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The Silent War in Africa

HIV/AIDS as a Security Threat in Sub-Saharan Africa



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Abstract

In 2000 the UN Security Council declared HIV/AIDS a risk to national and international security. No region in the world is as affected by the pandemic as sub-Saharan Africa, which hosts 64% of the world's HIV/AIDS cases. In this thesis we take a close look at the security implications of the HIV/AIDS pandemic in sub-Saharan Africa. Theoretically based on alternative security approaches, such as the Copenhagen school, Human security and Health security, and particularly inspired by the health security works by Andrew Price-Smith, the link between AIDS and security is clarified and categorized through literature review. Thereafter this link is illustrated through a comparative case study of Zimbabwe and Botswana. The results show that HIV/AIDS has serious impacts on security in sub-Saharan Africa at various levels. By lowering life expectancy, increasing infant mortality, giving rise to poverty and a vast amount of orphans, and by weakening economy, state capacity, law-enforcement personnel and armed forces HIV/AIDS constitutes a considerable threat not only to *personal* and *communal*, but also to *national* and *international security*. Through the case studies it was found that HIV/AIDS seems to constitute a greater threat to states characterized by: *low endogenous state capacity; low exogenous inputs; other intervening variables* and *low or non-existent political will*.

Key words: HIV/AIDS, Africa, Security, State Capacity, Political Will

Table of Contents

1	INTRODUCTION.....	1
1.1	Statement of Purpose.....	1
1.2	Method.....	2
1.3	Material.....	4
1.4	Theoretical Approach.....	5
1.5	Definitions and Limitations.....	5
1.6	Disposition.....	6
2	BACKGROUND.....	7
2.1	HIV/AIDS in Southern Africa.....	7
2.2	Unique Features of HIV/AIDS.....	8
2.3	HIV/AIDS as a Security Issue.....	9
3	THEORETICAL FRAMEWORK.....	10
3.1	Traditional Security.....	10
3.2	The Widening of the Security Concept.....	10
3.2.1	The Copenhagen School.....	11
3.2.2	Human Security.....	12
3.2.3	Health Security.....	12
3.3	Concluding Remarks.....	13
4	HIV/AIDS AS A SECURITY THREAT IN SUB-SAHARAN AFRICA.....	15
4.1	Personal Security.....	15
4.1.1	Life Expectancy, Infant Mortality and Poverty.....	15
4.1.2	Orphans.....	16
4.2	Communal Security.....	17
4.2.1	Economy.....	18
4.2.2	Governance and Policing.....	19
4.3	National Security.....	21
4.3.1	Military Forces.....	21

4.3.2	The AIDS-Conflict Continuum	22
4.4	International Security	23
4.4.1	Turbulence and Destabilization	23
4.4.2	Peacekeeping	23
4.5	Summary.....	24
5	CASE STUDIES.....	25
5.1	Zimbabwe	25
5.1.1	The Impact of HIV/AIDS.....	25
5.1.2	The Government’s Response.....	28
5.2	Botswana	28
5.2.1	The Impact of HIV/AIDS.....	29
5.2.2	The Government’s Response.....	30
5.3	Summary.....	31
6	DISCUSSION	32
6.1	Results	32
6.2	Material.....	34
6.3	Future Research	34
7	CONCLUSIONS	35
8	REFERENCES.....	36
	APPENDIX 1 (World AIDS Statistics)	40
	APPENDIX 2 (Statistical Tables)	41
	APPENDIX 3 (Resolution 1308)	44
	APPENDIX 4 (The Story of a Zimbabwean Grandmother).....	47

Prologue: An Ugly War

In an attention-grabbing prologue to the report on “HIV/AIDS as a Security Issue” the International Crisis Group¹ (2001) writes the following:

The war in Botswana rages unabated. While the origins of the conflict remain murky, the appalling devastation is painfully clear. Estimates vary, but more than 100,000 have died as a result of the fighting, and that figure continues to escalate by the day. One in three adults in Botswana has been wounded, and if fighting continues at this pace, it is estimated that life expectancy could fall to an almost medieval age 29. The war has already created more than 28,000 orphans. Grimly, Botswana’s morgues complain that they have no space for incoming bodies, and that the situation is now so bad that corpses sometimes are laid on the floor.

