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HIV/AIDS in Africa

SANDRA F. JOIREMAN

The response of the United States to the HIV/AIDS pandemic in Africa is an example of the redefined nature of security threats that characterizes the post–September 11 period. Even the most ardent realists now accept that serious threats exist to US security apart from those brewing in organized states. Scholars and governments have been forced to adopt a greater sensitivity to the issues that underlie international violence and terrorism, such as a lack of political freedom, state failure, poverty, and HIV/AIDS, the topic addressed in this chapter as an indirect threat to US security interests in Africa.¹

The US response to HIV/AIDS in Africa reflects the way in which Africa fits into the US national security agenda. Although increased awareness of the causes of terrorism has made Africa more critical to the national security agenda of the United States than it has been in the past, the African security concerns of greatest interest to US policymakers are terrorism and state failure. But a state cannot stand when great numbers of its peoples are decimated by disease. HIV/AIDS shares three similarities with poverty as a contributing factor to state failure. Both are regionalized, are temporally less immediate, and address human security insofar as they affect international security.

For the most part, African states do not pose a direct political threat to US security interests. The United States neither faces strong ideological enemies on the African continent nor engages in the kind of proxy wars that characterized the Cold War. With the recent opening of Libya to International Atomic Energy Agency inspectors, the actual national security threats to the United States from African governments are relatively few. However, economic underdevelopment, coupled with HIV/AIDS, may produce an environment in which weak or even failed states are unable to stem the growth of terrorist groups within their borders—groups that may or may not be linked up to international terrorist organizations such as Al-Qaida or

Islamic Jihad. Moreover, other threats to US security occasionally materialize in states unable to adequately police their own borders and assert state control outside the capital. An excellent example of just such a threat was the recent attempt to illegally export uranium from the Democratic Republic of Congo.²

HIV/AIDS is a security threat, but it is indirect and played out at multiple levels of analysis: within individual bodies; clustered within families and communities, wreaking havoc on their ability to cope with the day to day challenges of living; and with destabilizing effects on the state.³ It is the pervasiveness of the disease and the lack of treatment that multiplies its effect to the point that it becomes a security issue for states. Through the challenges it creates within those states, it emerges as an international security issue. Thus, HIV/AIDS links human security and international security in unique ways. AIDS is a disease; it is neither a weapon nor a state.⁴ Yet it has been perceived by two US administrations as a threat to national security because of its potential for destabilizing states. This fact is worthy of note: it is the first time that a disease has been interpreted as a national security threat.

After a brief description of the HIV/AIDS pandemic in Africa, I identify the development of HIV/AIDS as a perceived security threat and detail the specific security issues presented by HIV/AIDS in Africa. Then, I explore the linkages between national security and the recently passed "Global AIDS Bill." Last, I discuss the divergence of perspectives between African states and the United States regarding the threat of HIV/AIDS. I then make some observations regarding the future of HIV/AIDS as a security threat in Africa and the development of the "next" wave of HIV/AIDS in South Asia.

The HIV/AIDS Pandemic in Africa

Africa remains the continent most affected by HIV/AIDS. Eighty-one percent of the world's AIDS-related deaths occur in sub-Saharan Africa.⁵ The prevalence of AIDS (7.5–8.5 percent of the total population) is higher in sub-Saharan Africa than anywhere else in the world. An estimated 2.4 million adults and children died from AIDS in sub-Saharan Africa in 2005.⁶ At least 2 million adults are infected in Ethiopia, South Africa, Kenya, and Nigeria, and one in four adults have contracted the virus in Botswana, Lesotho, Swaziland, Zambia, and Zimbabwe.⁷ Furthermore, most of the world's women suffering from the AIDS virus—a shocking 83 percent—live in sub-Saharan Africa.⁸

On the African continent, HIV infection rates are not similar in all countries and all areas. The World Health Organization divides the conti-

ment up into regions; of these, southern Africa suffers the most, with its prevalence rates rising from 20.3 percent in 1997–1998 to 25.7 percent in 2001–2002. These percentages may result from the higher levels of urbanization found in southern Africa. East Africa's prevalence rate has decreased slightly, from a high of 13.7 percent to 11.4 percent, which is partially attributable to the significant and consistent HIV/AIDS awareness campaign by the Ugandan government. This trend has been followed by other countries in the region, most notably Ethiopia, where in the capital of Addis Ababa HIV prevalence rates for fifteen- to twenty-four-year-old pregnant women dropped from 24 percent in 1995 to 11 percent in 2003. The AIDS prevalence in West Africa has fallen slightly from 4.4 percent in 1999–2000 to 3.1 percent in 2003–2004.⁹

It is important to unpack these statistics in order to understand the nature of the epidemic and how it affects different countries. We can do that by looking at three “snapshots” of African countries dealing with HIV/AIDS: Uganda, South Africa, and Ethiopia. I have chosen these three because they are all politically stable, not currently at war, and at very different points in terms of the response to the pandemic and its prevalence within their borders.

Uganda

Uganda was one of the first African countries to experience the full impact of HIV/AIDS. At the height of the epidemic, infection rates were 14 percent throughout the country and much higher in some areas.¹⁰ Now HIV infection rates are down to 8 percent because most of the people infected earlier have died. Uganda has experienced the peculiar demographic challenge of HIV/AIDS; for example, the virus attacks people who are most sexually active and most economically productive (those between the ages of fifteen and forty-five). Uganda has suffered from a lack of teachers and medical professionals as a result of the epidemic. Thus the virus kills the population most necessary to development: the teachers, doctors, and entrepreneurs as well as the mothers and fathers raising children. In Uganda, high rates of the HIV/AIDS infection corresponded with conflict and instability in the country. As peace came in the mid-1980s, fewer people were displaced, soldiers and rebels returned to their barracks and hometowns, and infection rates began to decline. Uganda also embraced the challenge of reducing infection rates and launched a national educational campaign against HIV/AIDS beginning in 1986. The slogan of “Abstinence, Be Faithful, or Use a Condom”—often referred to as the ABC method—succeeded in getting across the message of safe sexual practices. The Ugandan model of HIV/AIDS prevention and awareness has been widely applauded and has shown significant results. President Yoweri Museveni supported the educa-

tional campaign and articulated it from the capital city to the classrooms in rural schools.

