HIV/AIDS in Africa and US National Security

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The US response to the HIV/AIDS pandemic in Africa is an example of the redefined nature of security threats that characterizes the post 9/11 era.[1] Even the most ardent realists now accept that there are serious threats to US security that exist apart from organized states. Scholars and governments have been forced to adopt a greater sensitivity to the issues that underlie international violence and terrorism, such as a lack of political freedom, state failure, poverty, and, in this case, disease.[2] In this chapter the HIV/AIDS pandemic is addressed as an indirect threat to US security interests in Africa.

The US response to HIV/AIDS in Africa exemplifies the way in which Africa fits into the national security agenda of the United States. Increased awareness of the causes of terrorism has made Africa more critical to the national security agenda of the United States than it has been in the past. The African security concern of greatest interest to the United States is state failure. HIV/AIDS is one factor contributing to state failure and is similar to other security threats, such as poverty, which are: 1) regionalized; 2) temporally less immediate; and 3) address human security insofar as it affects international security.

For the most part, African states do not pose a direct political threat to US security interests. The US does not face strong ideological enemies on the African continent nor is the US engaged in the kind of proxy wars that characterized the Cold War Era. With the recent accession of Libya to International Atomic Energy Agency inspectors, the actual national security threats to the United States from African governments are few indeed. However, economic underdevelopment, coupled with HIV/AIDS may produce an environment in which weak or even failed states are unable to stem the growth of terrorist groups within their borders - groups which may or may not be linked up to international terrorist organizations like Al-Qaeda or Islamic Jihad. Moreover, other threats to US security occasionally materialize in states which are unable to adequately police their own borders and assert state control outside the capital. An excellent example of just such a threat was the recent attempt to illegally export uranium from the Democratic Republic of Congo (Associated Press 2004).

HIV/AIDS is a security threat, but it is indirect and played out at multiple levels of analysis: within individual bodies; clustered within families and communities,

wreaking havoc on their ability to cope with the day to day challenges of living in Africa; and destabilizing the state.[3] It is the pervasiveness of the disease and the lack of treatment, which multiplies its effect to the point that it becomes a security issue for states and through the challenges it creates within those states, an international security issue. Thus, HIV/AIDS links human security and international security in unique ways. AIDS is a disease; it is not a weapon nor is it a state.[4] Yet, it has been perceived now under two US administrations as a threat to national security because of its potential for destabilizing states. This is worthy of note as it is the first time that a disease has been interpreted as a national security threat.

After a brief description of the HIV/AIDS pandemic in Africa, the first section of this chapter identifies the development of HIV/AIDS as a perceived security threat and details the specific security issues that are presented by HIV/AIDS in Africa. Then, the linkages between national security and the recently passed "Global AIDS Bill" are identified. Lastly, the divergence of perspectives between African states and the US regarding the threat of HIV/AIDS is discussed. The meanings of this divergence of perceptions are probed and some observations are made regarding the future of HIV/AIDS as a security threat in Africa and the development of the "next" wave of HIV/AIDS in South Asia.

The HIV/AIDS Pandemic in Africa

Africa remains the continent most affected by HIV/AIDS. Eighty-one percent of the world's AIDS-related deaths occur in Sub-Saharan Africa (Economic Commission for Africa 2003). AIDS prevalence is higher in Sub-Saharan Africa than anywhere else in the world at 7.5-8.5% of the total population. An estimated 2.3 million adults and children died from AIDS in sub-Saharan Africa last year (WHO/UNAIDS 2003: 5). At least 2 million adults are infected in Ethiopia, South Africa, Kenya and Nigeria, and one in five adults have contracted the virus in Botswana, Lesotho, Swaziland, Zambia and Zimbabwe (United Nations 2001) . Furthermore, most of the world's women suffering from the AIDS virus live in sub-Saharan Africa: a shocking 83% (Economic Commission for Africa 2003: 48).

On the African continent, HIV infection rates are not similar in all the countries and all areas. The World Health Organization divides the continent up into regions; of these, Southern Africa suffers the most, with its prevalence rates rising from 20.3% in 1997-1998 to 25.7% in 2001-2002 (World Health Organization 2003: 19). This may be a result of the higher levels of urbanization found in Southern Africa. Eastern Africa's prevalence rate has decreased slightly, from a high of 13.7% to 11.4%. This is partially due to the significant and consistent HIV/AIDS awareness campaign by the Ugandan government. This trend has been followed by other countries in the region, most notably Ethiopia, where in the capital of Addis Ababa, HIV prevalence rates for 15-24 yr. old pregnant women dropped from 24% in 1995 to 11% in 2003. The AIDS prevalence in West Africa has remained relatively stable at 4.3% from 1999-2002.