The toll on the beleaguered Botswanan military continues to be alarmingly high, with more than one-third of the forces suffering casualties. Such attrition reduces military preparedness, internal stability and external security. The conflict represents a painful reversal for one of Africa’s brightest success stories. The government finds that it must devote more and more of its budget to hospitals, medicines and other costs associated with the war.

Unfortunately, Botswana’s young and educated labor force – particularly civil servants – has been a frequent target of the violence – sapping the country of some of its most valued leadership and ensuring that the country will have fewer and fewer qualified managers as the conflict wears on. Botswanan President Festus Mogae declared to Reuters that his country faces a fundamental national crisis. “We are threatened with extinction...People are dying in chillingly high numbers.”

But there is no war in Botswana, simply a disease. The war raging in Botswana is AIDS. All the statistics are true, but not a single shot has been fired. However, AIDS is taking a toll as profound as any military confrontation around the globe, and it is a security threat to countries it assaults as well as their neighbors, partners and allies (ibid.).

¹ The International Crisis Group (from here on referred to as ICG) is a Non Governmental Organization that dedicates itself to the prevention and resolution of conflicts.

1 Introduction

During the past months I have buried myself in piles of books and articles about security and about AIDS² in Africa. The far reaching impacts of this fatal pandemic are hard to grasp and I believe that most people living in our part of the world are unaware of the grave consequences that it has for many people and countries in the world, not least of all in Africa. I used to think of AIDS as a horrible disease. Now I think of it as something much more than that.

1.1 Statement of Purpose

There is no war causing more death and destruction, there is no war on the face of the earth right now that is more serious, that is more grave, than the war we see here in sub-Saharan Africa against HIV/AIDS (statement made by U.S. Secretary of State Colin Powell; quoted in USIP³, 2001 p. 5).

AIDS has outgrown war as the leading cause of death in Africa by a factor of ten⁴ (UN, 2000). Elbe (2003, p. 7) claims that: “AIDS is becoming a far greater threat to human existence than armed conflict; in the next decade alone, the pandemic is expected to kill more human beings than all the combatants killed in the First World War, the Second World War, the Korean War and the Vietnam War combined”.

Considering that AIDS constitutes such a significant threat one might wonder why it is that so little has been written about it within the field of security studies and international relations. Boone & Batsell (2001, p. 3) accuse political science in particular for being slow to “grapple with the enormous implications of the AIDS crisis for much of the developing world” and call for more work that by linking AIDS and politics could contribute to the struggle to cope with the pandemic. Other scholars plead for “further empirical analysis” and “a sustained and focused research on individual countries” in order to be able to determine

² Acquired Immune Deficiency Syndrome

³ The United States Institute of Peace (from here on referred to as USIP) is an independent, nonpartisan federal institution created by the U.S. Congress to promote the prevention, management, and peaceful resolution of international conflicts.

⁴ In 1998 AIDS killed 2,2 million people in Africa, making the disease more than ten times more lethal than wars, which were responsible for an estimated two hundred thousand deaths in the same year (Boone & Batsell, 2001 p. 3).

how serious the impact of HIV⁵/AIDS is on a country-by-country basis (Price-Smith, 2002 p.174; Elbe, 2003 p. 60). According to Garrett (2005, p. 9) it is important to clarify the security dimensions of the HIV/AIDS pandemic because actions taken to confront the disease as matters of domestic policy or foreign aid may differ markedly from those taken to address threats to security.

The purpose of this thesis is to clarify, categorize and illustrate the link between AIDS and security and thereby encourage further debate/research within an area that in my view has not received the much needed attention within the field of political science. I also have the aspiration to find potential explanations of why the impact of HIV/AIDS might differ between different countries. The research question that aims to guide this thesis is as follows:

- How can the HIV/AIDS pandemic in sub-Saharan Africa be seen as a security threat?

