks 2008: 39). These scholars argued that certain social, political and economic forces place groups at a high risk of contracting HIV. Factors likely to create a “high-risk situation” included impoverishment and disenfranchisement, rapid urbanization, the anonymity of urban life, labour migration, widespread population movements and displacements, and social disruption and wars, especially counter-insurgency wars. In such circumstances, they argued, daily survival may be precarious and social bonds loosened, leading to high risk individual behaviour such as transactional sex. Marks (2008: 40) argues that all these factors were a reality in the experience of the black population of South Africa in the 1980s. HIV infection levels skyrocketed. By 1989, the NP government had to acknowledge that its lack of an HIV and AIDS policy was no longer tenable and began to redefine the challenge and took steps to address it more broadly (Fourie 2006: 99).

In 1992, as the ANC prepared for government, it participated with members of the NP government, trade unionists, HIV and AIDS activists and medical professionals in the National AIDS Convention of South Africa (NACOSA). NACOSA drafted the National AIDS Plan, which was to be government policy from 1994 onwards. The drafting process

was inclusive and the plan widely praised (Fourie 2006: 101). However, it had certain key weaknesses: for one, it overestimated the human and economic resources that would be available to the new government; it also pigeonholed HIV and AIDS policy under the central Department of Health. These weaknesses, as well as the simultaneous bureaucratic restructuring of the political system and perhaps a lack of prioritisation and commitment (Schneider and Stein 2001: 726; Palitza and Ridgard 2010: xi; Butler 2005b: 593), meant that once the ANC came to power, its AIDS policy got off to a slow and hesitant start (Schneider and Stein 2001: 726). What is more, a number of HIV and AIDS-related scandals surfaced during this time, such as those around the misappropriation of funds toward the musical screenplay *Sarafina II*; and the government's promotion of the antiretroviral drug Virodene, which was later found to contain toxic substances, while it rejected calls to administer the scientifically approved drug AZT to HIV positive pregnant women for the prevention of mother-to-child transmission (PMTCT) (Palitza and Ridgard 2010: x). During Nelson Mandela's term (1994-1999), South African HIV prevalence is estimated to have shot up from 1.8% of the population in 1994 to 10.1% in 1999<sup>39</sup> (Fourie 2006: 109).

Thabo Mbeki (1999-2008), who was to succeed Mandela as president in 1999, was involved in a large-scale review of the HIV and AIDS situation in 1997 and initially promised to promote greater public awareness and acknowledged of the multi-sectoral nature of the problem (Butler 2005b: 593). Yet by 1999 it was evident that Mbeki doubted the intellectual foundations of AIDS, taking a stance that would become labeled AIDS "denialism" (Nattrass 2007). With the newly-appointed health minister, Manto Tshabalala-Msimang, the government was claiming that antiretroviral drugs are "toxic" and Mbeki argued that instead of HIV, socio-economic factors (for example, nutrition), along with viral factors, might cause AIDS. When challenged upon this, he set up a presidential advisory panel to investigate the issue, but this panel was composed mainly of what Nattrass (2007) terms "AIDS dissidents"<sup>40</sup>.

By 2000 Mbeki's doubt became embedded in policy: the government released the *HIV/AIDS/STD Strategic Plan for South Africa 2000-2005* which was based on United Nations guidelines but lacked clear time frames and dates, and most importantly, evaded ART (Butler 2005b: 595). A national controversy ensued around health policies that

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<sup>39</sup> Note that these figures are for the population as a whole (unlike most estimates in this study, which are for adults aged 15-49). Fourie (2006: 109) compiled this data from estimates published by Dorrington and Johnson in 2002.

<sup>40</sup> For more extensive analyses of this stance and their motivation for it, see Butler (2005b), Nattrass (2007), and Gevisser (2007).

prevented the provision of ART to HIV-positive individuals through the public health system (Palitza and Ridgard 2010: xiii). Between 1999 and 2004, Afrobarometer surveys (2005) recorded a rapid increase in the percentage of South Africans citing HIV and AIDS as one of the priorities for government to address. The issue rose to equal importance as crime and security, as the second-most important priority (about 30% of South Africans mentioned both issues), with only unemployment and job creation ranking higher (at 77%). Its prioritisation remained relatively constant through consecutive surveys up to 2006 (Afrobarometer 2006). A sharp increase was also noted in the percentage of South Africans who were willing to divert government resources to addressing the disease, from 40% in 2002/3 to 56% in 2004.

The TAC, a civil society group dedicated to the HIV and AIDS problem, sued the government about its refusal to roll out PMTCT drugs to more than a handful of its pilot test sites. It won the case in 2001, and won again in 2002 after the government appealed. Govender (2007: 117) argues that the case was a very easy one from the position of the Court, as sufficient evidence was produced to demonstrate that the cost of the drug was not an issue and neither was its efficacy in preventing the transmission of HIV from mother to child. Thereafter, the TAC shifted its focus to the provision of ART to all who need it.

With growing pressure from within and outside the ANC, the government committed itself to scale up ART provision in November 2003 (Butler 2005b: 595). Rollout commenced slowly and scholars (Nattrass 2004; and Willan 2004, quoted in Quinlan and Willan 2005: 230) expressed their doubts about the commitment of the president and minister of health to HIV and AIDS and social welfare generally. Tshabalala-Msimang insisted on a healthy diet (including beetroot and onions) as an alternative to ART, claims for which she was ridiculed at the 2006 International AIDS Conference in Toronto, and which exposed South Africa's official AIDS policy to increased international criticism (Meldrum 2006). It was also observed that if HIV and AIDS allocation were left out, a decrease in the health budget was evident, meaning that this component of the health budget was crowding out other health spending (Nhlanhla, quoted in Quinlan and Willan 2005: 234). The president then publicly withdrew from debates about the disease, but continued to make controversial statements; in short, he was perceived not to provide leadership on the matter of AIDS (Quinlan and Willan 2005: 239). It was only when Tshabalala-Msimang was hospitalised in late 2006 that her deputy, Nozizwe Madlala-Routledge, and the Deputy President Phumzile Mlambo-Ngcuka took steps to revive the South African National AIDS Council (SANAC) and restore ties with civil society, including the TAC.

In 2007, government launched the HIV and AIDS and STI Strategic Plan for South Africa (NSP) 2007-2011, which aimed to provide ART to 80% of those who need them<sup>41</sup> by 2011. Following the resignation<sup>42</sup> of Thabo Mbeki in September 2008, interim president Kgalema Motlanthe replaced Tshabalala-Msimang with Barbara Hogan, who had openly identified with the TAC and opposed the government's AIDS denialism (Achmat and Hassan 2010). Hogan explicitly acknowledged that HIV causes AIDS, commended the work of medical, scientific and activist communities, and committed government to achieving the targets of the NSP (Hogan 2008; TAC 2008). Although making promising strides, she served for only six months before being replaced in 2009 by Aaron Motsoaledi in the Zuma administration. Motsoaledi won praise so far, fostering closer ties with NGOs and civil society and developing a creative new procurement process that forced international pharmaceutical companies to compete for the tender and provide breakdowns of their manufacturing costs, thereby successfully halving the price South Africa will pay for ART over the next two years (Parker 2010).

The ART target of the NSP (above) will probably not be reached by the end of 2011, but the country is making progress in this regard. In 2009, it reached 81% of children and 65% of adults who needed it, as opposed to the 2008 figures of 44% and 55% respectively (RSA 2010a: 44). Today, prevalence seems to have stabilized, but at extremely high levels (as in the rest of Sub-Saharan Africa – see Chapter 1): the latest estimates put the adult HIV prevalence rate at 17.8% of South Africans (UNAIDS 2010: A1). Data also shows that incidence is slowing down (Marais 2010: 306). Total AIDS deaths increased from 198 000 in 2001 to a high of 314 000 in 2005 and then declined to 281 000 in 2010 (Statistics South Africa 2010: 8).

However, HIV is not spread evenly across the population. For one, the age distribution of the epidemic is changing, with signs of increased safe sex among young people (UNAIDS 2010: 28) and South Africa has achieved almost 90% PMTCT coverage (UNAIDS 2010: 10), meaning that fewer children are born with HIV (see Figure 7). Furthermore Hein Marais (2010) emphasises that HIV and AIDS statistics, when disaggregated, reveal familiar patterns

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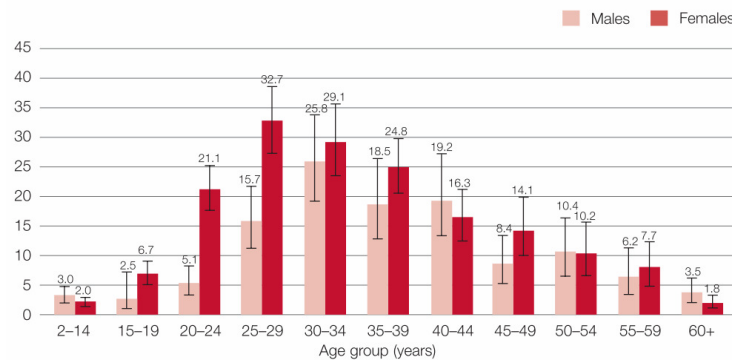
<sup>41</sup> “Those who need ART” are defined here according to the older WHO guidelines, namely, those whose CD4 counts are 200 or less (see footnote 9).

<sup>42</sup> In December 2007 at the landmark 52nd National Conference of the ANC in Polokwane, Limpopo, Mbeki lost his contest for re-election as president of the ANC to his rival Jacob Zuma. In September 2008, when Zuma was acquitted of the rape charges that Mbeki had used as a pretext to dismiss Zuma as deputy president, the ANC requested Mbeki to step down as president of South Africa. Kgalema Motlanthe finished Mbeki's term until the general elections in May 2009, after which Zuma was instated as president.

akin to South African patterns of social inequality. For instance, supporting the argument of Marks (2010) above, that the social conditions of black South Africans have rendered them especially vulnerable to HIV, Shisana, et al. (2005, quoted in Marais 2010: 306) reported in 2005 that 20% of (black) African adults, 3.2% of coloureds, 1.0% of Indians and 0.5% of whites were infected with the disease<sup>45</sup>. The link between HIV infection and poverty is less clear, but case studies have also demonstrated that in South Africa, HIV risk is embedded in “social ills” that tend to accompany poverty (Kalichman, et al. 2006 and Bärnighausen, et al. 2007, quoted in Marais 2010: 308). It is therefore possible, in South Africa, to generalize that the majority of PLWHA are poor and black (Marais 2010: 306). Furthermore, HIV is most prevalent among unskilled and semi-skilled workers (Vass 2005, quoted in Leibbrandt, Woolard, McEwen and Koep 2010: 47) and among urban, rather than rural dwellers (Marais 2011: 307). In the younger age cohorts, they are now also predominantly female (Marais 2010: 306).

**Figure 7. HIV Prevalence by sex and age in South Africa, 2008**

*Source: Shisana, Reble, Simbayi, Zuma and Jooste 2009: 31.*



## 4.2. Institutions

### 4.2.1. System of government

Has this epidemic impacted on democracy? We turn to institutions first. The South African government, though parliamentary in nature, combines some elements of presidentialism. Chapter 5 (section 86) of the constitution dictates that the National Assembly (parliament) elects a woman or man from among its members to be president. He or she is head of state

<sup>45</sup> A 2008 study (Shisana, et al. 2009) confirmed this pattern.

and head of government. He or she appoints the deputy president and the cabinet (executive) from the members of parliament, except for a maximum of two cabinet ministers, who may be appointed from outside the Assembly.

The South African legislature consists of two chambers: the National Assembly and the National Congress of Provinces. Since 1994, Parliament has been dominated by the ANC and its two coalition partners, the South African Communist Party (SACP) and the Council of South African Trade Unions (COSATU), in the “Tripartite Alliance”. Their share of the national vote has never been less than 62% and has been around two thirds since 1999: they obtained 62.65% in 1994; 66.35% in 1999; 69.69% in 2004 and 66% in 2009, which was the latest round of general elections (Friedman 2009: 109).

It was noted in Chapter 2 that the high stakes of presidential elections could lead to the perception among the opposition that democratic politics is a zero-sum game. The first mechanism that serves to include diverse political powers within the democratic system is the closed-list PR system used to constitute both the Parliament and the NCOP. Seats are allocated according to the Droop formula, which allows for a close match between the percentage of votes and the proportion of seats obtained. Since there are 400 seats, a party must obtain 0.25% of the national vote to win a seat in parliament. This low threshold enhances the inclusivity of the system, which is a key nation-building strength of PR systems in general, as it provides for fair representivity.

There are some checks in place to diffuse power and prevent the centralisation of power in the presidency. These include provisions for the South African Human Rights Commission, the Commission for Gender Equality and the Public Protector. However, these provisions may not entirely safeguard against an over-powerful presidency: Butler argues (2005a: 9) that during Mbeki’s first term, he challenged or undermined several of these provisions. Mbeki also became increasingly “disciplinarian” in his approach, stifling dissent in the party (Southall 2000: 202) and created structures of “upwards accountability” (as opposed to accountability towards the electorate or even the party in general) (Friedman 2009: 110). Natrass (2007: 47) attributes this move towards centralisation of power to the leadership style developed by the ANC in exile and the armed struggle against Apartheid as well as to the electoral system, which guarantees the top leaders of the ANC their seats in parliament. Although the centralisation of power was initially seen as a necessary step to increase the efficiency of the executive, it became apparent by 2007 that the government was achieving little more success on important issues such as crime and poverty reduction under the iron

fist of Mbeki (Friedman 2009: 110). It also looked like the silencing of civil society on issues like HIV and AIDS.

According to Butler (2005a), there are grounds to argue that AIDS served to counter this move toward centralisation. Butler (2005: 9) mentions, for example, how AIDS-related events led to the affirmation of a “quasi-federalist” system. National and provincial governments are separately elected. The Constitution provides for some provincial autonomy, but up until the debate around AIDS, policy had primarily been defined by central government and implemented by provinces, subject to national norms and standards. Amidst attempts at increasing centralization generally, and especially government’s attempts to control the availability of PMTCT drugs and information that would support the TAC’s case, provinces asserted their independence by publicly making statements opposing government policy and by making information available to the TAC showing that they had the capacity to provide PMTCT. The National Treasury in turn hid its support for provincial HIV and AIDS interventions by providing direct funding to provinces for the refurbishment of hospitals, thereby indirectly freeing up funds to spend on addressing the pandemic (Quinlan and Willan 2005: 235). Butler (2005: 9) therefore argues that one of the ways in which AIDS “partially reversed the growing trend to centralization” in the national government was by re-affirming that the provinces have a degree of policy autonomy.