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

Uganda

Uganda was one of the first African countries to experience the full impact of HIV/AIDS. At the height of the epidemic infection rates were 14% throughout the country and much higher in some areas.[5] Now HIV infection rates are down to 8%, as most of the people infected earlier have died. Uganda has experienced the peculiar demographic challenge of HIV/AIDS. The virus attacks people who are most sexually active and the most economically productive, between the ages of 15-45. Uganda has suffered from a lack of teachers and medical professionals as a result of the epidemic. Thus the virus kills the population most necessary to development: the teachers, doctors and entrepreneurs as well as the mothers and fathers raising children. In Uganda, high rates of HIV/AIDS infection corresponded with conflict and instability in the country. As peace came in the mid-1980s, fewer people were displaced, soldiers and rebels returned to their barracks and hometowns, and infection rates began to decline. Uganda also embraced the

challenge of reducing the infection rates and launched a national educational campaign against HIV/AIDS beginning in 1986. The slogan of "Abstinence, Be faithful, or use a Condom," – often referred to as the ABC method - succeeded in getting across the message of safe sexual practices. The Ugandan model of HIV/AIDS prevention and awareness has been widely applauded and has shown significant results. The educational campaign was supported by the president, Yoweri Museveni, and articulated from the capital city to the classrooms in rural schools.

South Africa

South Africa has the most HIV positive people of any country in the world. It is at the peak rate for new infections and little headway has yet been made to bring the infection rate down. Of South Africa's 45 million people, 5.3 million are infected by HIV (South Africa Department of Health 2003), and 25% of its economically active individuals are infected (Kaiser Family Foundation 2003). The staggering toll that AIDS is taking on South Africa's social and economic fabric has only recently been acknowledged by the government. By 2000 the government began an AIDS prevention and treatment program, yet, the government has been widely criticized for its ineffectiveness. In 2000 South Africa's ministry of health refused to provide anti-retroviral (ARV) treatment for cost reasons, and the President, Thabo Mbeki, publicly questioned whether HIV really caused AIDS (Inter Press Service 2000). By 2002, the government began to work more closely with NGOs and promoted limited antiretroviral use. South Africa's government will face a growing crisis as its health infrastructure clogs with AIDS patients and the number of AIDS orphans grows.

Ethiopia

Similar to South Africa, the Ethiopian government was slow to recognize the impact that HIV/AIDS could have on the country. It was late in beginning education and prevention programs. Throughout the 1990s Ethiopia faced an increasing number of deaths from tuberculosis, but failed to link these deaths to opportunistic infections resulting from HIV/AIDS. That began to change in 1999 under pressure from indigenous NGOs and international organizations. Ethiopia now recognizes that it has a struggle ahead in terms

of its efforts to cope with HIV/AIDS. There has been a significant effort to try and educate the population on the basics of virus transmission. However, there are still significant challenges as surveys show that young people have a lot of misconceptions about the disease, particularly in the rural areas (Shinn 2001). A recently established government office, the National HIV/AIDS Council, has not yet been as effective as it could be in focusing attention and resources on the disease. One of the biggest challenges for Ethiopia will be how to deal with the AIDS orphans in the next decade. By some estimates, up to a quarter of all children in Ethiopia could be orphaned from AIDS within the next eight years (UN Integrated Regional Information Network 2003). These orphans will present a challenge to the state in terms of education and job provision as well as a drain on a healthcare system that currently spends only $2 per year per citizen (UN Integrated Regional Information Network 2004a).[6]

These snapshots of three African states give some indication of the varied nature of the HIV/AIDS pandemic in Africa. It is everywhere a challenge to the state and to fragile health care systems, but different countries are in different stages of their response to HIV/AIDS. Muslim areas and states have been less affected by HIV/AIDS and West African average rates of infection have been lower than those in Eastern and Southern Africa (see appendix).

