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Racism or *Realpolitik*? U.S. Foreign Policy and the HIV/AIDS Catastrophe in Sub-Saharan Africa

David P. Fidler*

"The world stood by while AIDS overwhelmed sub-Saharan Africa."
Peter Piot, Executive Director of UNAIDS, July 7, 2002¹

I. INTRODUCTION

Infectious disease epidemics have played important roles in the history of humankind.² Historians have studied, for example, the continent-wide political, economic, and social impact of the bubonic plague—the "Black Death"—in fourteenth-century Europe.³ In the "age of discovery," European diseases decimated peoples across the American hemisphere, creating conditions more conducive for European conquest and destruction of native civilizations.⁴ Cholera epidemics in mid-nineteenth century Europe shocked governments across the continent into national and international political action that defined public health efforts on human diseases for over a century.⁵ Today, the history-transforming powers of infectious-disease epidemics are unfolding in the pandemic of the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS), which has already become one of the worst disease epidemics in human history in the space of two decades.⁶

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1. Peter Piot, Keeping the Promise, Speech at the Opening Ceremony of the XIV International AIDS Conference in Barcelona, Spain (July 7, 2002), at <http://www.unaids.org/whatsnew/speeches/eng/2002/Piot070702Barcelona.html> (last visited September 10, 2002).

2. See, e.g., WILLIAM H. MCNEILL, PLAGUES AND PEOPLES (1976).

3. See GEORGE ROSEN, A HISTORY OF PUBLIC HEALTH 41-47 (1958); DOROTHY PORTER, HEALTH, CIVILIZATION, AND THE STATE 31-34 (1999).

4. See ALFRED W. CROSBY, JR., THE COLUMBIAN EXCHANGE: BIOLOGICAL AND CULTURAL CONSEQUENCES OF 1492 (1972).

5. See NORMAN HOWARD-JONES, THE SCIENTIFIC BACKGROUND OF THE INTERNATIONAL SANITARY CONFERENCES 1851-1938 (1975); PETER BALDWIN, CONTAGION AND THE STATE IN EUROPE 1830-1930 (1999).

6. JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC 2002, at 44 (2002) ("Twenty years after the world first became aware of AIDS, it is clear that humanity is facing one of the most devastating epidemics in human history.").

Ominously, experts argue that the HIV/AIDS pandemic remains in its earliest stages.⁷

Most experts agree that the continent most devastated by HIV/AIDS is Africa⁸ because by the end of 2002 nearly seventy percent of all cases of HIV/AIDS have occurred in sub-Saharan Africa.⁹ While other regions of the world, most notably populous Russia, India, and China,¹⁰ face the onslaught of this virus and disease, HIV/AIDS has already reached the stage where it threatens the political, economic, and social future of the African continent. The human catastrophe of HIV/AIDS in sub-Saharan Africa remains difficult for most people to grasp because of the enormity of the disaster.¹¹ Many people look at the appalling numbers of HIV/AIDS cases in sub-Saharan Africa and, in agony and anger, ask how such a preventable, unnecessary debacle could occur and continue to ravage the fate of an entire continent.¹²

At the forefront of the controversy surrounding the HIV/AIDS catastrophe are questions concerning the tepid and tardy response of rich, Western nations to the HIV/AIDS crisis in sub-Saharan Africa. In particular, why has U.S. foreign policy been shaped as it has in connection with HIV/AIDS in Africa? The consensus in the community of global non-governmental organizations (NGOs) active on HIV/AIDS is, to put it mildly, that the United States has not responded

7. *Id.* (noting that "it is clear that the epidemic is still in its early stages"); UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2002, at 5 (2002) (noting that "[b]est . . . projections suggest that an additional 45 million people will become infected with HIV in 126 low- and middle-income countries . . . between 2002 and 2010"); Richard G. A. Feachem, *AIDS Hasn't Peaked Yet—And That's Not the Worst of It*, WASH. POST, Jan. 12, 2003, at B03 ("Horribly, the worst is still to come.").

8. UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC 2002, *supra* note 6, at 22 (noting that sub-Saharan Africa "remains by far the worst-affected region in the world"); UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2002, *supra* note 7, at 16 (stating that sub-Saharan Africa is "[b]y far the worst-affected region").

9. UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2002, *supra* note 7, at 6 (reporting estimates of HIV/AIDS cases in sub-Saharan Africa at 29,400,000 of 42,000,000 total cases). At the end of 2001, nearly 71% of all HIV/AIDS cases were in sub-Saharan Africa. UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC 2002, *supra* note 6, at 8 (showing estimates of HIV/AIDS cases in sub-Saharan Africa at 28,500,000 of 40,000,000 total global cases).

10. UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2002, *supra* note 7, at 7-15 (reporting on extent of HIV/AIDS epidemic in the Asia and Pacific region, including India and China, and the Eastern Europe and Central Asia region, including Russia); NAT'L INTELLIGENCE COUNCIL, THE NEXT WAVE OF HIV/AIDS: NIGERIA, ETHIOPIA, RUSSIA, INDIA, AND CHINA (Sept. 2002); Nicholas Eberstadt, *The Future of AIDS: Grim Toll in Russia, China, and India*, FOREIGN AFF., Nov./Dec. 2002, at 22.

11. Part II provides an overview of the HIV/AIDS tragedy in sub-Saharan Africa.

12. Piot, *supra* note 1.

So why, 20 years into the epidemic, are people with HIV still the targets of hate? Why are only 30,000 Africans getting antiretroviral treatment, when a hundred times that number need it? Why are three-quarters of a million babies born with HIV a year, when it is eminently preventable? Why have we failed to stop the dramatic expansion of HIV?

appropriately or adequately to the public health crisis in sub-Saharan Africa.¹³ These NGOs have pointed out not only the United States' limited financial contributions to HIV/AIDS efforts in sub-Saharan Africa, but also its determined effort to limit the supply of antiretroviral drugs in the countries in Africa most hard hit by the tragedy.¹⁴ Although members of the former Clinton administration and current Bush administration with responsibilities for U.S. foreign policy on HIV/AIDS would dispute these accusations, most observers would agree that U.S. foreign policy has been at the center of much sound and fury in connection with discourse on the HIV/AIDS debacle in sub-Saharan Africa.

The essence of the accusations against the United States is that this political, economic, and military superpower has exhibited a level of indifference and inaction on the African HIV/AIDS problem that is unjustifiable. Inevitably, the debate includes attempts to explain this indifference and inaction. This article explores two explanations of U.S. foreign policy on the African HIV/AIDS crisis which analyze the issue in fundamentally different ways. The first explanation argues that the lack of robust action on the part of the United States reflects racism. The second explanation asserts that the foreign policy behavior of the United States on HIV/AIDS in Africa is consistent with the teachings of *realpolitik*—the United States does not have pressing national security or geopolitical reasons for exercising its power in connection with the HIV/AIDS situation in sub-Saharan Africa.

The racism and *realpolitik* explanations construct the HIV/AIDS epidemic in Africa in different ways. I coin the terms "racidemic" and "anarchidemic" to capture how each position explains the HIV/AIDS problem in sub-Saharan Africa and analyze how well these concepts fit the reality of the African HIV/AIDS crisis.¹⁵ The last substantive part of the article analyzes whether a prominent development in global HIV/AIDS policy, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), provides a strategy for the states and non-state actors to steer a course between the extremes of racism and *realpolitik*.¹⁶

13. See, e.g., AFRICA ACTION, AFRICA POLICY FOR A NEW ERA: ENDING SEGREGATION IN U.S. FOREIGN RELATIONS 4 (Jan. 2003) ("The absence of U.S. leadership remains the greatest obstacle to a successful effort to defeat HIV/AIDS in Africa, and globally. While the U.S. has launched new initiatives to respond to AIDS in Africa, the response remains wholly inadequate.")

14. See *infra* Part II.

15. See *infra* Parts III – IV.

16. See *infra* Part V.

II. THE MODERN "BLACK DEATH:" THE HIV/AIDS CATASTROPHE IN SUB-SAHARAN AFRICA AND U.S. FOREIGN POLICY

A. The Global HIV/AIDS Epidemic: A Disaster in Two Decades

Tracing in detail the progress of the HIV/AIDS plague over the last twenty years is beyond the scope of this article but I hope to communicate some sense of the terrible growth of this pandemic in this section. Figure 1 from UNAIDS illustrates the rapid spread of HIV/AIDS around the world from zero cases in 1980 to 36.1 million cases by June 2001.¹⁷ Table 1 below also provides a statistical overview of the progress of this epidemic over the last five years.

Table 1. Summary of the Global HIV/AIDS Epidemic, 1998-2002¹⁸

Category	1998	1999	2000	2001	2002
<i>New HIV infections</i>	5.8 million	5.4 million	5.3 million	5 million	5 million
<i>People living with HIV/AIDS</i>	33.4 million	34.3 million	36.1 million	40 million	42 million
<i>Death from AIDS</i>	2.5 million	2.8 million	3.0 million	3.0 million	3.1 million
<i>Total AIDS deaths since the beginning of the epidemic</i>	13.9 million	18.8 million	21.8 million	24.8 million	27.9 million

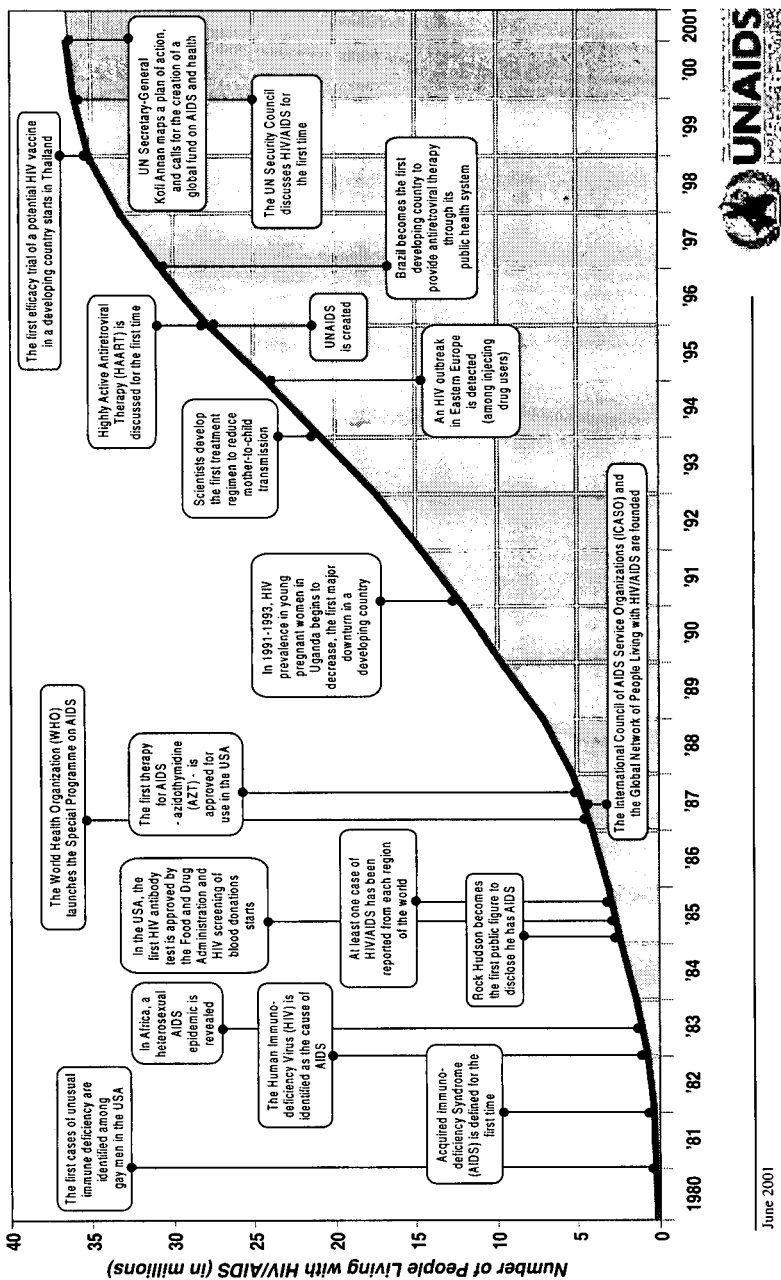
In addition, starting from a few cases in the United States in the early 1980s, HIV/AIDS has become a global plague, affecting every region of the world.¹⁹

17. UNAIDS, 20 YEARS OF HIV/AIDS (June 2001).

18. The data used to construct this table were taken from UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 1998, at 1 (1998); UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC: JUNE 2000, at 6 (2000); UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2000, at 3 (2000); UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC 2002, at 8 (2002); and UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2002, *supra* note 7, at 3.

19. Tbl.2., *infra* note 20.

20 years of HIV/AIDS



June 2001



Table 2. Global HIV/AIDS Estimates by Region as of End of 2002²⁰

Region	Estimated Number of HIV/AIDS Cases	Approx. Percentage of Total HIV/AIDS Cases
North America	980,000	2%
Caribbean	440,000	1%
Latin America	1,500,000	4%
Western Europe	570,000	1%
North Africa and the Middle East	550,000	1%
Sub-Saharan Africa	29,400,000	70%
Eastern Europe and Central Asia	1,200,000	3%
East Asia and Pacific	1,200,000	3%
South and Southeast Asia	6,000,000	14%
Australia and New Zealand	15,000	<1%
Total	42,000,000	100%

The global presence of HIV/AIDS and its continued penetration of populations around the world demonstrate that HIV and AIDS do not depend on the presence of particular climatic or cultural conditions. Another global infectious disease killer, malaria, differs in its threat profile because of the importance of a warm, wet climate to the mosquito vector. Tropical and equatorial regions face, therefore, a malaria threat greater than regions that experience suitable weather for mosquito populations only seasonably.²¹ Culturally, HIV/AIDS has penetrated rich and poor countries, European and Asian cultures, homosexual and heterosexual populations, drug addicts and hemophiliacs, and countries at the heart and on the periphery of globalization. Historical precedents for such a rapid, global pandemic are hard to find. Perhaps the only pandemic that may serve as a modern precedent is the global influenza epidemic of 1918-1919, which killed an estimated twenty million people around the world.²² Unlike HIV/AIDS, however, the great influenza pandemic came and went quickly and did not continue to wreak morbidity and mortality year in and year out.

HIV/AIDS has become endemic in every region of the world, posing a continual public health problem for governments, international organizations,

20. UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2002, *supra* note 7, at 34.

21. WORLD HEALTH ORGANIZATION, WHAT IS MALARIA? ROLL BACK MALARIA INFOSHEET 1 (March 2002) (noting that malaria is transmitted by the female Anopheles mosquito and "is found throughout the tropical and sub-tropical regions of the world and causes more than 300 million acute illnesses and at least one million deaths annually"). Sub-Saharan Africa also bears a great burden from malaria. *Id.* ("Ninety percent of deaths due to malaria occur in Africa, south of the Sahara—mostly among young children. Malaria kills an African child every 30 seconds.").

22. See GINA KOLATA, FLU: THE STORY OF THE GREAT INFLUENZA PANDEMIC OF 1918 AND THE SEARCH FOR THE VIRUS THAT CAUSED IT (1999).

and non-state actors. In this respect, HIV/AIDS resembles the global threat smallpox once posed to societies around the world before the development of effective vaccines and ultimately the eradication of the disease.²³ Worryingly, experts believe that the global HIV/AIDS pandemic is still in its early stages rather than being on the path to control or eradication through an effective vaccine.²⁴

B. "Death Stalks a Continent:"²⁵ The HIV/AIDS Catastrophe in Sub-Saharan Africa

Although the global scale of the HIV/AIDS epidemic is one of its frightening features, the most shocking aspect of the global statistics on HIV/AIDS is the impact of the epidemic on sub-Saharan Africa. As Table 2 (above) indicates, seventy percent of all HIV/AIDS cases are located in sub-Saharan Africa as of the end of 2002. Discourse on HIV/AIDS has focused a great deal of attention on the disproportionate impact of the plague on sub-Saharan Africa and this article cannot adequately summarize the voluminous and growing literature on the subject. Instead, this section provides a glimpse of the catastrophe that HIV/AIDS has become for sub-Saharan Africa.

UNAIDS notes that the heterosexual HIV/AIDS epidemic in Africa first came to global attention in 1984,²⁶ which was very early in the plague's development. In 1984, UNAIDS estimated that no country in sub-Saharan Africa had more than five percent of its population infected with HIV and most countries in this region had between zero and one percent HIV infection in their adult populations.²⁷ Despite the early global attention on Africa, in the early stages of the epidemic, HIV/AIDS policy making was focused on developed countries, such as the United States, where HIV/AIDS made its first dramatic appearances. By 1987, however, the creation of the World Health Organization's (WHO) Global Programme on AIDS indicated that public health experts saw the looming global nightmare on the horizon.²⁸ And the nightmare has come, especially for sub-Saharan Africa.

23. On the global scourge of smallpox, see DONALD R. HOPKINS, *THE GREATEST KILLER: SMALLPOX IN HISTORY* (2002); JONATHAN B. TUCKER, *SCOURGE: THE ONCE AND FUTURE THREAT OF SMALLPOX* (2001); and DAVID A. KOPLOW, *SMALLPOX: THE FIGHT TO ERADICATE A GLOBAL SCOURGE* (2003).