1.2 Method

In order to clarify and categorize the link between AIDS and security the method used will be that of literature review. Thereafter the method of comparative case studies is used to serve as an illustration of this link. This is not only an ideal way of concretizing the AIDS-security linkage, but also brings the opportunity to compare two cases, and thereby further deepen the understanding of the issue. The reason that only two cases have been chosen is that it will make it possible to go deeper than would have been the case had more cases been chosen. The choice of cases – Zimbabwe and Botswana – has to do with the fact that these two countries have some of the highest HIV-prevalence rates in the region (and in the world!). It is thus hoped that two more extreme cases will serve as efficient illustrators of the impact that HIV/AIDS can have on security. The reason these two cases were picked also has its explanation in that the governments in the two countries have responded to the HIV/AIDS pandemic in different ways. Whereas the disease initially was ignored in Zimbabwe, the Botswanan leaders seem to have confronted it with considerable efficiency.

Even though certain scholars emphasize the importance of determining the HIV/AIDS impact on a country-by-country basis due to their differences (Elbe, 2003 p. 60) it is possible to identify key variables and trajectories that are common to all countries with high prevalence rates.⁶ It is thus my hope that the

⁵ Human Immunodeficiency Virus

⁶ According to Price-Smith & Daly (2004, p. 5) the HIV-induced declines in population health and the subsequent decline in state capacity are generalizable, as the effects of debilitation and mortality will exhibit similar effects upon the macroeconomy and apparatus of governance across all similarly afflicted societies.

results of my case studies can be applicable to other countries within the sub-Saharan region. Perhaps it is also possible to see the results as some sort of possible future scenario of what could perhaps happen in other parts of the world where the HIV-prevalence rates are escalating at a worryingly fast pace, such as Russia, Ukraine, India and China.

While investigating HIV/AIDS as a security threat I have chosen not to focus on any particular level but rather to include a micro (i.e. *individual* and *communal security*), as well as a macro (i.e. *national* and *international security*) perspective. Perhaps one might argue that this is a far too broad and inclusive scope for analysis. However I argue that all these actor levels are intrinsically interwoven since they all affect one another. In order to enrich my analysis I have therefore consciously chosen to include all of them. Still it is true that the units subject to analysis are countries. There are two major reasons to this. Firstly, only by discussing country cases it is possible to reach the various levels for analysis (*personal, communal, national* and *international*). Secondly, it is only through country cases that I can fulfill my aspiration to find potential relevant variables that may explain the different impacts on different countries.

When one investigates the destabilizing impact of a pandemic in the developing world one is faced by a great problem. How is it possible to differentiate between the destabilizing impact of HIV/AIDS and the destabilizing consequences of other malicious factors, such as for example political corruption and drought? In order to solve this problem I intend to follow Price-Smith & Daly's suggestion and "think of the HIV/AIDS epidemic as a powerful 'stressor' that is exerting a significant negative influence on the nation's economic health and political stability" (Price-Smith & Daly, 2004 p. 5). To try to blame HIV/AIDS entirely for the malaise in countries with high prevalence rates such as Zimbabwe would be utterly unrealistic as it is obvious that such countries also suffer from a great deal of other problems that may well have a destabilizing effect on the country. Consequently the HIV/AIDS epidemic will from here on only be considered as one of many 'stressors' that have a profound negative impact on the affected society.

The second problem, linked to the above mentioned, is can HIV/AIDS actually be *measured* as a security threat? This naturally depends on one's definition of a security threat. It is here important to bear in mind that the impact of HIV/AIDS on a society is both direct (i.e. taking the lives of a great deal of a population) and indirect (i.e. reducing life expectancy and life quality; increasing poverty; eroding the economic strength and the institutions of governance of a country) (*ibid.*, p. 5). Although we have already decided to view AIDS merely as one "stressor" among others it is my belief that it to some extent is possible to measure its impact on various levels by viewing the statistics of HIV/AIDS related mortality and morbidity, that serve as clear indicators of HIV/AIDS as a security threat. There is extensive information available on the effects of HIV/AIDS on households, police and military forces, governmental institutions, as well as ordinary firms and companies.