The Evolution of HIV/AIDS as a Perceived Security Threat

HIV/AIDS has existed as an epidemiological challenge on the African continent since the 1970s. From the 1980s forward, the HIV/AIDS pandemic was recognized as a humanitarian crisis and an issue of human security. International responses occurred primarily through NGO activity and international institutions tasked with healthcare such as the World Health Organization, UNICEF and to some extent the United Nations High Commission on Refugees. Yet, it was not discussed in policy circles as a security threat until 1994, when Undersecretary of State for Global Affairs Timothy Worth noted the risks to state stability that develop in countries seriously affected by AIDS (Wirth 1994). It wasn't until 2000 that HIV/AIDS achieved a wider recognition as a security threat. It was then that the full impact of the disease on state capacity became apparent to external

observers (Richwine 2000). In 2000 the Clinton administration requested 250 million dollars in its budget for 2001 to fight the global AIDS pandemic (BBC 2000). The administration saw HIV/AIDS as a threat to the fledgling democracies on the African continent and noted the possibility of AIDS contributing to failed states because of its impact on state capacity to provide security, healthcare and education (US Government 2000).

What makes AIDS more than just an epidemiological crisis? Why has it made the leap from disease to security issue? In the following section answers to these questions will be addressed by examining the security concerns resulting from HIV/AIDS at the national and the international levels of analysis. Obviously, there is an individual aspect to the disease as well and HIV/AIDS is certainly a threat to individual or human security. It is the deaths of many aggregated individuals that lead to the national and international security threats.

African National Security Interests

At a national level the greatest immediate security threat from HIV/AIDS infection is that which comes from the weakening of the military when a significant percentage of soldiers become infected with HIV/AIDS. If the HIV infection rate keeps pace with other sexually transmitted diseases then the threat to the military is considerable. Stefan Elbe has noted that "Prevalence rates of sexually transmitted diseases among military personnel usually exceed those of the civilian population by a factor of two to five. In many African militaries, this is also true with regard to HIV"(Elbe 2002). In some countries the rates of HIV infection among the military are estimated to be as high as 50 and 60 percent (Heinecken 2000; UN Integrated Regional Information Network 2001). The number of infected soldiers in any given army is difficult to determine and countries are understandably reluctant to make this information public, even if they do know with some certainty.

> …the public admission of what may be high HIV infection rates among military personnel potentially compromises national and military security for some states by revealing what could be a substantial weakness in the military's combat readiness (Ostergard 2004: 12).

Noting that there might be reason for states to underestimate the rate of HIV infection in their military, there are still a few which exist. A concerted attempt has been made to collect available infection rate data and the results are found in the chart in the appendix.

High rates of HIV infection in the military increase the amount of money that needs to be devoted to recruitment, training and healthcare. Just as AIDS eliminates some of the most useful segments of the population in the civilian sector, so too it significantly impacts the officer corps and command structure of the armed forces. All the training that goes into the preparation of a single soldier with HIV/AIDS is lost when he has to leave the armed forces due to illness. Moreover, that particular soldier will not move up through the ranks and be available for leadership opportunities or lend his battlefield experience to the force. The average cost of training per soldier increases overall when more recruits have to be trained to compensate for those that have to leave the army due to HIV.[7] The end result of high rates of HIV infection will be an armed force which is less experienced and therefore less prepared than one in which the rates are substantially lower. Recognizing the high cost of training, the Kenyan, Tanzanian and Ugandan armed forces in Africa have made HIV testing mandatory for recruits. These countries then systematically exclude those that test positive (UNAIDS 2003).

If we can call the issue of HIV infection among soldiers the primary threat to national security, then there is a secondary and linked threat, that of the soldier as a vector of HIV transmission among the population. Zimbabwe's army is an example. By some estimates the army in the late 1980s through to 1990 was more that 70% HIV positive (Copley 1999: 5). These Zimbabwean forces were deployed to the Democratic Republic of Congo in the 1990s, undoubtedly spreading the disease there. Such a high percentage of infected soldiers may be unusual, but the scenario is not. Indeed, it is thought that the war in Angola exacerbated the spread of HIV/AIDS globally in the 1970s and that soldiers were the original vectors of the disease (Copley 1999: 4). Soldiers are particularly vulnerable to HIV infection because of risky sexual behavior. They are often deployed far from wives and family, resulting in a greater propensity to hire prostitutes and engage in the types of sexual activity associated with high rates of HIV transmission. Ironically, in many parts of Africa soldiers are also viewed as desirable potential mates because they have steady jobs and a reliable income. Thus, the opportunities for soldiers

to spread HIV through consensual sex are significant. Soldiers are also vectors in the spread of HIV through rape. As has been documented in many parts of Sub-Saharan Africa, war, displacement and genocide have led to the rape of women and girls and their subsequent infection with HIV. In the case of Rwanda the spread of HIV/AIDS among Tutsi women through rape was intentionally part of the genocide (Amnesty International 2000; Martens 2004; Sharlach 2000; Thomsom 2001; UNAIDS 2000).