24. UNAIDS, *REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC 2002*, *supra* note 6, at 44.

25. Johanna McGreary, *Death Stalks a Continent*, *TIME*, Feb. 12, 2001, at 36 (reporting on the African AIDS crisis).

26. *See* fig.1, *supra* note 18.

27. UNAIDS, *SPREAD OF HIV OVER TIME IN SUB-SAHARAN AFRICA, 1984-1999* (2000) (on file with author).

28. Kelley Lee & Anthony Zwi, *A Global Political Economy Approach to AIDS*, in *HEALTH IMPACTS OF GLOBALIZATION: TOWARDS GLOBAL GOVERNANCE* 13, 24 (K. Lee ed., 2003) (noting the creation of WHO's Global Programme on AIDS in 1987 "as the main multilateral channel for Western aid").

UNAIDS released grim estimates of the adult HIV-infection rates in sub-Saharan Africa at the end of 2001. According to UNAIDS, 9 countries had HIV-infection rates in their adult populations of between 15% and 39%, 14 countries had rates between 5% and 15%, 11 countries had rates between 1% and 5%, 1 country had rates between 0.1% and 0.5%, and 1 country had rates between 0.0% and 0.1%.²⁹ These statistics mean that 77% of the countries in sub-Saharan Africa have HIV-infection rates estimated to be equal to or over 5% of the adult population. UNAIDS estimated that, at the end of 2002, the adult prevalence rate for the entire region of sub-Saharan Africa was 8.8%.³⁰

In 2001, UNAIDS estimated that only one other country in the world, Haiti, has an adult HIV-infection rate of over 5%.³¹ The highest adult HIV seroprevalence rate in North America is 0.6% (the United States); Western Europe is 0.5% (Portugal and Switzerland); North Africa and the Middle East is 2.6% (Sudan); Eastern Europe and Central Asia is 0.9% (Russia); East Asia and the Pacific is 0.7% (Papua New Guinea); South and South-East Asia is 2.7% (Cambodia); and Australia and New Zealand both have rates of 0.1%.³²

Table 3. Estimated Percentage of Adults Infected with HIV/AIDS, as of End of 2001³³

Adult Prevalence Rate	Countries (%)
15%-39% infection rate	Botswana (38.9%) Kenya (15%) Lesotho (31%) Malawi (15%) Namibia (22.5%) South Africa (20.1%) Swaziland (33.4%) Zambia (21.5%) Zimbabwe (33.7%)
5%-15% infection rate	Angola (5.5%) Burkina Faso (6.5%) Burundi (8.3%) Cameroon (11.8%) Central Africa Republic (12.9%) Congo (7.2%) Côte d'Ivoire (9.7%) Mozambique (13%)

29. See tbl.3, *infra* note 33.

30. UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2002, *supra* note 7, at 6. The adult prevalence rate is defined as the proportions of adults (persons 15 to 49 years of age) living with HIV/AIDS. *Id.*

31. UNAIDS, A GLOBAL VIEW OF HIV INFECTION: 40 MILLION ADULTS LIVING WITH HIV/AIDS AS OF END 2001 (on file with author).

32. *Id.*

33. *Id.*

		Nigeria (5.8%) Rwanda (8.9%) Sierra Leone (7%) Togo (6%) Uganda (5%) Tanzania (7.8%)
1%-5% infection rate		Benin (3.6%) Chad (3.6%) Democratic Republic of Congo (4.9%) Equatorial Guinea (3.4%) Eritrea (2.8%) Ethiopia (6.4%) Gambia (1.6%) Ghana (3.0%) Guinea-Bissau (2.8%) Mali (1.7%) Somalia (1%)
0.5%-1.0% infection rate		Senegal (0.5%)
0.1%-0.5% infection rate		Madagascar (0.3%)
0.0%-0.1% infection rate		Mauritius (0.1%)
Infection rate not available		Comoros Djibouti Gabon Guinea Liberia Mauritania Niger

The sad statistical story of HIV/AIDS in sub-Saharan Africa does not, of course, provide a comprehensive picture of the devastation the disease has caused and continues to cause. HIV/AIDS has brought untold personal tragedy to Africans and their families; millions of AIDS orphans confront a bleak future without their parents.³⁴ Individuals infected with HIV/AIDS have been subjected to harmful stigma and discrimination because of ignorance and prejudice surrounding this epidemic.³⁵ Economically, HIV/AIDS has adversely affected or even reversed development in sub-Saharan Africa by weakening the

34. UNAIDS estimates that there were 14 million children orphaned by AIDS at the end of 2001. UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC 2002, *supra* note 6, at 8. Of this number, UNAIDS estimates that 11 million (77%) live in sub-Saharan Africa. *Id.* at 189.

35. See, e.g., Press Release, UNAIDS, WORLD AIDS DAY TARGETS STIGMA AND DISCRIMINATION (Nov. 30, 2002) (stating that "stigma and discrimination remain major barriers to reversing the AIDS epidemic"), at http://www.unaids.org/whatsnes/press/eng/pressarc02/WAD02addis301102_en.html (last visited Dec. 19, 2002).

foundations of economic growth—households, productive work forces, educational infrastructure, food production and security, and health care systems.³⁶ HIV/AIDS also exacerbates humanitarian crises, such as food emergencies.³⁷ Although other developing countries suffer the effects of HIV/AIDS, only in sub-Saharan Africa has the impact of HIV/AIDS been so large and devastating to the fate of the entire region.

The scale of this tragedy has reached such proportions that expressing the magnitude and nature of this disaster is difficult. Dr. Kevin de Cock of the United States Center for Disease Control and Prevention made a historical comparison in arguing "AIDS is undoubtedly Africa's biggest social catastrophe since the slave trade."³⁸ The disproportionate impact HIV/AIDS has had on sub-Saharan Africa led Salih Booker, executive director of Africa Action, to argue "AIDS is the black plague! It is mainly killing black people. And that is the cruel truth about why the world has failed to respond with dispatch."³⁹ Both de Cock and Booker argue that the blame for a social catastrophe of this size cannot be laid entirely at the feet of African governments or societies. What has the rest of the "international community" been doing as HIV/AIDS progressively eroded the future of sub-Saharan Africa? Comparing the HIV/AIDS catastrophe with the slave trade, and the argument that HIV/AIDS is a modern "black death," takes the sobering statistics on Africa's HIV/AIDS problem into the turbulent waters of globalized racism, to which this article will return in Part III.

C. "Leading the Fight?"⁴⁰ U.S. Foreign Policy Responses to the Global HIV/AIDS Crisis

1. U.S. Foreign Policy and Infectious Diseases

As with previous sections, attempting a twenty-year analysis of U.S. foreign policy on HIV/AIDS is beyond the scope of this article. My objective is to communicate at a basic level the general nature of the U.S. foreign policy approach to the growth of HIV/AIDS as a global public health problem generally and an African problem specifically. The foreign policies of the

36. UNAIDS, FACT SHEET: HIV/AIDS AND DEV., at http://www.unaids.org/fact_sheets/files/Dev_Eng.html (last visited Sept. 10, 2002).

37. UNAIDS, AIDS EPIDEMIC UPDATE: DECEMBER 2002, *supra* note 7, at 26.

38. REUTERS MEDICAL NEWS, AFRICAN AIDS CRISIS IS STILL LARGELY IGNORED (2001), at <http://www.reutershealth.com/frame2/eline.html> (last visited Mar. 15, 2001).

39. TAMARA STRAUS, ALTERNET, THE MORAL CALCULUS OF AIDS (2001), at <http://www.alternet.org/story.html?StoryID=10706> (last visited Aug. 28, 2002).

40. THE U. S. AGENCY FOR INT'L DEV., USAID: LEADING THE FIGHT AGAINST HIV/AIDS, at http://www.usaid.gov/pop_health/aids (last visited Sept. 10, 2002) (arguing that "[t]he U.S. government is the world leader in responding to the global pandemic of AIDS").

United States and other countries have long included concerns and action for preventing the spread of infectious diseases.⁴¹ The major reason for foreign-policy concern with infectious diseases was the threat such diseases posed to a nation's health and international commerce.⁴² In other words, some infectious diseases posed a direct threat to U.S. health and economic interests. The other major impetus for U.S. foreign policy interest in infectious diseases was humanitarian—to use U.S. resources to help less fortunate countries and peoples address pressing public health problems.⁴³

A crude characterization of U.S. foreign policy on infectious diseases in the twentieth century would involve arguing that the "direct threat" framework prevailed in the first half of the century and that the humanitarian framework prevailed in the second half—until the emergence of HIV/AIDS. In the first half of the twentieth century, the United States joined other developed nations in constructing international regimes involving treaties and international health organizations to coordinate efforts on the international spread of infectious diseases.⁴⁴ Driving these foreign policy activities were the perceptions that (1) the United States itself was vulnerable to infectious disease importation; and (2) U.S. exports to other countries were vulnerable to foreign efforts to prevent infectious disease importation.⁴⁵ International cooperation was critical to handling both of these direct threats to U.S. interests in the first half of the

41. For a historical overview of U.S. involvement in international health, see NEW DIRECTIONS IN INTERNATIONAL HEALTH COOPERATION: A REPORT TO THE WHITE HOUSE 39-40 (1978).

42. The development of international health diplomacy in the latter half of the 19th century reflected the conclusions of European countries and the United States that the health and economic threats posed by epidemic diseases, such as cholera, required international cooperation to mitigate. On the development of international health diplomacy in the last half of the 19th and first half of the 20th centuries, see HOWARD-JONES, *supra* note 5, and David P. Fidler, *The Globalization of Public Health: The First 100 Years of International Health Diplomacy*, 79 BULL. WORLD HEALTH ORG. 842 (2001).

43. A 1978 report to President Carter expressed the humanitarian aspects of U.S. involvement in international health when it stated that international health cooperation was a "responsibility of world citizenship" and involved the advancement of human rights. See NEW DIRECTIONS IN INTERNATIONAL HEALTH COOPERATION, *supra* note 41, at 42-43.

44. For historical overview of the development of international regimes on infectious diseases, see DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES 21-57 (1999).

45. Between 1851 and 1951, two of the major objectives of international cooperation on infectious diseases were preventing the importation of infectious diseases and harmonizing quarantine practices to minimize their impact on trade. See *id.* at 28-42. The United States actively participated in the international diplomacy that sought to achieve these objectives. *Id.* at 30 ("The reason for the emergence of the United States in international health cooperation parallels the explanation of European behaviour: the United States had suffered importations of cholera and yellow fever from other countries and was anxious to protect its population from such invasions."). The United States also participated in the negotiation of treaties, such as the International Sanitary Convention of 1903, that sought to harmonize quarantine laws and regulations to reduce their impact on trade. On quarantine harmonization in the International Sanitary Convention of 1903, see *id.* at 38-39.

twentieth century.⁴⁶

The second half of the twentieth century witnessed a dramatic change in how U.S. foreign policy saw infectious diseases. Major scientific and technological breakthroughs in vaccines and antibiotics helped the United States and other developed nations make significant strides in reducing morbidity and mortality from infectious diseases.⁴⁷ Pathogenic microbes still crossed borders through global trade and travel, but the United States and other developed countries were much less vulnerable to such microbial traffic than they had been earlier in the century.⁴⁸ As major U.S. trading partners such as European nations also brought infectious diseases under control, the trade costs of public health measures became less of a foreign policy issue.⁴⁹ As public health practices and technologies diffused throughout the international system in the post-World War II period, assisted by entities such as WHO, developing countries began to make some progress against infectious diseases as well. U.S. foreign policy concern with infectious diseases shifted to a more humanitarian perspective as the direct threat to U.S. interests from infectious diseases began to fade away. A 1978 report on international health cooperation illustrates the importance of humanitarianism because it posits a direct correlation between U.S. interest in human rights and human needs and the place of health in international relations.⁵⁰

2. Emergence of HIV/AIDS as a Foreign Policy Issue

When HIV/AIDS first emerged as a public health issue for the United States in 1981, it was a domestic rather than a global problem.⁵¹ The United States struggled internally to deal with a disease that first manifested itself in the

46. U.S. participation in the creation and operation of both treaties on infectious diseases (e.g., the International Sanitary Conventions of 1903, 1912, and 1926 and the Pan American Sanitary Code of 1924) and international health organizations (e.g., Pan American Sanitary Bureau (established in 1902), Office International d'Hygiène Publique (established in 1907), and the World Health Organization (established in 1948)) illustrate the importance of international health cooperation to the United States in the first half of the 20th century. Reflecting on U.S. historical involvement in international health cooperation, a 1978 report to President Carter stated that "[s]ince the 1800s, the United States has recognized that the maintenance and improvement of our health and well-being depend upon close cooperation with other nations." NEW DIRECTIONS IN INTERNATIONAL HEALTH COOPERATION, *supra* note 41, at 39.

47. David P. Fidler, *The Globalization of Public Health: Emerging Infectious Diseases and International Relations*, 5 IND. J. GLOBAL LEGAL STUD. 11, 27 (1997).

48. *Id.*

49. Although the General Agreement in Tariffs and Trade (GATT), established in 1947, allowed GATT contracting parties to restrict trade in order to protect human health (GATT, Article XX(b)), trade restrictions justified as protections against infectious disease importation were not a significant feature of state practice and disputes under GATT. See FIDLER, *supra* note 44, at 121-33 (analyzing history of Article XX(b) of GATT in connection with infectious diseases).

50. NEW DIRECTIONS IN INTERNATIONAL HEALTH COOPERATION, *supra* note 41, at 42.

51. AVERT, THE HISTORY OF AIDS, 1981-1986, at http://www.avert.org/his81_86.htm (last visited Feb. 3, 2003).

nation's male homosexual community.⁵² HIV/AIDS as an international issue did not emerge until later in the 1980s when evidence began to appear that a pandemic of unclear proportions might be underway. The first international conference on HIV/AIDS was held in April 1985; and, by the end of 1986, WHO had received reports of HIV/AIDS cases from eighty-five countries.⁵³ In the mid-1980s, President Reagan (not noted for vision in dealing with HIV/AIDS domestically) ordered:

federal agencies to develop a model that could predict the global spread of AIDS and its demographic effects. Working under the auspices of the State Department, the CIA led this research in cooperation with a number of other government entities (including the Departments of Energy and Defence). The initial focus was on Africa. . . .⁵⁴

According to the U.S. Agency for International Development (USAID), the United States began funding international efforts against HIV/AIDS in 1986,⁵⁵ two years after the heterosexual AIDS epidemic in Africa was first revealed. With such funding, the United States began a humanitarian effort to help other countries affected by HIV/AIDS. From 1988 through 1990, U.S. funding on HIV/AIDS problems overseas was under \$50 million annually,⁵⁶ suggesting that even as a humanitarian issue, HIV/AIDS was not a prominent concern for the United States.

The U.S. foreign policy apparatus kept an eye on the global march of HIV/AIDS under the first Bush administration. In 1991, intelligence officers distributed Interagency Intelligence Memorandum 91-10005, which projected that by 2000 the world would experience forty-five million HIV infections.⁵⁷ This estimate proved accurate because the total number of estimated cases of HIV/AIDS was forty million at the end of 2001 and forty-two million at the end of 2002.⁵⁸ Although critics argue the United States failed to act on such dire predictions from its own intelligence officers,⁵⁹ U.S. funding for global HIV/AIDS efforts increased to approximately \$75 million dollars in 1991 and

52. *Id.*

53. *Id.*

54. Loch K. Johnson & Diane C. Synder, *Beyond the Traditional Intelligence Agenda: Examining the Merits of a Global Public Health Portfolio*, in *PLAGUES AND POLITICS: INFECTIOUS DISEASE AND INTERNATIONAL POLICY* 214, 216 (A. Price-Smith ed., 2001).

55. U. S. AGENCY FOR 'INT'L DEV., USAID: LEADING THE FIGHT AGAINST HIV/AIDS, *supra* note 40.

56. *Waking Up to Devastation*, WASH. POST, at <http://www.washingtonpost.com/wp-srv/world/daily/july00/aidsgraphic2.htm> (last visited Sept. 10, 2002).

57. STRAUS, *supra* note 39.

58. See tbl.1, *supra* note 18.

59. *Id.*

almost \$100 million in 1992, the last year of the Bush administration.⁶⁰

3. HIV/AIDS as a Foreign Policy Issue During the Clinton Administration

Overseas funding for HIV/AIDS reached approximately \$125 million in 1993, the first year of the Clinton administration.⁶¹ These modest funding increases from 1991 to 1993 are perhaps less the result of the intelligence estimates than the evidence that the global spread of HIV/AIDS was getting worse in the early 1990s.⁶² The steady rise in U.S. funding of overseas HIV/AIDS efforts did not, however, continue through most of the rest of the Clinton administration. Aid for HIV/AIDS for 1994 through 1998 stayed at or under \$125 million, with 1999 seeing an increase to just under \$150 million.⁶³ This period, however, covers six years in which the global HIV/AIDS pandemic continued its terrifying growth, going from an estimated twenty million cases at the beginning of 1994 to an estimated thirty-five million cases at the end of 1999.⁶⁴ Thus, in these years when the Clinton administration kept international HIV/AIDS funding limited to under \$150 million, the global HIV/AIDS epidemic nearly doubled in size.