It could be argued that Mbeki’s policy on AIDS demonstrated the tight control he exercised over his inner circle, while becoming increasingly out of touch with the political sentiments of the party’s rank and file, many of them members of the TAC. The ousting of Mbeki at Polokwane in 2007 (see footnote above) demonstrated that a degree of internal democracy is still a reality in the ANC and that to an extent leaders remain accountable to members of the ANC (Friedman 2009: 110). The succession of Mbeki by Zuma contrasts sharply with the system of “automatic elitist succession”, witnessed in Botswana for example.

#### **4.2.2. Electoral System**

Unlike Botswana, South Africa employs a PR system at the national level. This section will contain a brief overview of the electoral system, followed by an analysis of literature on the impact of HIV and AIDS on South Africa’s electoral *systems* and electoral *governance*. South Africa’s general elections run every five years and allow voters to elect their provincial and national government on separate ballots. Elections for local government are also held every five years, taking place during the second year after the general elections. All elections to date



have been considered free and fair. The electoral management board in South Africa is known as the Independent Electoral Commission (IEC).

Using the PR system, the 400 seats in Parliament were allocated as follows in 2009: the ANC's 66% of the vote won it 264 seats; the DA, with 16.7% of the vote, won 67 seats; the Congress of the People (COPE), the party newly splintered off from the ANC, won 7.4% and 30 seats; the Inkatha Freedom Party (IFP) won 4.6% and 18 seats; and 1 seat each went to 9 smaller parties (Friedman 2009: 108). On municipal level, an MMP system is employed. There are three types of Municipalities (styled A, B and C). For local (A) and municipal (B) councils, half of ward councillors are elected on a FPTP basis while half are appointed through a PR list system. At the district level (type C) 60% of councillors are representatives from their local and municipal councils while 40% are elected on a FPTP basis by eligible residents (Strand, et al. 2005: 73).

It has been recommended that the national electoral system be reformed in order to make parliamentarians more accountable to the public. Two reports, the Van Zyl Slabbert Commission (Electoral Task Team 2003) and a second report by a panel of experts more recently (Afrobarometer 2009a: 1), have recommended electoral reform towards an MMP system. Renewed calls for reform have emanated from the opposition after Parliament passed a decision to disband the successful special investigative unit, the Scorpions, initially without consulting the public (as was required by law) (Afrobarometer 2009a). However, recent Afrobarometer (2009a) data indicates that electoral reform is not a great priority for South African citizens, and that their counterparts in 11 other African countries, including those with constituency based electoral systems, are not more satisfied with the performance of their MPs. Compared to their African counterparts elsewhere, South Africans are in fact marginally *more* confident in the power of elections to ensure that MPs represent the views of voters.

Looking purely at the impact of HIV and AIDS on electoral systems, Strand (2005: 7) and Chirambo (2008: 31) argue that the PR system is preferable to FPTP in states where HIV prevalence is high, such as South Africa. In an FPTP system, they argue that an increase in by-elections due to the death of elected representatives could become expensive (Chirambo 2008: 35-36; Strand 2005: 8); it could result in a weaker mandate for the new candidate because of low voter turnout and the replacement of MPs in Parliament may shift the balance of power between parties, often to the detriment of the opposition (Chirambo 2008: 32; Strand 2005: 10).

Given the PR list system employed to constitute the National Assembly of South Africa, this body was not exposed to the financial cost of by-elections or a shift in the balance of power: the affected party could simply fill the vacancy from its party list. A loss of individual democratic legitimacy due to the low voter turnout at by-elections, similarly, was not an issue in the PR system. With regards to national government, Strand, et al. (2005: 72) reported that 235 members of Parliament were replaced between 1994 and 2003, of whom 23 were replaced because of their demise. With a maximum of 5 deaths per year (in 1999 and again in 2002), and a lack of data that could permit extensive longitudinal comparisons, no clear pattern emerges and it is impossible to say with certainty to what extent AIDS was the cause of these deaths.

The MMP system employed on local level was expected to be more vulnerable to the effects of the pandemic. Chirambo and Steyn (2009) specifically studied the impact of HIV and AIDS on ward councillors in South Africa. Of 589 by-elections held in the country from 2001 to 2007, 285 were due to the death of a councillor, making death the biggest single cause of by-elections at this level. There was a concentration of deaths among 29-to-42-year olds, with the majority of deceased councillors dying before their 51st birthday. Although causes of death were not available, this data is suggestive of the mortality pattern of AIDS in South Africa (Chirambo and Steyn 2009: 42-46). Given this pattern and certain assumptions (Chirambo and Steyn 2009: 47), the authors concluded that the majority of deaths (the authors estimate 70%) were probably due to AIDS. This study therefore indicates that, although we cannot prove this conclusively, the disease probably had a substantial impact on ward councillor attrition. Some qualitative focus group data substantiated this (Chirambo and Steyn 2009: 49) but the research methods used in this study could not corroborate this.

Since it looks likely that AIDS deaths caused a significant number of by-elections, an evaluation of the impact of municipal by-elections in South Africa is in order. Firstly, in terms of financial cost, the authors calculate that South Africa spent at least R14,7 million (US\$946 667) on by-elections over the period in question. The IEC does not consider this an unsustainable figure (Hendrickse, quoted in Chirambo and Steyn 2009: 58). Secondly, in terms of power balance between political parties, the study found that local government by-elections are indeed contributing to shifts, with the ruling ANC the biggest beneficiary of by-elections, confirming Strand, et al.'s (2005: 68) hypothesis in this regard. Finally, low voter turnout in by-elections was indeed a reality, but the authors did not investigate the impact of low voter turnout on newly elected councillors' democratic legitimacy (Chirambo and Steyn 2009: 60-61). Organisationally, the authors found that mechanisms were in place to deal with

the loss of representation that communities experience for the time between the loss of a councillor and a by-election (Chirambo and Steyn 2009: 56-58). Chirambo and Steyn (2009: 5-6) discussed serious problems with local government service delivery, but the impact of HIV and AIDS was only one of several factors contributing to these.

In terms of *governance*, three broad potential risks were listed in Chapter 1, namely, reduced efficiency and loss of institutional memory associated with losing electoral management board (EMB) staff members; a bloated voters' roll (Chirambo 2008: 38; Strand 2005: 5); and for PLWHA, structural and attitudinal restrictions to voting (Strand 2005: 6; Chirambo 2008: 37). The first empirical study to investigate this topic in South Africa was by Strand, Matlosa, Strode and Chirambo (2005). In studying the IEC, these scholars generally could not prove or disprove the abovementioned expectations of scholars. They could find no data to indicate IEC staff attrition due to the disease, with only four permanent staff members dying from unspecified causes during the period studied (2001-2003) (Strand, et al. 2005: 88-91). Concerning volunteer staff, who are mostly teachers and according to certain studies are at great risk of infection (Chirambo 2008: 37), insufficient data was available. In studying the 2004 general elections, the authors did not become aware of any trouble with updating of the South African voters' roll, although an increase in deaths among young adults was noted by staff members (Strand 2005: 93). It was with the "special vote" that Strand, et al. (2005) detected an important impact. The special vote (for those unable to vote on the day) was available and utilized in the 2004 election, but citizens in regions heavily affected by HIV and AIDS did not make greater use of this facility than elsewhere, and the authors argue that information about eligibility for the special vote was not clearly communicated to PLWHA (Strand, et al. 2005: 164-5). Having HIV or providing care to a person living with HIV or AIDS did not render South Africans any less likely to value their right to vote, but these individuals expressed fear of stigma and discrimination at the polling stations (Strand, et al. 2005: 165-166). They also mentioned logistical obstructions to voting, such as lack of toilets and lack of transport (Strand, et al. 2005: 168-169). These findings indicate that the political participation of PLWHA is restricted. As Strand (2005: 11) argued, "[u]nless electoral governance is designed so as to maximise the actual opportunity for people who are directly or indirectly affected by HIV/AIDS to participate in elections, the risk is that the political voices of this critical and growing constituency will never be heard." Another general election took place in 2009, and a similar study to the one by Strand, et al. (2005) may provide vital new data and enable longitudinal comparison.

To summarise, electoral systems at the national level are protected from an increase in by-elections by the PR list system, meaning that at least in terms of minimizing the effects of HIV and AIDS on democratic institutions, it is not advisable to reform the electoral system. Electoral systems at local government level have been burdened with many by-elections, many of which were caused by deaths that follow AIDS mortality patterns. These by-elections were not deemed financially unsustainable, but increased the proportion of seats held by the ruling party. With regards to scholars' expectations that these by-elections may affect councillor legitimacy or service delivery negatively, no hard evidence has been forthcoming. The main concern regarding the impact of HIV and AIDS on electoral governance is Strand, et al.'s (2005) finding that PLWHA face structural and attitudinal restrictions to voting. This is an important area for further investigation.

Because South Africa continues to extend access to ART, with access extended from a small minority of those who needed it in 2003 to 65% of adults in 2009 (see introductory section above) the impact of HIV and AIDS on electoral systems and electoral governance will have changed since the abovementioned studies were conducted. New studies of the impact of HIV and AIDS on the 2009 general elections and 2011 local government elections would enable valuable longitudinal comparisons.

### **4.2.3. Political Rights and Civil Liberties**

This section presents a brief overview of the status of political rights and civil liberties in South Africa. It then makes mention of the constitutional provision for socio-economic rights and the impact of court cases concerning the right of citizens to ART on citizens' ability to exercise their political rights and civil liberties in South Africa.

The South African Bill of Rights, written into Chapter 2 of the 1996 Constitution, incorporates all universally accepted fundamental rights and freedoms (Govender 2006: 119), including the right to access to healthcare. The country has done better than expected in upholding essential civil and political liberties (Friedman 2009: 109), but has lost some ground according to its Freedom House ratings since 1994 (see Table 2).

**Table 2. South African Freedom House Ratings, 1973-2010***Sources: Freedom House (2011c); Freedom House (2011d).*

<u>Year</u>	<u>PR</u>	<u>CL</u>	<u>Year</u>	<u>PR</u>	<u>CL</u>	<u>Year</u>	<u>PR</u>	<u>CL</u>	<u>Year</u>	<u>PR</u>	<u>CL</u>	<u>Year</u>	<u>PR</u>	<u>CL</u>
			1980	5	6	1990	5	4	2000	1	2	2010	2	2
			Jan.1981-Aug. 1982	5	6	1991	5	4	2001	1	2	2011	2	2
			Aug.1982-Nov.1983	5	6	1992	5	4	2002	1	2			
1973	4	5	Nov.1983-Nov.1984	5	6	1993	5	4	2003	1	2			
1974	4	5	Nov.1984-Nov.1985	5	6	<b>1994</b>	2	3	2004	1	2			
1975	4	5	Nov.1985-Nov.1986	5	6	1995	1	2	2005	1	2			
1976	4	5	Nov.1986-Nov.1987	5	6	1996	1	2	2006	2	2			
1977	5	6	Nov.1987-Nov.1988	5	6	1997	1	2	2007	2	2			
1978	5	6	Nov.1987-Nov.1988	5	6	1998	1	2	2008	2	2			
1979	5	6	Nov.1988-Dec.1989	6	5	1999	1	2	2009	2	2			

The country scored a 2 for political rights and a 3 for civil liberties in 1993. These scores improved to 1 and 2 respectively in 1994. Thereafter the trends are (a) that political rights fared better than civil liberties, and (b) that political rights eroded slightly since 2006.

Civil liberties have remained constant at a score of 2. The rights of detained and accused prisoners, the excessive use of force by the police, anti-foreigner sentiments, violence against women and the slow realisation of broad socio-economic rights, especially in rural areas, are some of the issues clouding the country's record in this regard (Human Rights Watch 2005, quoted in Govender 2006: 118). There are also indications that the situation with regards to freedom of the press is deteriorating. A Freedom House (2010b) publication, *Freedom of the Press*, moved South Africa into the "partly free" category in terms of its media freedom in 2010. The report cited "top government officials' hostile rhetoric toward the media"; "official encroachments on the editorial independence of the South African Broadcasting Corporation (SABC)" and the passage of the Film and Publications Act, which "legitimizes some forms of prepublication censorship" ostensibly to protect against child pornography and hate speech (Freedom House 2010b). Since the publication of the 2010 *Freedom of the Press* report, the Protection of Information Bill (RSA 2010b) was tabled before parliament, raising further controversy. Rights-related NGOs and media companies initially pointed to the harshness of proposed sentences for revealing unauthorised information and the broad definition of state security, arguing that the proposed legislation could be used to veil corruption and illegal activity (Sole, Dawes and Brummer 2008). Some concessions have been made, but the Bill remains controversial, criticised by civil society, parliamentary opposition and legal experts as a threat to democratic transparency and as inconsistent with the Constitution (Donnelly 2011). This Bill, coupled with a proposed Media Tribunal whose

legislation has not yet been drafted, have raised fears that government is taking steps to reduce its accountability and protect corruption from public scrutiny.

In explaining the decline in South Africa's political rights score, Freedom House (2007) cited "the ruling ANC's growing monopoly on policy making and its increasingly technocratic nature" – by implication, Freedom House was arguing that the political rights of South Africans outside the ANC (be it the opposition, whose share of the vote was shrinking consistently until 2009, or ordinary citizens) to influence public policy was being compromised. Since then, with a score of 2 for both civil rights and political liberties, the country is closer to the borderline between states classified by Freedom House as "free" and those considered "partly free". Provided one accepts Freedom House's analysis as a good reflection of the level of democraticness in a given country (as does Diamond, see Chapter 2), this decline in South Africa's rating could be seen as possible proof of democratic erosion (Schedler 1998: 103). The notion that the ANC under Mbeki exercised a "growing monopoly on policymaking" is supported by the work of Butler (2005a: 600). However, given the successful challenge to the government's HIV and AIDS policy in 2001-2003, and the more collaborative policy formation on this issue thereafter, it is unlikely that the decline in rating was directly related to this disease alone. Suggestions of constraints to the electoral participation of South African PLWHA and their caretakers (see above) were not mentioned in Freedom House reports.

Aside from the abovementioned political rights and civil liberties usually associated with democracies, the Bill of Rights in the South African Constitution provides for certain socio-economic rights. These include Section 25, the right to property, Section 26, the right to housing, Section 29, the right to education, and, importantly for the purpose of this study, Section 27. This section grants citizens access to health care services, along with the right to food, water and social security. It adds that the state must take "reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights" (RSA 1996).