South Africa

South Africa has the most HIV-positive people of any country in the world. It is at the peak rate for new infections, and little headway has yet been made to bring the infection rate down. Of South Africa's 45 million people, 5.3 million are infected with HIV,¹¹ and 25 percent of its economically active individuals are infected.¹² The staggering toll that AIDS is taking on South Africa's social and economic fabric has only recently been acknowledged by the government. By 2000, the government began an AIDS prevention and treatment program, but it has been widely criticized for its ineffectiveness. In 2000, South Africa's ministry of health refused to provide antiretroviral treatment for cost reasons, and President Thabo Mbeki publicly questioned whether HIV really caused AIDS.¹³ By 2002, the government began to work more closely with nongovernmental organizations (NGOs) and promoted limited antiretroviral use. South Africa's government will face a growing crisis as AIDS patients clog its health infrastructure and the number of AIDS orphans grows.

Ethiopia

Like the South African government, the Ethiopian government was slow to recognize the impact that HIV/AIDS could have on its country and was late to begin education and prevention programs. Throughout the 1990s, Ethiopia faced an increasing number of deaths from tuberculosis but failed to link these deaths to opportunistic infections resulting from HIV/AIDS. Under pressure from indigenous NGOs and international organizations, the situation began to change in 1999. Ethiopia now recognizes that it has a struggle ahead in terms of its efforts to cope with HIV/AIDS. Recently, it began a significant effort to educate the population on the basics of virus transmission. However, significant challenges remain, as surveys show that young people have a lot of misconceptions about the disease, particularly in the rural areas.¹⁴ A recently established government office, the National HIV/AIDS Council, has not yet been as effective as it could be in focusing attention and resources on the disease. One of the biggest challenges for Ethiopia will be how to deal with the AIDS orphans in the next decade. By some estimates, AIDS could orphan up to a quarter of all children in Ethiopia by 2011.¹⁵ These orphans will challenge the state's ability to provide education and jobs and will also drain a healthcare system that currently spends only \$2 per year per citizen.¹⁶

These snapshots give some indication of the varied nature of the

HIV/AIDS pandemic in Africa. It is everywhere a challenge to the state and to fragile health care systems, but different countries are at different stages of their response to HIV/AIDS. Muslim areas and states have generally been less affected by HIV/AIDS, and West African average rates of infection have been lower than those in southern and East Africa (see Appendix at end of chapter).

The Evolution of HIV/AIDS as a Perceived Security Threat

HIV/AIDS has existed as an epidemiological challenge on the African continent since the 1970s. From the 1980s onward, the HIV/AIDS pandemic was recognized as a humanitarian crisis and an issue of human security. International responses occurred primarily through NGO activity and international institutions tasked with health care, such as the World Health Organization, the United Nations Children's Fund (UNICEF), and to some extent the United Nations High Commission on Refugees. Yet it was not discussed in policy circles as a security threat until 1994, when Undersecretary of State for Global Affairs Timothy Wirth noted the risks to state stability that develop in countries seriously affected by AIDS.¹⁷ It was not until 2000 that HIV/AIDS became more widely recognized as a security threat. At that time the full impact of the disease on state capacity became apparent to external observers.¹⁸ In 2000, the Clinton administration requested \$250 million in its 2001 budget to fight the global AIDS pandemic.¹⁹ The administration saw HIV/AIDS as a threat to the fledgling democracies on the African continent. It also commented on the possibility of AIDS contributing to failed states because of the state's inability to provide security, health care, and education.²⁰

What makes AIDS more than just an epidemiological crisis? Why has it made the leap from disease to a security issue? I answer these questions in the following section by examining the security concerns resulting from HIV/AIDS at the national and international levels. Certainly, HIV/AIDS is a threat to individual or human security: I show how the deaths of many individuals have turned HIV/AIDS into a national and international security threat.

African National Security Interests

The greatest immediate security threat from HIV/AIDS infection at a national level is that which comes from the weakening of the military when a significant percentage of soldiers become infected with HIV/AIDS. If the HIV infection rate keeps pace with other sexually transmitted diseases, the threat to the military is considerable. Stefan Elbe has noted, "Prevalence

rates of sexually transmitted diseases among military personnel usually exceed those of the civilian population by a factor of two to five. In many African militaries, this is also true with regard to HIV."²¹ In some countries, the rates of HIV infection among the military are estimated to be as high as 50 to 60 percent.²² The number of infected soldiers in any given army is difficult to determine, and governments are understandably reluctant to make this information public, even if they do know it with some certainty. According to Robert L. Ostergard, "the public admission of what may be high HIV infection rates among military personnel potentially compromises national and military security for some states by revealing what could be a substantial weakness in the military's combat readiness."²³ Even though states thus have good reason to underestimate the rate of HIV infection in their military, some data do exist. The Appendix at the end of this chapter records the results of a concerted attempt to collect available infection rate data among military personnel in Africa.