These statistics illuminate some ironies in U.S. foreign policy on HIV/AIDS. The Clinton administration launched foreign policy initiatives on emerging and re-emerging infectious diseases.⁶⁵ In June 1996, Vice President Gore declared that "there is no more menacing threat to our global health today than emerging infectious diseases,"⁶⁶ and President Clinton issued a Presidential Decision Directive in order to focus U.S. foreign policy more on infectious diseases.⁶⁷ It even classified emerging and re-emerging diseases, including HIV/AIDS, as a national security concern for the United States.⁶⁸ The budget expenditures on HIV/AIDS during this period of renewed U.S. foreign policy interest in infectious diseases suggest, however, that the federal government as a whole did not take the direct threat of infectious diseases, such as HIV/AIDS in sub-Saharan Africa, seriously. Even as a humanitarian concern, U.S. overseas

60. *Waking Up to Devastation*, *supra* note 56.

61. *Id.*

62. *See* fig.1, *supra* note 17.

63. *Id.*

64. *Id.*

65. *See, e.g.*, NAT'L SCIENCE & TECH. COUNCIL COMM. ON INT'L SCIENCE, ENGINEERING, & TECH. WORKING GROUP ON EMERGING & RE-EMERGING INFECTIOUS DISEASES, INFECTIOUS DISEASES—A GLOBAL HEALTH THREAT (1995).

66. Al Gore, Address before the National Council for International Health (June 12, 1996).

67. NAT'L INTELLIGENCE COUNCIL, THE GLOBAL INFECTIOUS DISEASE THREAT AND ITS IMPLICATIONS FOR THE UNITED STATES (2000), at <http://www.cia.gov/cia/publications/nic/report/nie99-17d.html> (last visited Dec. 12, 2002).

68. *Id.*

HIV/AIDS spending stagnated as the pandemic exploded.⁶⁹

U.S. assistance for foreign HIV/AIDS efforts began to increase again in the year 2000 and has been increasing since. USAID reported that, in 2002, the HIV/AIDS budget was \$510 million, "almost a 400 percent increase since 1999."⁷⁰ This increase came, however, reactively; in the 2000-2002 period, the scale of the HIV/AIDS crisis, particularly in sub-Saharan Africa, became a shocking global embarrassment.⁷¹ The increase in funding, especially in the last years of the Clinton administration, also has to be compared against the Clinton administration's efforts to prevent developing countries, including those in sub-Saharan Africa, from increasing their access to effective antiretroviral treatments under patent to U.S. and other Western pharmaceutical companies.⁷² Rather than ramp up U.S. foreign policy efforts on HIV/AIDS in sub-Saharan Africa, the Clinton administration backed pharmaceutical companies and their patent rights in the face of a calamity in sub-Saharan Africa of almost biblical proportions. Thus, neither the "direct threat" framework nor the humanitarian approach to infectious diseases mattered much in the foreign policy of the Clinton administration.

4. HIV/AIDS as a Foreign Policy Issue under the Bush Administration

The rhetoric from the second Bush administration in its first two years of office has again sounded the theme of U.S. leadership on the global HIV/AIDS pandemic.⁷³ In a Fact Sheet released in July 2002, the U.S. State Department outlined U.S. government support for the global fight against HIV/AIDS. This support includes a fiscal year 2003 budget request of \$1.117 billion for U.S. international spending to combat HIV/AIDS.⁷⁴ This request represents a 13.1%

69. See *supra* text accompanying note 61 for figures on stagnate U.S. aid for HIV/AIDS from 1994 through 1998.

70. The U.S. AGENCY FOR INT'L DEV., *supra* note 40.

71. See *supra* tbls. 1-3 in text for statistics on the scale of the HIV/AIDS pandemic.

72. See, e.g., Caroline Thomas, *Trade Policy, the Politics of Access to Drugs and Global Governance for Health*, in HEALTH IMPACTS OF GLOBALIZATION: TOWARDS GLOBAL GOVERNANCE 177,182-185 (K. Lee ed., 2003) (analyzing the use of U.S. power against countries seeking greater access to antiretroviral drugs).

73. Paula J. Dobriansky, Under Secretary of State for Global Affairs, *The Global Fight Against HIV/AIDS, Tuberculosis, and Malaria*, Statement Before the Senate Foreign Relations Committee, Feb. 13, 2002, at <http://www.state.gov/g/rls/rm/2002/8025.htm> (last visited Sept. 10, 2002) ("I want to underscore this Administration's commitment to this battle. Under the leadership of President Bush, the U.S. Government continues to be the global leader in the fight against HIV/AIDS.").

74. U.S. DEPT. OF STATE, FACT SHEET: UNITED STATES GOVERNMENT SUPPORT FOR THE FIGHT AGAINST HIV/AIDS (July 5, 2002), at <http://www.state.gov/r/pa/prs/ps/2002/11731.htm> (last visited Sept. 10, 2002). The Global AIDS Alliance criticizes how the Bush administration calculates its support for global HIV/AIDS efforts, arguing that the White House exaggerates the U.S. contribution by including sums spent on research rather than listing only money to be spent for on-the-ground delivery of services. GLOBAL AIDS ALLIANCE, PRESIDENT GEORGE W. BUSH'S EMERGENCY PLAN FOR AIDS RELIEF IN SUB-SAHARAN AFRICA AND THE CARIBBEAN: AN

increase over spending in fiscal year 2002 (\$988 million) and a 53.9% increase from fiscal year 2001 (\$726 million).⁷⁵ The budget request includes U.S. pledges to the Global Fund, bilateral international HIV/AIDS assistance, and President Bush's \$500 million International Mother and Child HIV Prevention Initiative, announced in July 2002, "that seeks to prevent the transmission of HIV/AIDS from mothers to infants and improve health care delivery in Africa and the Caribbean."⁷⁶

There is further evidence that the Bush administration places a higher foreign policy priority on HIV/AIDS globally. First, the United States agreed to adopt a declaration on public health and intellectual property rights at the Doha Ministerial Meeting of the World Trade Organization (WTO) in November 2001 in which WTO member states gave public health priority over patent rights.⁷⁷ Second, the facts sheets, information, and speeches distributed by the U.S. State Department accept the dire global HIV/AIDS situation and use blunt words to describe the problem facing the world.⁷⁸ Although such rhetoric does not persuade many critics that the United States is taking a leadership role in the HIV/AIDS debacle in sub-Saharan Africa, the rhetoric is at least an indication that the U.S. government acknowledges a catastrophe has unfolded that will strain humanity's ingenuity and resources to contain and reverse.⁷⁹ Third, the Bush administration's national security strategy, released in September 2002, included frequent references to HIV/AIDS.⁸⁰ Fourth, in December 2002, the

ANALYSIS BY THE GLOBAL AIDS ALLIANCE 4 (2003). The Global AIDS Alliance argues that U.S. spending on global HIV/AIDS efforts (excluding research) during the Bush administration have been \$565 million for fiscal year 2001 (compared to the Bush administration's claim of \$726 million), \$826 million for fiscal year 2002 (compared to the Bush administration's claim of \$988 million), and \$1.086 billion for fiscal year 2003 (compared to the Bush administration's claim of \$1.117 billion). *Id.* at 5. Even after adjusting for research, the numbers indicate that the Bush administration's proposed fiscal 2003 budget for global HIV/AIDS efforts was nearly double the amount spent in fiscal year 2001.

75. *Id.*

76. U.S. DEPT. OF STATE, FACT SHEET: UNITED STATES GOVERNMENT SUPPORT FOR THE FIGHT AGAINST HIV/AIDS, *supra* note 74.

77. WORLD TRADE ORG., DECLARATION ON THE TRIPS AGREEMENT AND PUBLIC HEALTH (2001), at http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm (last visited Sept. 10, 2002).

78. *See, e.g.*, U.S. Secretary of State Colin Powell, The Role of Public-Private Partnerships in the Global Fight Against HIV/AIDS, Remarks at the Open Forum Conference (June 24, 2002), at <http://www.state.gov/secretary/rm/2002/11384.htm> (last visited Sept. 10, 2002).

79. *See* Feachem, *supra* note 7, at B03 (quoting Secretary of State Colin Powell as calling HIV/AIDS "a catastrophe worse than terrorism" and stating that "[o]ne threat that troubles me perhaps more than any other does not come out of the barrel of a gun, it is not an army on the march, it is not an ideology on a march. It's called HIV/AIDS").

80. THE NATIONAL SECURITY STRATEGY OF THE UNITED STATES vi (Sept. 2002) ("We will also continue to lead the world in efforts to reduce the terrible toll of HIV/AIDS and other infectious diseases"); *id.* at 19 ("We will ensure that the WTO intellectual property rules are flexible enough to allow developing nations to gain access to critical medicines for extraordinary dangers like HIV/AIDS, tuberculosis, and malaria."); *id.* at 22 (noting funding increases to poor countries for HIV/AIDS); *id.* at 23 (stating that growth and development in countries afflicted by HIV/AIDS and

Bush administration announced that the United States would permit African and other developing countries "to override patents on drugs produced outside their countries to fight HIV/AIDS, malaria, tuberculosis, and other infectious epidemics, including those that may arise in the future."⁸¹

Bush administration policy on the global HIV/AIDS problem dramatically changed in January 2003 when President Bush announced his proposal for an Emergency Plan for AIDS Relief (Emergency Plan) in his State of the Union Address.⁸² Bush asked Congress to support his proposal to spend \$15 billion—\$10 billion of which would be new money—for a five-year effort on HIV/AIDS prevention, treatment, and care in nations in Africa and the Caribbean that are badly affected by HIV/AIDS.⁸³ The Emergency Plan would virtually triple U.S. financial support for international HIV/AIDS assistance.⁸⁴ President Bush claimed the Emergency Plan would provide antiretroviral treatment for two million HIV-infected persons, prevent seven million new infections, and provide care and support for ten million HIV-infected individuals and AIDS orphans⁸⁵ primarily in fourteen countries in Africa and the Caribbean.⁸⁶ The Bush administration claimed that the Emergency Plan "will be the first global effort to provide advanced antiretroviral treatment on a large scale in the poorest, most afflicted countries."⁸⁷ To implement the Emergency Plan, the Bush administration plans to create an ambassador-level Special Coordinator for International HIV/AIDS Assistance, who will report directly to the Secretary of State.⁸⁸

U.S. politicians, world leaders, and AIDS experts and activists generally hailed the announcement of the Emergency Plan.⁸⁹ Senator Bill Frist stated his

other epidemics is threatened and that the United States strongly backed the new global fund for HIV/AIDS); *id.* at 27 (noting that the spread of HIV/AIDS is on the U.S.-China foreign policy agenda).

81. THE WHITE HOUSE, FACT SHEET: THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF, (Jan. 29, 2003), at <http://www.state.gov/p/af/rls/fs/17033pf.htm> (last visited Jan. 30, 2003).

82. George W. Bush, State of the Union Address (Jan. 28, 2003), at <http://www.whitehouse.gov/news/releases/2003/01/20030128-19.html> (last visited Feb. 3, 2003).

83. *Id.*

84. THE WHITE HOUSE, *supra* note 81.

85. *Id.*

86. *Id.* (listing Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia as the target countries for the Emergency Plan).

87. *Id.*

88. *Id.*

89. U.S. DEP'T OF HEALTH & HUMAN SERV., WORLD LEADERS APPLAUD PRESIDENT BUSH'S ANNOUNCEMENT OF UNPRECEDENTED FUNDING TO FIGHT HIV/AIDS, at <http://www.globalhealth.gov/5years.shtml> (last visited Feb. 3, 2003); Charlotte Denny, *US Trebles AIDS Spending in Africa*, THE GUARDIAN, Jan. 30, 2003 (noting AIDS campaigners praise for the Emergency Plan), at <http://www.guardian.co.uk/Print/0%2C3858%2C4594380%2C00.html> (last visited Feb. 3, 2003); Stephen Mbogo, *Praise for President's New Africa AIDS Funding Pledge*,

belief that the Emergency Plan will, in ten years, be considered the most important part of Bush's speech.⁹⁰ Stephen Lewis, United Nations special envoy on HIV/AIDS in Africa, asserted that the Emergency Plan is "the first dramatic signal from the U.S. administration that it is now ready to confront the pandemic and to save or prolong millions of lives. . . . It transforms the response; it opens the floodgates of hope."⁹¹ Jeffrey Sachs, special advisor to the United Nations Secretary-General, described the Emergency Plan as "an enormous breakthrough [because] [i]t's the first time in the history of this pandemic that we are seeing a commitment for anything on the scale that is necessary."⁹² Rock star and AIDS activist Bono declared that "[f]or AIDS to be a priority in the State of the Union is a piece of history, for the President to lead the world on educating on the global AIDS crisis is true historic leadership."⁹³ The Global AIDS Alliance responded by asserting that "[t]his announcement marks a watershed moment in the global response to the AIDS pandemic."⁹⁴ With the Emergency Plan, the Bush administration's claim that fighting the HIV/AIDS pandemic is a foreign-policy priority for the United States⁹⁵ has become more credible.⁹⁶

5. Hard Questions Remain

This cursory overview of U.S. foreign policy on HIV/AIDS since the 1980s does not answer some of the hardest questions about the HIV/AIDS catastrophe in sub-Saharan Africa. Perhaps the most chilling question asks how countries, such as the United States, allowed this human tragedy to occur despite having

CNSNEWS.COM, Jan. 29, 2003 (citing praise from African AIDS experts), at <http://www.cnsnews.com/ForeignBureaus/archive/200301/FOR20030129j.html> (last visited Feb. 3, 2003).

90. *Caution to the Winds*, THE ECONOMIST, Feb. 1, 2003, at 27 (reporting the thoughts of Senator Frist).

91. Laurie Garrett & Samson Mulugeta, *AIDS Plan Offers Hope—But Some Activists Worry Global Funds May Not Reach Victims*, NEWSDAY, Jan. 30, 2003, available at <http://www.newsday.com/news/health/ny-woaids303109187jan30.01.1801554.story?coll=ny%2Dhealth%2Dheadlines> (last visited Feb. 3, 2003).

92. Ron Kampeas, *Unlikely Allies Sway Bush on AIDS Relief*, SEATTLETIMES.COM, Jan. 30, 2003, available at http://seattletimes.nwsourc.com/text/134624685_aids300.html (last visited Feb. 3, 2003).

93. DEBT, AIDS, TRADE IN AFRICA, DATA'S REACTION TO PRESIDENT BUSH'S EMERGENCY PLAN FOR AIDS RELIEF, at http://www.datadata.org/press_sotu_response.htm (last visited Feb. 2003).

94. GLOBAL AIDS ALLIANCE, *supra* note 74, at 2.

95. THE WHITE HOUSE, *supra* note 81 ("President Bush has made fighting the HIV/AIDS pandemic a priority of U.S. foreign policy.").

96. Dana Wilkie, *Many Surprised when Bush Urged Fight on AIDS in Africa*, SAN DIEGO UNION TRIB., Jan. 30, 2003 (quoting Cesar Portillo of AIDS Healthcare Foundation arguing that, despite HIV/AIDS being perceived as the domain of the Democratic Party, the Bush administration has "responded with much more energy and effectiveness on global AIDS than their predecessors ever did"), at http://www.signonsandiego.com/news/uniontrib/thu/news/news_1n30aids.html (last visited Feb. 3, 2003).

anticipated that a tragedy would happen and watching it occur without a serious foreign policy response. The elevation of HIV/AIDS as a foreign policy issue in the United States only came *after* the scale of the disaster could no longer be ignored. To return to Peter Piot's quote at the beginning of this article, what explains why the United States and the rest of the developed world stood by and watched HIV/AIDS overwhelm sub-Saharan Africa?

III. RACIDEMIC: HIV/AIDS, RACISM, AND U.S. FOREIGN POLICY

A. Racism and the HIV/AIDS Crisis in Sub-Saharan Africa

The depressing statistics reviewed in Part II on the scale and impact of HIV/AIDS, demonstrate that this great plague disproportionately affects the black peoples of Africa. The racial profile of this pandemic has led experts and NGOs active on HIV/AIDS issues to accuse the United States and other affluent, predominantly white countries of racism in their policies toward this African crisis.⁹⁷

These accusations target past and present racism as being at the heart of the HIV/AIDS epidemic in Africa. Past racist policies and practices, from slavery to colonialism, created a socio-economic environment in which HIV/AIDS has flourished. The link between poverty and HIV/AIDS is well-established in HIV/AIDS epidemiology.⁹⁸ The confluence of the poverty in sub-Saharan Africa and the emergence of a deadly virus spread through common human behaviors only reinforces that "poverty is the faithful squire of pestilence."⁹⁹ The lingering effects of past racism is perhaps seen most disturbingly in South Africa, where the current democratic government struggles to overcome the deep structural inequalities created and perpetuated by the apartheid regime. Salih Booker and William Minter have argued that "[t]he global pattern of AIDS deaths . . . also evokes the racial order of old South Africa. . . . AIDS thus points to more fundamental global inequalities than those involving a single disease, illuminating centuries-old patterns of injustice. Indeed, today's international political economy . . . should be described as 'global apartheid.'"¹⁰⁰

The discourse about racism's role in the HIV/AIDS epidemic does not end with bitter words about the continuing grip of the prejudiced hand of old racism. Critics of U.S. foreign policy on HIV/AIDS argue that racism has animated

97. See *infra* notes 101 and 117 and accompanying text.

98. UNAIDS, HIV/AIDS, HUMAN RESOURCES, AND SUSTAINABLE DEVELOPMENT 5 (2002) (noting that the HIV/AIDS epidemic "flourishes especially among people and communities deprived of the elementary benefits of successful development (public social services such as education and health care, secure employment, shelter, and social safety nets essential for sustaining livelihoods)").