Govender (2006: 114) notes that it was feared these socio-economic rights would be "reduced to a wish list as it would be extremely difficult to prove that government had acted irrationally and in bad faith". However, the outcome of the PMTCT case *Minister of Health and others v Treatment Action Campaign and others* (Constitutional Court of South Africa 2002, see introductory section) and its appeal, demonstrated that the government could be required to justify its policy choices that impacted on socio-economic rights, taking into account the

minimum core of the right, available resources and other factors and would be held “to the benchmark of reasonableness” (Govender 2006: 116-117). This case, it has been argued, indirectly strengthened citizens’ ability to participate in decision-making, beyond the issue of access to PMTCT drugs. Butler (2005a: 15) argues that the TAC, by relying on the Constitution and the courts as democratic institutions which are designed to protect citizens’ rights, strengthened these institutions and advanced judicial activism as a means of calling the executive to account (Butler 2005a: 15). At the more individual level, Robins (2006: 314) argues that HIV and AIDS activism has mediated and retold the traumatic experiences of AIDS sufferers, enabling the revitalisation of large numbers of formerly isolated and stigmatized HIV and AIDS sufferers into a social movement. Many PLWHA, through organisations such as the TAC and *Médecins sans Frontières* (MSF or Doctors Without Borders), have participated in activism and policy debates around broader issues such as the National Health Insurance (NHI). Therefore it could be argued that through the legitimisation of rights-based legal challenges to the state and the political empowerment of previously marginalised citizens, the politics around the constitutional right to access to medical care has intersected with – and strengthened – political rights and civil liberties in South Africa. This will be elaborated upon in the section concerning civil society below.

### **4.3. Socio-economic factors**

#### **4.3.1. Affluence, economic growth and inequality reduction**

South Africa is an upper middle income country with an estimated *per capita* income in 2009 of \$10 060 (PPP) (World Bank 2010a). When Przeworski, et al.’s (1996) \$6 000 mark for “impregnable” democracies is adjusted for inflation, to \$12 195.78 in 2010 prices (see Chapter 2), South Africa is not affluent enough to render its democracy “impregnable”: it lies in the upper ranges of “fragile” democracies.

Economic growth, although modest, has been consistent, averaging 3.27% per quarter between 1993 and 2010 and experiencing only three quarters of negative growth due to the 2009 global financial crisis (TradingEconomics 2011). As the economy has grown, so have real earnings for those in the formal sector (Burger and Yu 2007: 15) – but high unemployment and a large percentage of individuals living in absolute poverty are an inequality inheritance that the country is struggling to rectify. Van der Berg (2010: 19) argues that the main challenge in South Africa remains the condition of the labour market, namely, the low human capital of the unskilled bulk of the population (see the discussion of

education in the next section). Inequality is therefore extremely high and has not been reduced since 1994 – in the mid-2000s, the poorest 5 million South Africans received only 0.2% of GDP while the richest 5 million received 51% (Marais 2010: 317). However, the racial dimension of inequality has softened, with more differentiation in earnings within racial groups (Van der Berg 2010: 19). A system of social grants since the 1990s has been expanded to become one of the largest in the world (as a percentage of GDP) for a country that is not a “welfare state”<sup>44</sup> and has been successful in partially relieving the effects of extreme poverty (Van der Berg, Burger, Burger, Louw and Yu 2006: 9-10).

The arguments of Mattes (2003) regarding the potential impact of HIV and AIDS on economics in countries with high prevalence of HIV were described previously. Citing Przeworski, et al. (1996), he argued that affluence, economic growth and inequality reduction all influence the endurance of democracy positively and that affluence has a particularly strong correlation with democratic survival. Mattes (2003: 3-6) reviewed what literature was available in 2003 about the impact of HIV and AIDS on the economies of heavily affected countries. All projections of this impact were negative, particularly with regard to slower economic growth and increasing inequality, with the exception of uncertainty about the influence of HIV and AIDS on *per capita* income (some scholars believed that it could rise due to the high levels of mortality). AIDS-related pressure on fiscal budgets could also reduce the funds available for other development priorities (Mattes 2003: 5-6). But he emphasised there were no case studies yet, only conjecture in search of testable hypotheses.

Using differing methodologies, three studies (quoted in Smit and Ellis 2009: 250) published in the beginning of the 2000s predicted that South Africa’s economic growth from year to year would be lower with AIDS than without it: ING Barings (Quattek 2000) estimated it at 0.3 percentage points lower while Laubscher, Smit and Visagie (2001) put the figure at between 0.33 and 0.63. Arndt and Lewis (2000) projected a more pessimistic reduction of 1.6% percentage points in economic growth. The latter scholars furthermore projected that the growth of *per capita* income could decline (although it would not be reversed) as a result of the epidemic while the former two studies found that the epidemic would result in higher *per capita* growth rates because of population reduction. In short, differing methodologies reached quite different conclusions about the macroeconomic impact of the epidemic – but contradicting Butler (2005: 4) who stated that economists had yet to reach any consensus on

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<sup>44</sup> Welfare states, like Sweden, make benefits available to all citizens. In South Africa, social grants are paid to about 14 million beneficiaries, most of them poor and black, in a population of 50 million.



the general macroeconomic impacts of AIDS, there was widespread agreement that the epidemic would result in lower GDP growth rates.

The most recent study of the macroeconomic impact of HIV and AIDS was undertaken by the Bureau for Economic Research (BER) in 2004/5 and a summary of the findings was published by Smit and Ellis (2009). The study simulated three scenarios: one in which AIDS did not exist in South Africa; one in which some HIV prevention programmes were in place, but no ART was provided; and one in which a large-scale ART programme consistently reached 50% of those who needed it. The time period for which the simulations were run is 2000-2020.

The BER considered that AIDS would impact the economy in the following ways (see Smit and Ellis 2009: 254-258). It would lead to a lower fertility rate and higher mortality, thereby reducing population growth and the size of the labour force. Higher levels of government health care and welfare expenditure was inevitable, and the study assumed that 50% of health care costs would simply crowd out other health priorities. Companies would face direct costs in the form of medical aid and death benefits to their employees, as well as a much bigger (and less avoidable) burden of indirect costs related to absenteeism, lost experience and skills, recruitment and training and lower labour productivity. Funerals would impact on household consumption expenditure and personal savings.

The study confirmed that, as has been argued for a decade (particularly by Nattrass 2004), the macroeconomic benefits of providing ART to South Africans who need it far outweigh the costs. In the scenario of AIDS with no ART, GDP growth could be 0.46 percentage points lower per annum for the period 2000-2020 than in the scenario in which AIDS did not exist in the country. Considering that South Africa's average growth rate is 3.27% per annum, this figure would make a dent in economic growth, but not come close to reversing it. If ART is provided to 50% of those who need it, the figure lowers to 0.38 percentage points. The amount of GDP "saved" by providing ART to 50% of those who need it was almost thrice the projected cost of the medicine – and given the better prices that South Africa has recently negotiated with pharmaceutical companies (see the introductory section of this chapter), this "saving" may be even greater. Even purely in terms of the government's fiscal considerations, ART made sense: providing ART meant that the AIDS-related budget

deficit would be 10% smaller than it would be if government provided no ART<sup>45</sup> (instead of increasing the government deficit by an annual average of 0.73% of GDP, it would increase it by only 0.66%). In short, there are steps to be taken to ameliorate the impact of AIDS, but it will slow economic growth. Although this is far from positive for democratic consolidation, it is not catastrophic either.

In contrast to this relatively mild impact on macroeconomic growth, the projected impact of the epidemic on population growth was quite pronounced. For this reason the model predicted that the average income *per capita* would be higher because of AIDS than it would have been without it<sup>46</sup>, and since the virus decimates the labour force much more than it impacts on employment creation, Smit and Ellis (2009: 260) found that the country could expect that, albeit in a grim way, AIDS would greatly reduce the unemployment rate. In the absence of AIDS the model projected an unemployment rate of 21% by 2020 as opposed to a rate of only 8.7% by the same year in the case of AIDS without ART. The authors did not provide an estimate for the unemployment rate if 50% ART is provided, stating only that providing ART meant that more employment would be created. At the same time, the provision of ART would reduce the AIDS mortality rate (as mentioned before). The projected decrease in unemployment because of HIV and AIDS is therefore uncertain. Leibbrandt, et al. (2010: 23) pointed out that the unemployment rate<sup>47</sup> increased in the period 2001-2008 despite the loss of a proportion of the labour force to AIDS, because this loss has been offset by increased participation in the labour market (in other words, more individuals are seeking employment). Other events, such as the global financial crisis of 2008/9, could also not be taken into account when the simulation was run in 2004/5, while the provision of ART now exceeds the level factored into the above simulation and has become cheaper (as mentioned before). The point is that the authors considered AIDS a factor that would reduce unemployment – but other factors, unanticipated or underestimated in the study in question, seem to be working in the opposite direction, increasing the labour force and reducing employment opportunities.

Unfortunately the study drew no conclusions about the effect of the epidemic on income inequality, which must take into account the net effect of a smaller labour force, slower

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<sup>45</sup> This is not to say that providing ART is cheap. There are concerns about the future affordability of antiretroviral drugs (Marais 2011: 318). The argument here is that the cost of not providing ART would be even less affordable as other welfare costs would be driven up.

<sup>46</sup> Smit and Ellis qualify this statement by emphasising that the model does not capture the long-term effect of AIDS on human capital formation, which according to Bell, et al. (2006) could be severely affected.

<sup>47</sup> These scholars use the broad definition of unemployment, which includes those who have sought work in the past four weeks instead of the past week.

economic growth and job creation and the vulnerability of the poor. Such a study is sorely needed, as aggregate figures such as the ones discussed above may mask the development of an increasingly “polarised” society (Marais 2010). Marais (2010: 310) argued that the disease disproportionately impacts upon those individuals who are already impoverished, stressed and unable to deflect the costs of illness and death beyond the confines of their lives, therefore “driving an even thicker wedge between the privileged and the deprived”. In other words, he postulated that the epidemic is reinforcing the patterns of inequality already so pronounced in South Africa. However, it is possible that the South African GINI coefficient, which Przeworski, et al. (1996) use to measure income inequality, could remain stable or actually improve, given the contradictory influences of an increase in the number of poor citizens and a simultaneous reduction in the size of the labour force (which was expected to decrease unemployment, although other factors seem to have offset this effect). In this case, the divide between minimum wage earners and the very poor would widen – how such structural changes may influence a democracy’s chances at survival has not been studied.

To conclude, the implications for democratic consolidation are mixed. The available literature projected that HIV and AIDS would impact negatively on economic growth, but that this impact would be less severe amid the current move to scale up access to ART than without it. It was expected that the disease would even speed up the growth of *per capita* incomes through a reduction in population growth. Unfortunately, there was no quantitative analysis of the impact of HIV and AIDS on inequality, but there are indications that poor South Africans carry a disproportionate share of the AIDS burden.

#### 4.3.2. Trends in Human Development (UN HDI)

South Africa’s HDI, like that of Botswana, has declined in the past 20 years despite economic growth and efforts to expand access to basic services.

**Table 3. South African Human Development Index, selected years, 1990-2010**

*Source: UNDP 2010.*

1990	1995	2005	2006	2007	2008	2009	2010
0.601	0.634	0.587	0.588	0.590	0.592	0.594	0.597

South Africa’s HDI rating rose to 0.634 in 1995, but then fell substantially to 0.587 in 2005 (see Table 3). Despite incremental gains thereafter, it ended in 2010 at a worse level than in

1990. Since South Africans' income *per capita* consistently improved over the period 1995 to 2005 and the education rating fell by only 0.19 points (see Table 3 below), this fall is attributable mostly to the third variable that makes up the HDI, namely life expectancy, which declined by almost a decade during the past 10 years (see Figure 8 below). Thereafter, with the downward trend in life expectancy reaching a turning point and the education rating slowly climbing upwards, the country's overall HDI began to rise again, ending at 0.597 in 2010. This did not prevent it from slipping to 110th (down 6 places from 104th in 2005) in comparison with the HDI of other countries in the world (UNDP 2010).

Since the previous section included a discussion of the impact of HIV and AIDS on *per capita* incomes, this section will only discuss the state of South Africa's education and health and the likely influence of the disease on these two aspects of the UN HDI.

**Table 4. South African Education Index, selected years**

*Source: UNDP 2010.*

1990	1995	2005	2006	2007	2008	2009	2010
0.549	0.667	0.648	0.653	0.656	0.66	0.664	0.668

The UNDP's Education Index for South Africa combines mean years of schooling for adults aged 25 years and expected years of schooling for children of school going age. The rating improved considerably<sup>48</sup> between 1990 and 1995; dropped marginally in the decade leading up to 2005 and thereafter continued on an incremental upward trend (see Table 4). This indicates that, compared to 1990, South Africans receive several more years of schooling today. Although the country's education index has not been improving at a rapid pace, the table shows that the declines in overall HDI are mostly not attributable to the education index.

It is important to note that this index does not measure the quality of education that citizens receive. This table reflects an encouraging trend of increased years of schooling among South Africans, which has been the norm throughout the 1900s for all race groups. Although schooling was only made compulsory for black South Africans after 1994 (Fiske and Ladd 2003: 4), low quality education was expanded for a great part of the population during

<sup>48</sup> The reason for the great difference between 1990 and 1995 is not indicated. It is possible that different data sources were incorporated after 1994, and/or that the expected years of schooling for children in 1995 was unrealistically high in 1995 and adjusted downward thereafter.

Apartheid, dramatically reducing the gap in the average number of years of schooling for the different race groups (Van der Berg 2010: 17). In 1994, South Africa's new government inherited racially defined, separate departments of education. Since then the system has undergone some far-reaching changes including the merging of the old departments, the introduction of an outcomes-based curriculum and changes in the framework for educators' qualifications (Louw, Shisana, Peltzer and Zungu 2009: 205-6).

Unfortunately, studies indicate that by international standards, the quality of South African education has not improved (Louw, et al. 2009: 205-6). By 2008, Servaas van der Berg still wrote that "[m]assive differentials on achievement tests and examinations reflect South Africa's divided past. Improving the distribution of educational outcomes is imperative to overcome labour market inequalities." If AIDS impacts negatively on education, particularly education for poor black learners, it compounds this problem.

It was projected in 2001 that HIV prevalence among teachers could rise from 12% in 2001 to 30% in 2010 (AbT associates, quoted in Bennel 2005a: 453). This prompted a broad-scale study by the Human Sciences Research Council (HSRC) in 2004-2005. The results of this study, which surveyed 20,626 educators in 1,766 South African schools, were analysed by Shisana, Peltzer, Zungu-Dirwayi and Louw (2005), Peltzer (2008) and Louw, et al. (2009).

Firstly, the study confirmed fears that HIV prevalence was high among educators, but did not match Chirambo's (2008: 31) assertion that in Southern Africa, a third of teachers are infected with HIV. By testing specimens voluntarily provided (by 83% of the educators) for HIV, they found that 12.7% of educators were HIV positive, and that young female educators were particularly affected, with a prevalence rate of 21% (Louw, et al. 2009: 208). This is high, but the age, gender and racial distribution of HIV among teachers was quite similar to that of the general population (Shisana, et al. 2005: 55-56).