High rates of HIV infection in the military increase the amount of money that needs to be devoted to recruitment, training, and health care. Just as AIDS eliminates some of the most useful segments of the civilian population, so too does it have a significant impact on the officer corps and command structure of the armed forces. The training that goes into the preparation of a single soldier is lost when he or she is affected by HIV/AIDS and has to leave the armed forces. The average cost of training per soldier increases overall when more recruits have to be trained to compensate for those who have to leave the army due to HIV.²⁴ Moreover, that particular soldier will not move up through the ranks and be available for leadership opportunities or lend his battlefield experience to the force. The end result of high rates of HIV infection will be a less experienced and therefore less prepared armed force than one in which the rates are substantially lower. Recognizing the high costs of training and frequent turnover, the Kenyan, Tanzanian, and Ugandan armed forces in Africa have made HIV testing mandatory for recruits. These countries then systematically exclude those who test positive.²⁵

If we can call the issue of HIV infection among soldiers the primary threat to national security, the secondary and linked threat is the soldier as a vector of HIV transmission among the population. Zimbabwe's army is an example. By some estimates, the army from the late 1980s to 1990 was more than 70 percent HIV-positive.²⁶ These Zimbabwean forces were deployed to the Democratic Republic of Congo in the 1990s, undoubtedly spreading the disease there. Such a high percentage of infected soldiers may be unusual, but the scenario is not. Indeed, it is thought that the war in Angola exacerbated the spread of HIV/AIDS globally in the 1970s and that soldiers were the original vectors of the disease.²⁷ Soldiers are particularly vulnerable to HIV infection because of risky sexual behavior. They are

often deployed far from wives and family, resulting in a greater propensity to hire prostitutes and engage in the types of sexual activity associated with high rates of HIV transmission. Also, in many parts of Africa, soldiers are viewed as desirable mates because they have steady jobs and a reliable income. Thus, the opportunities for soldiers to spread HIV through consensual sex are significant. Soldiers are also vectors in the spread of HIV through nonconsensual sex, that is, rape. As has been documented in many parts of sub-Saharan Africa, war, displacement, and genocide have led to the rape of women and girls and their subsequent infection with HIV. In Rwanda, the spread of HIV/AIDS among Tutsi women through rape was an intentional part of the genocide.²⁸

International Security Threats

These national security threats emanating from high rates of HIV infection are reflected in international security issues as well. Why would the high rates of HIV infection be a problem for other states, and why would the United States, in particular, be concerned about this issue? Three specific issues regarding the spread of HIV represent either a threat to US interests or a specific threat to US security: (1) the interest of the United States in having African peacekeeping forces available for regional interventions, (2) US investment in training African forces abroad in antiterrorism, and (3) the threat of failed states.

Since the invasion of Somalia in 1992, the United States has had an explicit preference for regional peacekeeping efforts in Africa rather than the deployment of US forces. Accordingly, an attempt has been made to train members of African militaries for peacekeeping operations. The most prominent of these efforts has been the African Contingency Operations Training Assistance program (ACOTA), which built on and expanded the African Crisis Response Initiative (ACRI) program developed by the Clinton administration. ACOTA focuses on training African militaries in the development of a common peacekeeping doctrine, interoperability, and standard communications technology. It seeks thereby to facilitate the effectiveness, coordination, and rapid deployment of African forces in response to African humanitarian and security crises. The goal of ACRI/ACOTA is to train eight to ten African battalions of 600 to 800 soldiers, each with additional specialized companies for combat support.²⁹ Countries receiving training and funds through the ACOTA program are expected to deploy their troops quickly in response to UN requests for peacekeeping forces, something in which the United States has an interest. Senegal, Uganda, Malawi, Mali, Ghana, Benin, and Côte d'Ivoire have thus far participated in training exercises.³⁰ US Army Special Operations officers staff the initial ten-week training, which includes computer-simulated exercises. This initial training

is followed up by refresher courses. The significant difference between ACRI and ACOTA is that the latter includes training and equipment for light infantry and small unit operations, which are intended to enable peacekeeping and peace enforcement in hostile environments. In addition, a greater attempt is made to tailor the country programs to the specific needs of each country.³¹

Yet as HIV/AIDS begins to take its toll on the armed forces, the ability of those forces to deploy quickly in response to a threat is impeded. It is also less likely that countries in which the armed forces are stretched thin due to HIV/AIDS will be willing to participate in peacekeeping operations or regional interventions. That was one of the earliest points of concern with regard to HIV/AIDS and its effect on international security from the perspective of the United States.³² Robert Ostergard has noted that in addition to difficulties in carrying out peacekeeping operations and foreign interventions, armed forces may be limited by HIV infection in their ability to carry out operations in their own countries.³³

However, the relationship between HIV infection and peacekeeping operations is not everywhere problematized. In spite of US concerns about HIV/AIDS negatively affecting the availability of soldiers for peacekeeping operations, the relationship between HIV and peacekeeping may be fundamentally different. In some African militaries, peacekeeping operations have also served as an incentive for HIV/AIDS prevention in Africa. The opportunity of a potentially lucrative and rewarding peacekeeping assignment is being used as an incentive to encourage HIV prevention in the Ghanaian military.³⁴ The Ghanaian military high command encourages HIV prevention and condom use. HIV-positive soldiers are forbidden from serving on peacekeeping operations and miss the prestige and extra pay that these assignments bring. According to Brigadier General Daniel Twum, “[Soldiers] are aware of this policy and make an active personal effort to prevent themselves from catching the virus in order to take part in these operations.” The Ghanaian military has a lower rate of HIV infection than the population at large, which currently has an infection rate of 3.8 percent.³⁵ General Twum’s statement suggests that African peacekeeping assignments may be an incentive for HIV/AIDS prevention and should therefore be supported for reasons of both security and public health.

As a consequence, evidence regarding peacekeeping is mixed. It is in the interest of US security to have available African peacekeepers, and if the Ghanaian case is any example, it also appears to be in the interest of African armed forces as well. To the extent that peacekeeping is viewed as a coveted assignment, setting high standards for peacekeepers, including HIV-negative status, will lead to higher standards across the board for the armed forces. It would help if policies mirroring those of the Ghanaian

armed forces were implemented in other militaries and received the support of countries to which these militaries are deployed. Such receiving countries may be reluctant to accept African peacekeepers who are HIV-positive.³⁶ For example, Eritrea has asked that the UN not allow HIV-positive soldiers to be part of the UN peacekeeping force monitoring the border between Eritrea and Ethiopia.³⁷ Such policies raise important human rights issues regarding discrimination against those who are HIV-positive and will serve to further the stigmatization of HIV-positive people in African countries.