International Security Threats

These national security threats emanating from high rates of HIV infection are reflected in international security issues as well. Why would the high rates of HIV infection be a problem for states and why would the US, in particular, be concerned about the issue? Here US security interests in the HIV/AIDS pandemic in Africa will be explicitly examined. There are three specific issues regarding the spread of HIV that are either a threat to US interests or a specific threat to US security. These are 1) the interest of the US in having African peacekeeping forces available for regional interventions; 2) US investment in training African forces abroad in anti-terrorism; and 3) the threat of failed states.

In the section above the issue of the effect of HIV/AIDS on the national military was discussed. Yet, issues of troop readiness have a wider impact than just national security. High rates of HIV infection in the military and troop readiness are related to US security interests in two specific ways: they affect the utility of African forces in regional peacekeeping and they weaken states' ability to respond to their own security crises. Since the invasion of Somalia in 1992, the United States has had an explicit preference for African peacekeeping efforts in Africa rather than the deployment of US forces. Accordingly, there has been an effort to train members of African militaries in peacekeeping operations. The most prominent of these efforts has been the African Contingency Operations Training and Assistance (ACOTA) program. ACOTA focuses on training African militaries in the development of a common peacekeeping doctrine, interoperability and standard communications technology in order to facilitate the effectiveness, coordination and rapid deployment of African forces in responses to African humanitarian and security crises. It continues and expands the African Crisis

Response Initiative (ACRI) Program developed by the Clinton Administration. The goal of ACRI/ACOTA is 8-10 African battalions of 600-800 soldiers each with additional specialized companies for combat support (Seal 2002: 15-16). Countries receiving training and funds though the ACOTA program are expected to deploy their troops quickly in response to UN requests for peacekeeping forces. Senegal, Uganda, Malawi, Mali, Ghana, Benin and Cote D'Ivoire have thus far participated in training exercises (Malaquias 2002). US Army Special Operations officers staff the initial two and one-half month training, which includes computer simulated exercises. This initial training is followed-up by refresher courses. The significant difference between ACRI and ACOTA is that under ACOTA there is training and equipment for light infantry and small unit operations. This is meant to enable peacekeeping and peace enforcement in hostile environments. There is also a greater attempt to tailor the country programs to the specific needs of each country (Handy 2003). The expectation of ACRI and ACOTA trained forces is that they will be able to deploy quickly as peacekeeping troops in areas of Africa in which the US has an interest.

Yet, as HIV/AIDS begins to take its toll on armed forces, the ability of those forces to deploy quickly in response to a threat is impeded. It is also less likely that countries in which the armed forces are stretched thin due to HIV/AIDS will be willing to participate in peacekeeping operations or regional interventions. This was one of the earliest points of concern with regards to HIV/AIDS and its effect on international security from the perspective of the United States (United States Institute of Peace 2001). Robert Ostergard has noted that in addition to difficulties in carrying out peacekeeping operations and foreign interventions, armed forces may be limited by HIV infection in their ability to carry out operations in their own countries (Ostergard 2004: 24).[8]

However, the relationship between HIV infection and peacekeeping operations is not everywhere problematized. In spite of US concerns about HIV/AIDS negatively affecting the availability of soldiers for peacekeeping operations, the relationship between HIV and peacekeeping may be fundamentally different. In some African militaries, peacekeeping operations have also served as an incentive for HIV/AIDS prevention in Africa. The opportunity of a potentially lucrative and rewarding peacekeeping assignment is being used as an incentive to encourage HIV prevention in

the Ghanaian military.[9] The Ghanaian military high command encourages HIV prevention and condom use. HIV positive soldiers are forbidden from serving on peacekeeping operations and miss the prestige and extra pay that these assignments bring. According to Brigadier General Twum " [Soldiers] are aware of this policy and make an active personal effort to prevent themselves from catching the virus in order to take part in these operations." The Ghanaian military has a lower rate of HIV infection than the population at large which currently has an infection rate of 3.8% (UN Integrated Regional Information Network 2004b). General Twum's statement suggests that African peacekeeping assignments may be an incentive for HIV/AIDS prevention and should therefore be supported for reasons of both security and public health. Certainly this is a positive and unanticipated African military response to international security issues.