Secondly, the quality of education was affected by HIV at the learner, family and community level. The majority of teachers who were aware of learners affected or infected by HIV extended emotional, psychological and/or material support to such learners. 45% of such teachers reported not having time to attend to the educational needs of all learners in the class and 28% found it difficult to teach learners. At the family level, educators who had infected or affected family members were frequently struggling to cope with their workload (34.5%), were stressed (43.5%) and "sad and depressed" (45.4%). At the community level, frequent attendance of funerals (38% of respondents had attended an AIDS-related funeral

in the past two years) was likely to impact upon teacher attendance, especially in African communities where attending a funeral could often mean missing one or two days of work. Thirdly, according to this study an HIV-infected educator was the single factor that had the greatest impact, on the school in general as well as on fellow educators specifically: having an HIV-infected colleague in 39.5% of cases led to larger classes; in 57.8% to a shortage of educators; in 59.1% to educators teaching subjects they were not trained for on behalf of their ill colleagues; and in 71% of cases, to many educators feeling depressed. It was not clear from the article how many teachers were already receiving ART if they needed it, but apparently ART was not yet provided at schools, making it difficult for educators who needed ART to access medication without missing school.

This study indicated that HIV and AIDS are indeed negatively affecting education in South Africa. As Bennell (2006) pointed out, however, in South Africa teacher mortality itself would not likely pose a catastrophic threat to the education system as a whole. For instance, by 2003, teacher mortality (all causes) had risen and then declined in KwaZulu-Natal and had never reached more than 1% of teachers (Babcock-Walters and Wilson, quoted in Bennell 2006: 3). Bennell (2006: 3) suggests that the decline could be explained by teacher behaviour change and access to ART. Instead of a direct link between AIDS and a single aspect of the education system (such as the death of teachers), it is the composite impact of the disease that places strain on an already struggling system.

As pertains to health, some background is appropriate. Previously, the system prioritised the health of whites above that of blacks (Youde 2007; Fourie 2006; Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, Jewkes and Karim, Flisher, Mayosi, Tollman, Churchyard and Coovadia 2009). Treatable conditions such as tuberculosis and cholera were common causes of death among black adults; similarly, gastroenteritis, chest infections and diarrhea in children were among the dominant causes of death among the non-white population, while white children mostly died of accidents such as drowning (Youde 2007: 70). Youde (2007: 71-72) argues that the National Party government often ignored diseases that seemed containable among the non-white population (such as polio and typhoid fever); that it used healthcare resources as a form of control over various racial groups, and that what resource-intensive policies it did launch among blacks often came with heavy ideological baggage. Thompson (1995, quoted in Youde 2007: 70) notes that by the 1970s the life expectancy rates for white South Africans were comparable with those in the United States and Western Europe while government estimates of black life expectancy rates were 15 years lower. Life expectancy during Apartheid may be based largely on informed guesses, as the Apartheid

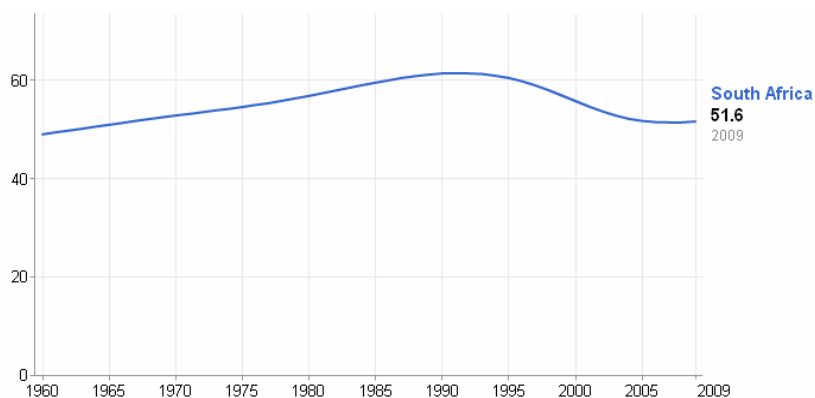
government did not require the recording of births and deaths among the black population (Seedat, quoted in Youde 2007: 70).

Since 1994 South Africa has seen an expansion in basic health services and particularly a great increase in social and welfare benefits (Chopra, et al. 2009: 2). Health expenditure is high and many supportive policies are in place, yet healthcare outcomes remain poor and correlated with race. Mortality among black children, for instance, remains four times higher than for white children (Chopra, et al. 2009: 2). This may be partly explained by the fact that the private healthcare sector, which provides services to a (more privileged) minority of the population, receives about 60% of health expenditure, leaving 23-33 million South Africans dependent on an under-funded and poorly managed public health system. The public health care system is also increasingly under-staffed, with the proportion of total nurses and general practitioners working in the private (as opposed to the public) healthcare system having doubled since the 1980s. The proposed NHI is currently debated as a means to rectify this situation (Marais 2010: 313).

The pandemic also contributes massively to poor health outcomes in South Africa (Chopra, et al. 2009: 1). The impact of the disease on mortality is vividly illustrated in life expectancy. Life expectancy – the average for all citizens – had climbed steadily until, in 1992, the average newborn South African baby could expect to live 61.5 years. This was still not near the life expectancy of citizens in countries with comparable *per capita* incomes, but the steady improvement was encouraging. Within the next decade and a half, that figure dropped rapidly, reaching a low of 51.4 years in 2007 – a figure it had last seen in 1966 (see Figure 8). It has now begun to climb slowly.

**Figure 8. South Africa Life Expectancy at birth, 1960 - 2009**

*Source: World Bank 2011c.*



Although noting that some parts of the health system have been reinvigorated by the challenge of HIV and AIDS, members of *The Lancet* team for South Africa emphasised in a series of articles on health in South Africa that increased AIDS-related morbidity and mortality threaten to overwhelm the South African health system (Chopra, et al. 2009: 1). Not only does the disease place strain on fiscal resources, but there is also evidence of a “brain drain” out of the public sector into HIV and AIDS-related programmes, thereby worsening the overall capacity of the health system (Chopra, et al. 2009: 5). Those who remain in public hospitals are often frustrated, citing burn-out, low morale and dysfunctional systems as chronic problems in the system (Van Holdt and Murphy 2007, quoted in Marais 2010: 314). The HIV and AIDS pandemic also brings with it several other health challenges. Spreading exceptionally fast because of the weak immune systems of PLWHA, tuberculosis (TB) has become a serious epidemic and has developed multi drug-resistant (MDR) and exceptionally drug-resistant (XDR) strains. Had ART been rolled out earlier, this could have been prevented (Chopra, et al. 2009: 3). As mentioned in Chapter 1, the timely provision of ART to Ugandan HIV patients increased their life expectancy by up to 28 years (for those who initiated treatment at age 35) (Malan 2011).

In short, challenges in the health and education systems are compounded by the additional pressure of HIV and AIDS. The impact on the education system is significant but not catastrophic on its own. In the health system, the disease has had a major impact, not only on those infected with HIV, but on the system as a whole as it adds pressure to resources and enables the spread of other diseases.

### **4.3.3. Civil Society**

A robust civil society is deemed an essential factor in the process of democratic consolidation (Linz and Stepan 1996: 17; Bratton and Van de Walle 1997:254; Leftwich 2000: 146-147). Scholars (Mattes 2003: 9; Strand 2005: 3; De Waal 2006: 41-42; 2003: 13) have differed concerning the likely impact of HIV and AIDS on civil society (see Chapter 1). Unlike much of Africa (including Botswana), South Africa does not suffer from a “missing middle” (Chazan 1992: 282), at least until the end of Apartheid. It had a vibrant civil society sector. Many scholars have cited South Africa as an example of a civil society that was actually mobilised to get involved in public life because of HIV and AIDS.

After 1994, a key reason for mobilisation – anti-Apartheid activism – fell away and initially, the behaviour of many civil society organisations was informed by the expectation that



“adversarial social struggle with the government” was no longer relevant. The dominant ANC government also co-opted many civil society associations, many CSOs were granted the opportunity to influence policy through engagement and cooperation with the government (Ballard, Habib, Valodia and Zuern 2006: 1). However, new social struggles – many of them linked to continued poverty and inequality – also soon emerged. Bolstered by the “positive” socio-economic rights enshrined in the Constitution and the newfound opportunity to use the Constitutional Court to influence policy (Friedman and Mottiar 2006: 24-25), this proliferation of new CSOs have called the government to account for perceived inactivity, or insufficient effort, to provide in its citizens’ rights (Friedman 2003: 8; Ballard, et al. 2006: 2) such as adequate housing, sufficient jobs and the social and welfare services it has promised (Ballard, et al. 2006: 2). South African CSOs are also quick to challenge policies that are seen to be infringing on their political rights and civil liberties. Civil society in South Africa thus functions to challenge the state both where it is perceived as overweening and, notably, to “push” the government into policy areas where they believe it “can respond to social demands but chooses not to” (Friedman 2003: 8).

It is likely that South Africa’s CSOs have had some negative experiences with HIV and AIDS. As mentioned in Chapter 1, Mattes (2003: 9) noted research that indicated that South African CSOs suffered losses in terms of productivity and human capital because of HIV and AIDS. In an exploratory study, Ryann Manning (2002, quoted in Mattes 2003: 9 and De Waal 2006: 41-42) found that civil society organisations in South Africa’s KwaZulu-Natal province were being affected by the disease as increasing numbers of their staff and volunteers succumbed to the disease. Moolman (2004) discussed the challenges of CSOs in the face of HIV and AIDS and reported on a workshop where South African CSO representatives sought solutions, but does not report on the perceived extent of the impact on these organisations. The negative impact of the disease on CSOs is thus under-researched.

On the other hand, scholars (especially Butler 2005a) argue that South Africa’s civil society may have been positively impacted by the politics around HIV and AIDS. The TAC, one of the most prominent rights-related CSOs, was founded as a direct response to HIV and AIDS in South Africa to campaign for the right of PLWHA to access to health care, as enshrined in Section 27 of the Constitution. Arguably one of the most successful of the South African social movements, the TAC is seen to have led the campaign (also through the courts) to pressure the cabinet into approving the rollout of ART to South Africans during Mbeki’s tenure (Friedman and Mottiar 2006: 24).

The TAC was founded in 1998 by a group of activists who drew up a petition calling on the South African government to develop a treatment plan for all those living with HIV and AIDS. Still active today, its states that it “advocates for increased access to treatment, care and support services for people living with HIV and campaigns to reduce new HIV infections” (TAC 2011). The group mobilised mostly among the black working class, the unemployed (particularly unemployed black women) and trade unions. It emphasised the civil rights of the poor and the working class to health care, employing class-based politics in contrast to the reliance of Mbeki and his (elite) supporters on race and cultural nationalist rhetoric (Robins 2004: 661-2). At the same time the TAC has also drawn support from health professionals and university students, and developed an organisational structure and support network that ultimately represented diverse class, ethnic, occupational and educational backgrounds (Robins 2004: 663).

Confronting a popularly elected government as opposed to one widely deemed illegitimate (as some members had done as anti-Apartheid activists), the group has been particularly careful not to be seen to threaten democratically elected leaders. Instead, it has exhibited a willingness to “change strategic calculations to accommodate formal democracy” (Friedman and Mottiar 2006: 25). In this sense, the TAC is an example of a CSO that is beneficial to democratic consolidation: it does not aim to seize government or dispute the legitimacy of the democratic regime, but rather operates within, and therefore reinforces, democratic norms (Chazan 1992: 283; Linz and Stepan 1996: 18).

The action of civil society, and the TAC in particular, is the key reason why Butler (2005a) argues that the impact of AIDS in South Africa has not only been negative, but also in some sense positive for democratic consolidation, because it deepened democracy institutionally.

Firstly, as also discussed earlier in this chapter, Butler (2005a: 12-13) argues that the TAC case against the government (*Minister of Health and others v Treatment Action Campaign and others* 2002), which it won, legitimated judicial activism to enforce the provision of constitutionally protected socio-economic rights. In a new democracy in which the (elected) executive had sometimes questioned the legitimacy of the judiciary, the TAC case resoundingly affirmed the legitimacy of judicial independence within constitutional democracy.

Secondly, Butler (2005a: 13-15) argues that the TAC broke ground in terms of engagement with the government in a post-Apartheid environment. On the one hand, the group made it very difficult for the government to write it off as a vocal minority that lacked the

majoritarian or liberation credentials of the ANC and therefore did not deserve the government's audience. The organisation, after all, opposed not only the government's AIDS policies, but also the "western" international pharmaceutical industry, which was protected by international patents from selling AIDS drugs at prices affordable to the South African government. Challenging the government's attempts to "whitewash" them or frame them as "anti-black", many TAC activists expressed their support for the ANC and the Tripartite Alliance, and COSATU was one of the TAC's key partners and some of the TAC's symbols and songs also drew inspiration from the anti-Apartheid struggle (Robins 2006: 665). On the other hand, while demonstrating their support of the ANC generally, they certainly did not conform to government AIDS policy. In short, they found a balance between "craven deference" – which would not advance their goals – and "blind confrontation" (Butler 2005a: 14).

Besides taking care to portray itself, the TAC invested in innovative methods of campaigning. The TAC took to the streets *and* debated in courtrooms; it also made use of the internet, the media and its networks of South African and international CSOs. The TAC educated its members with regards to AIDS science and marshaled scientific research to support its case. It also engaged in acts of civil disobedience, such as buying cheap generic AIDS drugs (which were at the time unavailable to the South African public health system) in Thailand and illegally distributing them in South Africa (Robins 2004: 665), an action which drew such international attention that the pharmaceutical companies concerned were pressured into abandoning legal action to prevent the government from importing cheaper generic medicines.

The TAC is thus a case study of a strong civil society movement in an African democracy. It owes its existence, and directs much of its work, to the HIV and AIDS epidemic in South Africa. Given its role in affirming the legitimacy of the legal system and judicial activism and its groundbreaking example of engagement with the post-Apartheid government, it may be argued that civil society in South Africa (not just those concerned directly with HIV and AIDS) would have operated in a less favourable environment had it not been for the TAC. It may even serve as an example to those civil society associations that opposed the government's proposed censorship of the media in the "protection of information" debates in 2010-2011.

#### 4.4. Assessment

The South African experience with AIDS has been highly political. The AIDS stance of the government under Mbeki and health Minister Tshabalala-Msimang, labeled AIDS “denialism” by its opponents, was influenced by South Africa’s political history and sparked great controversy locally and abroad. While its negative influence on human development will be felt directly and indirectly for decades to come, the direct impact of the disease has, in some instances, been positive.

In terms of the system of government, events around AIDS affirmed that provinces have a degree of policy independence vis-à-vis the national government and weakened the legitimacy of the increasingly centralist Mbeki as the developments around the disease revealed his disdain for debate even with his fellow ANC members.