1.3 Material

When it comes to the material it should be underlined that not too much research has been conducted that link HIV/AIDS and security. There are three main scholars: Firstly, Andrew Price-Smith, who has conducted a thoroughgoing research within the field of health security. Of particular use has been his 2002 book “The Health of Nations. Infectious Disease, Environmental Change, and Their Effects on National Security and Development”, as well as a report he has co-authored with John Daly, that investigates the links between HIV/AIDS, state capacity, and political conflict in Zimbabwe (Price-Smith & Daly, 2004). Secondly, we have Stefan Elbe, who has studied the impacts of HIV/AIDS on armed forces and peace-keeping operations. Finally there is the brand new, within the field renowned, report by Laurie Garrett: “HIV and National Security: Where are the Links?” (Garrett, 2005).

When it comes to the HIV/AIDS statistics it is by nature only possible to obtain approximate prevalence rates. As Price-Smith points out, the lack of transparency frequently hinders the collection of accurate field data and the dissemination of accurate statistics within a country. Political barriers may rise in order to hide the true state of affairs (Price-Smith & Daly, 2004 p. 44). This is not the least the case of the military who is often heard to consider their armies’ infection rates as classified information due to the potential vulnerabilities it would highlight (Elbe, 2003 p. 17).

There is also a risk that regional authorities for various reasons avoid giving out the correct information. They may have an interest in exaggerating an infectious disease situation in order to receive greater amounts of aid, or conversely downplaying the gravity of the situation in order to prevent the loss of revenue from trade and tourism⁷ (Price-Smith, 2002 p. 45). For this reason it is commonplace that the HIV/AIDS statistics vary considerably among different sources (see for example Elbe, 2003 pp. 18-19). Nevertheless the available data, patchy as they at times might be, are doubtlessly sufficient as a broad indicator of trends (*ibid.*, p. 17).

⁷ In the case of Kenya, where tourism is a significant source of GDP, the government refused to admit the scope of the AIDS problem until late 1997, by which time more than a million Kenyans were already infected (Caron, 1999 p. 30).

1.4 Theoretical Approach

Due to its focus on HIV/AIDS as a security threat the theoretical approach of this thesis lies close to what in the literature has been labeled health security (see section 3.2.3). Nevertheless I also wish to underline that other security approaches are automatically interwoven by my entering into different actor levels, such as *personal*, *communal*, *national* and *international security*. When it comes to *personal security* the human security approach becomes a natural theoretical approach, whereas *communal security* is more in line with the Copenhagen School, and *national* and *international security* seem to require a somewhat more traditional realist approach to security. In chapter 3 we shall have a closer look at these different theoretical approaches and investigate how they are linked to the analysis. The use of the different levels of security has been inspired by ICG (2001), who discusses HIV/AIDS as a security threat at five different levels: *personal security*, *economic security*, *communal security*, *national security* and *international security*.⁸

1.5 Definitions and Limitations

In the literature HIV/AIDS is referred to in terms of *epidemic*, as well as *pandemic* (even Price-Smith himself uses these two terms interchangeably). However I believe that such central terms need to be defined more closely. According to Price-Smith (2002, p. 5) an *epidemic* is an outbreak of disease that exhibits both geographical and temporal boundaries. A *pandemic* is an outbreak of disease that is not geographically restricted (e.g. HIV), nor is it necessarily confined within a set time frame (e.g. malaria, tuberculosis). Nevertheless the general pattern will be followed and both terms will be used in this thesis.