Thus, evidence regarding peacekeeping is mixed. It is in the interests of US security to have available African peacekeepers, and if the Ghanaian case is any example, it also appears to be in the interest of African armed forces as well. To the extent that peacekeeping is viewed as a coveted assignment, high standards for peacekeepers, including HIV negative status, will lead to higher standards across the board for the armed forces. Policies mirroring those of the Ghanaian armed forces would be helpfully implemented in other militaries and would receive the support of countries to which these militaries are deployed, which may be reluctant to accept African peacekeepers who are HIV positive.[10] For example, Eritrea has asked that the UN not allow HIV positive soldiers to be part of the UN peacekeeping force monitoring the border between Eritrea and Ethiopia (Bazergan 2001). Such policies raise important human rights issues regarding discrimination against those who are HIV positive and will serve to further the problem of stigmatization of the HIV positive within African countries.

The focus on peacekeeping is just a subcategory of the largest type of US investment in security in Africa – military to military contacts and training. The second threat to US interests in Africa from HIV is the increased cost of training armed forces in Africa for more traditional operations. The US regularly trains African military forces. Some of this training is funneled through ACOTA, but more traditional training occurs through the International Military Educational Training Program (IMET), which has existed for decades with the purpose of training troops and officers in African militaries

at US sites.[11] In 2002 this program trained approximately 1600 members of African armed forces. The countries which have been the largest recipients of this training (in dollar amount) included Botswana, Ethiopia, Ghana, Senegal, Kenya, Nigeria and South Africa (Volman 2003).[12] Defense dollars allocated to IMET and ACOTA are designed to serve US interests abroad. However, if HIV/AIDS is leading to the death, disability or discharge of soldiers being trained via IMET dollars then the net benefit to the US in terms of security will be decreasing.[13]

IMET training is also linked to the global anti-terrorism effort. Since the Sept 11 attacks there has been a two-fold push by the Bush administration 1) to strengthen the ACOTA program to enable it to train soldiers for more "robust" assignments than peacekeeping (Malaquias 2002) and 2) to shift the focus of US military training to those countries with terrorist threats in order to expand the reach of the US in the struggle against terrorism (Garcia 2002). President Bush noted on March 11, 2002 "we will not send American troops to every battle, but America will actively prepare other nations for the battles ahead" (Bush 2002).

Thus the status of African armed forces is of critical importance to the US in terms of their ability to participate in peacekeeping and to strengthen global anti-terrorist efforts. It would be a great asset to African militaries and to US national security interests if the US would make the provision of anti-retroviral drugs to African armed forces a part of the US security strategy in Africa. This would address at least one aspect of the problem of HIV in African armed forces. If we can assume that those that are targeted for IMET or ACOTA training have already benefited from the available training of their own militaries and are at least of middle rank, and that those selected for IMET and ACOTA training are some of the best and brightest, then the provisions of anti-retroviral drugs would safeguard, not only the investment of US training dollars, but also the quality of the command structure of African militaries.

The third area in which HIV/AIDS presents a threat to US national security is that HIV/AIDS weakens states. The issue of the armed forces is just one example of the ways in which a state can be adversely affected by HIV/AIDS. The same issues of investment in training and the development of a hierarchy are replicated among the ranks of teachers, doctors, nurses and other educated people, even politicians. There is a great

fear that HIV/AIDS will create weak states; and those weak states will become failed states. The US and other countries now recognize that state failure in Afghanistan provided a conducive environment for terrorists to train and organize their attacks against Western targets. Failed states are a threat to global security (Rotberg 2002; Rubin 2002). The US has a national security interest in making certain that state failure is contained so as to make the world a safer place and the US a safer country. Sept 11 revealed the danger of allowing state failures and humanitarian emergencies to go unaddressed. In Africa, examples of failed states in Liberia and Somalia provide ready illustrations that there is some foundation to that fear. Liberian state failure pushed the whole Mano River region into war, creating the movement of arms and people into nearby states. Somalia is another African example of a failed state, and in this case state failure has been linked to terrorism.[14] Thus much of the rhetoric coming from US government officials regarding HIV/AIDS in Africa and national security uses state failure as the critical link between those two issues (Powell 2002; United States Institute of Peace 2001; US Government 2000; Wirth 1994). In the section below the recent US response to that threat will be examined.