The focus on peacekeeping is just a subcategory of the largest type of US investment in security in Africa—military-to-military contacts and training. The second threat to US interests in Africa from HIV is the increased cost of training armed forces in Africa for more traditional operations. The United States regularly trains African military forces. Some of this training is funneled through ACOTA, but more traditional training occurs through the International Military Education and Training program (IMET), which has existed for decades to train African troops and officers at US sites.³⁸ In 2002, IMET trained approximately 1,600 members of African armed forces. The countries that have been the largest recipients of this training (in dollar amounts) include Botswana, Ethiopia, Ghana, Senegal, Kenya, Nigeria, and South Africa.³⁹ Defense dollars allocated to IMET and ACOTA are designed to serve US interests abroad. However, if HIV/AIDS is leading to the death, disability, or discharge of soldiers being trained via IMET dollars, then the net benefit to the United States in terms of security will decrease.⁴⁰

IMET training is also linked to the global antiterrorism effort. Since the September 11 attacks, the Bush administration has pushed both to strengthen the ACOTA program to enable it to train soldiers for more “robust” assignments than peacekeeping⁴¹ and to shift the focus of US military training to those countries with terrorist threats in order to expand the reach of the United States in the struggle against terrorism.⁴² On March 11, 2002, President George W. Bush noted, “We will not send American troops to every battle, but America will actively prepare other nations for the battles ahead.”⁴³

Thus the status of African armed forces is of critical importance to the United States in terms of their ability to participate in peacekeeping and to strengthen global antiterrorist efforts. It would be a great asset to African militaries and to US national security interests if the United States provided antiretroviral drugs to African armed forces as part of the US security strategy in Africa. That would address at least one aspect of the problem of HIV/AIDS in African armed forces. If we can assume that those targeted for IMET or ACOTA training have already been trained by their own militaries and are at least of middle rank and that those selected for IMET and

ACOTA training are some of the best and brightest, then the provision of antiretroviral drugs would safeguard the investment of US training dollars as well as the quality of the command structure of African militaries.

The third area in which HIV/AIDS presents a threat to US national security is its impact on weak states. The armed forces serve as just one example of the ways in which a state can be adversely affected by HIV/AIDS. The same issues of investment in training and the development of a hierarchy are replicated among the ranks of teachers, doctors, nurses, politicians, and other educated people. There is a great fear that HIV/AIDS will weaken African states and that those weak states will fail. The United States and other countries now recognize that state failure in Afghanistan provided an environment conducive for terrorists to train and organize their attacks against Western targets. Failed states are a threat to global security.⁴⁴ The United States therefore has a national security interest in making certain that state failure is contained so as to make the world a safer place and the United States a safer country. September 11 revealed the danger of allowing state failures and humanitarian emergencies to go unaddressed. In Africa, examples of failed states such as Liberia and Somalia provide ready illustrations that this fear has some foundation. Liberian state failure pushed the whole Mano River region into war, creating the movement of arms and people into nearby countries. Somalia is another African example, and in that case state failure has been linked directly to terrorism.⁴⁵ Thus much of the rhetoric coming from US government officials regarding HIV/AIDS in Africa and national security uses state failure as the critical link between these two issues.⁴⁶ In the section below, I examine the recent US response to that threat.

The Bush Administration and Global HIV/AIDS

The Bush administration embraced the HIV/AIDS threat as both a human and a national security issue. In a 2002 speech, Colin Powell stated:

AIDS is not just a compelling moral issue; it is not just a humanitarian issue; it is far more than just a health issue. It is a security issue. It is a destroyer of nations. It is a destroyer of societies. It has the potential to destabilize regions, perhaps even entire continents. It can tear the social fabric apart within any nation. It can rob young democracies of citizens they need to build freer, better futures for themselves and for their children. HIV/AIDS is an economic issue, leaving nations without human resources to grow and develop, ultimately sapping global well-being.⁴⁷

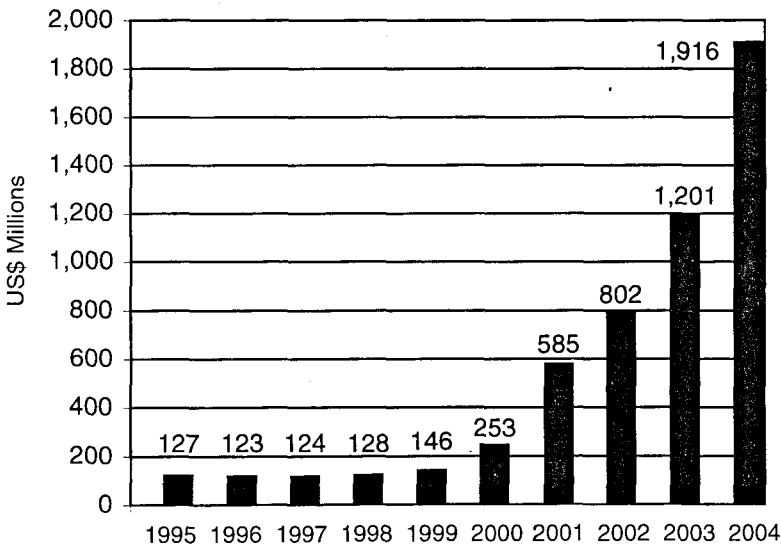
The desire to take some sort of national action on an issue that was increasingly articulated as a humanitarian disaster as well as a national

security threat led to the announcement of a new bill to fight global HIV/AIDS. It was called the President's Emergency Plan for AIDS Relief (PEPFAR). The announcement was first made in the 2002 State of the Union address. President Bush promised \$15 billion over a five-year period to fight AIDS, or \$3 billion per year, a sum that would have been a huge increase over previous funding levels. After appropriations, that number was substantially reduced, yet the final contribution remained significant.⁴⁸ In fiscal year 1995, the US government gave \$127 million to international HIV/AIDS programs. In fiscal year 2005, that allocation reached \$2.2 billion. The percentage of discretionary US government AIDS funding going to international programs has increased from 3 percent in 1996 to 22 percent in 2004.⁴⁹ Figure 7.1 depicts the increase.