99. David P. Fidler, *Return of the Fourth Horseman: Emerging Infectious Diseases and International Law*, 81 MINN. L. REV. 771, 809 (1997).

100. Salih Booker & William Minter, *Global Apartheid*, THE NATION, July 9, 2001, available at <http://www.thenation.com> (last visited Feb. 27, 2003).

approaches to this African problem. One accusation from a coalition of NGOs captures the essence of this position: "The rich countries of the North have the technology and resources to prevent millions of unnecessary AIDS-related deaths in the South. Why don't they? We charge that their failure to respond is a function of racism."¹⁰¹ Similarly, Salih Booker of Africa Action has argued that "[i]t is the devaluation of black lives that has enabled the Western world to turn its eyes away from this global health crisis."¹⁰²

B. The Concept of a "Racidemic"

Arguments that racism affects U.S. foreign policy on HIV/AIDS in Africa raise the profile of racism as an explanatory factor in the progress of this plague. Public health experts understand that disease epidemics are complex phenomena, involving microbial, environmental, economic, social, and political factors that often combine in bewildering complexity.¹⁰³ The devastation wrought by HIV/AIDS around the world stems, in part, from the nature of the virus in question—a new retrovirus for which human populations have no genetic or immunological defenses.¹⁰⁴ This microbial novelty combined with older epidemiological patterns in which human behavior and socio-economic conditions aid the spread and penetration of a disease through populations. Attributing a disease epidemic to one factor, such as racism, threatens to oversimplify a very complex epidemiological reality.

Such cautionary words about the causal forces of disease epidemics would ring with more authority in the HIV/AIDS context if the racial impact of the epidemic were more balanced. The shocking statistics reviewed above confront all concerned with a brutal reality that demands explanation. Arguments that racism influences the foreign policies of the United States and other Western nations toward the HIV/AIDS epidemic in Africa essentially assert that this epidemic is a *racidemic*, a disease epidemic driven by the ugly dynamics of racism.

I coin the term "racidemic" to focus more analytical attention on the charges of racism made in the context of HIV/AIDS in sub-Saharan Africa. The accusations of racism make good political rhetoric, especially given the racial

101. TREATMENT ACTION CAMPAIGN, AFRICA ACTION, PHYSICIANS FOR HUMAN RIGHTS, STUDENT GLOBAL AIDS CAMPAIGN, AND OXFAM GB, RACISM AND AIDS (on file with author) [hereinafter RACISM AND AIDS].

102. SALIH BOOKER, FOREIGN POLICY IN FOCUS, MAKING A STATEMENT IN DURBAN, (2001), at http://www.foreignpolicy-infocus.org/commentary/0108durban_body.html (last visited Aug. 28, 2002).

103. INST. OF MED., EMERGING INFECTIONS: MICROBIAL THREATS TO HEALTH IN THE UNITED STATES 34-112 (1992) (discussing the many factors that influence the emergence of infectious diseases).

104. ROBERT GALLO, VIRUS HUNTING: AIDS, CANCER & THE HUMAN RETROVIRUS—A STORY OF SCIENTIFIC DISCOVERY 237-59 (1991) (describing how the human immunodeficiency virus works).

profile of the HIV/AIDS pandemic; but such criticisms are not made simply to score rhetorical points in the debating clubs of globalization. These accusations against the United States and other predominantly wealthy, white countries elevate the explanatory power of racism in connection with the African HIV/AIDS problem. In this section, I explore the concept of a "racidemic" analytically and then, in the following section, apply the analytical concept of a racidemic to the HIV/AIDS catastrophe in sub-Saharan Africa.

I define a "racidemic" as a disease epidemic in which racism plays an important causal role in the spread and perpetuation of the disease. Racidemics may involve either infectious or non-communicable diseases, but my focus in this paper is on an infectious agent and disease, HIV/AIDS. Theoretically, "public health" is about the protection and promotion of population health, as opposed to focusing on the health of the individual.¹⁰⁵ Public health is a classical "public good," meaning that the primary responsibility for protecting and promoting population health falls on the government because the incentives and resources of private actors (e.g., individuals, corporations, and civic groups) are insufficient.¹⁰⁶ Preventing and controlling disease epidemics is the *raison d'être* of public health.¹⁰⁷ The racidemic concept means, therefore, that public not private racism is a central causal factor in an epidemic's spread and continuation.

The racidemic concept does not hold that racism is the only cause behind a disease epidemic because epidemics are complex phenomena involving many causal factors. Making an analogy to tort law, the racidemic concept posits that racism is a proximate cause of an epidemic's dynamics. In other words, the demographic and geographic profiles of the HIV/AIDS pandemic would not look the way they do *but for* the presence of racism on the part of Western governments. An analogy to slavery might help clarify the causal role of racism in connection with Africa's HIV/AIDS problem. Racism is not central to slavery as a concept because slavery can occur, and has occurred, between peoples of the same race (e.g., slavery among ancient Greek city states). Understanding slavery as practiced in the United States requires, however, comprehending the role of racism—the dehumanization of Africans on the basis of their race—in the dynamics of American slavery. Without racism, slavery in the United States would not have existed or exhibited the characteristics it did.

The HIV/AIDS epidemic would have reached Africa whether or not racism played a role in the epidemic's dynamics. The nature of microbial traffic is such

105. INST. OF MED., *THE FUTURE OF PUBLIC HEALTH* 40 (1988) (defining public health as "the fulfillment of society's interest in assuring the conditions in which people can be healthy"). See also Lawrence O. Gostin, *Public Health Law: A Renaissance*, 30 J. L. MED. & ETHICS 136, 136 (2002) (noting that public health focuses on "the health and safety of populations rather than the health of individual patients").

106. INST. OF MED., *supra* note 105, at 7 (noting the government's primary role in protecting and promoting public health).

107. ROSEN, *supra* note 3, at 1 (noting that the control of transmissible disease has been one of the major health problems humans have faced in organizing their community life).

that many pathogenic microbes spread around the world through trade and travel.¹⁰⁸ HIV/AIDS emerged on the cusp of a new era of globalization in commerce, travel, and cultural interaction; so the virus would have spread globally, including through Africa, with or without racism. Although not the case with HIV/AIDS, the racademic concept includes disease epidemics deliberately introduced into populations on the basis of racism. Such racial bio-warfare occurred in the eighteenth century when British troops attempted to spread smallpox in native Indian populations through contaminated blankets.¹⁰⁹ More ominously, experts have raised the specter of "genetic warfare," in which states or terrorist groups could develop biological weapons targeted to affect a particular race's unique genetic make-up.¹¹⁰

The racademic concept does not cover epidemics involving race in at least two circumstances. First, some diseases (e.g., sickle cell anemia) affect only certain racial groups because of those groups' genetic profile.¹¹¹ Second, a racial group may suffer disproportionately from a disease that affects all races because the group has never experienced the disease before and is therefore immunologically vulnerable. Perhaps the best example of this phenomenon is the devastation European diseases, such as measles and smallpox, wrought on immunologically innocent populations in the Americas during the initial European forays into the New World.¹¹² Although these European conquests certainly involved racism, the racism had nothing to do with the disease epidemics as the European invaders were ignorant about the nature of infectious diseases and their spread.

As with racism generally, the racism animating a racademic can be direct or indirect. Direct racism would mean that government public health and other policies directly discriminate on the basis of race by intentionally treating one racial group less favorably than another. Such direct public health racism could take a number of forms, including (1) racial bio-warfare; (2) creation and/or maintenance of health-threatening conditions on the basis of race (e.g., deliberate failure to provide clean water supplies to certain racial groups); and

108. Stephen S. Morse, *Factors in the Emergence of Infectious Diseases*, in *PLAGUES AND POLITICS*, *supra* note 54, at 18-19 (discussing the role of international travel and commerce in the spread of infectious diseases).

109. George W. Christopher et al., *Biological Warfare: A Historical Perspective*, 278 *JAMA* 412 (1997) (describing British effort during the French and Indian War (1754-1767) to spread smallpox to Native American tribes hostile to the British).

110. BRITISH MED. ASSOC., *BIOTECHNOLOGY, WEAPONS, AND HUMANITY* 53-67 (1999) (analyzing the potential for the development of genetic weapons).

111. MEDLINE PLUS HEALTH INFORMATION, *SICKLE CELL ANEMIA*, at <http://www.nlm.nih.gov/medlineplus/ency/article/000527.htm#causesAndRisk> (last visited September 11, 2002) ("Sickle Cell Disease is much more common in certain ethnic groups[,] affecting approximately one out of every 500 African Americans.").

112. CROSBY, *supra* note 4, at 37 (noting that infectious disease "killers came to the New World with the explorers and conquistadors. The fatal diseases of the Old World killed more effectively in the New, and the comparatively benign diseases of the Old World turned killer in the New.").

(3) intentional denial to provide all racial groups with equal health services.

Indirect racism would involve government public health programs and other policies under which diseases disproportionately affect certain racial groups. Such disparate public health impact would not be the objective but the result of government policy, making it difficult to argue that the government intended to create the disproportionate racial impact. Under the racademic concept, critics of U.S. foreign policy on HIV/AIDS in Africa do not have to prove that the United States intends to discriminate against black Africans. The accusations of racism may be based on the effect of U.S. policies and practices on black Africans as a racial group. Disparate racial impact exists when a disease epidemic disproportionately affects one racial group's morbidity and mortality compared to one or more other racial groups. Governmental failure to address such disparities in the impact of a public health crisis constitutes indirect racism and becomes a proximate cause for the epidemic's spread and perpetuation.

C. HIV/AIDS as a Racademic

Accusations that the nature of the HIV/AIDS epidemic in Africa reflect racism involve arguments that both direct and indirect racism are proximate causes. As with racism generally, the most powerful claims fall under the heading of indirect racism because it is difficult, if not impossible, to find evidence that a government deliberately designed its HIV/AIDS foreign policy to discriminate against black Africans. For this reason, my analysis will focus on the arguments that indirect racism drives the HIV/AIDS epidemic in sub-Saharan Africa.

The claim that HIV/AIDS is a global racademic combines two arguments: (1) statistics demonstrate that the HIV/AIDS pandemic has a disproportionate impact on black Africans; and (2) governments of predominantly white countries with the technology and resources to help address this disparate racial impact of HIV/AIDS have not responded sufficiently. More sharply, the lingering effects of past direct racism against Africa, especially poverty, join forces with the current indirect racism to create the racademic of HIV/AIDS. Statistics cited in Table 3 above may reveal, for example, the residual public health effects of the apartheid regime in South Africa because countries directly affected by this regime (South Africa and the neighboring Lesotho, Swaziland, Namibia, Botswana, and Zimbabwe) have some of the highest adult HIV-infection rates in the world.¹¹³

Although controversies exist about the estimates of HIV/AIDS cases in Africa,¹¹⁴ very few people doubt that HIV/AIDS is devastating countries in sub-

113. See tbl.3, *supra* note 33.

114. See, e.g., RICHARD C. CHIRIMUUTA & ROSALIND J. CHIRIMUUTA, *AIDS, AFRICA, AND RACISM* (1989) (challenging the image of Africa as the origin of the HIV/AIDS epidemic and Western images of the African continent as devastated by HIV/AIDS).

Saharan Africa and that black Africans have, to date, disproportionately felt the fury of this plague.¹¹⁵ More disagreement exists about the adequacy of the United States' and other countries' responses to this public health nightmare in Africa. Defenders of the United States might argue that many actions by the U.S. government demonstrate its concern for the plight of Africans in connection with HIV/AIDS, including U.S. leadership in funding HIV/AIDS programs and declaring HIV/AIDS in sub-Saharan Africa a matter of international peace and security.¹¹⁶ The case that the *racidemic* thesis illuminates U.S. foreign policy on HIV/AIDS is, however, powerful.

As noted above, during the Reagan and first Bush administrations, the U.S. government generated estimates of the likely scale of the global HIV/AIDS epidemic that proved accurate. These intelligence estimates did little, if anything, to shape U.S. foreign policy on HIV/AIDS as the dire predictions came true in the course of the 1990s. HIV/AIDS only became an important foreign policy issue under the Clinton administration and the second Bush administration *after* the full scale and horror of this plague's impact on Africa and other developing countries became widely known. By this time, the calculated indifference of the United States and other rich, predominantly white nations helped fuel a public health disaster in Africa of historic proportions.

More importantly, the concern the United States developed under the Clinton administration for HIV/AIDS as a foreign policy issue proved hypocritical, at best, and cynical, at worst. The Clinton administration declared that HIV/AIDS in sub-Saharan Africa constituted a national security concern for the United States.¹¹⁷ This administration proceeded, however, to oppose the efforts of governments in Africa, principally South Africa, and other parts of the developing world to make antiretroviral treatments more accessible through compulsory licensing and parallel importing.¹¹⁸ The Clinton administration

115. *See supra* statistics cited in tbls.2-3 accompanying notes 20 & 33.

116. *See supra* analysis in Section II.C.

117. *See* ANDREW T. PRICE-SMITH, *THE HEALTH OF NATIONS: INFECTIOUS DISEASE, ENVIRONMENTAL CHANGE, AND THEIR EFFECTS ON NATIONAL SECURITY AND DEVELOPMENT* 124-26 (2002) (reviewing Clinton administration policies that infectious diseases, including HIV/AIDS, constituted national security threats to the United States).

118. *See, e.g.*, James Love, Director of the Consumer Project on Technology, Statement before the House of Representatives Subcommittee on Criminal Justice, Human Resources, and Drug Policy (July 22, 1999), *reprinted in* DAVID P. FIDLER, *INTERNATIONAL LAW AND PUBLIC HEALTH: MATERIALS ON AND ANALYSIS OF GLOBAL HEALTH JURISPRUDENCE* 262-63 (2000). Love argues:

[i]n the face of this human tragedy [i.e., the global HIV/AIDS crisis], the US government is carrying out a global battle to keep drug prices high. The US government has organized a cross-agency team that is largely directed by the global pharmaceutical industry to monitor and influence legislation in virtually every country on earth. The scope of this campaign is enormous. The US government insists on having the opportunity to review and comment on regulations or legislation involving the pharmaceutical industry by any foreign government. As part of this campaign, the US government actively opposes the use of compulsory licensing and parallel imports, two important mechanisms that countries use to obtain less expensive drugs.

fought African and other developing countries very hard over access to antiretroviral therapies under patent to U.S. and Western pharmaceutical companies.¹¹⁹ The actions by the Clinton administration, in the context of access to antiretrovirals, demonstrated that its rhetoric about HIV/AIDS in Africa as a national security threat was empty. In addition, the Clinton administration did not significantly increase U.S. foreign assistance for HIV/AIDS from 1994 through 1999 when the pandemic was getting out of control. When the United States truly believes that it faces a national security threat, it can find enormous sums to address the threat.¹²⁰

The racademic thesis can also be applied to the development of HIV/AIDS policy under the second Bush administration. Critics of racism in U.S. foreign policy on HIV/AIDS excoriated the Bush administration after the head of USAID made remarks in June 2001 that revealed, at best, a lack of diplomatic sensitivity for the HIV/AIDS problem in sub-Saharan Africa.¹²¹ AIDS activists have almost universally criticized the Bush administration's contributions to the Global Fund as inadequate.¹²² The Bush administration completed the U.S. retreat on access to antiretrovirals at the World Trade Organization ministerial meeting in Doha, Qatar in November 2001; but this climb down perhaps owed

Id.

119. Ellen 't Hoen, *TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha*, 3 CHI. J. INT'L L. 27, 30 (2002) (noting how the "US had put pressure on South Africa by withholding trade benefits and threatening further trade sanctions" to force the South African government to repeal legislation allowing compulsory licensing and parallel importing).

120. See *supra* analysis in Section IV.C.

121. John Donnelly, *Prevention Urged in AIDS Fight: Natsios Says Fund Should Spend Less on HIV Treatment*, BOSTON GLOBE, June 7, 2001, at A8. USAID Director Andrew Natsios commented:

[many Africans] don't know what Western time is. You have to take these (AIDS) drugs a certain number of hours each day, or they don't work. Many people in Africa have never seen a clock or a watch their entire lives. And if you say, one o'clock in the afternoon, they do not know what you are talking about. They know morning, they know noon, they know evening, they know the darkness at night.

Id.