The Bush Administration and Global HIV/AIDS

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

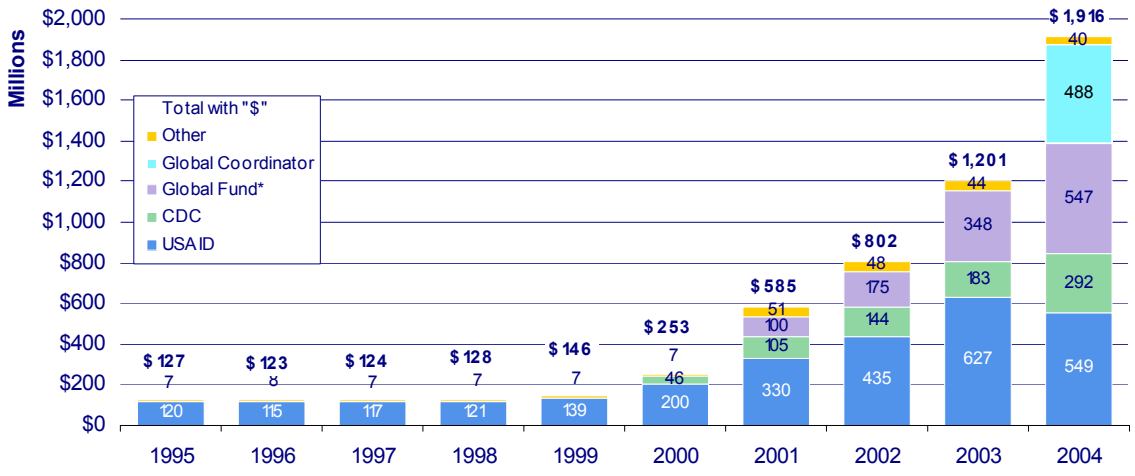
> "AIDS is not just a compelling moral issue, it is not just a humanitarian issue; it is far more than just a health issue. It is a security issue. It is a destroyer of nations. It is a destroyer of societies. It has the potential to destabilize regions, perhaps even entire continents. It can tear social fabric apart within any nation. It can rob young democracies of citizens they need to build freer, better futures for themselves and for their children. HIV/AIDS is an economic issue, leaving nations without human resources to grow and develop, ultimately sapping global well-being."(Powell 2002)

The desire to take some sort of national action on an issue which was increasingly articulated as a humanitarian disaster as well as a national security threat led to the announcement of a new bill to fight global HIV/AIDS. It was called The President's Emergency Plan for AIDS Relief (PEPFAR). The announcement was first made in the

2002 State of the Union address. President George W. Bush promised 15 billion dollars over five years dedicated to fight AIDS. As articulated in the bill, this would have meant 3 billion dollars a year, a sum which would have been a huge increase over previous funding levels. After appropriations that number was substantially decreased, yet the final contribution was still significant.[15] In Fiscal Year 1995 the US Government gave 127 million dollars to international HIV/AIDS programs. In 2004 that number will be 1.9 billion dollars.[16] The percentage of discretionary US Government AIDS funding going to international programs has increased from 3% in 1996 to 22% in 2004 (Summers and Kates 2004: 4, 8). The figure below depicts the increase in funds graphically.

Figure 1

Federal Funding for International HIV/AIDS
FY 1995-2004 (Excluding International Research)
(US$ Millions)



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

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

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

> UNAIDS, in sub-Saharan Africa, many military forces have infection rates as much as five times that of the civilian population. HIV/AIDS poses a serious security issue for the international community by- increasing the potential for political instability and economic devastation, particularly in those countries and regions most severely affected by the disease; decreasing the capacity to resolve conflicts through the introduction of peacekeeping forces because the environments into which these forces are introduced pose a high risk for the spread of HIV/AIDS; and increasing the vulnerability of local populations to HIV/AIDS in conflict zones from peacekeeping troops with HIV infection rates significantly higher than civilian populations (PL 108-25, 2003).

Though it might be overstated, the security threat noted in the PEPFAR legislation is one taken seriously by the US government and it has put HIV/AIDS on the US agenda in terms of both security and the commitment of funds. Yet, not all African countries are covered by the PEPFAR legislation. It targets twelve African countries: Botswana, Cote D'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia. Others are left out for reasons which have not been made clear. Moreover, other countries at risk from the spread of HIV/AIDS, most notably India, are not currently targeted for funding. The substantial new funding represented by PEPFAR will affect human security, though motivated by national security.[17]

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

US National Security and Public Health in Africa: A divergence of perspectives

Whatever the motivation for US concern with AIDS in Africa, the flow of money to the continent to assist with the crisis being caused by AIDS deaths and HIV infections will be welcomed. The question must be asked, will this money serve the goal of

strengthening weak African states and bolstering US security interests? If past foreign aid targeted at public health and education is any example, the answer is no. If the United States pours money into African states to strengthen their public health systems over a five year period, there is a possibility that African states will respond by withdrawing national funding in the areas where foreign funds are coming in. To some degree this makes sense - why should states allocate scarce resources to areas that are already receiving funding? In the past, NGO involvement in Africa has resulted in states abdicating from their responsibility to provide basic education and healthcare to their citizenry (Van de Walle 2001). The ironic effect is that when states abdicate their responsibility for providing these basic public goods, they become weaker, while the underlying intent of this funding initiative is to strengthen African states.