In the PEPFAR legislation, international security issues are noted as one of the pressing concerns justifying the extraordinary commitment of US funds to fighting HIV/AIDS internationally:

HIV/AIDS weakens the defenses of countries severely affected by the HIV/AIDS crisis through high infection rates among members of their military forces and voluntary peacekeeping personnel. According to

Figure 7.1 Federal Funding for International HIV/AIDS, FYs 1995–2004 (excluding international research; US\$ millions)



Source: Todd Summers and Jennifer Kates, "Trends in U.S. Government Funding for HIV/AIDS—Fiscal Years 1981–2004," Chart Pack, publication number 7032, www.kff.org.

UNAIDS, in sub-Saharan Africa, many military forces have infection rates as much as five times that of the civilian population. HIV/AIDS poses a serious security issue for the international community by increasing the potential for political instability and economic devastation, particularly in those countries and regions most severely affected by the disease; decreasing the capacity to resolve conflicts through the introduction of peacekeeping forces because the environments into which these forces are introduced pose a high risk for the spread of HIV/AIDS; and increasing the vulnerability of local populations to HIV/AIDS in conflict zones from peacekeeping troops with HIV infection rates significantly higher than civilian populations.⁵⁰

Though it might be overstated, the US government takes the security threat noted in the PEPFAR legislation seriously, and it has put HIV/AIDS on the US agenda in terms of both security and the commitment of funds. Yet only twelve African countries are covered by the PEPFAR legislation: Botswana, Côte d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia. Others are left out for reasons that have not been made clear. Moreover, other countries at risk from the spread of HIV/AIDS, most notably India, are not currently targeted for funding.

The substantial new funding represented by PEPFAR will affect human security, even though the effort is motivated by national security.⁵¹ PEPFAR legislation represents a different form of engagement than has previously been present between the United States and Africa. The United States has not previously dedicated so many resources to fighting a disease overseas, nor has a disease been portrayed as a national security threat. In fact, AIDS has been killing Africans in large numbers for fifteen years with little US regard for its effects beyond the NGO level. However, the terrorist attacks of September 11, 2001, changed the way the US security establishment conceives of US interests. In the general reconceptualization of security, Africa became far more important than it had been in the immediate post-Cold War era, largely because of the threat of failed states.

US National Security and Public Health in Africa

Whatever the motivation for US concern with AIDS in Africa, the flow of money to the continent to assist with the crisis being caused by AIDS deaths and HIV infections will be welcomed. The question must be asked, Will this money serve the goal of strengthening weak African states and bolstering US security interests? If past foreign aid targeted at public health and education is any example, the answer is no. If the United States pours money into African states to strengthen their public health systems over a five-year period, possibly African states will respond by withdrawing national fund-

ing in the areas where foreign funds are coming in. To some degree that makes sense: Why should states allocate scarce resources to areas that are already receiving funding? In the past, NGO involvement in Africa has resulted in states abdicating their responsibility to provide basic education and health care to their citizenry.⁵² The ironic effect is that when states stop providing these basic public goods, they grow weaker, despite the underlying intent of this funding initiative to strengthen African capabilities.

In addition, the timing of the PEPFAR legislation and its long-term effects also give cause for concern. In the first year of funding, the US government requested less than \$3 billion because of a stated desire to see the infrastructure in place through which the aid can be funneled. The bill states that 55 percent of the money allocated by the PEPFAR legislation would go toward the purchase of antiretroviral drugs. That is good news indeed: with treatment, HIV infection can change from a death sentence to a serious but chronic disease. But when the five years of funding runs out, will Africans just return to the business of dying?⁵³

Additionally, it is unclear to what extent African governments see HIV/AIDS as a security threat. Certainly, good reason exists for them to do so. Yet for them, HIV/AIDS is also much more than a security threat. It is a public health disaster that drains from state coffers precious funds needed to combat even more pervasive diseases such as malaria. It is a drain on the educational system and burdens the state with large numbers of orphans to care for (or not to care for and then suffer the consequences). Moreover, HIV/AIDS affects the efficiency of a country's workforce. One HIV-testing project in Tanzania indicated that HIV/AIDS is the dominant cause of lost labor productivity and thus has an impact on company revenue.⁵⁴ HIV/AIDS also affects the efficiency of labor, when even those who are not HIV-positive are obligated to care for the dying or to participate in frequent funerals and ritualized memorials for those that have died.

The US focus on HIV/AIDS as a security issue could be a boon for African governments struggling with their response to overwhelming numbers of HIV-positive citizens. Yet US and African perspectives seem to diverge as African states struggle with more than just the security elements of the AIDS pandemic. The burdens that structural adjustment places on countries should also be noted. Although the US policy of support for combating the HIV/AIDS pandemic is laudable, it coexists with US support for structural adjustment programs that promote fee-based health care and primary education. Some evidence links structural adjustment with the spread of HIV/AIDS in Kenya, where the imposition of fees led to a decline in attendance at clinics.⁵⁵ With growing numbers of AIDS orphans and families impoverished by multiple AIDS deaths, the US support of fee-based services puts these basic public goods out of the reach of those the United States is trying to assist through targeted HIV/AIDS funding.

Conclusion

Security threats emanating from the HIV/AIDS pandemic are played out in an African context in which there are few ongoing international conflicts and the primary goal of most states is development. In those countries with high infection rates, HIV/AIDS has impeded overall development and lowered life expectancies significantly. It is important to recognize, however, that the HIV/AIDS pandemic does not affect every country in Africa in a similar fashion. Infection rates are substantially greater in southern Africa and East Africa than in West and North Africa.