With regards to the definition of security I chose to depart from Richard Ullman's definition of a security threat as "an action or sequence of events that (1) threatens drastically and over a relatively brief span of time to degrade the quality of life for the inhabitants of a state, or (2) threatens significantly to narrow the range of policy choices available to the government of a state or to private, non-governmental entities (persons, groups, corporations) within a state" (Ullman, 1983 p. 123). This seems to be a logical choice since the HIV/AIDS pandemic significantly may degrade the quality of life for the inhabitants of a state and considerably reduce state capacity (Price-Smith, 2002 p. 119). By including the

⁸ In this thesis I have nevertheless chosen to include *economic security* issues at the *communal security* level, and thereby maintaining an actor focus.

“inhabitants of a state”, as well as the “policy choices available to the government of a state” it is my belief that Ullman covers all actor levels used in this thesis (*personal, communal, national and international security*).

With regards to the limitations I here wish to underline that, even though international security will be mentioned as a security aspect in the general presentation of HIV/AIDS as a security threat in sub-Saharan Africa (chapter 4) this aspect will not be taken into account when it comes to the specific case studies (chapter 5). The reason for this is the limited space. Furthermore it might also be argued that the impact of HIV/AIDS on international security in the cases of Zimbabwe and Botswana is of little significance compared to economically and strategically more important African states, such as South Africa or Nigeria. Nevertheless I believe it is important to include the international aspect in the general presentation so as to make the reader aware of the global impact that the HIV/AIDS pandemic in sub-Saharan Africa might have. Furthermore, one might perhaps argue that the choice of cases could have included more conflict prone countries, with high HIV-prevalence rates, in order to point out the connections between HIV/AIDS, instability and conflict. However, as we shall see, the relationship of the AIDS pandemic to violent conflict in Africa is far too complex to be expressed in simple cause-and-effect terms (USIP, 2001 p. 1). Therefore the choice made is to focus on HIV/AIDS as a security threat in a more general sense, rather than as a direct cause of conflict (see more about this issue in section 4.3.2).

1.6 Disposition

This thesis aims to take us through a ravaged landscape of AIDS-torn households, societies and countries. We will start out in chapter 2 with a brief background presentation of the central aspects of this thesis – HIV/AIDS and southern Africa. In order to understand how this fatal pandemic can possibly constitute a security threat it is essential that we have a look at the concept of security, and how this has been widened constantly since the end of the Cold War to include not only militaristic threats, but also non-militaristic ones. This will be the scope of chapter 3. In chapter 4 there will subsequently be a general presentation of HIV/AIDS as a security threat in sub-Saharan Africa, where we are taken through the various levels of *personal, communal, national and international security*. Thereafter follows chapter 5, which is subject to the two case studies of Zimbabwe and Botswana. Finally, in chapter 6, there will be a discussion on the results, where the two case studies will be compared to each other. This chapter will also discuss the material used and give suggestions for future research. The thesis will be ended with summarizing conclusions in chapter 7. Each chapter will be ended with a summary in an attempt to facilitate for the reader.

2 Background

2.1 HIV/AIDS in Southern Africa

Sub-Saharan Africa is home to 24 of the 25 countries with the world's highest HIV-prevalence (UNAIDS/UNICEF/USAID, 2004 p. 8). In sub-Saharan Africa HIV/AIDS is spread predominantly through heterosexual sex. Susceptibility and vulnerability to HIV/AIDS are linked to the economic and social characteristics of both individuals and society (Barnett & Whiteside, 2002 p. 15). Even though polygamous cultures characterized by multiple sexual partners help to spread the disease rapidly, the labor migration and the economically motivated sexual relationships that follow from economic deprivation also play an important role in the spread of HIV/AIDS in Africa (Tibaijuka, 1997 pp. 964-966).

Over the past two decades it is estimated that 25 million people have died from AIDS-related illnesses (Elbe, 2003 p. 7). According to the UNAIDS⁹/WHO (2005a) approximately 40,3 million people around the world live with HIV/AIDS. 25,8 million of these people live in sub-Saharan Africa (see World AIDS Statistics, Appendix 1, p. 40). This means that about 64% of the world's HIV/AIDS cases are to be found in sub-Saharan Africa, even though only a tenth of the world's population lives in the region (Pharaoh & Schönteich, 2003 p. 2).