With regards to the electoral system, the PR system through which national government is elected mostly protects it from the negative effects of the disease, but these are being felt to some extent on a local level, with an increase in by-elections which have shifted the balance of power in favour of the ruling party. Perhaps the most important finding to emerge so far is the apparent lack of participation of PLWHA in the 2004 national elections. The electoral participation of this large proportion of society is a political right and, incidentally, one which they value highly. A follow-up study could shed light on whether this problem improved during the 2009 elections.

With regards to political rights and civil liberties, the decline in Freedom House ratings since 2006 does not seem directly linked to HIV and AIDS, and the action of the TAC with regards to the disease has encouraged an active pursuit of socio-economic rights using the democratic institutions of the Constitution and legal system; and has empowered citizens to participate in the development of public policy.

With regards to socio-economic factors, the macroeconomic impact of HIV and AIDS is not clear-cut. The disease was projected to impact negatively on economic growth, but positively on *per capita* income. The impact on income inequality has not been quantified but scholars suggest that the poor will find it more difficult to escape poverty because of the disease. The research of Przeworski, et al. (1996) would therefore suggest a mixed effect on the “life expectancy” of South Africa’s democracy. Of course, a range of assumptions had to be made

about South Africa's economic prospects for the period 2000-2020 and the projections may prove incorrect because of unanticipated or underestimated changes.

Human development has been severely affected by the disease, as it compounds other unrelated challenges in both the education and health systems. The health system in particular is under great strain. If the theory of Welzel, et al. (2003) is borne in mind (see Chapter 2), a lower level of human development could damage the value South Africans attach to democracy.

Finally, the impact of HIV and AIDS on civil society seems to have been mostly positive. It has affirmed the people's right to organise and protest democratically; broken ground in terms of its tactics and engagement with the government; and affirmed the legitimacy of the judiciary vis-à-vis the executive government. What negative impact the pandemic is having on the productivity and human capital of CSOs is unclear and requires further research.

In short, it appears that HIV and AIDS have had some positive effect on especially the democratic institutional framework within which politics take place, particularly revitalising civil society, but it also impacts negatively on socio-economic development in South Africa. Whether AIDS is South Africa's greatest challenge is debatable – especially as it is intertwined with the challenges of high levels of poverty, unemployment and inequality. If the country can succeed in scaling up access and adherence to ART, it can further mitigate the negative effect of the disease.

## CHAPTER 5: COMPARATIVE ANALYSIS

### 5.1. Introduction

This thesis studied the impact of HIV and AIDS on democratic consolidation in two African democracies. As discussed in Chapter 1, Mattes (2003) and others warned that this impact is potentially negative, particularly with regards to economic indicators, while Butler (2005a) emphasises some of the positive impacts that the epidemic had in South Africa, notably on civil society and the legitimacy of democratic institutions, inter alia through the courts. A multivariate model of democratic consolidation, developed in Chapter 2, was used to assess the impact of the pandemic on some key institutional (political system, electoral system, and political and civil liberties) and socio-economic factors (macroeconomic indicators, human development and civil society) in Botswana and South Africa. This chapter compares the findings and relates them to the arguments mentioned before. These comparisons are made by focusing on similarities and differences between Botswana and South Africa.

### 5.2. Institutional comparison

Botswana and South Africa are both parliamentary democracies that nevertheless feature a powerful executive president. They differ in the electoral system employed at national level – South Africa uses a PR list system while Botswana uses an FPTP system – but both countries regularly host free and fair elections. Each has been relatively successful in protecting citizens’ constitutional rights and is considered Free by Freedom House. These are similarities above the consolidation line, but neither have had any Huntingtonian “turnovers” (see the institutional requirements for democratic consolidation in Chapter 2). The current political system in Botswana has been in place and continuously ruled by the BDP since its independence almost five decades ago. South Africa’s system, ruled by the ANC, is not yet twenty years old.

The first institutional factor of democratic consolidation that was studied is the system of government. Although Chapter 2 focused on the benefits to democratic consolidation of parliamentary versus presidential systems of government, the political systems in place in the two countries studied are quite similar, combining a parliamentary system with the strong executive president typical of African democratic systems. Therefore the states chosen for this study did not allow for a comparison of the effectiveness of parliamentary and

presidential systems in the context of HIV and AIDS. Yet, despite their similar design, these two governments handled HIV and AIDS differently, with divergent outcomes (so far) for their respective political systems.

Given the extensive powers they both enjoy, the positive response of president Mogae and the initial response of president Mbeki to HIV and AIDS, labeled “denialism”, were important factors contributing to their states’ ability to address the pandemic. Botswana developed the most extensive ART distribution system in Africa (in terms of the proportion of citizens reached) and life expectancy levels began to increase from 2002 onwards, while in South Africa these levels continued to deteriorate until as late as 2007. While it may be argued that a purely parliamentary system in South Africa would have diffused policymaking power and minimised the harm of Mbeki’s denialism, his power to enforce a “denialist” policy was successfully challenged. It did not lead to serious political instability as presidentialism often has according to scholars such as Linz (1990) and Przeworski, et al. (1996). The successors of Mogae and Mbeki – Ian Khama and Jacob Zuma<sup>49</sup> respectively – are taking a more moderate stance, with Khama acknowledging the pandemic but allowing former president Mogae to continue spearheading the national response as chair of NACA and promote HIV and AIDS efforts internationally, and President Jacob Zuma confirming medical orthodoxy and the importance of HIV and AIDS efforts while upholding the court decision of 2002 on the provision of ART (Constitutional Court of South Africa 2002).

Instead of emphasising the importance of the choice of political system for South Africa’s democratic consolidation, Butler (2005a) points to the fact that the system in place is new and malleable. The era of HIV and AIDS coincided with the advent of South Africa’s democracy and with it the opportunity for Mandela, Mbeki, Motlanthe and Zuma to set precedents with regards to the president’s relationship to other democratic institutions. Butler (2005a) argues that the HIV and AIDS controversy demonstrated Mbeki’s willingness to undermine checks and balances and centralise executive power. It is therefore auspicious that Mbeki’s initial “denialist” policies were attacked and defeated by civil society organisations through the mechanisms of legitimate activism and the courts. The response of civil society, the courts, the provinces and the ANC itself demonstrated that presidential authority has limits: future presidents can expect a challenge through the mechanisms provided by the constitution if they make similarly controversial public policy. Democratic consolidation of the attitudinal and constitutional dimensions (Linz and Stepan 1996: 15) was

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<sup>49</sup> Kgalema Motlanthe was Mbeki’s immediate successor, serving out the remainder of Mbeki’s term, from September 2008 to May 2009.

demonstrated as these actors showed a commitment to democratic procedure amidst a policy crisis.

In contrast, the political system in place in Botswana has a relatively long and stable history. Masire (who was in office in 1985 when the first AIDS cases were reported in Botswana) supported HIV and AIDS efforts and Mogae (president from 1998 to 2008) demonstrated a level of commitment to addressing the pandemic that earned him international praise. This reaped political benefits for him and probably helped the BDP to remain popular, the majority of Botswana's citizens are satisfied with the government's efforts in terms of HIV and AIDS policy. But while South Africa responded to the president's AIDS "denialism" by entrenching restraints on the power of the executive, there is no evidence in the literature surveyed that the popularity of the Botswana presidents' vigorous efforts to address HIV and AIDS significantly impacted the relationship between president and parliament, civil society, the courts, or other institutions with regards to health and other policy development. Civil society remains relatively weak, and the executive, led by the president, continues to dominate the legislature.

The second institutional factor is the electoral system. Botswana's FPTP system, in place since the advent of democracy in the country, is typical of FPTP systems globally (see Chapter 2) in that it disproportionately advantages the ruling BDP. This party's support base is rural, and 80% of seats in parliament represent rural areas, while at least half the population is urbanised. As a result many votes for the opposition are effectively "wasted" (notably in the 2004 elections, in which the BDP won 51% of the national vote and was awarded 77% of the seats in parliament). The FPTP system does at least ensure that there is an MP accountable to each geographic constituency. In South Africa there is a PR system and the composition of parliament is highly representative of parties' national support, but as is typical of such systems, the lack of constituency accountability of MPs to voters is often seen as problematic.

In Chapter 2 it was pointed out that both of the abovementioned electoral systems have advantages and disadvantages and that neither electoral system is necessarily always the best for democratic consolidation. Leftwich (2000: 138) emphasised that whichever system is used, that system must be deemed legitimate by voters and the process considered free and fair. The political considerations of the democracy in question should be considered – for instance, the need for political inclusivity in a previously divided society (Lijphart 1991), or



the need for a high level of accountability between political elites and the electorate (Reynolds 1995). This discussion in Chapter 2 was focused on national elections.

On the one hand, in the context of HIV and AIDS, it may be suggested that the direct representation (and accountability) of MPs to their constituencies in Botswana was a major advantage, as it would compel them to lobby on behalf of their voters with regards to an issue of local concern, such as high infection levels in the mining towns or tourist hubs (see Chapter 3) and the corresponding need for healthcare services. The first HIV case was reported in an opposition constituency, Selebi-Phikwe, in 1985, and Botswana's commendable, government-driven response started shortly thereafter (in 1986). Whether this is indeed partly attributable to its constituency system has not yet been established, however.

On the other hand, the financial cost and quality of representation of the two systems were weighed up by such scholars as Strand (2005) and Chirambo and his colleagues (2008). Strand (2005) expressed the expectation, and Chirambo (2008) the finding<sup>50</sup>, that PR systems would function better than FPTP systems if increasing numbers of elected representatives died due to the disease, as a PR system is cheaper and less cumbersome to administer, requiring no by-elections (the next person on the party list simply fills the vacancy). It was therefore to be expected that the proponents of electoral reform in Botswana could point to the effects of the disease to strengthen their case. Instead, it is not clear whether the disease has significantly affected national electoral systems in either state, or citizens' trust in them. Very few parliamentarians died while serving their terms and qualitative data regarding the health of MPs was confidential and not forthcoming. With only four deaths among MPs, and none of them attributable with certainty to AIDS, since HIV was first recorded in the country, the FPTP system of Botswana was apparently neither more costly, nor more cumbersome. But in a poorer country like Malawi, which also utilises an FPTP system, this verdict may have been different.

The importance of local electoral systems was not touched upon earlier, yet Strand's (2005) discussion of the negative effects of an AIDS-induced increase in by-elections in FPTP systems included their potential effect on local councils. Even though HIV and AIDS policy is not made at this level of government, he (Strand 2005) and Chirambo and Steyn (2009: 1) considered the potential effects of an increase in by-elections problematic for the quality of democracy. It was at this level of government – a level at which both countries employ MMP systems – that the Gossett and Lotshwao study (2010) and the Chirambo and Steyn study

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<sup>50</sup> This finding (Chirambo, et al. 2008: 31) was made with regards to southern African states generally.

(2009) found mortality patterns typical of AIDS among directly elected representatives. These studies strongly suggested that both South Africa and Botswana have been forced to conduct more local government by-elections because of AIDS. Relating their findings to the expectations of Strand (2005) and others (mentioned above), these scholars found that by-elections had not become unaffordable. The assertion that by-elections would favour the ruling party was found to be true for South Africa, but false for Botswana, where the BDP lost more by-election seats in local by-elections than it won. Finally, in South Africa there was anecdotal evidence of a reduction in the quality of representation. However, this was not investigated in this thesis.

With regards to electoral governance, both Botswana and South Africa seem relatively unaffected. On the part of electoral management boards, neither Botswana's nor South Africa's IEC reported major operational obstacles related to HIV and AIDS. It is possible that the relative affluence of the two states in question made it easier for them to cope with such challenges as a dying voter corps (which necessitates frequent updating of the voters' rolls) and staff replacement and training. In a poorer country (such as Zambia or Malawi), the pandemic may have a more destabilising effect on electoral governance. On the voters' side, there is little research on the ability of people living with HIV and AIDS to participate in elections. Botswana's PLWHA are not a vocal or coherent pressure group, and little research has been conducted about their challenges, but a group of South African PLWHA were available for Chirambo and Steyn's (2009) study. These individuals expressed a fear of stigma and discrimination at voting stations, as well as challenges with regards to the "special vote". Given South Africa's improvements in the rollout of ART and the passing of another general election in 2009, a follow-up study was recommended in Chapter 4.

Botswana and South Africa have thus had similar experiences with HIV and AIDS and elections. These similarities are above the consolidation line: regular and free and fair elections were never threatened by HIV and AIDS while the marked increase in deaths that both states experienced at local level remained affordable in terms of by-elections. From this point of view, therefore, while HIV and AIDS may be a health and even an economic problem, it is not a political crisis.

The effect of the HIV and AIDS pandemic on political rights and civil liberties was also analysed. According to Freedom House the political rights of citizens in both countries have

recently worsened<sup>51</sup>. Both countries are considered Free, but political rights in South Africa remain better protected than those in Botswana. Botswana now scores a 3 for political rights and a 2 for civil liberties and is placed on the borderline between Free and Partly Free. South Africa (whose political rights score declined due to the ruling party's growing monopoly on policy making) remains more securely in the Free category with political rights and civil liberties each rated at 2.

Are these declines related to HIV and AIDS? This study has found very little evidence that they are. The official reasons given for the declines did not mention HIV and AIDS – Botswana's decline was to a great extent due to perceptions that President Ian Khama tends to intolerance; and South Africa's due to the ruling ANC's growing monopoly on policy making and its increasingly technocratic nature. As discussed in Chapters 3 and 4, the publication *Human rights protected?* (AIDS and Human Rights Research Unit 2007) reported in detail the extent to which human rights are legally protected with regards to HIV and AIDS in South Africa (especially since 2002) and Botswana (since 1986). While there were infringements (importantly, the constitutional right of South African PLWHA to access to healthcare was initially denied), it has been argued in the two states studied, the disease did not lead to political rights and civil liberties being gravely infringed upon, using Freedom House's definitions of these concepts.

Firstly, political rights, defined as “rights that enable people to participate freely in the political process” by Freedom House (2011a) have not been altered by HIV and AIDS, except to an extent for some PLWHA, who faced obstacles to voting as mentioned above – but this needs to be researched in more depth. On the whole, virtually all citizens of Botswana and South Africa may still “vote, compete for public office and elect representatives who have a decisive impact on public policies and are accountable to the electorate” (Freedom House 2011a). Thanks to organisations such as the TAC, participation in policymaking has arguably even increased for many previously marginalised people living with HIV and AIDS.