US interests regarding HIV/AIDS in Africa have evolved over time, from exclusively humanitarian interests to those of international security. PEPFAR is a short-term measure that will ameliorate but not eliminate, the threat of failed states in Africa. Although it is laudable that the United States is active in combating the HIV/AIDS pandemic, comprehensive programs, far beyond the reach of those suggested by the PEPFAR legislation, will be needed to establish long-term, sustainable HIV/AIDS prevention programs. Even with comprehensive long-term educational and health care programs, the task has only begun, for by many assessments Africa is not the only continent that will experience the ravages of the AIDS epidemic. The next wave of increasing HIV infections and AIDS deaths is expected to play out in Asia, particularly on the Indian subcontinent. There, the security implications of the HIV/AIDS epidemic will be magnified, as the issues of HIV infection within the armed forces and the weakening of the state develop in a context of the India-Pakistan conflict, the arms race, and the delicate situation in Kashmir.

Appendix: HIV Prevalence Rates, 2003

Country	HIV/AIDS Prevalence Among Individuals 15-49 Years Old, General Population (percentage)	HIV/AIDS Prevalence, Military Population (percentage)
Southern Africa		
Swaziland	38.8	
Botswana	37.3	
Lesotho	28.9	
Zimbabwe	24.6	50
South Africa	21.5	60-70
Namibia	21.3	
Zambia	16.5	

(continues)

Appendix, continued

Country	HIV/AIDS Prevalence Among Individuals 15-49 Years Old, General Population (percentage)	HIV/AIDS Prevalence, Military Population (percentage)
Malawi	14.2	
Mozambique	12.2	
Angola	3.9	40-60
East Africa		
United Republic of Tanzania	8.8	15-30
Kenya	6.7	
Burundi ^a	6.0	
Rwanda	5.1	
Ethiopia	4.4	
Uganda	4.1	
Djibouti	2.9	
Eritrea	2.7	10
Sudan	2.3	
Somalia ^a	1.0	
Central Africa		
Central African Republic	13.5	
Gabon	8.1	
Cameroon	6.9	
Congo	4.9	10-25
Chad	4.8	
Democratic Republic of Congo	4.2	40-60
Equatorial Guinea ^a	3.4	
West Africa		
Côte d'Ivoire	7.0	10-20
Sierra Leone ^a	7.0	61 ^b
Liberia	5.9	
Nigeria	5.4	10-20
Burkina Faso	4.2	
Togo	4.1	
Guinea	3.2	
Ghana	3.1	
Guinea-Bissau ^a	2.8	
Benin	1.9	
Mali	1.9	
Gambia	1.2	
Niger	1.2	
Senegal	0.8	
Mauritania	0.4	

Sources: Radhika Sarin, "A New Security Threat: HIV/AIDS in the Military," *World Watch* 16, no. 2 (March-April 2003): 16-22; Doctors for Life, "AIDS Statistics," *Doctors for Life Living Safely AIDS Projects*, December 2000; Stefan Elbe, "HIV/AIDS and the Changing Landscape of War in Africa," *International Security* 27, no. 2 (2002): 159-177; Kevin O'Brian, "AIDS and African Armies," *Atlantic Monthly* 292, no. 1 (July 2003): 86-87; UNAIDS, "Table of Country-Specific HIV/AIDS Estimates and Data, End 2003," *2004 Report on the Global AIDS Epidemic*, July 2004, www.unaids.org/bangkok2004/report_pdf.html. These numbers of HIV-infected people were calculated as a percentage of the population given by UNDP for 2003.

Notes: a. 2001 figures.

b. 1998 figure.

Notes

My thanks go to Jonathan Miner, Kim Gilsdorf, and Emily Monteith for their able research assistance. All faults remain my own.

1. Collier et al. have identified the linkages between civil war and the spread of AIDS. Civil wars are linked to the spread of HIV/AIDS because they make staying healthy more difficult and reduce the amount of money available to governments to spend on public health. Paul Collier, V. L. Elliott, Havard Hegre, Anke Hoeffler, Marta Reynal-Querol, and Nicholas Sambanis, *Breaking the Conflict Trap: Civil War and Development Policy* (New York: Oxford University Press, 2003).

2. Associated Press, "Congo Officials Seize Illegal Uranium," March 22, 2004, www.cnn.com/2004/WORLD/africa/03/22/congo.uranium.ap/.

3. The peculiar nature of the transmission of the disease through sexual contact and mother-to-child transmission means that it does not affect each member of a community in a similar fashion, such as a natural disaster or a famine might. Rather, it clusters deaths within families and vulnerable populations such as sex workers, truck drivers, and migrant laborers. For a description of the local-level impact of AIDS, see Carolyn Baylies, "The Impact of AIDS on Rural Households in Africa: A Shock Like Any Other?" *Development and Change* 33, no. 4 (2002): 611–632.

4. Here I use AIDS rather than HIV/AIDS because I am referring to the disease of acquired immunodeficiency syndrome specifically rather than to the virus that causes it as well.

5. Economic Commission for Africa, *Economic Report on Africa 2003: Accelerating the Pace of Development* (Addis Ababa: Economic Commission for Africa, 2003).

6. WHO/UNAIDS, *AIDS Epidemic Update* (Geneva: Joint United Nations Programme on HIV/AIDS, 2005), 3.

7. United Nations, "Countries Most Affected by HIV/AIDS Are Least Able to Pay for Prevention and Treatment: However, Governments Initiating Actions to Confront Challenge." New York: Department of Public Information, Press Release, News and Media Services Division, November 6, 2001, www.un.org/News/Press/docs/2001/aids18.doc.htm.