Between 1997 and 2001 adult HIV-prevalence rates increased at a startlingly fast pace in SADC¹⁰ countries. For example Lesotho experienced an increase of 269% over this four year period (*ibid.*, p. 3) (see Appendix 2, table 1, p. 41). According to Pharaoh & Schönteich the total global HIV-prevalence rate at the end of 2001 was 1,2 %. The twelve continental member states of the SADC had an average adult¹¹ HIV-prevalence rate of 20,6%, followed by sub-Saharan Africa as a whole (9%). HIV-prevalence rates were thus in 2001 seventeen times higher in the SADC region than the average global rate (*ibid.*). Sub-Saharan Africa is hence “the epicenter of the HIV pandemic” (Price-Smith, 2002 p. 6).

⁹ Joint United Nations Programme on HIV/AIDS

¹⁰ Southern African Development Community. The continental member states of SADC are: Angola, Botswana, Democratic Republic of Congo (DRC), Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. The two non-continental states are Mauritius and the Seychelles (Pharaoh & Schönteich, 2003 p. 2).

¹¹ An adult is defined in terms of men and women aged 15-49 (UNAIDS/WHO, 2004a).

Sub-Saharan Africa not only differs from the rest of the world in terms of number of infected people, but also with regards to the number of infected women, being the only region where women have a higher prevalence rate than men. In 1997 close to four fifths of the world's HIV-positive women were to be found in sub-Saharan Africa (UNAIDS, 1997), and in 2005 57% of the adults living with HIV in the region were women, as compared to 25% in North America (UNAIDS/WHO, 2005a).

2.2 Unique Features of HIV/AIDS

As one of the infectious diseases to have emerged over the past few decades HIV/AIDS is unique in several ways (Pharaoh & Schönteich, 2003 p. 2). In contrast to diseases such as Malaria and Tuberculosis, HIV/AIDS does not strike hardest at the young, the weak or the elderly. On the contrary, its effects are felt particularly in the ranks of the most productive members of society (Piot, 2000 p. 2176). This has, as we shall see, fatal consequences for the societies where the spread of HIV/AIDS is rampant.

Like other infectious disease epidemics, HIV/AIDS follows an 'S' curve, meaning that the number of people infected with HIV initially climbs slowly and gradually until a critical mass of people is infected. After this 'tipping point'¹² is reached, the number of new infections accelerates. In the final phase of the epidemic the curve flattens and then begins to turn downwards as people regain their health or the number of disease related deaths begins to outnumber new infections (Barnett & Whiteside, 2002). What makes the HIV/AIDS epidemic different from other epidemics in this aspect is the presence of two 'S' curves: one of asymptomatic HIV, the other symptomatic of 'full-blown' AIDS (Pharaoh & Schönteich, 2003 p. 2). The fact that the HIV curve precedes the AIDS curve by about five to eight years has contributed to HIV/AIDS being more deadly than other life threatening diseases such as cholera or Ebola fever. The reason for this is that these latter diseases have a time span in which its victims progress from infection to visible illness and possible death in a matter of days or weeks. This serves to immobilize sufferers – thereby restricting the spread of the disease – and alert health authorities who can then act to combat its spread. In the case of HIV/AIDS the long period between infection and the appearance of symptoms allows the virus to spread unabated, and facilitates ignorance and denial of the disease (Barnett & Whiteside, 2002 p. 48). The long time span of the HIV/AIDS pandemic leads to what Price-Smith & Daly (2004, p. 34) call an "attrition

¹² After the epidemic has reached the "tipping point" of 1% it will spread at a much faster pace. For example in South Africa it took five years for prevalence rates to move from 0.5% to 1%. Then, in only seven years, it jumped from 1% to 20% (Piot, 2004 ; quoted in: Brown, 2004).

process”, that slowly and inexorably destroys a nation’s economy, institutions and social mores. Referring to the “long wavelength problem” of HIV/AIDS Garrett (2005, p. 20) writes about the pandemic as a “protracted Black Death”, creating waves of infection, followed years later by waves of acute disease, and finally years after that, by waves of death and family disruption.