These remarks brought swift and furious condemnation from HIV/AIDS activists and experts. See, e.g., John Donnelly, *Natsios Called Racist; Firing Sought*, BOSTON GLOBE, June 9, 2001, at A11; *NGOs Council Accuses USAID Head of Racism*, PANAFRICAN NEWS AGENCY DAILY NEWSWIRE, June 13, 2001; and Amir Attaran et al., *Dead Wrong on AIDS*, WASH. POST, June 15, 2001, at A33.

122. See, e.g., HEALTH GLOBAL ACCESS PROJECT, GLOBAL AIDS CATASTROPHE MUST BE A HIGH PRIORITY (accusing the Bush administration of starving the Global Fund of financial resources), at <http://www.globaltreatmentaccess.org> (last visited Sept. 11, 2002); MEDÉCINS SANS FRONTIÈRES, G8 ONE HUNDRED PERCENT TALK, FIVE PERCENT FINANCE ("The UN estimates that for AIDS alone there is need for US\$10 Billion dollars annually. For 2002 the G8 have allocated a mere US\$580 million dollars. That's a shortfall of almost 96%.") at <http://www.accessmed-msf.org> (last visited Sept. 11, 2002); INT'L COUNCIL OF AIDS SERV. ORG., GLOBAL FUND UPDATE: INFORMATION ON THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA FOR NGOS AND CIVIL SOCIETY 10-11 (June 2002) (criticizing level of existing financial commitments to the Global Fund and arguing that the U.S. contribution should be around \$3.5 billion).

more to the U.S. response to the anthrax attacks¹²³ and need for assistance in its war on terrorism in the aftermath of the events of September 11th.¹²⁴ Experts connect proposed increases in U.S. foreign aid after September 11th with the need for foreign support for the war on terrorism rather than any change of heart about the need for significant flows of foreign aid from the United States.¹²⁵ Although referenced in its national security strategy, the idea that HIV/AIDS in sub-Saharan Africa is a national security threat to the United States has not been prominent on the foreign policy agenda in the wake of September 11th and the subsequent anthrax attacks on the United States.¹²⁶

The place of HIV/AIDS on the U.S. foreign policy agenda in the Bush administration sometimes approached the surreal, as when the rock singer and AIDS activist Bono accompanied former Treasury Secretary Paul O'Neill to Africa in an attempt to educate O'Neill about the African HIV/AIDS crisis.¹²⁷ In the wake of World AIDS Day on December 1, 2002, Stephen Mallaby argued that the Bush administration was "unengaged," "on the defensive," and lacking "a serious AIDS strategy."¹²⁸ Mallaby noted the Bush administration's pride in pledging \$500 million to the Global Fund but observed that "Britain, with an economy less than a sixth the size of America's, has pledged \$215 million," which makes Britain's pledge, in proportional terms, approximately three times more generous than the United States' contribution.¹²⁹

Whether the Bush administration's proposed Emergency Plan blunts the force of the racademic thesis remains an open question. With the domestic economy suffering, the federal budget deficit increasing, and an expensive war with Iraq looming, Congress may not fund the Bush administration's proposal at the level requested. Salih Booker, who has accused the U.S. government of racism on HIV/AIDS in Africa,¹³⁰ noted that "a previous \$5 billion announced

123. See David P. Fidler, *Bioterrorism, Public Health, and International Law*, 3 CHI. J. INT'L L. 7, 21-22 (2002) (discussing impact of anthrax attacks on patent issue at the WTO ministerial meeting at Doha).

124. Helene Cooper & Robert Winestock, *Tough Talkers: Poor Nations Win Gains in Global Trade Deal, as U.S. Compromises*, WALL ST. J., Nov. 15, 2001, at A1.

125. JESSICA T. MATHEWS, CARNEGIE ENDOWMENT FOR INTERNATIONAL PEACE, SEPTEMBER 11, ONE YEAR LATER: A WORLD OF CHANGE 9 (18th ed. 2002) (arguing that "the new U.S. interest in aid and development stems from the anti-terrorism connection").

126. *Id.* at 10 ("One final effect of 9/11 should not be overlooked. The new agenda of attacking terrorism around the world and building greater security at home is so consuming that it blots out other issues of major consequence.").

127. Adam Zagorin, *On the Road with Bono and O'Neill: On Their Tour of Africa, the Rock Star Hopes to Convince the Treasury Secretary of the Value of More U.S. Aid*, TIME.COM, May 28, 2002, at <http://www.time.com/time/world/article/0,8599,250323,00.html> (last visited Sept. 11, 2002).

128. Sebastian Mallaby, *An AIDS Policy that Would Add Up*, WASH. POST, Dec. 2, 2002, at A21.

129. *Id.*

130. See *supra* note 102 and accompanying text.

with fanfare [was] eventually buried in political wrangling between the White House and Capitol Hill."¹³¹ Booker also expressed skepticism about the Emergency Plan, arguing that "[i]n the past, the administration has used an Arthur Anderson form of accounting. They project money that will be spent way into the future while people are dying today."¹³²

Skeptics about the Bush administration's commitment to fighting the HIV/AIDS pandemic may also observe that the administration presented this effort at a time when the United States needs world support for the on-going war on terrorism, the pending military effort in Iraq, and its international trade agenda.¹³³ Even those inclined to give the Bush administration the benefit of the doubt would have to acknowledge that the Emergency Plan comes at a time when the HIV/AIDS pandemic has reached such a colossal scale that even fifteen billion dollars over five years seems insufficient if not sustained over time and supported by increased funding from other developed countries.¹³⁴ Experts have estimated that at least \$10 billion is needed *annually* to bring the HIV/AIDS pandemic in Africa and other parts of the developing world under control.¹³⁵ The five-year Emergency Plan represents a proposed level of U.S. funding of \$3 billion annually, leaving other developed nations to contribute around \$7 billion annually. The United Nations special envoy on HIV/AIDS in Africa, Stephen Lewis, argued that "[t]he international financial delinquency that has haunted the response to AIDS in Africa is hardly that of the United States alone; it extends, without exception, to all the wealthy donor nations."¹³⁶ Lewis voiced his hope that the Emergency Plan stimulates greater, desperately needed contributions from other developed countries.¹³⁷ The Global AIDS Alliance has also raised concerns about the Emergency Plan, including the continued inadequacy of the level of U.S. financial support for global efforts on

131. Garrett & Mulugeta, *supra* note 91. Médecins Sans Frontières likewise argued that "this and past US administrations have a history of renegeing on promises made to the international community related to increasing access to [HIV/AIDS] treatment". Press Release, Médecins Sans Frontières, MSF Welcomes President Bush's Commitment to Scale-Up Access to Affordable AIDS Treatment, But Warns US Against Breaking Promises, Taking a Unilateral Approach (Jan. 30, 2003), at <http://www.msf.org> (last visited Feb. 3, 2003).

132. Garrett & Mulugeta, *supra* note 91. Médecins Sans Frontières similarly expressed concern that the major funding proposed under the Emergency Plan would not begin until fiscal year 2004. Médecins Sans Frontières, *supra* note 131.

133. See, e.g., Wilkie, *supra* note 96 (reporting the view of some skeptics of the Emergency Plan that his global trade agenda motivated President Bush's proposal).

134. Danna Harman, *How Best to Spend the New AIDS Money*, CSMONITOR.COM, Jan. 31, 2003 (quoting Kenyan minister of social services, Najib Balala, as stating that "[f]ifteen billion might sound like a lot, but spread over the course of five years and across the continent, it's actually not much"), available at <http://www.csmonitor.com/2003/0131/p01s04-woaf.html> (last visited Feb. 3, 2003).

135. *Id.*

136. Garrett & Mulugeta, *supra* note 91.

137. Harman, *supra* note 134.

HIV/AIDS.¹³⁸

The racademic thesis explains U.S. government inaction and hypocrisy on HIV/AIDS in Africa over the course of the development of the pandemic as evidence of indirect racism. In addition to the NGO community, the racademic thesis has found support among public health leaders in international organizations on the front lines of the HIV/AIDS battle. Peter Piot, Executive Director of UNAIDS, told the World Conference on Racism in 2001 that "if the AIDS epidemic had centered on Europe, rather than Africa, and had affected predominantly white people, the response to it would have been faster and more generous."¹³⁹ Piot also singled out unequal access to antiretroviral therapies as one of the worst examples of global discrimination.¹⁴⁰ Piot essentially described the dynamics of the HIV/AIDS pandemic in racademic terms—at the heart of the spread and perpetuation of HIV/AIDS sits racism.

D. Implications of HIV/AIDS as a Racademic

Sub-Saharan Africa's relationship with the rest of the world began through the slave trade and colonialism in which whites in Europe and North America practiced blatant racism against the black peoples of the African continent. This

138. GLOBAL AIDS ALLIANCE, *supra* note 74, at 3-5. At the time of writing, other questions about the Emergency Plan remained outstanding, including whether the Plan would purchase generically produced antiretrovirals. Médecins Sans Frontières argued that:

[t]he price of AIDS medicines dropped below \$300 because of generic drug competition But, up until last week, the US was still leading a fight at the World Trade Organization to restrict countries from having the maximum flexibility to take advantage of international trade rules that allow them to produce and export the cheapest medicines possible. This is either a major shift in US policy on this issue, or sheer hypocrisy.

Médecins Sans Frontières, *supra* note 131.

139. BBC News, *Racism 'Helping Spread of AIDS,'* Sept. 5, 2001, at <http://news.bbc.co.uk/2/hi/africa/1527599.stm> (last visited Aug. 28, 2002); *see also* Straus, *supra* note 39 (quoting Piot arguing that "[i]f this would have happened in the Balkans, or Eastern Europe, or in Mexico, with white people, the reaction would be different"). A NGO coalition made the same point more dramatically:

Imagine if 4.5 million of Holland's 16 million people were sick with a treatable disease but medicines were too expensive to treat them. Imagine if 17 million Europeans had died in just 15 years of a treatable disease. There would be an outcry. Governments, the European Union, even NATO would step in to prevent unnecessary deaths. Money would pour in, medicines would be made available, research on a vaccine boosted. . . . In the rich world, HIV/AIDS is a manageable chronic disease. In Africa, AIDS carries a painful death sentence as the body wastes under opportunistic infections for which public hospitals lack medicines.

RACISM AND AIDS, *supra* note 101.

140. *Racism 'Helping Spread of AIDS,' supra* note 139. *See also* MÉDECINS SANS FRONTIÈRES, FROM DURBAN TO BARCELONA: OVERCOMING THE TREATMENT DEFICIT 3 (2002) (noting that the WHO "estimates that, in developing countries, only 230,000 people of the 6 million who are sick enough to need ARVs are receiving them. Half of them live in one country, Brazil. This leaves more than 5.7 million people in developing countries—96% of those in urgent need—without treatment").

racism depopulated and destabilized African societies in a manner which proved difficult, if not impossible, to overcome in later years. Many people believe that the legacy of this direct racism still haunts Africans today as evidenced by the weakness of their governments, the poverty of their economies, and the vulnerability of their societies.¹⁴¹ During decolonization, African countries began to expunge the racism through which their peoples had been dragged during the process of entering world politics. The end of the apartheid regime in South Africa in the early 1990s marked another, perhaps final, victory over direct racism in Africa.

The HIV/AIDS epidemic began to take firm hold in Africa almost simultaneously with this final defeat of overt white racism on the continent. Again Africa faces a continental-wide depopulation and destabilization because of racism—the racademic of HIV/AIDS. Locating historical precedents for a racademic of this magnitude and portents is impossible. Bubonic plague ravaged the European continent in the 14th century, radically affecting political, economic, and social structures for the decades, if not centuries, that followed. Racism played no role in this continent-shaking epidemic. European diseases decimated native American populations in the "age of discovery," helping pave the path for the European conquest of the New World and changing the fate of native inhabitants forever. Given the complete lack of European understanding of these diseases, these hemispheric-shaping epidemics were also not racidemics. For many, HIV/AIDS is a shameful racademic that will help determine the future of generations of Africans according to the dictates of indirect racism. Just as racism determined Africa's original place in world politics, the HIV/AIDS racademic will ensure that racism maintains its malevolent grip on Africa's future in the twenty-first century through HIV/AIDS destruction of African lives and hopes.

141. See, e.g., the emphasis placed on the legacy of slavery and colonialism at the World Conference on Racism in 2001; See Declaration of the World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance, Sept. 7, 2001, at <http://www.unhcr.ch/html/racism/Durban.htm> (last visited Sept. 10, 2002). The Declaration states:

Noting with concern the continued and violent occurrence of racism, racial discrimination, xenophobia and related intolerance, and that theories of superiority of certain races and cultures over others, promoted and practised during the colonial era, continue to be propounded in one form or another even today, Alarmed by the emergence and continued occurrence of racism, racial discrimination, xenophobia and related intolerance in their more subtle and contemporary forms and manifestations, as well as by other ideologies and practices based on racial or ethnic discrimination or superiority, Strongly rejecting any doctrine of racial superiority, along with theories which attempt to determine the existence of so-called distinct human races . . .

IV. ANARCHIDEMIC: HIV/AIDS, *REALPOLITIK*, AND U.S. FOREIGN POLICY

A. Realism and the HIV/AIDS Crisis in Sub-Saharan Africa

The racademic thesis attempts to explain the indifferent behavior of the U.S. government in the face of a historic human calamity in sub-Saharan Africa. The thesis makes racism the key explanatory variable, the proximate cause of the nature of the spread and penetration of HIV/AIDS in Africa. Though powerful, the racademic thesis is not the only theoretical explanation of the behavior of the U.S. government toward HIV/AIDS in sub-Saharan Africa. In this part of the article, I explore a competing thesis that explains U.S. foreign policy behavior on HIV/AIDS in terms of the tenets of the international relations theory called "realism" or, as it is more colorfully known, *realpolitik*.¹⁴²

Realism has been and, in the opinion of many, remains the dominant theory for explaining the behavior of states in the international system.¹⁴³ Realism as a theory of international relations has taken a number of forms, from classical to structural realism.¹⁴⁴ Despite some diversity, realist thinking seeks to explain the effect of anarchy on the behavior of states in the international system.¹⁴⁵ Unlike politics within a sovereign state, international politics occur in anarchy—a political environment in which the actors recognize no common or superior authority. Realist theory posits that this anarchical environment imposes certain political dynamics on the dominant actors—states.¹⁴⁶ These dynamics revolve around competition for power, influence, and survival. In this anarchical, competitive context, states focus on their material capabilities, such as military and economic power, in their dealings with other states.¹⁴⁷ Competition involving material capabilities in an anarchical environment produces

142. The use of international relations theory in analyzing global health issues is unusual. As Lee & Zwi noted, "little attention has been devoted to health in the IR field, and even less to AIDS." Lee & Zwi, *supra* note 28, at 13.

143. For overviews on realism as a theory of international relations, see REALISM: RESTATEMENTS AND RENEWAL (B. Frankel ed., 1996); Timothy Dunne et al., *Realism, in THE GLOBALIZATION OF WORLD POLITICS: AN INTRODUCTION TO INTERNATIONAL RELATIONS* 141 (J. Baylis & S. Smith eds., 2001).

144. Dunne, *supra* note 143, at 147-49 (writing on the diversity within realist thought).

145. Benjamin Frankel, *Restating the Realist Case: An Introduction, in REALISM: RESTATEMENTS AND RENEWAL, supra* note 143, at ix, xv (noting that a central realist theoretical premise is that the world is anarchic); John J. Mearsheimer, *The False Promise of International Institutions*, 19 INT'L SECURITY 5, 10 (1994/95) (arguing that one of realism's core assumptions is that the international system is anarchic).

146. Dunne, *supra* note 143, at 150 (noting that "[f]or realists, the state is the main actor").

147. KENNETH WALTZ, *THEORY OF INTERNATIONAL POLITICS* 131 (1979) (listing "size of population and territory, resource endowment, economic capability, military strength, political stability, and competence" as important categories of material capabilities); Jeffrey W. Legro & Andrew Moravcsik, *Is Anybody Still a Realist?*, 24 INT'L SECURITY 5, 16 (1999) (arguing that one of realism's core assumptions is the primacy of material capabilities for states).

uncertainty and mistrust, which limit the ability of states to sustain cooperation on mutual interests.¹⁴⁸ The potential for conflict and violence is always present.¹⁴⁹ Realism is a grim, pessimistic theory about how international politics operate.¹⁵⁰

Under realism, the lodestar for a state's foreign policy is power defined in material terms.¹⁵¹ As Morgenthau famously put it, "statesmen think and act in terms of interest defined as power."¹⁵² The power calculus is two-fold: states look for opportunities to increase or extend their material power vis-à-vis rival states and for threats to their power, interests, and survival from other states. The most important element of material power in foreign policy is military power,¹⁵³ but states recognize the importance of economic power generally and specifically for their military capabilities.¹⁵⁴ Realism posits that these foreign policy dynamics exist because of the anarchical nature of international politics and apply equally to democracies and dictatorships. What happens in domestic politics and society does not, according to realism, act as an independent variable in explaining foreign policy and international politics.¹⁵⁵

In thinking about the relevance of realism to the HIV/AIDS problem in Africa, the reader may have already recalled the Clinton administration's declaration that HIV/AIDS in sub-Saharan Africa constituted a national security threat to the United States.¹⁵⁶ Although diplomacy on infectious diseases has a long history, the Clinton administration's attempt to elevate a foreign epidemic to the status of a national security problem was novel.¹⁵⁷ It was an effort to place a public health crisis—not typically a concern in *realpolitik* thinking—into

148. Mearsheimer, *supra* note 145, at 12 (arguing that, in the world of the realist, cooperation among states is limited and difficult).