There is also cause for concern regarding the timing of the PEPFAR legislation and its long term effects. In the first year of funding the US government requested less than 3 billion in the initial "ask" because of a stated desire to see the infrastructure in place through which the aid can be funneled. The bill states that 55% of the money allocated by the PEPFAR legislation will go towards the purchase of anti-retroviral drugs. This is good news indeed, as with treatment, HIV infection can change from a death sentence to a serious, but chronic disease. But when the five years of funding runs out, will Africans just return to the business of dying?[18]

Additionally, it is unclear to what extent African governments see HIV/AIDS as a security threat. Certainly there is reason for them to do so, yet for them HIV/AIDS is also much more than merely a security threat. It is a public health disaster that drains from state coffers precious funds needed to combat even more pervasive diseases such as malaria. It is a drain on the educational system, and burdens the state with large numbers of orphans for which to care (or not to care for and then suffer the consequences). Moreover, HIV/AIDS affects the efficiency of a country's workforce. One HIV-testing project in Tanzania indicated that HIV/AIDS is the dominant cause of lost labor productivity and thus impacts the revenue of companies (Schuyler 2002: 6). HIV/AIDS also affects the efficiency of labor when even those that are not HIV positive are obligated to care for the dying or to frequently participate in funerals and ritualized memorials of those that have died. Certainly, the US focus on HIV/AIDS as a security

issue could be a boon for African governments struggling with responding to overwhelming numbers of HIV positive citizens. Yet there seems a divergence of perspectives between US and African countries as African countries must struggle with more than just the securitized elements of the AIDS pandemic. The burdens that structural adjustment places on countries should also be noted. While the US policy of support for combating the HIV/AIDS pandemic is laudable, it coexists with US support for structural adjustment programs that promote fee-based healthcare and primary education rather than the free provision of these services by states. There is some evidence linking structural adjustment with the spread of HIV/AIDS in Kenya where the imposition of fees led to a decline in attendance (Altman 2003: 422). With growing numbers of AIDS orphans and families impoverished by multiple AIDS deaths, the US support of fee-based services puts these basic public goods out of the hands of those the US is trying to assist through targeted HIV/AIDS funding.

Conclusion

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

US interests regarding HIV/AIDS in Africa have evolved over time. As the pandemic first took hold of the continent US concerns were humanitarian. However, as the fear of failed states increased, attention to HIV/AIDS grew correspondingly. In the post September 11 world, HIV/AIDS has become securitized - taking on the characteristics of a threat to international security as well as a threat to individual human security. US security interests in Africa exist in three specific areas: the need for trained and available African peacekeeping troops; US interests in training African militaries in anti-terrorism through the IMET program; and, the threat of failed states. HIV positive soldiers undermine US investments in African armed forces and ultimately US security

interests in Africa. However, there is some evidence from Ghana that US investment in training of African soldiers may actually lead to reduced rates of HIV infection as AIDS education in the armed forces can be coupled with financial and status incentives that come from participation in international training efforts, and encourage soldiers as well as equip them to remain HIV negative. What is clear is that the US has an interest in guarding its investment in African military training.

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

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Appendix

HIV Prevalence Rates 2003

Country	HIV/AIDS Prevalence Age (years) 15-49 % in general population	HIV/AIDS Prevalence % in Military
Swaziland	*38.8*	
Botswana	*37.3*	
Lesotho	*28.9*	
Zimbabwe	*24.6*	*50*
South Africa	*21.5*	*60 to 70*
Namibia	*21.3*	
Zambia	*16.5*	
Malawi	*14.2*	
Central African Republic	**13.5**	
Mozambique	*12.2*	
United Republic of Tanzania	8.8	15 to 30
Gabon	**8.1**	
Cote de'Ivoire	7.0	10 to 20
Sierra Leone (2001)*	7	61 (1998)
Cameroon	**6.9**	
Kenya	6.7	
Burundi (2001)*	6.0	
Liberia	5.9	
Nigeria	5.4	10 to 20
Rwanda	5.1	
Congo	**4.9**	**10 to 25**
Chad	**4.8**	
Ethiopia	4.4	
Democratic Republic of Congo	**4.2**	**40 to 60**
Burkina Faso	4.2	
Uganda	4.1	
Togo	4.1	
Angola	*3.9*	*40 to 60*
Equatorial Guinea (2001)*	**3.4**	
Guinea	3.2	
Ghana	3.1	
Djibouti	2.9	
Guinea-Bissaau (2001)*	2.8	
Eritrea	2.7	10
Sudan	2.3	
Benin	1.9	
Mali	1.9	
Gambia	1.2	
Niger	1.2	
Somalia (2001)*	1	
Senegal	0.8	