8. Economic Commission for Africa, *Economic Report on Africa 2003*, 48.

9. World Health Organization, *HIV/AIDS Epidemiological Surveillance Update for the WHO Africa Region 2002* (Harare, Zimbabwe: WHO Regional Office for Africa, 2003), 19; World Health Organization, *HIV/AIDS Epidemiological Surveillance Report for the WHO Africa Region 2005 Update* (Harare, Zimbabwe: WHO Regional Office for Africa, December 2005), 25.

10. This percentage is the overall infection rate. A more reliable estimator is the infection rate for pregnant women. In 1992, 29.5 percent of all pregnant women in urban areas in Uganda were testing positive for HIV infection. By 2000 that rate had dropped to 11.3 percent, according to the Economic Commission for Africa, *HIV/AIDS in Sub-Saharan Africa: An Overview* (Yaounde, Cameroon: Economic Commission for Africa, 2002).

11. South African Department of Health, *Report of the Joint Health and Treasury Task Team on Treatment Options to Enhance Comprehensive Care for HIV/AIDS in the Public Sector*, South African Department of Health, Pretoria, 2003, www.gov.za/issues/hiv/ttr/index.html.

12. Kaiser Family Foundation, *Kaiser Family Foundation Daily HIV/AIDS Report*, October 6, 2003, www.kff.org (accessed April 20, 2004).

13. "Heir Inapparent," *Time*, European Edition, November 17, 2000, www.time.com/time/europe/webonly/africa/2000/11/mbeki.html.

14. David H. Shinn, "HIV/AIDS in Ethiopia: The Silence Is Broken; the Stigma Is Not," *Africa Notes* (Washington, DC: Center for Strategic and International Studies, 2001).

15. UN Integrated Regional Information Network, *Ethiopia: Warning over High Toll of AIDS Orphans* (Africa English Reports), United Nations, Office for the Coordination of Humanitarian Affairs, 2003.

16. This amount contrasts with approximately \$112 a year in South Africa, a number calculated by dividing the public health budget by the population. E-mail message to author, March 10, 2004, from UN Integrated Regional Information Network, *Ethiopia: Focus on the Local Manufacture of Anti-retroviral Drugs*.

17. Timothy Wirth, "Foreword," *Global HIV/AIDS: A Strategy for U.S. Leadership: A Consensus Report of the CSIS Working Group on Global HIV/AIDS (Panel Report)*, ed. K. A. Hamilton and C. A. Ducker (Washington, DC: Center for Strategic and International Studies, 1994).

18. Lisa Richwine, "U.S. Calls Spread of AIDS Globally a Security Threat," *Boston Globe* online, 2000, www.aegis.com/news/ads/2000/AD000772.html.

19. BBC, "U.S.: AIDS Is Security Threat," *BBC News*, May 1, 2000, <http://news.bbc.co.uk/1/hi/world/americas/731706.stm>.

20. White House, *National Security Strategy for a New Century* (Washington, DC: Government Printing Office, December 1999).

21. Stefan Elbe, "HIV/AIDS and the Changing Landscape of War in Africa," *International Security* 27, no. 2 (2002): 159–177.

22. Lindy Heinecken, "AIDS: The New Security Frontier," *Conflict Trends* 3, no. 4 (2000): 12–15; UN Integrated Regional Information Network, *HIV/AIDS Devastating Military*, March 3, 2001, www.aegis.org/news/irin/2001/ir010301.html.

23. Robert L. Ostergard, "HIV/AIDS, the Military and the Future of Africa's Security," 12. Paper presented at the ISA annual convention, Montreal, Canada, March 17–20, 2004.

24. There is also a debate on when soldiers should be required to leave the armed forces if they are HIV-positive. Should they be made to leave when they test positive for HIV (sero-positive), or should it be when they become symptomatic? There are human rights and legal issues involved in forbidding a soldier from serving in the armed forces or in peacekeeping operations if he is HIV-positive but asymptomatic. See Roxanne Bazergan, "Testing Times," *World Today* 57, no. 5 (2001): 6–8.

25. UNAIDS, Workshop on HIV/AIDS Activities with Armed Forces in Kenya, Tanzania, Uganda. Entebbe, Uganda, 2003.

26. Gregory R. Copley, "AIDS and African Armies: A Crisis Worse Than War," *Defense and Foreign Affairs Strategic Policy* 27, no. 11 (1999): 5.

27. *Ibid.*, 4.

28. Amnesty International, "Rape and Other Forms of Sexual Violence Against Girls and Women," *AFR 51/035/2000*; Jackie Martens, "Congo Rape Victims Seek Solace," *BBC News*, 2004, <http://news.bbc.co.uk/1/hi/world/africa/3426273.stm>; Lisa Sharlach, "Rape as Genocide: Bangladesh, the Former Yugoslavia, and Rwanda," *New Political Science* 22, no. 1 (2000): 89–102; Alistair Thomsom, "Refugee Rapes Fuel AIDS in Africa's War Zones," Reuters News Media, 2001, www.aegis.org/news/re/2001/RE010645.html (accessed March 29 2004); UNAIDS, "AIDS Becoming Africa's Top Human Security Issue, UN Warns," press release, 2000.

29. Jason C. Seal, "Peacekeeping Initiatives in Africa: A Preliminary Analysis," *Strategy Research Project* (Carlisle, PA: US Army War College, 2002), 15–16.

30. Assis Malaquias, "Peace Operations in Africa: Preserving the Brittle State?" *Journal of International Affairs* 55, no. 2 (2002): 415–440.

31. Russell J. Handy, "Africa Contingency Operations Training Assistance: Developing Training Partnerships for the Future of Africa," *Air and Space Power Journal* 17, no. 3 (2003): 57–65.