Finally, the fact that HIV/AIDS is transmitted primarily through sexual intercourse embeds it in the most intimate aspects of people’s lives. This means that HIV/AIDS often is kept within the realm of the private, facilitating secrecy and further ignorance and denial (Pharaoh & Schönteich, 2003 p. 2).

2.3 HIV/AIDS as a Security Issue

There is a plethora of evidence of HIV/AIDS having turned from being merely a health issue to being considered a security threat. Referring to AIDS as a “global aggressor that must be defeated” U.S. Vice President Al Gore spearheaded the efforts to have the United Nations Security Council devote a session to the implications of AIDS on international security in 2000 (Price-Smith 2002, pp. 123-124). The debate that followed was the first in the Council’s history that discussed a health issue as a threat to peace and security. UN Secretary-General Kofi Annan told the Council:

The impact of AIDS in Africa is no less destructive than that of warfare itself. By overwhelming the continent’s health and social services, by creating millions of orphans, and by decimating health workers and teachers, AIDS is causing social and economic crises which in turn threaten political stability...In already unstable societies, this cocktail of disasters is a sure recipe for more conflict. And conflict, in turn, provides fertile ground for further infections (Kofi Annan at the Special UN Security Council Session on AIDS in Africa, 2000; quoted in: Pharaoh & Schönteich 2003, p. 1).

HIV/AIDS was subsequently recognized by much of the international community as a novel and growing threat to both national and international security (Price-Smith, 2002 p. 123). On July 17th 2000 the UN Security Council adopted Resolution 1308, declaring the HIV/AIDS a risk to stability and security (see Resolution 1308, Appendix 3, pp. 44-46). Since then, governments world-wide have recognized the magnitude and alarming rate in which the AIDS epidemic is growing. In June 2001 the Member States unanimously adopted the UN Declaration of Commitments on HIV/AIDS during the UN General Assembly Special Session on HIV/AIDS, in which they declared that AIDS “constitutes a global emergency and one of the most formidable challenges to human life and dignity,.....” (Kristofferson, 2002).

Another sign of the securitization of the epidemic is the UNAIDS increased cooperation with the DPKO (Department of Peacekeeping Operations), as well as with ICG. As Peter Piot notes it is also a fact that HIV/AIDS no longer is an issue primarily handled by Health Ministers, but rather by Presidents and Prime Ministers around the world (Conference on AIDS and National Security, 2005).

3 Theoretical Framework

3.1 Traditional Security

The traditional approach to security rests on realistic assumptions about the struggle for power between political units. Even though different branches of political realism disagree about whether the fundamental cause of political conflict and the struggle for power and security lies with human nature (classical/neoclassical realism), or with the logic of anarchy (structuralism/neo-realism) they are united in their beliefs about world politics, as characterized by dominating significance of sovereign states, the drive of states to survive and maximize power, the expectation of interstate struggles, crises, and war, and the sanction of military force as an instrument of policy (Booth, 2005 p. 5).

Stephen Walt takes perhaps the strongest traditionalist position. Walt (1991, p. 212) warns scholars of the danger of too broad a conception of security and contends that not only should scholars keep a thin conception of security, but that “the main focus of security studies is easy to identify [...] it is the phenomenon of war”. Therefore, security can be defined as “the study of the threat, use and control of military force”, and security studies should “explore the conditions that make the use of force more likely [...] and the specific policies that states adopt in order to prepare for, prevent, or engage in war”.