Secondly, civil liberties, which “allow for the freedoms of expression and belief, associational and organizational rights, rule of law, and personal autonomy without interference from the state” (Freedom House 2011a) are similarly relatively well-protected in these states, at least as far as HIV and AIDS are concerned. For instance, in both countries HIV is a non-notifiable

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<sup>51</sup> The declines occurred at a time when Freedom House has declared the longest running global decline in political rights and civil liberties in the 40-year history of the survey (Freedom House 2011e).

disease except in narrowly defined circumstances (see Chapters 3 and 4), limiting discrimination against PLWHA. Those HIV and AIDS-related abuses that have been documented both in Botswana and South Africa (see Chapters 3 and 4) were not mentioned in Freedom House reports, except for South Africa's experience with AIDS "denialism".

The controversial HIV and AIDS policy of president Mbeki is mentioned by Freedom House (2011d), but did not result in a lower civil liberties rating (see Chapter 4). This political episode may even have had some positive outcomes for civil liberties: as noted, Butler (2005a) argued that the politics around the constitutional right to access to healthcare, especially civil society's court victories over the state, strengthened the rights of the infected population and demonstrate that those citizens have the right to freely organize, express criticism of, and litigate against the government. These events did not improve civil liberties to such an extent as to merit an increase in the countries' Freedom House ratings, but De Waal (2006: 119) mostly seems justified in arguing that democratisation has thus far been protected by the voluntaristic, human rights-based approach adopted towards AIDS policy.

Having reviewed these three institutional factors, it can be said that the two countries' experiences with regards to HIV and AIDS and electoral systems have been similarly mild despite their differing electoral systems; and that the pandemic has also not resulted in an erosion of political rights and civil liberties ratings for either state. The impact of HIV and AIDS on the political system has however differed for the two countries under consideration. In South Africa, this impact was significant and even positive while in Botswana little impact was observed. This difference can be ascribed to the fact that South Africa's political system was more responsive to challenges, leaving more room for precedents to be established. It even compelled a "denialist" president to support more orthodox HIV policies.

### **5.3. Socio-economic comparison**

The neighbouring states of Botswana and South Africa are home to populations dissimilar in size and composition: Botswana's almost 2 million citizens are relatively homogenous, while South Africa's 50 million are more racially and ethnically heterogeneous. The two countries are both relatively affluent (among the top six in Africa, and far above Przeworski's "extremely fragile" level), have had stable, moderate economic growth over the past decade and a half, but suffer from high income inequality. In South Africa, state services, including healthcare and education, were historically distributed in a highly discriminatory manner.

Despite considerable state spending post-1994, many South Africans still do not have access to basic state services, and municipal services in many townships are dysfunctional. Botswana's government has for a longer time attempted to service even rural areas, which is logistically more difficult than servicing urban areas, and achieved considerable success. A history of political resistance (pre-1994) has also emboldened South African civil society, while their counterparts in Botswana are more deferential.

Economic variables were the first socio-economic factor to be studied. As mentioned in Chapter 1, Mattes (2003) used the work of Przeworski, et al. (1996) to discuss the potential effect of HIV and AIDS on democratic consolidation through economic factors in high prevalence countries. He found that the pandemic would mostly have a detrimental impact on these factors and therefore would most likely affect the outlook for democratic consolidation. He also expressed the expectation that fiscal pressures and taxes would increase. However he emphasised there were no case studies yet, only conjecture in search of testable hypotheses, and that a drop in ART prices or innovative awareness campaigns could change the trajectory of the pandemic. The sections on economic factors in Chapters 3 and 4 drew upon studies that were undertaken recently enough to take into account the fact that first-line ART had indeed become more affordable since the publication of Mattes' paper.

HIV and AIDS were expected to affect economic growth negatively in both countries (although without ART, the impact would be much more severe). The Jefferis, et al. (2008) study projected that even if Botswana achieved 80% ART coverage (which it now has), its economy would still grow at 1.2 percentage points less per annum than it would have in the absence of HIV and AIDS. This is a substantial impact if compared to the country's growth levels over the past two decades (see Chapter 3). In the South African case, the BER (2004/5) study summarised by Smit and Ellis (2009) suggested a much milder impact of 0.38 percentage points less growth per annum, assuming only 50% ART coverage (the country surpassed this level of coverage in 2009). Botswana's economy is thus impacted much more, even with higher levels of ART coverage. One reason for this is, of course, that its HIV prevalence is simply higher than that of South Africa. With an estimated 25% of adults aged 15-49 infected with HIV (UNAIDS 2009c: 19), Botswana is bound to see a greater impact on its economy than South Africa, where the corresponding figure is 16.9%. Secondly, the economy of Botswana is far less diversified, and its second biggest export industry, agriculture, is expected to be hard hit by HIV and AIDS, although this is speculation, as a sectoral breakdown of the projected impact in South Africa was not given in Smit and Ellis (2009). Third, it is possible that HIV prevalence levels are more similar between the skilled

and unskilled in Botswana. Because companies find it very expensive to replace skilled workers, Botswana's economy may suffer more. In South Africa infection is concentrated mainly among those with low skills, who are less expensive to replace. Finally, unemployment in Botswana, although having grown fast since the 1990s, is lower than that in South Africa, where structural unemployment has been a problem for several decades (see Chapter 4). Botswana may thus also find it more difficult than South Africa to replace the unskilled labourers it loses due to AIDS.

**Table 5. The influence of *per capita* income on democratic endurance**

*Source: Przeworski, et al (1996: 41); own calculations.*

Strength of democratic regime	<i>Per Capita</i> Income 1985	Adjusted for 2009*	Botswana 2009	South Africa 2009
"Impregnable"	Above \$6 000	Above \$12 195	<u>\$13 384</u> Slightly above the "impregnable" bottom line	-
"Fragile"	Between \$6 000 and \$1 000	Between \$12 195 and \$2 032	-	<u>\$10 060</u> Slightly under the "impregnable" level; at the upper end of "fragile"
"Extremely Fragile"	Below \$1 000	Below \$2 032	-	-

\* PPP, current international \$.

With regards to affluence, HIV and AIDS are expected to have opposite effects on Botswana and South Africa. Mattes (2003) pointed out that some literature suggests that AIDS could increase *per capita* incomes as it implies slower population growth. This was supported by Smit and Ellis (2009) for South Africa and rejected by Jefferis, et al. (2008) for Botswana. Neither country was expected to see a decline in *per capita* incomes, but in Botswana it was projected that *per capita* incomes would grow *slower than would have been the case had there been no AIDS*, as the disease affects economic growth more severely than the growth of the population (see discussion in Chapter 3), while in South Africa *per capita* incomes were projected to grow *faster than would have been the case had there been no AIDS*, as the effect on economic growth was expected to be relatively mild while the growth of the population and the workforce would slow considerably (see discussion in Chapter 4). In light of Przeworski, et al.'s (1996) finding that higher levels of affluence are conducive to democratic consolidation (see Chapter 2), AIDS could also be said to slow down an economic trend that is necessary for democratic consolidation in Botswana and, ironically, to speed it up in South Africa. However, South Africa arguably needs the push more than Botswana since it has not

yet reached the “impregnable” zone of affluence in which Botswana falls, judged by Przeworskian standards (see Table 5).

With regards to the reduction of inequality, it is important to note that GINI coefficient estimates of the impact were not presented for either country. Still, it can be deduced from the literature that Botswana’s prospects in the face of HIV and AIDS are more negative, while South Africa’s picture is more complicated. This is because Botswana’s more severe projected reduction in economic growth would slow the growth in the demand for labour, so that poor households, even those not directly affected by HIV and AIDS, risk being poorer than in the absence of HIV and AIDS. In South Africa, unemployment was expected to be greatly reduced by HIV and AIDS, but optimism in this regard should be tempered, not only by the fact that other factors (see Chapter 4) seem to be cancelling out the impact of HIV and AIDS on unemployment, but by strong indications that HIV and AIDS affects the poor disproportionately more and pushes more South Africans into poverty, correlating with the findings of Price-Smith and Daly (2004) for Zimbabwe. Marais (2010; 2011) is particularly forceful in arguing that the “heightened marginalisation of the very poor” is problematic in the light of South Africa’s already ineffective attempts at reducing inequality.

In short, in terms of all three economic variables that Przeworski, et al. (1996) consider important for democratic consolidation, Botswana was believed to be worse off because of HIV and AIDS than it would otherwise have been. However, the democracy still remains unlikely to “die” (in Przeworski, et al.’s (1996) terminology) if one takes into account its already high level of income *per capita*, as well as such factors as the government’s commitment to treat patients. In practice, citizens of Botswana have until now consistently expressed very high levels of support for democracy and rejected authoritarianism (see Chapter 3). In contrast, South Africa’s population was more likely to be on average more affluent because of HIV and AIDS, but at the same time, the poor may become impatient with slow economic growth and continued (possibly aggravated) inequality.

Both studies found that, as Mattes (2003) argued, the disease placed fiscal pressure on the governments of Botswana and South Africa but that government spending on ART makes fiscal sense. While both states rely to an extent on foreign donor funding to afford ART, neither state is close to becoming primarily a mechanism for ART distribution that would heed the instruction of foreign donors above the needs of individual citizens (De Waal 2006: 114). Fiscal pressure also impacts on governments’ ability to address other developmental priorities.

With regards to human development, the UN HDI ratings of both South Africa and Botswana saw an unprecedented decline as the pandemic spread across their borders. Given the complex social effects of the disease, the UN HDI (an index that purposefully consists of only three key indicators) cannot offer a comprehensive indication of the damage the disease does to human development in these countries, except for the impact on life expectancy.

With regards to education, a survey of recent ratings and literature has suggested that the quantitative effect of HIV and AIDS on education was initially overestimated. Botswana and South Africa score the same relatively high figure in the United Nations Human Development Report of 2010 at 0.668. This is a figure that combines citizens' mean years of schooling and expected years of schooling, and therefore quantitatively measures the reach of the education system without evaluating its quality. Both countries made considerable progress in terms of this score between 1990 and 2010. This means that citizens are gradually increasing their mean years and expected years of schooling. With regards to teachers, it is no longer accepted knowledge that teachers are at particularly high risk of infection (De Waal 2006: 114; Birdsall and Hamoudi 2006: 139). An in-depth HSRC study (Louw, et al. 2009) showed that South African teachers' infection levels, although high for certain age, sex and race groups, are not remarkably higher than those of their demographic peers. Moreover, if these HIV positive teachers obtain appropriate ART, they can remain productive for many years. In Botswana, no data was available for the prevalence rate among teachers, but annual teacher deaths never amounted to more than 1% of their total in this country (Bennell 2005). HIV positive teachers who do need ART are likely to have access to it, because Botswana's government began providing ART to teachers as early as 1999, three years before it commenced ART rollout to the general population in 2002 (Bennell 2006: 2).

Education quality must be taken into account along with education quantity (Kinghorn and Kelly 2005: 493-494). South Africa's education system is failing to improve education outcomes such as its learners' performance in international literacy tests. This problem may be compounded by HIV and AIDS: the Louw, et al. study (2009) found that the quality of education is at risk when educators, learners, and/or members of the community are infected with the disease. This is a difficult proposition to measure quantitatively and is not taken into account in the composition of the UN HDI. Again, as Marais (2011) emphasises, education in poor areas (where learners already tend to receive a lower quality education) will be more affected than in affluent areas with often better schools. The situation is expected to be similar in Botswana, but further study is required.



It can thus be said that the effect of HIV and AIDS on education in Botswana and South Africa is very similar, in that it has not reversed a trend of increasing years of schooling but poses a threat to the quality of education, and does so to a greater extent in poorer and, perhaps, rural, communities.

As already mentioned, the most drastic reduction in human development is the reduction in life expectancy. This is true in both Botswana and South Africa. However, there is a key difference in terms of scale: the South African public health system must reach a far greater and more diverse population than that of Botswana. Additionally, the South African system, unlike that in Botswana, required an overhaul after democratisation in 1994. Consequently, whereas not much mention is made of Botswana's health system, scholars argue South Africa's health system is under tremendous strain in terms of finances and insufficient human resources<sup>52</sup> not only because of HIV and AIDS but also because of TB and other diseases whose spread are facilitated by the spread of HIV and AIDS. (At the same time, the country boasts a private healthcare system that is among the best in the world but serves only a minority of the population.) In Botswana, life expectancy levels have begun to climb from a low of 49 years (in 2002) to 54.1 years (in 2008). Although this is still considerably lower than the 64.1 year level the country had attained in 1989, it indicates that the country is succeeding in improving public health. In South Africa, similar progress is recent and slow, reaching its lowest point (51.4 years) as late as 2007. The restoration of life expectancies in both countries hinges upon the successful implementation of HIV prevention efforts. In the meantime, the South African public health system, lagging behind that of Botswana in HIV and AIDS treatment, reflects particularly poorly on the ability of the government to provide the basic needs of all citizens.

The literature on education and life expectancy thus indicates that citizens of Botswana and South Africa – especially the disadvantaged – are experiencing more suffering and less improvement in the conditions of their daily lives than had HIV and AIDS not affected these countries. This is particularly worrisome in South Africa, a state where the population expects democracy to deliver extensive material benefits (Bratton and Mattes 2001: 5). Depending upon whether voters separate their support for the ANC from their support for democracy, it is possible that they would simply punish the ANC by voting for its competitors (which is not yet the case, judging by recent election results), or alternatively,

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<sup>52</sup> These issues are highlighted in the present debate about the proposed National Health Insurance in South Africa.

support unconstitutional alternatives, such as violent municipal protests. This is when democracy begins to suffer.

However, in neither country have the grave socio-economic effects of the pandemic amounted to societal collapse or political crisis as was predicted in earlier literature. Chapter 2's suggestion that declining human development is not conducive to democratic consolidation may still hold true to an extent, but it has not amounted to an outright rejection of democracy or widespread preference for undemocratic alternatives (see Afrobarometer data in Chapters 3 and 4). Voters may also embrace democratic options, such as punishing the ruling party by voting for another party if they do not consider the government's service delivery adequate.

Finally, Botswana and South Africa's civil society sectors have been affected by, and responded to, HIV and AIDS in different ways. As Mattes (2003) suggested, the risk of losing key members of civil society to the disease is relevant. Some indications that this is happening were mentioned in Chapter 4, but more research is needed. As De Waal (2006) found, the impact may differ from state to state, with some citizens becoming more involved in civil society while others, burdened by illness or illness-related pressures, withdraw from public life. Of possibly greater import in terms of consolidating democracy is the behaviour of civil society groups (see Linz and Stepan 1996, as discussed in Chapter 2) who continue to operate – and here the situation looks more positive for South Africa than for Botswana.

In South Africa the policy challenges around HIV sparked the founding of the TAC, an organisation that has become an iconic example of a vocal, critical civil society in a post-struggle environment (similar to the Right2Know campaign against the Protection of Information Bill presently debated). Arguably, civil society in general would have operated less effectively, and in a less favourable environment, had the TAC not affirmed the legitimacy of the legal system and judicial activism and broken ground in terms of engagement with the post-Apartheid government. It drew broad-based support, challenged a popularly elected government and respected democratic rules of engagement. This experience suggests that De Waal (2006: 119) was justified in arguing that, with appropriate political mobilisation, African democracies could not only survive AIDS but, as Butler (2005a) points out, become stronger because of it.