Mauritania	0.4	

Sources: Sarin, Radhika, "A New Security Threat: HIV/AIDS in the Military," *World Watch*, 16(2) (Mar/Apr 2003) p. 16-22; Doctors for Life. "AIDS Statistics." Doctors for Life Living Safely AIDS Projects. December 2000. Elbe (2002) http://www.hbc.dfl.org.za/statistics.htm. April 27th, 2004; O'Brian, Kevin. "AIDS and African Armies" *Atlantic Monthly*. (1993) Vol 292, No. 1. July/Aug 2003. p. 86-87; UNAIDS. "Table of country-specific HIV/AIDS estimates and data, end 2003." *2004 Report on the global AIDS epidemic.* July 2004. http://www.unaids.org/bangkok2004/report_pdf.html.

Key:
Italic - Southern Africa
Normal - Eastern Africa
Bold- Central Africa
Underline - Western Africa

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

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

[3] The peculiar nature of the transmission of the disease- through sexual contact and mother to child transmission- means it doesn't affect each member of a community in a similar fashion, such as a natural disaster or a famine might. Rather, it clusters deaths within families and vulnerable populations such as sex workers, truck drivers and migrant laborers. For a description of the local level impact of AIDS See Baylies, Carolyn. 2002. The Impact of AIDS on Rural Households in Africa: A Shock Like Any Other. *Development and Change* 33 (4):611-632.

[4] Here I use AIDS rather than HIV/AIDS as I am referring to the disease of Acquired Immunodeficiency Syndrome specifically rather than to the virus which causes it as well.

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

[6] This contrasts with approximately $112 a year in South Africa, a number calculated by dividing the public health budget by the population.

[7] There is also a debate on when soldiers should be required to leave the armed forces if they are HIV positive. Should they be made to leave when they test positive for HIV (sero-positive), or should it be when they become symptomatic. There are human rights and legal issues involved in forbidding a soldier from serving in the armed forces or in peacekeeping operations if he is HIV positive but asymptomatic. See Bazergan, Roxanne. 2001. Testing Times. *World Today* 57 (5):6-8. Some countries are reluctant to have peacekeepers in their country that are HIV positive. Eritrea, for example, has asked that peacekeepers with the UN Mission in Ethiopia and Eritrea be screened for HIV/AIDS. UNAIDS has opposed routine testing without consent as a violation of the human right to privacy and discrimination.

[8] One further issue which is rarely noted in the literature, perhaps because it has more national, rather than international impact, is the issue of battlefield casualties. AIDS changes the nature of the treatment of the wounded. When rates of infection among troops are high, medics will want to take as much precaution as

possible in handling battlefield injuries. Moreover, there will be far less willingness to treat enemy casualties when the fear of HIV infection is strong.

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

[10] In a study conducted by UNAIDS 94% of the militaries responding to inquiries conduct some form of HIV testing but only 55% have a declared policy regarding testing 2004. *AIDS Brief for sectoral planners and managers: Military Sector,* Health Economics and HIV/AIDS Research Division, University of KwaZulu-Natal, [cited April 21 2004]. Available from http://www.nu.ac.za/heard/aidsbriefs/sec/Military.pdf.

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

[12] The countries are noted here because they are not the same countries as those participating in ACRI. ACRI is specifically targeted at peacekeeping, but IMET funds can be used for training over a wider range of issues.

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

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

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

[16] This number differs from the 2.4 billion allocated because of funding for the newly established Global AIDS Coordinator at the State Department, now Randall Tobias. This was a choice to establish a particularly American program rather than work through the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global fund has received "high marks" from international auditors and is extremely short of funds, but the US legislation avoided using the Global Fund entirely in spite of pressure from lobbyists New York Times. 2004. Bush's AIDS Initiative. *New York Times*, February 16..

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

[18] I am actually of the opinion that even a five year delay in death is a good thing, so this should not be interpreted in a completely negative light. 5 years extra years can allow parents to find homes for their children and be present with them for that much more time. This presence is not insignificant if it means leaving a 15 year old as opposed to a ten year old, or an 8 year old as opposed to a three year old, and so on.