149. *Id.* at 9 ("International relations is not a constant state of war, but it is a state of relentless security competition, with the possibility of war always in the background.").

150. *Id.* ("Realism paints a rather grim picture of world politics.").

151. Legro & Moravcsik, *supra* note 147, at 17 (arguing that realism holds that a state's influence in the international system "is proportional to its underlying power, defined as access to exogenously varying material resources").

152. HANS MORGENTHAU, *POLITICS AMONG NATIONS: THE STRUGGLE FOR POWER AND PEACE* 5 (5th ed. rev. 1978).

153. Dunne, *supra* note 143, at 144 (noting that "[p]ower is crucial to the realist lexicon and traditionally has been defined narrowly in military strategic terms").

154. WALTZ, *supra* note 147, at 131 (recognizing the importance of economic capabilities to state power).

155. Anne-Marie Slaughter, *International Law and International Relations*, 285 *RECUEIL DES COURS* 9, 34 (2000) (noting realism's conception of states as interchangeable, opaque, hard, and clearly defined billiard balls, an image that illustrates realism's lack of interest in domestic politics).

156. *See supra* Sections II.B & III.C.

157. David P. Fidler, *Public Health and National Security in the Global Age: Bioterrorism, Infectious Diseases, and Realpolitik*, *GEO. WASH. INT'L L. REV.* (forthcoming 2003) (arguing that the Clinton administration's position on the national security threat posed by infectious diseases was unique in U.S. foreign policy on infectious diseases).

the foreign-policy framework developed under the influence of realism. The reader should also recall that the Clinton administration's own behavior on HIV/AIDS in Africa did not support its labeling of this problem as a national security concern.

From a realist perspective, the indifference exhibited by the United States and other great powers in the international system toward the HIV/AIDS problem in sub-Saharan Africa is not difficult to explain or understand and has nothing to do with racism. Put bluntly, the HIV/AIDS crisis in sub-Saharan Africa poses no threat to the existence or exercise of U.S. economic and military power in the international system and is not, thus, a first-order priority for U.S. foreign policy. For realists, racism does not enter the calculus of statecraft because racial attitudes contribute nothing to the primary objectives of marshalling the state's material capabilities to deal with the dangers the anarchical system creates for all states. Realism holds that the United States and other great powers would only focus intently on the HIV/AIDS problem in sub-Saharan Africa if that region was of critical strategic, military, economic, or national security interest. The racademic thesis argues that the United States allows Africans to die from AIDS in the millions because of racism. Realism disagrees. The people dying from AIDS in sub-Saharan Africa do not get more great-power assistance because they live in countries and a region of marginal importance in international politics. Realists might agree that this perspective is heartless but not racist.

B. The Concept of an "Anarchidemic"

As a theory, realism explains parsimoniously how the foreign policies of the great powers could exhibit such indifference to HIV/AIDS in Africa and rejects the racademic thesis. Thus, realism provides a radical alternative to the argument that racism drives the HIV/AIDS epidemic in sub-Saharan Africa. To flesh out this alternative perspective, I develop the realist counterpoise to the racademic concept, what I call the concept of the "anarchidemic."

I define an anarchidemic as a disease epidemic in which the dynamics of anarchical international politics determine the spread and perpetuation of the disease. The anarchidemic concept draws on realism's theoretical framework for thinking about international relations. Realists recognize, as public health experts have historically observed, that "germs don't recognize borders."¹⁵⁸ This fact does not, however, change the underlying dynamics of states interacting in anarchy. Realists acknowledge that dealing with the transnational potential of pathogenic microbes might require international cooperation. This fact does not change the difficulties states face in creating and sustaining effective cooperation in their anarchical environment. At the end of the day, microbial threats complicated by the anarchical political structure of international relations

158. David P. Fidler et al., *International Considerations*, in *LAW IN PUBLIC HEALTH PRACTICE* 93 (R. A. Goodman et al. eds., 2002) (noting that "[i]nfectious disease specialists have long argued that 'germs do not carry passports'").

should be dealt with like other threats—primarily through self-help and secondarily through cooperation, all based on calculations centered on material capabilities. As Waltz argued, "[t]o achieve their objectives and maintain their security, units in a condition of anarchy . . . must rely on the means they can generate and the arrangements they can make for themselves. Self-help is necessarily the principle of action in an anarchic order."¹⁵⁹

From a realist perspective, HIV/AIDS is an anarchidemic. Within their territories, the great powers of the international system transformed HIV/AIDS from an incurable infectious disease into a medical condition that can, in many cases, be managed as a chronic disease with appropriate medicines.¹⁶⁰ This epidemiological transition occurred because the great powers engaged in self-help, especially with regards to developing effective antiretroviral therapies. The progress made in the United States against HIV/AIDS owes little, if anything, to international cooperation or international institutions, such as the WHO or UNAIDS. HIV/AIDS as a problem in the United States was never, in the realist perspective, a serious foreign policy issue or problem.

HIV/AIDS in Africa reflects an anarchidemic because this tragedy reveals the dynamics of a disease epidemic that affects mainly poor, marginalized states with limited ability to manage a disease crisis on their own. Sub-Saharan Africa is not critical to U.S. military, strategic, and economic interests; so the level of engagement of the United States in this region, under realist theory, would be limited, a perspective that accords with the level of indifference and inaction shown by the United States on HIV/AIDS in this region. Nicholas Eberstadt captured this dynamic in a *Foreign Affairs* article:

Africa's AIDS catastrophe is a humanitarian disaster of world historic proportions, yet the economic and political reverberations from this crisis have been remarkably muted outside the continent itself. The explanation for this awful dissonance lies in the region's marginal status in global economics and politics. By many measures, for example, sub-Saharan Africa's contribution to the world economy is less than Switzerland's. In military affairs, no regional state, save perhaps South Africa, has the capacity to conduct overseas combat operations, and indeed sub-Saharan governments are primarily preoccupied with local troubles. The states of the region are thus not well positioned to influence events much beyond their own borders under any circumstances, good or ill—and the cruel consequence is that the world pays them little attention.¹⁶¹

Locating the sub-Saharan countries affected by HIV/AIDS on the United

159. WALTZ, *supra* note 147, at 111.

160. U.S. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV/AIDS UPDATE—A GLANCE AT THE EPIDEMIC ("During the mid-to-late 1990's, advances in HIV treatments led to dramatic declines in AIDS deaths and slowed the progression from HIV to AIDS [in the United States]."), at <http://www.cdc.gov/nchstp/od/news/At-a-Glance.pdf> (last visited Dec. 18, 2002).

161. Eberstadt, *supra* note 10, at 23.

Nations Development Programme's Human Development Index (HDI) provides support for the anarchidemic thesis because this exercise illustrates the extent to which sub-Saharan Africa is on the margins of world politics. Of the thirty-six countries ranked as countries with "low human development" by UNDP, twenty-eight are in UNAIDS' sub-Saharan Africa region. The last twenty-seven countries on UNDP's HDI (countries ranked 147-173) are all in UNAIDS' sub-Saharan Africa region. The context of "low human development," which much of sub-Saharan Africa suffers, feeds many different political, economic, and social problems that beset countries least able to respond effectively. Another indicator of how sub-Saharan Africa exists at the margins of world politics is that, of the forty-two countries labeled "Heavily Indebted Poor Countries" (HIPC) by the World Bank, thirty-two are listed in UNAIDS' sub-Saharan Africa region.¹⁶² Table 4 provides a summary of the HDI and HIPC data for UNAIDS' sub-Saharan Africa grouping.

Table 4. Sub-Saharan African Countries Affected by HIV/AIDS on the UNDP's Human Development Index (HDI) and on the World Bank's HIPC List for 2002

Adult Prevalence Rate	Countries (%)	Country Ranking in HDI (out of 173) ¹⁶³	Heavily Indebted Poor Country ¹⁶⁴
15%-39% infection rate	Botswana (38.9%)	126	
	Kenya (15%)	134	X
	Lesotho (31%)	132	
	Malawi (15%)	163	X
	Namibia (22.5%)	122	
	South Africa (20.1%)	107	
	Swaziland (33.4%)	125	
	Zambia (21.5%)	153	X
5%-15% infection rate	Zimbabwe (33.7%)	128	
	Angola (5.5%)	161	X
	Burkina Faso (6.5%)	169	X
	Burundi (8.3%)	171	X
	Cameroon (11.8%)	135	X
Central African Republic (12.9%)	165	X	

162. WORLD BANK, GROUPING OF HIPCS UNDER THE ENHANCED HIPC INITIATIVE: STATUS AS OF JULY 2002, at http://www.worldbank.org/hipc/progress-to-date/HIPC_Grouping_July02.pdf (last visited Sept. 12, 2002).

163. UNITED NATIONS DEV. PROGRAMME, HUMAN DEVELOPMENT REPORT 2002: DEEPENING DEMOCRACY IN A FRAGMENTED WORLD 149-52 (2002).

164. WORLD BANK, *supra* note 162.

	Congo (7.2%)	136	X
	Côte d'Ivoire (9.7%)	156	X
	Mozambique (13%)	170	X
	Nigeria (5.8%)	148	
	Rwanda (8.9%)	162	X
	Sierra Leone (7%)	173	X
	Togo (6%)	141	X
	Uganda (5%)	150	X
	Tanzania (7.8%)	151	X
1%-5% infection rate	Benin (3.6%)	158	X
	Chad (3.6%)	166	X
	Democratic Republic of Congo (4.9%)	155	X
	Equatorial Guinea (3.4%)	111	
	Eritrea (2.8%)	157	
	Ethiopia (6.4%)	168	X
	Gambia (1.6%)	160	X
	Ghana (3.0%)	129	X
	Guinea-Bissau (2.8%)	167	X
	Mali (1.7%)	164	X
	Somalia (1%)	NA	X
0.5%-1.0% infection rate	Senegal (0.5%)	154	X
0.1%-0.5% infection rate	Madagascar (0.3%)	147	X
0.0%-0.1% infection rate	Mauritius (0.1%)	67	
Infection rate not available	Comoros	137	X
	Djibouti	149	
	Gabon	117	
	Guinea	159	X
	Liberia	NA	X
	Mauritania	152	X
	Niger	172	X

For many countries in UNAIDS' sub-Saharan Africa grouping, armed conflict exacerbated their economic and public health travails as HIV/AIDS penetrated Africa. The Stockholm International Peace Research Institute (SIPRI) recorded nineteen armed conflicts in Africa in the decade between 1990 and

2000,¹⁶⁵ the same decade in which HIV/AIDS exploded as a problem in Africa. Of those nineteen armed conflicts, sixteen (eighty-four percent) involved countries UNAIDS lists in its sub-Saharan Africa category.¹⁶⁶ SIPRI noted that "[t]he vast majority of conflicts in Africa have concerned governmental power in each year of the period [1990-2000],"¹⁶⁷ indicating the difficulties such conflicts would pose for the government's primary responsibilities to protect and promote public health.

Infectious diseases spread across borders, taking advantage of the fragmented political authority international anarchy produces; and diseases, such as HIV/AIDS, take deep hold in populations whose governments and societies have entrenched political and economic problems, have limited resources with which to respond, and require international public health assistance. The very marginalization of such states creates, however, difficulties for them to attract sufficient and sustained international cooperation. The nature of anarchy between states makes such international cooperation difficult, helping sustain the spread and penetration of the disease domestically and its spread internationally.

From the realist perspective, anarchidemics have been around longer than HIV/AIDS. Morbidity and mortality from most infectious diseases occur in developing not developed countries,¹⁶⁸ and this has been true for nearly a century. International efforts to eradicate or mitigate the toll of infectious disease deaths have had some success, especially in the case of smallpox's eradication; but most public health experts acknowledge that infectious diseases have reached crisis proportions again in developing countries.¹⁶⁹ Such increased levels of infectious disease morbidity and mortality in poor parts of the world do not, in most cases, represent the kind of threats realism recommends powerful states address as first-order priorities. Thus, anarchidemics for the great powers get relegated as foreign policy issues.

165. STOCKHOLM INT'L PEACE RESEARCH INSTITUTE, SIPRI YEARBOOK 2001, at 53 (2001) (registering the following African countries as experiencing armed conflict in the 1990-2000 decade: Algeria, Angola, Burundi, Chad, the Republic of Congo, the Democratic Republic of Congo (formerly Zaire), Eritrea-Ethiopia, Ethiopia, Ethiopia (Eritrea), Guinea Bissau, Liberia, Morocco, Mozambique, Rwanda, Sierra Leone, Somalia, South Africa, Sudan, and Uganda).

166. *Id.* (The sixteen countries were: Angola, Burundi, Chad, the Republic of Congo, the Democratic Republic of Congo, Eritrea-Ethiopia, Ethiopia, Ethiopia (Eritrea), Guinea Bissau, Liberia, Mozambique, Rwanda, Sierra Leone, Somalia, South Africa, and Uganda).

167. *Id.*

168. WORLD HEALTH ORG., REMOVING OBSTACLES TO HEALTHY DEVELOPMENT 2 (1999) (reporting that most infectious disease deaths occur in developing countries and that one in two deaths in developing countries is caused by infectious disease).

169. WORLD HEALTH ORG., WORLD HEALTH REPORT 1996: FIGHTING DISEASE, FOSTERING DEVELOPMENT v (1996) (arguing the world faces "a global crisis in infectious diseases.").

C. HIV/AIDS as an Anarchidemic

The morbidity and mortality profiles of anarchidemics reflect the hierarchy of power and influence in international politics, and the differential geographic impact of HIV/AIDS certainly reflects the power hierarchy of states in the international system. Poor, weak countries suffer much more than rich, powerful countries.¹⁷⁰ To paraphrase the ancient Greek historian Thucydides, the HIV/AIDS anarchidemic underscores that the strong do what they will and the weak suffer what they must,¹⁷¹ even in the public health context. The criticisms of U.S. foreign policy on HIV/AIDS support this *realpolitik* interpretation of HIV/AIDS in Africa because most of these criticisms hone in on the lack of U.S. engagement in the African public health catastrophe. When the U.S. government did become engaged during the Clinton administration, it was to challenge other countries' attempts to infringe on the patent rights of U.S.-based pharmaceutical companies, a source of American economic, pharmaceutical, and biotechnological power in the international system. The Bush administration's Emergency Plan only comes when the foreign policy costs of ignoring the global HIV/AIDS catastrophe have become serious enough to require more significant political attention.¹⁷²

Another telling comparison is to look at the U.S. financial contributions to the Global Fund with the U.S. government's spending plans for homeland security and bioterrorism in the wake of anthrax attacks. Prior to the proposed Emergency Plan, the United States contributed \$500 million to the Global Fund, as compared to \$19.5 billion in fiscal year 2002 and a proposed \$37.7 billion for fiscal year 2003 for homeland security after the September 11th attacks¹⁷³ and \$1.4 billion in fiscal year 2002 and a proposed \$5.9 billion for domestic biodefense for fiscal year 2003.¹⁷⁴ In addition, the United States pledged \$10 billion toward the \$20 billion G-8 Global Partnership Against the Spread of

170. See *supra* tbl.4.

171. THUCYDIDES, THE HISTORY OF THE PELOPONNESIAN WAR 351 (R. Crawley trans., 1982) (describing the Athenians arguing to the Melians that "right, as the world goes, is in question only between equals in power, while the strong do what they can and the weak suffer what they must").

172. Some media analysis of the Emergency Plan indicates that lobbying by Christian leaders in the United States played a significant role in convincing President Bush to propose the Emergency Plan. See, e.g., Kampeas, *supra* note 92 (noting influence of religious leaders) and Wilkie, *supra* note 96 (noting influence of religious leaders). Because realism does not take account of such internal domestic political factors in explaining international relations, the anarchidemic thesis shows little interest in the influence of religious leaders on President Bush in connection with the global HIV/AIDS problem. Other international relations theories that take account of the dynamics of domestic politics, such as liberalism, would find such involvement by religious leaders in the domestic politics of HIV/AIDS relevant and worth exploring. On liberalism as a theory of international relations, see Andrew Moravcsik, *Taking Preferences Seriously: A Liberal Theory of International Politics*, 51 INT'L ORG. 513 (1997).

173. MICHAEL E. O'HANLON ET AL., PROTECTING THE AMERICAN HOMELAND: A PRELIMINARY ANALYSIS 138 (2002).

174. *Id.*

Weapons and Materials of Mass Destruction in June 2002.¹⁷⁵

Bioterrorism and the threat of biological weapons constitute serious national security threats in the realist foreign-policy framework because they threaten material sources of U.S. power; and U.S. behavior on these issues, especially the sums of money it is preparing to spend on national security, homeland security, and biodefense, are consistent with the tenets of *realpolitik*. Realists argue that such priority-setting flows from the anarchical structure of international politics, and these dynamics shift foreign-policy attention and resources away from domestic problems in other countries. This shifting effect is another reason why HIV/AIDS is an anarchidemic—the dynamics of anarchical international politics pull the great powers away from serious engagement in HIV/AIDS issues in Africa.