In Botswana, on the other hand, the government's response has been considered pro-active enough not to provoke a critical response from a (weak) civil society. Here, the disease has

contributed to the trend of a proliferation of civil society organisations, but these organisations (AIDS-related and others) remain unable or unwilling to express vocal criticism of the government. Many of these groups depend on the government for funding; others may simply be aware that confrontation with the country's political leaders could cost them popular support. If the recent trade union strikes in this country (related to salary increases) are the cause or effect of changing attitudes toward confrontational political engagement, behaviour might change. But HIV and AIDS were not an issue in these strikes.

#### **5.4. Assessment**

Having compared the experiences of Botswana and South Africa concerning the impact of HIV and AIDS on the factors of the multivariate model of democratic consolidation, some conclusions may be drawn. The most important is that at present, despite the cost and socio-economic implications of the disease, there are no indications that HIV and AIDS are directly threatening to destroy or even erode the democracies of Botswana or South Africa. If state collapse is “a real possibility” (Whiteside 2008: 92), the contribution of HIV and AIDS to increasing this possibility is not as great as was initially expected. Even the FPTP electoral system employed by Botswana, reputed to be less suitable for HIV and AIDS communities, continues to function effectively. No democratic institutions in either country were weakened to the point of collapse. Remarkable as this may seem, as De Waal (2006) pointed out, African democracies have functioned amid socio-economic crises for decades. That human development plummeted while the quality of democracy remained relatively high suggests that, under certain conditions, retarded human development levels may not have a significant impact on democratic consolidation. But this is an issue for further research.

Botswana and South Africa had certain similarities which limited the impact of HIV and AIDS in both states. Their experience with the disease also differed in certain respects, demonstrating the importance of their differing contexts. While a brief assessment of these similarities and differences may now present suggestions for the likely impacts of HIV and AIDS on other African democracies, some limitations of the study must be borne in mind, and will be discussed in the last chapter.

The affluence of the two states is an important positive similarity. The findings of this study suggest that affluence makes it possible for Botswana and South Africa to overcome AIDS-related economic challenges as well as those related to electoral governance. It also allows

these states to remain somewhat independent from foreign donors in terms of funding their efforts to combat the disease. Since Botswana and South Africa – together with Mauritius – are among the richest states in Southern Africa, other poorer states are likely to find the financial costs of HIV and AIDS more debilitating<sup>53</sup>.

Another important positive commonality, which influences every socio-economic factor studied, is the availability of ART. (South Africa still lags behind in this regard, as discussed in Chapter 4.) While the affluence of the states in question is no doubt key to their ability to provide ART, international support can also be successfully secured. Appropriate antiretroviral treatment significantly increases life expectancy, relieves the fiscal burden of social care on the state, and protects productivity and continuity. Thus both economies and levels of human development are spared some of the ravages of the disease that seemed inevitable a mere decade ago. Moreover, by its visible effectiveness ART ameliorates the desperation of individuals infected and affected by HIV and AIDS and reinforces the perception that governments can meet their voters' needs. If legitimacy hinges on citizens' perceptions of democratic government as able to provide for those in need, ART contributes to maintaining popular support for democracy and negates the suggestions of De Waal (2003: 8) and Mattes (2003: 8) that the disease could cause a crisis of democratic legitimacy.

A further similarity concerns the high levels of inequality in both Botswana and South Africa. The worst HIV and AIDS-related suffering falls upon the poor and marginalised while the elites and to an extent, the middle class, remain in a far better position to absorb economic losses and secure good education and health (through corporate medical programmes and private health care) despite the disease. In this way inequality has contributed to the overall stability observed so far (Whiteside 2008, quoted in Marais 2011: 317) despite the fact that between a sixth and a quarter of adults in each country were being infected with a deadly virus. What instability there is at present cannot be directly traced to the disease, but it remains possible that the desperation of the disadvantaged will eventually have more direct effects on the democratic systems in these states.

The similarities between Botswana and South Africa are that both are affluent in terms of income *per capita* and have access to ART, but have high income inequality. The differences between the impact of HIV and AIDS on Botswana and South Africa have to do, firstly,

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<sup>53</sup> Poverty may make it more difficult for states to deal with HIV and AIDS, but does not necessarily threaten democratic endurance (Przeworski, et al. 1996). The case of India demonstrates that when institutions remain strong, democracies can endure even when the population is poor.

with differing levels of infection. A greater percentage – 25% – of Botswana’s adults suffer from the disease, as opposed to 16.9% of the same age group in South Africa. Another important difference is the policy response of the government: the South African government’s response gave its citizenry much reason to criticise it, and as a result, public protest and court action were “tested” in a way that Botswana’s constitutionally granted methods of criticising the government were not. That South Africa’s democracy was in some ways strengthened by the challenge cannot hold true for every democracy in a similar position, however, as it had a remarkably robust civil society and judiciary even before HIV entered the country.

Finally, the impact of HIV and AIDS differed between Botswana and South Africa because of their notable differences in terms of socio-economic structure. South Africa’s economy is diversified which seems to make it less economically vulnerable to the effects of HIV and AIDS on labour-intensive industries. The country is relatively unique in this regard. Other less diversified African economies may experience the more stark negative effects of HIV and AIDS as were projected for Botswana. On the other hand, Botswana’s human development index is recovering faster than South Africa’s, not only because of the former state’s earlier positive policy responses but also, it has been suggested here, because it has developed its public health and education systems over several decades of stability, thereby placing it in a better position than South Africa to respond to the new challenges posed to these systems by HIV and AIDS. Also, its population is twenty-five times smaller, more homogenous and may not necessitate the complex policy responses required in a large heterogeneous society such as South Africa’s.

In conclusion, this thesis has placed the contradictory arguments of scholars with regards to the impact of the disease within a framework that deems both institutional and socio-economic factors important for democratic consolidation. In doing so, it has highlighted positive and negative impacts for both the democratic institutions and the socio-economic conditions of Botswana and South Africa. Similarities between these states’ experiences with HIV and AIDS often hinged upon the states’ combination of relative affluence, the availability of ART and high inequality, while many of their differences revolved around their differing prevalence levels, divergent policy responses of their respective governments, and socio-economic structures.

## CHAPTER 6: CONCLUSION

### 6.1. Introduction

The impact of HIV and AIDS on democratic consolidation has been investigated by means of a comparative analysis of two African democracies affected by this pandemic – Botswana and South Africa. In each case criteria relevant to consolidation were assessed. These criteria were derived from a multivariate model encapsulating both institutional and socio-economic factors. This chapter will evaluate the most important findings of the study and the methodology employed to reach them.

The main finding was that, at present, despite the cost implications of the disease, there are no indications that HIV and AIDS are directly threatening to destroy the democracies of Botswana or South Africa. This finding differs from the expectations expressed by Mattes (2003), Barnett and Whiteside (2006) and other authors and comes closer to supporting the arguments of Butler (2005a) and De Waal (2006)<sup>54</sup>. As this main finding could be seen as controversial, further research is suggested to clarify some of these issues. Notably, it is suggested that the impact of the disease on poorer Southern African states should be compared to that on Botswana and South Africa, as it is possible that the comparative affluence of both states in question shields them from some negative impacts that other (poorer) Southern African states may not be able to avoid. It is emphasised that the negative impacts of the disease on the two states are mostly socio-economic: apart from costs and implications for governments' budgets, this study could not provide evidence that consolidation theory was undermined. The conclusions are uncertain and could also be tested in further research.

### 6.2. Evaluation of methodology and main findings

Although this study was broad in focus, it used a minimalistic multivariate model to assess the impact of HIV and AIDS. This limited the extent to which the impact on each factor could be scrutinised. Moreover, the methodology was confined to desktop research, with no empirical component. It was therefore neither based on interviews, nor on questionnaires, nor on the surveys of health departments, local governments, or sufferers themselves.

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<sup>54</sup> It is acknowledged that the four scholars mentioned here had differing regional foci; however, all of them discussed the possibility that HIV and AIDS may detrimentally affect democratic consolidation, democratic politics and/or political stability.

The multivariate model employed consisted of six variables: three are institutional and three are socio-economic. The three institutional factors are the system of government (especially the president and the executive); the electoral system; and political rights and civil liberties. The findings concerning the impact of HIV and AIDS on these will now be summarised. Thereafter its impact on the three socio-economic factors, namely economic variables (consisting of economic growth; affluence and trends in inequality); human development and civil society, will be analysed.

The first institutional factor studied was the system of government. Amid presidential denials of the disease in South Africa, civil society successfully challenged the president's controversial HIV and AIDS policy in 2000-2002. It did so using democratic mechanisms, i.e. the courts, advocacy and peaceful protest, demonstrating that presidential authority has limits (Butler 2005a). This set an important precedent and suggests that democratic consolidation of the attitudinal and constitutional dimensions (Linz and Stepan 1996: 15) was taking place. In Botswana, the government was more pro-active despite civil society being much weaker, and there is no literature indicating that the dynamics within the system of government changed significantly because of the way in which HIV and AIDS were managed. The first notification of HIV in Botswana occurred in 1985, and by 1986/7 the government responded to the pandemic. It became the first in Africa to provide PMTCT drugs to HIV positive pregnant women in the public health system and started large-scale rollout by 2002. It has now achieved universal coverage.

The role of HIV and AIDS in the context of the different electoral systems was one key area where a potential risk to democratic consolidation could be tested. Electoral management boards continue to function effectively, probably because they can afford to overcome the challenges posed by increased AIDS-related illness and death among voters and electoral staff. It is safe to say that the disease made no significant difference to the functioning or outcome of either the FPTP national electoral system in Botswana or the PR system in South Africa.

This does not challenge Strand's (2005: 7) argument or Chirambo's (2008: 31) finding that, in Southern African electoral systems generally, PR is superior to FPTP in the context of HIV and AIDS. The negligible number of deaths and by-elections in the parliament of Botswana (Gossett and Lotshwao 2010) could be testimony to the ability of MPs who are living with HIV (should there be any) to obtain medication and to remain productive. At the level of local government, both countries employ MMP systems, and Gossett and Lotshwao (2010)

and Chirambo and Steyn (2009) suggest that the disease is causing an increase in by-elections at this level, where municipal and/or ward constituencies must be filled. These by-elections are cumbersome and quite costly. In poorer countries with fewer resources the impact on (especially FPTP) electoral systems could have been worse, especially at the national level.

A study of the available literature, particularly human rights reports and Freedom House publications, suggests that the negative impact of HIV and AIDS on political rights and civil liberties is not significantly positive or negative enough to warrant a change in ratings. This factor is an essential element of this study, presenting us with a gauge of the quality of democracy actually enjoyed by the citizens of the two countries and the way the government responded. Freedom House, using its definition of civil liberties, holds that these rights are as well-protected in Botswana today as they were twenty years ago. Citizens of South Africa have enjoyed a similarly wide range of civil liberties since 1994, although under Mbeki's presidency, official "denialism" of the destructive nature of the disease threatened the sufferers' constitutional right to access to health care and medication. While both states' political rights scores have recently declined somewhat in Freedom House's annual publication (they both are rated as free), the explanations given for these declines did not suggest that HIV and AIDS were directly to blame (the explanations for the declines can be found in Chapters 3 and 4). This supports De Waal's (2006) argument: whatever negative effects the disease is having, it is not significantly negatively affecting the quality of democracy – yet. Butler (2005a) argues that in South Africa, it should be recognised that the politics around HIV and AIDS have even had some positive consequences for the entrenchment of civil liberties, namely by demonstrating that citizens have the right to organise, freely express criticism, and litigate against the government to win important policy interventions. This was a victory not only for the TAC but for all those sufferers who meet the requirements for state intervention.

The overall impact of HIV and AIDS in Botswana and South Africa on the three institutional factors studied has thus until now been minimal, as far as the available literature indicates. As the consolidation of democracy is by definition dependent upon the existence of legitimate and effective democratic institutions (see Chapter 2), this is an important finding.



Moving on to the overall socio-economic impact of HIV and AIDS, the situation, as revealed by this desktop study, is more negative<sup>55</sup>, although the question of whether it necessarily erodes democracy remains unanswered. The factors studied, which will now be discussed in turn, are economic variables (economic growth; affluence; and trends in inequality); human development; and civil society.

As suggested by Mattes (2003), the work of Przeworski, et al. (1996) has been used to understand the impact of economic variables (economic growth, affluence, and inequality trends) on the likely survival of democracy. A more detailed report of the findings can be found in Chapter 5, but some highlights will be mentioned here. The economies of both states are expected to grow *slower than had there been no pandemic*, but not to register negative growth. Botswana's economic growth rate is expected to be affected more severely (despite the commodities boom) than its population growth, with the net effect that *per capita* incomes might grow slower than had there been no HIV and AIDS. But according to the calculations of Chapter 2 and in terms of the work of Przeworski, et al. (1996: 41), Botswana is already so affluent as to be "impregnable" – and at this level of affluence (above \$6,000 *per capita* income<sup>56</sup>) democracies "can be expected to live forever". South Africa, in contrast, with a much bigger population and larger economy, has not attained the level of *per capita* income where its democracy can be considered "impregnable", but it is well above the level at which democracies should be considered "extremely fragile" (Przeworski, et al. 1996: 41). In this country, citizens' average income is projected to grow *faster than had there been no HIV and AIDS*. In an ironic way, therefore, AIDS may theoretically "promote" democratic consolidation in terms of *per capita* incomes, as the growth of the population (and the labour force) slows considerably (the death rate has begun to level off). Both studies found that the provision of ART makes sense in terms of fiscal expenditure and economic growth, as it makes HIV sufferers live longer and lead more productive lives. (It was found in Uganda that antiretrovirals, properly used, add almost 28 years of life to HIV sufferers who began treatment at the age of 35 – see Malan 2011.)

With regards to trends in income inequality, Przeworski, et al. (1996: 42-43) used GINI coefficients to argue that these trends have an impact on democratic survival. None of the literature surveyed on the economic impact of HIV and AIDS in Botswana and South Africa

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<sup>55</sup> Except for a brief period during the global financial crisis, both Botswana and South Africa are consistently registering economic growth - Botswana especially, given the current commodity boom (see Chapter 3). HIV and AIDS are not expected to reverse this trend in either country.