32. US Institute of Peace (USIP), "AIDS and Violent Conflict in Africa," *Special Report* (Washington, DC: USIP, 2001).

33. One further issue rarely noted in the literature, perhaps because it has more of a national than an international impact, is battlefield casualties. AIDS changes the nature of the treatment of the wounded. When rates of infection among troops are high, medics will want to take as many precautions as possible in handling battlefield injuries. Moreover, a strong fear of HIV infection results in far less willingness to treat enemy casualties. Robert L. Ostergard, "HIV/AIDS, the Military, and the Future of Africa's Security," paper presented at the ISA annual convention, Montreal, Canada, March 17–20, 2004, 24.

34. These assignments are so lucrative because they are usually funded by the UN Security Council at a standard rate per soldier, which is substantially higher than base pay in most African countries.

35. UN Integrated Regional Information Network, *Ghana: ECOWAS Governments Tackle HIV/AIDS in Their Armed Forces* (United Nations, Office for the Coordination of Humanitarian Affairs, 2004).

36. In a study conducted by UNAIDS, 94 percent of the militaries responding to inquiries conducted some form of HIV testing, but only 55 percent had a declared policy regarding testing in 2004. *AIDS Brief for Sectoral Planners and Managers: Military Sector*, Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal, www.nu.ac.za/heard/aidsbriefs/sec/Military.pdf (accessed April 21, 2004).

37. Roxanne Bazergan, "Testing Times," *World Today* 57, no. 5 (2001): 6–8.

38. See www.defenselink.mil/policy/isa/africa/sa-definitions.html for a further description of the program. The IMET program trains foreign military officers and troops from around the world, not just in Africa. It might be familiar to readers in its most infamous incarnation as the program that funded the School of the Americas.

39. The countries are noted here because they are not the same countries as those participating in ACRI, which specifically targets peacekeeping. IMET funds can be used for training over a wider range of issues. Daniel Volman, *U.S. Military Involvement in Africa by Country*, Association of Concerned Africa Scholars, February 11, 2003, www.prairienet.org/acas/military/militarysummary.html (accessed April 5, 2004).

40. I do not know at this point if the United States screens those it trains for HIV infection, which would seem an advisable course of action. The United States does screen its own recruits and tests those on active and reserve duty. Even if screening occurs for those receiving IMET training, it does not prevent infection after the training is given, so the net benefit to the United States still has the potential to decrease if infection rates are high.

41. Assis Malaquias, "Peace Operations in Africa: Preserving the Brittle State?" *Journal of International Affairs* 55, no. 2 (2002): 415–440.

42. Victoria Garcia. 2004. *U.S. Foreign Military Training: A Shift in Focus*, Center for Defense Information, 2002, www.cdi.org/terrorism/miltraining-pr.cfm (accessed April 6, 2004).

43. George W. Bush, *President Thanks World Coalition for Anti-Terrorism Efforts*, White House, 2002, www.whitehouse.gov/news/releases/2002/03/print/20020311-1.html (accessed April 12, 2004).

44. Robert I. Rotberg, "Failed States in a World of Terror," *Foreign Affairs* 81, no. 4 (2002): 127–142; Barnett Rubin, "A Blueprint for Afghanistan," *Current History* 101, no. 654 (2002): 153–158.

45. This view is highly contested. Although he admits that Somalia is considered a threat by many people in the US national security bureaucracy, Ken Menkhaus argues that Somalia is linked to terrorism by those who are much more concerned with the global political scene than with facts on the ground in Somalia. Ken Menkhaus, "Somalia: In the Crosshairs of the War on Terrorism," *Current History* 100 (May 2002): 210–218.

46. Colin L. Powell, "Powell Says Partnerships Needed to Stem AIDS Epidemic," June 24, 2002, www.usembassy.it/file2002_06/alia/a2062407.htm (accessed December 26, 2005); US Institute of Peace, "AIDS and Violent Conflict in Africa," *Special Report* (Washington, DC: USIP, 2001); White House, *National Security Strategy for a New Century* (Washington, DC: Government Printing Office, December 1999); Wirth, "Foreword."

47. Colin L. Powell, "Powell Says Parties Needed to Stem AIDS Epidemic," June 24, 2002, www.usembassy.it/file2002_06/alia/a2062407.htm (accessed March 25, 2004).

48. Politically, the PEPFAR bill provided a counterpoint to Bush administration policies that have been termed neoimperialist. The bill appeared to be an example of the Bush administration's compassionate conservatism, and the administration received kudos in the press and in politically unsympathetic circles for this example of constructive engagement. When it came to the appropriations process for the bill, the public hype played against the Bush administration. Their initial "ask" on the PEPFAR bill was only \$2 billion, rather than the promised \$3 billion. Intense lobbying efforts and sympathetic Republican congressional allies managed to increase the allocated amount to \$2.4 billion for the FY 2004 budget, in spite of stress on the budget from US engagement abroad in Afghanistan and Iraq.

49. Jennifer Kates and Todd Summers, *Trends in U.S. Government Funding for HIV/AIDS Through FY 2005* (Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2004), www.kff.org/hivaids/upload/U-S-Government-Funding-for-Global-HIV-AIDS-Through-FY-2005.pdf.

50. United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, PL 108-25.

51. Assuming, of course, that the money is effectively distributed and goes beyond just the purchase of antiretroviral drugs. That is an important step, but strengthening the public health sector in many African states is also on the agenda and would have lasting benefits if it does occur.

52. Nicholas van de Walle, *African Economies and the Politics of Permanent Crisis, 1979–1999* (New York: Cambridge University Press, 2001).

53. I actually believe that even a five-year delay in death is a good thing, so this comment should not be interpreted in a completely negative light. Five extra years can allow parents to find homes for their children and be present with them for that much more time. This presence is not insignificant if it means leaving a fifteen year old as opposed to a ten year old, or an eight year old as opposed to a three year old, and so on.

54. Tamara Schuyler, "AIDS," in C. Press, ed., *World at Risk* (Washington, DC: CQ Press, 2002), 6.

55. Dennis Altman, "AIDS and Security," *International Relations* 17, no. 4 (2003): 422.