The discourse on whether HIV/AIDS in Africa constitutes a national security threat to the United States also supports the anarchidemic thesis. The behavior of the Clinton administration revealed that it did not believe its proclamation that HIV/AIDS in sub-Saharan Africa was a national security threat. Academic analyses of this question have likewise found little support for holding that HIV/AIDS in Africa represents a direct national security threat to the United States.¹⁷⁶ At most, commentators argue that HIV/AIDS in Africa could destabilize countries and the regions, eventually having an adverse, indirect affect on U.S. strategic, political, and economic interests in the southern African region.¹⁷⁷ More tellingly, however, the discourse on the indirect national security threats posed by HIV/AIDS often moves from sub-Saharan Africa to countries such as India, Russia, or China, in which the United States has strategic and economic interests.¹⁷⁸ While included in this discourse, sub-Saharan Africa ends up being subordinated to "countries of strategic interest," again revealing how the dynamics of *realpolitik* shape HIV/AIDS in Africa into an anarchidemic. Thus, even where sub-Saharan Africa is most important to the national security debate it is ultimately peripheral.

The anarchidemic thesis posits that this marginalization of HIV/AIDS as a

175. Alan P. Larson, Under Secretary for Economic, Business and Agricultural Affairs, *G-8 Global Partnership Against the Spread of Weapons and Materials of Mass Destruction*, Testimony Before the House International Relations Committee (July 25, 2002), at <http://www.state.gov/e/rls/rm/2002/12190pf.htm> (last visited Sept. 11, 2002).

176. See, e.g., PRICE-SMITH, *supra* note 117, at 179 (arguing that "short of the re-appearance of a rapid and lethal pandemic, disease does not present an immediate threat to the stability of states with high initial state capacity. Therefore, the globalization of disease is not a direct threat to the security of industrialized nations at the present time"); R. L. Ostergard, *Politics in the Hot Zone: AIDS and National Security in Africa*, 23 *THIRD WORLD Q.* 333, 339 (2002) (arguing that "[t]he spread of the HIV/AIDS epidemic in Africa was not a *direct* security threat to the West in any sense of the word").

177. PRICE-SMITH, *supra* note 117, at 179 (arguing that "infectious disease will continue to undermine stability throughout the developing countries, compromising key foreign policy concerns of the developed states (such as global political and economic stability), and it may contribute to the development of indirect threats to the security of the developed countries").

178. Eberstadt, *supra* note 10, at 22-45.

foreign policy and national security concern has nothing to do with race or racism. The dynamics of an anarchidemic for the foreign policy of a country are exogenous because the anarchical nature of international politics determines them. Racism is an endogenous explanatory factor—racism comes from the inside out. Under realism, racism finds no place in the structure and dynamics of international politics and the make-up of foreign policies.

D. Implications of HIV/AIDS as an Anarchidemic

Ironically, viewing the HIV/AIDS crisis in Africa as a racidemic or anarchidemic yields the same conclusion: sub-Saharan Africa and its public health problems are marginalized in international politics. Both theses paint grim pictures of human and state behavior at the beginning of the twenty-first century. The anarchidemic thesis creates, however, different theoretical obstacles for thinking about how to deal with the HIV/AIDS debacle in Africa. Unlike the racidemic thesis, the anarchidemic thesis is fatalistic because its explanatory power is drawn from a structural analysis of international politics that contains no theory of change or progress. In short, unless sub-Saharan Africa develops an importance to the material military and economic capabilities of the United States and the other great powers of the international system, the anarchidemic of HIV/AIDS will continue to rage, ameliorated at the margins by international humanitarian efforts, such as those undertaken in the Global Fund and proposed in the Bush administration's Emergency Plan.

The anarchidemic thesis has another sobering implication. Should the HIV/AIDS crisis in sub-Saharan Africa become more important to the exercise of U.S. material power, then the nature of the response from the United States would not make HIV/AIDS activists entirely comfortable. In this context, realists would expect U.S. foreign policy to shift from indifference obscured by public-relations spin toward unilateral exercise of U.S. power. The Bush administration's Emergency Plan perhaps reflects what realism would anticipate. The Bush administration plans to maintain control of virtually all the proposed fifteen billion dollars rather than channel it through existing multilateral efforts, such as UNAIDS or the Global Fund. Even the one billion dollars earmarked for the Global Fund is subject to U.S. conditions that the Fund produce results,¹⁷⁹ which is another example of the United States exercising its power in this realm.

179. THE WHITE HOUSE, *supra* note 81 (stating that the Emergency Plan includes one billion dollars for the Global Fund, "conditioned on the Fund showing results").

V. BETWEEN RACISM AND *REALPOLITIK*? THE GLOBAL FUND TO FIGHT AIDS,
TUBERCULOSIS, AND MALARIA

A. Innovation in the Midst of a Nightmare: The Global Fund

Although international efforts on the HIV/AIDS epidemic have existed since WHO created the Global Programme on AIDS in 1987, the growth in the scale of the HIV/AIDS nightmare into the late 1990s, especially in sub-Saharan Africa, provoked renewed international activity. The most significant development at the international level in recent years has been the creation of the Global Fund.¹⁸⁰ Many experts perceive that the Global Fund is an innovative breakthrough in global public health that offers a chance, perhaps the last chance, for the international community to harness its resources and energies to turn the tide against HIV/AIDS in Africa and elsewhere.¹⁸¹

The Global Fund differs radically from traditional intergovernmental cooperative efforts on public health. Traditionally, states recognizing the need for international public health cooperation utilized treaties and/or international organizations. Both these responses to common public health challenges were overwhelmingly state-centric and built on the Westphalian architecture of international relations. Initial international responses to HIV/AIDS followed this pattern of using the Westphalian architecture of international law and international organizations to facilitate cooperation on the epidemic (e.g., WHO's Global Programme on AIDS followed by the creation of UNAIDS). WHO's Global Programme and UNAIDS both used international human rights treaties and norms to frame prevention and treatment strategies and advice to states.¹⁸²

The worsening of the HIV/AIDS epidemic in Africa and other parts of the developing world despite the creation of the Global Programme, and then UNAIDS, provided powerful evidence that the traditional Westphalian instruments of international organizations and treaties were woefully insufficient to deal with this global public health tragedy. The crisis HIV/AIDS posed for the Westphalian public health architecture had many aspects, but central to the failings of this architecture were (1) a lack of sufficient international funding for HIV/AIDS prevention and treatment in the developing world; and (2)

180. THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA, at <http://www.globalfundatm.org> (last visited Sept. 9, 2002).

181. For an analysis of the Global Fund, see Allyn L. Taylor, *Public-Private Partnerships for Health: The United Nations Global Fund on AIDS and Health*, 35 J. MARSHALL L. REV. 400 (2002).

182. On HIV/AIDS and human rights, see LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC (1997); OFFICE OF THE HIGH COMM, FOR HUMAN RIGHTS & UNAIDS, HIV/AIDS AND HUMAN RIGHTS: INTERNATIONAL GUIDELINES (1998); David Patterson & Leslie London, *International Law, Human Rights and HIV/AIDS*, 80 BULL. WORLD HEALTH ORG. 964 (2002).

incomplete HIV/AIDS prevention and treatment strategies and policies at the national level.

Rather than retrofit the old Westphalian public health architecture again, political and public health leaders fashioned an innovative response in the form of the Global Fund. The Global Fund is not a classical international organization because its governance structure includes non-governmental organizations as voting members.¹⁸³ Although states play an important role in the funding and decision-making of the Global Fund, the enterprise is designed to function as a "public-private partnership" rather than as a traditional intergovernmental institution in which member states alone control the proceedings.¹⁸⁴

The Global Fund also eschews the traditional Westphalian public health reliance on the treaty. The Global Fund is neither a treaty-based organization, such as WHO, nor an entity embedded in formal intergovernmental frameworks, such as UNAIDS. Legally, the Global Fund is a non-profit entity established under Swiss law¹⁸⁵ and, thus, in legal form looks more like a NGO than an intergovernmental institution. Financial commitments from states to the Global Fund are also not treaty-based because the Fund involves no treaty obligations for states.

As its name suggests, the Global Fund is a funding mechanism that attempts to provide financial resources for national-level prevention and treatment projects on HIV/AIDS, tuberculosis, and malaria.¹⁸⁶ This function also distinguishes the Global Fund from traditional international health organizations, such as WHO, which are not funding agencies for national public health projects. In essence, the Global Fund is designed to effect redistribution of financial resources from rich to poor countries for public health purposes. Although much of the work of WHO and other international health organizations focuses heavily on developing countries, none has had the explicit mandate to redistribute financial resources from rich to poor countries.

Innovation is also present in the way in which the Global Fund carries out its funding mandate. The Global Fund subjects project proposal to scientific and

183. GLOBAL FUND, NGOS AND CIVIL SOCIETY, at http://www.globalfundatm.org/ngo_civil.html (last visited Sept. 10, 2002).

184. On the growing importance of public-private partnerships in global public health, see PUBLIC-PRIVATE PARTNERSHIPS FOR PUBLIC HEALTH (M. R. Reich ed., 2002); Kent Buse & Gill Walt, *Globalisation and Multilateral Public-Private Health Partnerships: Issues for Health Policy*, in HEALTH POLICY IN A GLOBALISING WORLD 41-62 (K. Lee et al. eds., 2002); Kent Buse & Amelia Waxman, *Public-Private Health Partnerships: A Strategy for WHO*, 79 BULL. WORLD HEALTH ORG. 748 (2001); Roy Widdus, *Public-Private Partnerships for Health: Their Main Targets, Their Diversity, and Their Future Directions*, 79 BULL. WORLD HEALTH ORG. 713 (2001); Kent Buse & Gill Walt, *Global Public-Private Partnerships, Part I: A New Development for International Health?*, 78 BULL. WORLD HEALTH ORG. 549 (2000); Kent Buse & Gill Walt, *Global Public-Private Partnerships, Part II: What Are the Health Issues for Global Governance*, 78 BULL. WORLD HEALTH ORG. 699 (2000).

185. U.S. DEP'T OF STATE, GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA (June 21, 2002), at <http://www.state.gov/t/pa/prs/ps/2002/11371.htm> (last visited Sept. 10, 2002).

186. GLOBAL FUND, OVERVIEW, at <http://www.globalfundatm.org/overview.html> (last visited Sept. 10, 2002).

technical scrutiny to ensure that only projects based on scientific evidence and public health principles receive funding.¹⁸⁷ The criteria for being funded also include the principle that the proposed project involves not only government but also non-governmental participation.¹⁸⁸ The "public-private partnership" dynamic of the Global Fund itself is, thus, replicated at the level of the national project. Such a requirement is simply not found in the traditional Westphalian public health architecture of international organizations and international law.

The various innovative features of the Global Fund lead experts to see it as an exciting development in "global governance."¹⁸⁹ The traditional Westphalian architecture for public health cooperation represented international governance because the structure and dynamics of the cooperation were almost exclusively state-centric. The Global Fund's incorporation of non-state actors into its central governing structure and its requirement that funded projects involve the participation of civil society groups move the endeavor away from international governance toward global governance. Such global governance occurs without the use of state-based treaty law or intergovernmental structures. Finally, the governance function of this innovative creation is also beyond the typical pattern of Westphalian public health cooperation because the Global Fund's mandate involves the redistribution of financial resources from rich to poor countries.

B. The Global Fund's Implications for the Racist and Anarchic Theses

For purposes of this article, the Global Fund's development raises the question whether this new brand of global governance helps move policy and discourse on HIV/AIDS in Africa beyond the perspectives offered by the racist and anarchic theses. Some commentators who accuse the United States and other Western countries of racism in their foreign policies on HIV/AIDS believe that the Global Fund offers the potential for racism in

187. GLOBAL FUND, PRINCIPLES, at <http://www.globalfundatm.org/principles.html> (last visited Sept. 10, 2002).

188. *Id.* (stating one of the Global Fund's main principles as "[f]ocus on the creation, development and expansion of government/private/NGO partnerships").

189. On "global governance" in the public health context, see Ilona Kickbusch, *Global Health Governance: Some Theoretical Considerations on the New Political Space*, in HEALTH IMPACTS OF GLOBALIZATION, *supra* note 28, at 192-203; Allyn L. Taylor, *Global Governance, International Law and WHO: Looking Towards the Future*, 80 BULL. WORLD HEALTH ORG. 975 (2002); R. DODGSON, ET AL., GLOBAL HEALTH GOVERNANCE: A CONCEPTUAL REVIEW (KEY ISSUES IN GLOBAL HEALTH GOVERNANCE DISCUSSION PAPER NO. 1) (2002), at <http://www.lshtm.ac.uk/centres/cgch/Publications.htm> (last visited Sept. 10, 2002); K. LOUGHLIN AND V. BERRIDGE, GLOBAL HEALTH GOVERNANCE: HISTORICAL DIMENSIONS OF GLOBAL GOVERNANCE (Key Issues in Global Health Governance Discussion Paper No. 2) (2002), at <http://www.lshtm.ac.uk/centres/cgch/Publications.htm> (last visited Sept. 10, 2002); DAVID FIDLER, GLOBAL HEALTH GOVERNANCE: OVERVIEW OF THE ROLE OF INTERNATIONAL LAW ON PROTECTING AND PROMOTING GLOBAL PUBLIC HEALTH (Key Issues in Global Health Governance Discussion Paper No. 3) (2002), at <http://www.lshtm.ac.uk/centres/cgch/Publications.htm> (last visited Sept. 10, 2002).

HIV/AIDS policies to be overcome or at least mitigated.¹⁹⁰ The presence of non-governmental actors in both the global and national level activities of the Global Fund offers opportunities to keep international human rights, especially the principle of racial non-discrimination, at the center of decision-making. As the racademic thesis argues, the state-centric public health cooperation failed to prevent racism from significantly affecting the dynamics of the HIV/AIDS pandemic. Without the effective implementation of the human rights principle of racial non-discrimination, efforts to combat HIV/AIDS globally will fail. Hence, proponents of more global action on HIV/AIDS see promise in the global governance strategy at the heart of the Global Fund.¹⁹¹

The Global Fund's potential to elevate and implement effectively the principle of racial non-discrimination depends, however, on the amount of financial resources available to the Fund. The larger the Global Fund's financial resources the more powerful the Fund's global governance mechanism will be in fostering a human-rights approach to the HIV/AIDS issue in Africa and other developing countries. Calls for rich countries to provide significant sums of money for global HIV/AIDS efforts, on the order of nine to ten billion dollars a year, frequently come from experts and groups who have pushed the human rights agenda in the face of the worsening nightmare of HIV/AIDS.¹⁹²

While the Global Fund's development provides some solace in the face of the racademic thesis, this new global governance initiative does not resonate with the perspective contained in the anarchademic thesis. Theoretically, realism views non-state actions as irrelevant in the dynamics of structural anarchy.¹⁹³ States are the units that matter and that shape the nature of international politics. The Global Fund's move from the state-based Westphalian public health architecture challenges, therefore, the realist outlook on not only public health but also international relations. Commentators who have applied realism to global public health problems typically reject realism as a relevant framework of

190. See, e.g., Booker, *supra* note 102 (arguing that the United States can help overcome racism in HIV/AIDS policies by pledging \$3 billion to the Global Fund).

191. See, e.g., Press Release, UNDP, UNDP PANELISTS: AIDS RESPONSE "DESPERATELY UNDER-FUNDED" (July 10, 2002), at <http://www.undp.org/dpa/pressrelease/releases/2002/july10jul02.html> (last visited Sept. 11, 2002) [hereinafter UNDP Panelists] ("The Global Fund is the most promising single instrument to fight AIDS," said Dr. Jeffrey Sachs, world renowned development economist and Special Adviser to the UN Secretary-General for the Millennium Development Goals (MDGs). "It is our last best hope.").

192. B. Schwarlander et al., *Resource Needs for HIV/AIDS*, SCIENCEEXPRESS, June 21, 2001 (reporting a June 2001 estimate of government and civil society representatives that \$9 billion annually would be needed for global HIV/AIDS purposes), at <http://www.scienceexpress.org> (last visited Sept. 10, 2002). After the XIV International AIDS Conference in Barcelona in July 2002, the UNAIDS Secretariat argued that "[t]en billion dollars, more than three times what is being spent today, is needed for a minimum response to the epidemic." UNAIDS SECRETARIAT, UNAIDS, WHAT IS A PROMISE WORTH? (July 25, 2002), at http://www.aids2002.com/ViewArticle.asp?article=T-CMS_Content/News/7252002025752PM.xml (last visited Sept. 10, 2002).

193. Dunne, *supra* note 143, at 151 ("For realists, states are the only actors that really 'count.'").

analysis,¹⁹⁴ which underscores how radically different the global governance approach of the Global Fund is from the anarchidemic thesis.