<sup>56</sup> This figure is based on 1985 values and should be adjusted for inflation as was done in Chapter 2. (See Table 5 in Chapter 5.)

provide GINI coefficient estimates. However it was emphasised that in both Botswana and South Africa, poor households (rural and informal sectors) affected by HIV and AIDS are expected to face further impoverishment and marginalisation while their richer compatriots are better placed to recover from HIV- and AIDS-related demands on their finances (including access to medical aid or, for civil servants, government ART systems), and that high unemployment among unskilled and semi-skilled labourers will keep their wages low despite their attrition because of AIDS, while any AIDS-induced reduction in an already limited skilled workforce will increase these workers' wages. These projections imply growing inequality in states which have already, over several decades, proved unable to reduce inequality.

The abovementioned economic projections are drawn primarily from two publications – the Jefferis, et al. (2008) study for the case of Botswana (the Molatole and Thaga study of 2006 is also useful), and the Smit and Ellis (2009) summary of the latest BER study (2005/6) for the case of South Africa (Marais's is also useful). These studies focused on the macroeconomic impact of HIV and AIDS – neither of them dealt with the question of democracy. These studies take into account the fact that the governments in question are rolling out ART – they assumed constant 50% coverage for South Africa and 80% coverage for Botswana<sup>57</sup>. While a direct numerical comparison of their projections is probably inappropriate, the methodology employed by the two studies is broadly similar: the effects of the disease on key economic impact channels are projected and combined to produce macroeconomic projections, which are tested for robustness where the accuracy of assumptions is uncertain (Jefferis, et al. 2008: 114-116; Smit and Ellis 2009: 246). Butler (2005: 4-5) argued that there was no consensus among economists on the general economic impact of HIV and AIDS, and while there may still be some dispute, these studies benefit from newer data than those that were available at the time of Butler's writing and are, as far as this researcher can ascertain, the most valid economic research available estimating the impact of this complex disease at this time. But Butler also dealt with the implications for democracy, just as Mattes (2003) did.

The United Nations Human Development Index (UN HDI) ratings for both Botswana and South Africa were reversed because of HIV and AIDS and gradually recovered to reach and surpass pre-pandemic levels. Plummeting life expectancy, which is one of three factors

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<sup>57</sup> Botswana began wide-scale ART distribution in 2002 and has now achieved universal access to ART (see Chapter 3). South Africa's ART distribution officially commenced in 2003 and has made significant progress since 2008, now reaching an estimated 65% of adults who need it (according to the old WHO guidelines - see footnote 9).

incorporated into each state's overall HDI rating, had the greatest part in dragging these countries' human development ratings down, has been recovering since the early 2000's but is still far from fully recovered. But whether UN HDI ratings are a good measurement of human development in the context of HIV and AIDS can be questioned: the index, which combines education, health and affluence in a single figure between 0 and 1, purposefully incorporates only a handful of key indicators and may lead the researcher to overlook the effects of the pandemic on important aspects of human development such as inequality. Two of these effects will be briefly mentioned.

The first such effect is a possible deterioration in the quality of education. The indicator used to measure education, namely, the average years of schooling enjoyed by citizens, does not measure the quality of schooling at all, while studies such as the South African one by Louw, et al. (2009) suggest that it is the quality of schooling that risks being compromised because of the AIDS burden borne by learners, educators and communities. The fact that in terms of the UN HDI, both Botswana's and South Africa's education ratings have been on a sustained upward curve<sup>58</sup> over the past two decades, may therefore mask the qualitative damage done by HIV and AIDS, inaccurately suggesting progress when a comparison of students' performance in international literacy tests would indicate deterioration. In fact, many previously disadvantaged schools in South Africa are quite rightly viewed as dysfunctional. It is also methodologically difficult to ascribe teachers' competence and discipline, or otherwise, to the HIV and AIDS problem.

The second effect is the possibility of a polarisation in human development, masked by aggregate figures. Again researchers (particularly Marais 2011, who looked at the South African case) emphasised that the human development of the poorer classes is likely to suffer the most while the upper classes can still access superior healthcare and education. Generally, UN HDI does not reveal differences between public and private, or between urban and rural circumstances. In both countries, the focus is mainly on urban rather than rural areas. The use of standard UN HDI does therefore not reveal important intra-country inequalities.

Finally, in South Africa, HIV and AIDS policy contestation by civil society had the (perhaps unforeseen) effect of deepening the institutional framework for democratic politics, by demonstrating that "the people have a right and a responsibility to organise and protest" (Butler 2005a: 13). It was argued that the TAC broke ground for other South African civil society organisations by legitimising constructive and critical engagement between civil

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<sup>58</sup> Except for a spike in South Africa's ratings in 1995 - see Chapter 4 for a discussion of this.

society and government and also through the courts. In Botswana, civil society has historically been much weaker, and remains so today. Although the country has over the past two decades seen a proliferation of civil society organisations, some of them addressing the HIV and AIDS pandemic, the sector remains deferential to government. But there was no need to challenge government with regards to its HIV and AIDS policy in the 1990's, because government response was quite pro-active, as mentioned above.

In short, the impact of HIV and AIDS on the socio-economic factors studied is more salient than its impact on institutional factors. In Botswana, the disease is likely to retard both economic growth<sup>59</sup> and gains in *per capita* income, and will possibly increase inequality. It has reversed gains in life expectancy. In fact, no literature suggests that any good has come of the disease in terms of Botswana's socio-economic circumstances. In South Africa, the picture is more complicated. As in Botswana it is expected that economic growth may be retarded and inequality increased by the disease, while life expectancy is particularly hard hit. However, in South Africa, it is suggested that in terms of at least one economic variable, the speed at which *per capita* income grows, the economy might be better off than had there been no pandemic. But the impact on democracy remains uncertain, except for Butler's views on civil society.

The notion that the disease does not currently threaten democratic consolidation, even in Botswana where this study found that the disease has a detrimental impact on all the economic effects studied (see above) as well as life expectancy, may seem surprising. Here it is necessary to bear in mind that the relevance of socio-economic factors is not as clear cut as the relevance of institutions to democratic consolidation.

The link between democratic erosion/breakdown and regressions in human development is particularly unclear, as was stated at the outset (see section 2.1.2.4). The comparative analysis undertaken in this thesis suggests that widespread human suffering can take place without significantly influencing democratic institutions (at least initially, and under certain conditions<sup>60</sup>). The theory of Przeworski, et al. (1996), which establishes a strong link between democracies' chances of survival and the economic variables studied in this thesis, is based on inductive generalisation of political trends in the past. Butler (2005: 5-7) does not dispute

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<sup>59</sup> The impact of the disease is one of many processes (both positive and negative, such as the global economic climate, government job creation projects, the rollout of social grants, skilled emigration and attempts to attract investment) that influence these economies, meaning that the effects discussed here will not be directly evident in economic statistics.

<sup>60</sup> One of these conditions may be deep socio-economic inequality, a characteristic of both countries studied here. This will be discussed in the final section.

the potential negative socio-economic effects of the disease (for South Africa), but argues that political science models are both theoretically impoverished on their own terms and inadequate to understand a world with AIDS, as they may be fatally undermined by fundamental shifts in citizens' behaviour in the midst of an HIV and AIDS pandemic. In such a situation, it may be more valuable to evaluate democracies using concepts such as Linz and Stepan's (1996) "only game in town" and the behavioural dimension of democratic consolidation. It must be agreed, at least, that institutional impacts should be considered more directly relevant to democratic consolidation while the relevance of socio-economic impacts must be argued through falsifiable inductive theories such as those of Przeworski, et al. (1996).

### **6.3. Suggestions for further research**

In 2003 a framework with regards to the potential impact of HIV and AIDS on democratic consolidation in Southern Africa was suggested by Mattes (2003). This scholar emphasised that most of the expectations expressed in his article with regards to the topic were based on logic and conjecture, with no case studies yet. He highlighted the possibility of conducting comparative cross-sectional research on the topic in the Southern African region. This thesis has conducted such research on a desktop basis. Hopefully it can contribute to all of the above.

This section will summarise the findings and suggest that further comparative research should include poorer African countries, African countries with high HIV prevalence levels but with lower levels of ART distribution and less unequal societies. Finally, the need for in-depth research into the impact of HIV and AIDS on the effectiveness of democratic governance is emphasised.

A comparison of the impact of HIV and AIDS on democratic consolidation in South Africa and Botswana, using a minimalist multivariate model that includes institutional and socio-economic variables, has yielded the finding that at present there are no indications that HIV and AIDS is directly threatening to destroy these democracies. To use Schedler's (1998: 103) terms, there has not been evidence of a process of "democratic erosion", nor of a looming "democratic breakdown", precipitated by the pandemic. One could even say that, for the time being, HIV and AIDS have not threatened the future of democracies to the extent that dominant ruling parties and their often unaccountable presidencies (or monarchs) may have accomplished in some countries. Marais (2011: 310), reviewing the impact of the disease in

South Africa on many of the same factors as studied in this thesis, concludes: “[a]t face value, much of the doomsaying seems overwrought.” However, as mentioned above, certain socio-economic factors have been severely impacted: in both countries, growing inequality and slower economic growth are expected while life expectancy has been reduced; and in Botswana, increases in affluence are expected to occur more slowly than they otherwise would have. According to the thinking of Przeworski, et al. (1996) and Leftwich (2000) these impacts are not conducive to the endurance of democracy. The continued influence of these effects upon democracies should be monitored.

The findings presented in this study are not generalisable to all Southern African states. Chapter 5 discussed the key differences and similarities between Botswana and South Africa and how these differences and similarities affected the impact of the pandemic. The similarities identified there may guide us toward suggestions for further research. The first such similarity was that these states are exceptionally affluent in comparison with their poorer Southern African neighbours. Only Mauritius enjoys comparable levels of wealth, with a *per capita* income (PPP) of \$11 658 (World Bank 2011d). As noted in Chapter 5, the states’ relative affluence helps them to overcome challenges related to the socio-economic impact of HIV and AIDS, and on electoral governance (such as updating voters’ rolls and facilitating a high number of local government by-elections, as well as parliamentary elections in Botswana’s FPTP system). It also allows these states to remain somewhat more independent of foreign donors in terms of funding their efforts to address the disease. Including poorer Southern African states, such as Zambia, Malawi or Mozambique in a comparative study of the impact on HIV and AIDS on democratic consolidation would demonstrate the relative importance of national affluence in coping with the pandemic.

Secondly, the states in question are both making ART available to a growing proportion of those who need it. In Botswana this proportion exceeds 80%; South Africa’s has surpassed 65%. As described in Chapter 5, because of ART, these democracies are spared some of the institutional, economic and social ravages of the disease that seemed inevitable a mere decade ago. Therefore, the availability of ART might be essential to softening the blow, directly and indirectly, to democratic consolidation, thereby producing the perhaps surprising main finding of this study, namely that democracies are not (yet) collapsing under the weight of HIV and AIDS.

The possibility of this was noted by Mattes (2003: 11) who pointed out that most of his article was based on the assumption that in Southern Africa, HIV-infection was akin to a

death sentence. This has changed, with studies revealing that HIV patients in Africa, with appropriate ART, can live almost as long as those who are HIV negative – in Uganda it is almost 28 years longer for patients who initiate treatment at the age of 35 (Malan 2011) – and that the region is making encouraging progress in ART rollout (UNAIDS 2010). Where those that need it do not access and adhere to this treatment, Southern African countries would still face the morbidity and mortality of large parts of their productive adult population, presenting them with continuing AIDS-related problems that the countries studied here have avoided. For instance, it was argued that Botswana might be avoiding an increase in expensive parliamentary by-elections because of MPs' access to ART. This would be even cheaper under PR systems as by-elections would not be necessary. States that employ the FPTP electoral system at national level but where ART is not as widely available as in Botswana (such as Malawi) could be compared to states where ART is reaching the population more effectively. ART coverage continues to increase throughout Africa, but poorer countries are more dependent on donors than their affluent neighbours, Botswana and South Africa.

Thirdly, this study has argued that not only is societal inequality in both Botswana and South Africa probably compounded by HIV and AIDS, as discussed above, but it also acts “as a barrier and filter preventing the effects of AIDS from snowballing into systemic collapse” (Whiteside 2008, quoted in Marais 2011: 317) despite the deepening suffering of those already disempowered, and mainly in the rural areas where health services are more stretched. The implication of this argument, which may be investigated in future studies, is that more egalitarian Southern African states affected by the disease may experience more system-wide shocks and therefore a more detrimental impact on their democratic consolidation.

A final suggestion concerns perhaps the greatest limitation of this thesis: the damage the disease is doing to the quality and effectiveness of governance was not studied. While the damage done to businesses in terms of a loss of human capital and high turnover of staff will show in economic indicators such as growth, unemployment and inequality, the damage done to the state will show in its inability to fulfil its duties to citizens. In this regard, Butler (2005: 6-7) speaks of a “double crisis of administrators and delivery actors”. As noted before, if the state's capacity to deliver is severely compromised, or if the public comes to believe that it is, this may affect the legitimacy of the political system (Butler 2005a: 7). Our desktop methodology could not investigate this. The effect of HIV and AIDS on a broad range of

aspects of governance should therefore be assessed in future studies, going beyond desktop research, to include fieldwork and questionnaire research.

The possibility that HIV and AIDS may affect the effectiveness of government detrimentally, was discussed by De Waal (2003), Mattes (2003: 6), Butler (2005: 5-7), Pharaoh and Schönteich (2003: 6) and Barnett and Whiteside (2006: 323-324) (see Chapter 1). Studies of the disease in the military already demonstrate personnel weakness (Rupiya 2006; Heinecken 2001; 2003; 2009; Whiteside, De Waal and Gebre-Tensae 2006). While some of these risks have been investigated (such as the functioning of electoral management boards) or play into factors that were investigated (such as the pressure on health systems) in this thesis, others – such as the impact of the disease on the functioning of the bureaucracy, judiciary and criminal justice system (Butler 2005a: 6), parliament, the police and soldiers (Mattes 2003: 6) and municipalities (Chirambo and Steyn 2009: 5-6), have not been investigated. While it is possible that scholars understandably underestimated the extent to which ART would become effective and available, it may also be that the deterioration which they expected could indeed be identified through a more detailed study of the abovementioned structures. To do so would be no small task.

In conclusion, it should be borne in mind that this pandemic is a “long-wave event”, in which large-scale effects emerge gradually over decades (Barnett 2006: 302-303). The impact of the disease upon each of the factors studied may still worsen or improve, or come to be understood in new ways. Already, this thesis benefits from the passage of time: as a vivid example, in 2011 one can confidently say that publications such as “*Halfway to the holocaust*” by Shell (2000) – evoking bleak images of what a Southern Africa ravaged by AIDS may look like by 2010 – were exaggerated. In the same way, this thesis has assessed what is known now using a desktop methodology. It has demonstrated the appropriateness of a multivariate model to conduct such a study, but it cannot predict which events may change the trajectory of the pandemic in the future. Government, business and civil society have roles to play. Moreover, changes in terms of the pricing and international funding of ART, as well as the effectiveness of these drugs, could prove particularly important in future.



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