The strategy developed in the Global Fund does not, however, ignore all insights about international relations found in *realpolitik*. The Global Fund's strategy appreciates the need for the political and financial support of the great powers, such as the United States. The need for this support involves creating sufficient incentives for the great powers to participate in the endeavor. The Global Fund crafts these incentives by promising a more efficient and effective way for donor countries to support national-level HIV/AIDS programs in regions hardest hit by the epidemic. The donors do not have to take on new international legal duties under the Global Fund's strategy, and the Fund's implementation mechanisms rely on non-state actors and national governments rather than donor governments and the bureaucracies of international organizations. The Global Fund comprises, therefore, a way for the great powers to engage in the HIV/AIDS fight in a manner that avoids both indifference and heavy-handed intervention. In short, perhaps the Global Fund offers a realistic strategy to ensure that HIV/AIDS in Africa does not continue to be an anarchidemic.

As described and analyzed above, the Global Fund may promise an approach to the HIV/AIDS catastrophe in sub-Saharan Africa that can help steer the epidemic by the Scylla of racism and the Charybdis of *realpolitik*. The racidemic and anarchidemic theses each contain powerful explanations of the African HIV/AIDS epidemic, but neither provides a progressive blueprint for allowing state and non-state actors to get a better handle on the situation. The racidemic thesis identifies racism as a problem and puts the human rights principle of racial non-discrimination on the normative agenda. This principle has, however, been on the normative human rights agenda for decades within the traditional Westphalian public health architecture with results the racidemic thesis decries.¹⁹⁵ The global governance approach of the Global Fund gives the normative spirit that animates the racidemic thesis a different architectural blueprint for fighting racism and HIV/AIDS.

The realism that informs the anarchidemic thesis does not offer a progressive blueprint because *realpolitik* denies the possibility of progress in international relations. The HIV/AIDS anarchidemic has reached such dire proportions that even the heartlessness of realism has had to take note. The Global Fund's approach offers the great powers a way to try to stabilize the

194. PRICE-SMITH, *supra* note 117, at 183 (rejecting realism as a theory of international relations in connection with infectious disease threats); Dennis Pirages, *Ecological Theory and International Relations*, 5 IND. J. GLOBAL LEGAL STUD. 53, 54 (1997) (rejecting realism in connection with thinking about microbial threats to humanity).

195. See, e.g., International Convention on the Elimination of All Forms of Racial Discrimination, Mar. 7, 1966, 660 U.N.T.S. 195; International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171, art. 2.1 (prohibiting, *inter alia*, discrimination on the basis of race in connection with civil and political rights); International Covenant on Economic, Social, and Cultural Rights, Dec. 16, 1966, art. 2.2, 993 U.N.T.S. 3 (prohibiting, *inter alia*, discrimination on the basis of race in connection with economic, social, and cultural rights).

anarchidemic of HIV/AIDS so that any future threat it might pose to their foreign policy interests is forestalled, mitigated, or postponed. The current national security threat from HIV/AIDS in Africa is sufficiently low that it does not warrant elevating HIV/AIDS to the top of the national security and foreign policy agendas. The Global Fund allows the great powers, nevertheless, to take some low-cost action that may pay reputation benefits in the short term and more concrete foreign policy benefits in the long term.

The United States has gradually increased the foreign policy importance of the HIV/AIDS pandemic, culminating in the Bush administration's Emergency Plan. The Emergency Plan suggests that the global HIV/AIDS pandemic has become so severe that continued inaction or ambivalence from the United States creates problems for U.S. foreign policy interests that need to be mitigated. Consistent with the anarchidemic thesis, the Emergency Plan represents a shift away from the multilateralism and "global governance" of the Global Fund toward the unilateral exercise of U.S. power. Supporters of the Global Fund have criticized the unilateralism of the Emergency Plan.¹⁹⁶ The Emergency Plan now overshadows the Global Fund both in terms of resources and political support available from the United States for global HIV/AIDS efforts.

C. Substance, Structure, and the State: The Perils of Partnerization in Public Health

At the center of the Global Fund's innovation is the strategy of the public-private partnership, in which both state and non-state actors pool resources and efforts to tackle global disease problems in the developing world. In public health and other areas of world politics, the strategy of "partnerization" has become a significant feature of policy action and academic discourse.¹⁹⁷ The Global Fund's potential to transform the HIV/AIDS epidemic in Africa from a racidemic and/or anarchidemic depends on the success of its partnerization process. The success of this process, in turn, depends on the ability of partnerization in the HIV/AIDS context to overcome the substantive policy problems identified by the racidemic thesis and the structural political challenges described in the anarchidemic thesis.

The power of partnerization in the context of the Global Fund is only now

196. Mark Heywood of the South Africa-based Treatment Action Campaign expressed his group's concern that most of the new money would be spent bilaterally rather than through the Global Fund. Garrett & Mulugeta, *supra* note 91. Louise Robinson of Care International argued that the Emergency Plan's funds should flow through the Global Fund rather than bilateral processes. Harman, *supra* note 134. Rachel Cohen of Médecins Sans Frontières' Campaign for Access to Essential Medicines warned that U.S. unilateralism on HIV/AIDS will squander money and lose lives and argued that the United States should "redirect more of the promised funds to existing multilateral funding bodies, rather than waste time and money on creating new ones." Médecins Sans Frontières, *supra* note 131. The Global AIDS Alliance argued that the Emergency Plan undermines the Global Fund because the Plan "leaves the Fund without sufficient resources to support scaling up of programs that are currently underway." GLOBAL AIDS ALLIANCE, *supra* note 74, at 3.

197. See sources cited *supra* note 184.

being tested. Even at these early stages, however, grave concerns exist about the perils partnerization faces in the global public health crisis posed by HIV/AIDS. These perils are practical and theoretical. Practically, partnerization through the Global Fund may be too little too late given the growth of the HIV/AIDS epidemic in Africa and its short-term tragic trajectory. The Global Fund only came into existence once the HIV/AIDS epidemic had deeply penetrated all levels of African societies, confronting partnerization with a colossal catastrophe moving exponentially toward more profound continental calamity. These practical perils grow larger when one considers the small scale of the Global Fund's coffers. Donations to the Global Fund have reached nowhere near the estimated annual need of ten billion dollars; and, despite pleas for vastly increased pledges,¹⁹⁸ there is little evidence to suggest that funding levels will reach what experts think is realistically required given the scale of the crisis.

More ominously, the Global Fund's short-term financial health is in jeopardy. *The Economist* reported in October 2002 that "[o]n current projections . . . the fund will run out of cash in the second quarter of 2003. And even if it survives that, the projected shortfall in 2004 is \$4.6 billion."¹⁹⁹ The Global AIDS Alliance also observed in October 2002 that the Global Fund "faces de-facto bankruptcy" and attacked the United States' contribution level by arguing that "[t]he [Bush] administration is noteworthy in making proclamations, but negligent in providing money. The fund's lack of resources is a joke."²⁰⁰ In January 2003, the Global Fund announced that it did not have sufficient funds to complete a third round of funding and needed more than \$6 billion over the next two years.²⁰¹ The Bush administration's proposed Emergency Plan would make the U.S. contribution to the Global Fund to \$1 billion over the next five years (approximately \$200 million per year), which still leaves the Global Fund in desperate need of funds.²⁰² Further, the \$1 billion

198. See UNDP Panelists, *supra* note 191.

199. *AIDS: The Next Wave*, THE ECONOMIST, Oct. 19, 2002, at 75.

200. Clare Kapp, *Global Fund Faces Uncertain Future as Cash Runs Low*, 360 THE LANCET, Oct. 19, 2002. Mallaby observed that the Director of the Global Fund "reckons that his fund's rapid-disbursement mechanism needs \$7 billion in new donor money during the next two years. The U.S. share of that would be \$2 billion, and yet in the 2003 budget the administration is asking for only a 10th of that." Mallaby, *supra* note 128, at A21.

201. Press Release, Global Fund to Fight AIDS, Tuberculosis, and Malaria, Global Fund Awards \$866 Million in Grants to Fight AIDS, TB and Malaria; United States Takes Chair of Global Fund Board; Tommy Thompson is Elected (Jan. 31, 2003) ("At the close of its fourth Board meeting, financial statements made clear that the Global Fund lacks the resources to approve a third round of grants in October 2003. At least US\$6.3 billion in additional total contributions are needed over the next two years."), at http://www.globalfundatm.org/journalists/journalists_pr.html (last visited Jan. 31, 2003); Feachem, *supra* note 7, at B03 (noting that the Executive Director of the Global Fund argues that the Fund needs an additional \$2 billion in 2003 and \$4.6 billion more in 2004).

202. Debt, AIDS, Trade in Africa, *supra* note 93 (noting that the Emergency Plan's one billion dollars for the Global Fund over five years means that the U.S. contribution to the Fund would only be \$200 million annually); Garrett & Mulugeta, *supra* note 91 (noting that the \$200 million annual contribution to the Global Fund represents a decrease from current levels of U.S.

U.S. contribution is "conditioned on the Fund showing results,"²⁰³ suggesting that U.S. contributions to the Global Fund will not continue or increase without the Fund producing effective programs. It is not clear how the Bush administration intends to measure the Fund's performance for purposes of funding. The Bush administration does not plan to channel the rest of the proposed \$15 billion through the Global Fund, indicating the United States will not provide resources to the Global Fund on the scale the Fund believes is necessary. The size of the challenge combined with the scarcity of resources can make partnerization through the Global Fund seem like a band-aid on a coffin.²⁰⁴

Theoretically, partnerization poses some problems for thinking about and acting on global public health issues. These perils connect to issues of substance, structure, and the role of the state identified in the racidemic and anarchidemic theses. In both theses, the state was at the heart of the analysis not public-private partnerships. The racism fueling the HIV/AIDS epidemic in Africa was *public* racism located in governmental foreign policies of countries such as the United States. In other words, the substantive problem—racism—vests in the behavior of the state. Although the Global Fund seeks to deal with such racism through partnerization, this process of confronting racism is, at best, indirect. The hope is to overcome state-based racism through partnerization, a process with public and private participation. A less sanguine view of partnerization would hold that, through this process, the underlying racism of state attitudes becomes obscured and more difficult to dislodge. Governments accused of racism in the context of HIV/AIDS policies can point to their support of the Global Fund as refutation of these accusations. Partnerization might, thus, become a convenient way to bury the traces of the indirect racism the racidemic thesis exposes. There is a substantive reason—racism—why the coffin bears only a band-aid.

In the anarchidemic thesis, the state is central because of realism's perspective on international anarchy. The dynamics of *realpolitik's* anarchy are, therefore, the dynamics of public actors not public-private partnerships. If it registers at all in realist thinking, partnerization registers as an expedient tool of

funding pledged to the Global Fund). The Global AIDS Alliance calculates that the United States should contribute at least \$2.2 billion to the Global Fund annually if the Fund is realistically going to receive the level of resources it requires to fulfill its mandate. GLOBAL AIDS ALLIANCE, *supra* note 74, at 5.

203. THE WHITE HOUSE, *supra* note 81 ("The \$15 billion includes \$1 billion for the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria, conditioned on the Fund showing results.").

204. ACCESS NEWS, PERSPECTIVES ON THE GLOBAL FUND: HOPE OR BETRAYAL FOR PEOPLE WITH HIV/AIDS?, ACCESS NEWS: CAMPAIGN FOR ACCESS TO ESSENTIAL MEDICINES 2 (July 2002). The Global Fund "is starved for cash: the first round nearly bankrupted it, leaving many wondering how sustainable funding will be. This funding deficit represents an enormous political failure on the part of donor governments who had promised dramatic increases in financial support." *Id.* Morton Rostrup, President of MSF's International Council, is quoted as arguing that "[t]oday and every day, more than 8,000 people with AIDS will die. Yet the international community refuses to mount and fund an adequate global response—we are faced with nothing less than a crime against humanity." Press Release, MSF-Health GAP, Waiting to Treat AIDS is a Crime (July 7, 2002), at <http://www.accessmed-msf.org/prod/publications.asp?scntid=9720021030234&contenttype=PARA&> (last visited Sept. 12, 2002).

the great powers rather than as some fundamental change in the structure or dynamics of international politics. Partnerization helps obscure, as a result, the structural dynamics of international anarchy that begin and end with states. For the great powers, such obfuscation is convenient because it allows them to appear as supporters of innovation in governance of international relations when in fact not buying into the partnerization theory at all. In other words, partnerization characterizes issues that are not sufficiently important to be accorded the full exercise of state power, authority, and resources. Again, compare U.S. contributions to the Global Fund to U.S. spending on biodefense and defense against other weapons of mass destruction noted earlier. In that sobering comparison, one finds the essence of the *realpolitik* perspective: states address serious national security threats generated by international anarchy with the exercise of significant public governmental, economic, and military capabilities. Further, the proposed Emergency Plan suggests the United States will increase its involvement in HIV/AIDS in Africa not through the Global Fund but through exercising its power more unilaterally. There is a structural reason—anarchy—why the coffin bears only a band-aid.

The theory of public health itself underscores the perils of partnerization identified through the racidemic and anarchidemic theses. Although the voluntary cooperation of individuals and partnerships within civil society groups play important roles in protecting and promoting population health, the primary responsibility for public health is governmental responsibility.²⁰⁵ The public functions of the state are at the heart of public health not public-private partnerships.²⁰⁶ Translated beyond the borders of a single state, this theoretical core of public health places public interactions among states at the heart of analysis. Key instruments of public health thus become international law and international organizations. The partnerization phenomenon has grown, however, in response to the perception that the traditional Westphalian public health architecture has not produced effective responses to global disease scourges such as HIV/AIDS.

Theoretically, the peril of partnerization is the move away from the core idea that population health is a public, governmental responsibility—a *public* good—toward a conception of population health in which responsibilities proliferate into the private realm, transforming the public good into a civic good. The theoretical foundation for public health as a civic good for which public and private actors are responsible is not, however, clear. Although partnerization involves states, this process may divert attention away from the fundamental failure of governments to address public health at home and abroad.

205. INST. OF MED., *supra* note 103, at 7. "The mission of public health is addressed by private organizations and individuals as well as by public agencies. But the governmental public health agency has a unique function: to see to it that vital elements are in place and that the mission is adequately addressed." *Id.*

206. See Mark A. Rothstein, *Rethinking the Meaning of Public Health*, 30 J. L., MED. & ETHICS 144, 144-46 (2002) (advocating for rethinking the meaning of public health by narrowing its scope to "government intervention as public health").

Perhaps the failure of the traditional Westphalian public health architecture, from states to international organizations, to craft an effective response to HIV/AIDS in Africa suggests that the basic public health theory needs radical revision, for which partnerization provides a vision. What is hard to see, especially in the face of the magnitude of the HIV/AIDS crisis in Africa and the nature of the great powers' response to the Global Fund's mission, is partnerization robust enough to make a difference in the midst of Westphalian despair.

VI. CONCLUSION

Even persons experienced in and hardened by the world politics of public health look at the appalling statistics concerning HIV/AIDS in Africa and wonder how such a human disaster could have happened. This article explored different explanations of this continental disaster—the racidemic and anarchidemic theses. Although certainly not the only possible explanations for the HIV/AIDS tragedy in Africa, these theses do not ignore or attempt to finesse the catastrophe and its continuation by focusing on the novel biomedical challenges the deadly retrovirus presents. Nor do they hide behind accusations that Africans and their governments are primarily to blame. The racidemic and anarchidemic theses may be flawed in many ways, but they cannot be faulted for providing forthright, comprehensive explanations of one of humanity's worst disease plagues.

Whether the Global Fund's global governance through partnerization provides a middle path between the racidemic and anarchidemic theses remains uncertain, especially in light of the dramatic development of the Emergency Plan. The innovation in the Global Fund is important, even if doubts remain about its capability to overcome the sheer scale of the public health challenge, the substantive problem of racism, and the structural problem of anarchy. For many, the only escape for Africa and other developing countries from the HIV/AIDS scourge is the technological breakthrough of a safe, effective, and affordable vaccine—the Holy Grail of HIV/AIDS policy.²⁰⁷

While the racidemic and anarchidemic theses are sufficiently haunting on

207. See INT'L AIDS VACCINE INITIATIVE, THE WORLD NEEDS AN AIDS VACCINE, at <http://www.iavi.org/need/needs.htm> (last visited Sept. 11, 2002). According to the International AIDS Vaccine Initiative:

More than 95% of all new infections are in developing countries, making HIV/AIDS among the most serious threats not only to global health, but to global development. Prevention programs—including education, condom and clean needle distribution and peer counseling—have slowed the spread of HIV, but have not stopped it. Treatment advances have yielded important new AIDS therapies, but the cost and complexity of their use put them out of reach for most people in the countries where they are needed the most. In industrialized nations where drugs are more readily available, side effects and increased rates of viral resistance have raised concerns about their long-term use. *Only an AIDS vaccine can end the HIV/AIDS pandemic.*

their own, these theses imply that, should HIV/AIDS ever relinquish its grip on the continent, racism and *realpolitik* also await post-plague Africa unless racial attitudes about Africans change or Africa's structural marginalization in anarchy ends. A vaccine for HIV/AIDS will not render Africans immune from suffering the perpetuation of racism and *realpolitik*.