3.2 The Widening of the Security Concept

Security is nowadays an essentially disputed concept. The “traditionalist”, military-centered visions are at odds with “alternative” approaches that intend to widen the security concept. According to Buzan, the “wide” versus “narrow” debate grew out of dissatisfaction with the intense narrowing of the field of security studies imposed by the military and nuclear obsessions of the Cold War (Buzan, Waever & de Wilde, 1998 p. 2). Whereas the traditionalists want security studies to remain centered around the threat or use of force, the wideners clearly want to expand the security concept in order to adapt it to the new threats

generated by globalization (Booth 2005, p. 2). An early example of a widener is Richard Ullman (1983, p. 129), who warned that defining security solely in military terms is misleading, as a focus on military security can distract governments from other, more dangerous threats, thus making states less secure.¹³ Emma Rotschild (1995, p. 55) has classified the debates about extending security into four stands. The first involves the extension of security:

from the security of nations to the security of groups and individuals: it is extended downwards from nations to individuals. In the second, it is extended...upwards, from the nation to the biosphere....In the third operation it is extended horizontally, or to the sorts of security that are in question...the concept of security is extended, therefore, from military to political, economic, social, environmental, or "human" security....In a fourth operation, the political responsibility for ensuring security...is diffused in all directions from national states, including upwards to international institutions, downwards to regional or local government, and sideways to nongovernmental organizations, to public opinion and the press, and to the abstract forces of nature or of the market.

3.2.1 The Copenhagen School¹⁴

In his book "People, States and Fear" (1991, first ed. 1983) Barry Buzan intends to broaden the concept of security to encompass five major sectors: *military* (a matter of offensive and defensive capabilities of states); *political* (the stability of states, its government, and its ideology); *economic* (a state's access to resources, finance, and markets); *societal* (the sustainability of identity, language, and custom) and *environmental* (the planetary biosphere). Even though Buzan considers the individual as the "irreducible base unit" for discussions about security, the central referent of security in his thesis remains the state: "Although individual security does represent a distinct and important level of analysis, it is essentially subordinate to higher-level political structures of state and international system. Because this is so, national and international security cannot be reduced to individual security" (*ibid.*, p. 54). By the early 1990s, Buzan and Waever further developed the notion societal security (Buzan, Waever & de Wilde, 1998). Whereas state security has sovereignty as its core value, societal security has its focus on identity. Even though societal security was not to replace a focus on state security the idea was that it should be more at the center for analysis.

Buzan's widening of the security concept was an important contribution, not only by introducing a number of different sectors into the security discourse, but also by stressing how these sectors all interact with one another (Buzan, 1991 pp. 19-20). From Buzan we learn that we must interpret security as relational and

¹³ For Ullman's definition of what constitutes a security threat see 1.5.

¹⁴ Dubbed the "Copenhagen School" by Bill McSweeney (1996) this school primarily consists of the works of the two prominent scholars Barry Buzan and Ole Waever.

interdependent, as: “Individual national securities can only be fully understood when considered in relations both to each other and to larger patterns of relations in the system as a whole” (*ibid.*, p. 22).

3.2.2 Human Security

The human security approach was developed by the UNDP (United Nations Development Program) in 1994¹⁵ (Bajpai, 2000, pp. 6-7), and has been taken up by international bodies, such as the World Bank and the IMF (International Monetary Fund), as well as by some governments, such as the Canadian, the Japanese and the Norwegian (Smith, 2005 p. 53; Paris, 2001 p. 87).

Human security challenges not only traditional security but also the Copenhagen School in that its referent subject is the individual, rather than the state (Ostergard 2002, p. 335). According to the human security scholars new historical possibilities emerged with the end of the Cold War, and the individual can be practically addressed since the major powers no longer constitute “fearsome enemies”. The situation after 1991 is therefore the reverse of the Cold War. *Personal* or *human* security is now the central concern of security; and traditional national security concerns are less important (Bajpai, 2000 pp. 21-22).

The UNDP report outlines seven areas of human security: economic security, food security, *health security*, environmental security, *personal security*, community security, and political security (Smith, 2005 p. 52). The values at the heart of the human security approach are the safety and well being of the individual in physical terms, as well as individual freedom. Contrary to the traditional security approach where military force stands out as the primary security instrument, the human security gives virtually no room for the use of force. Rather the means by which human security goals are to be reached is development (Bajpai, 2000 p. 30).

3.2.3 Health Security

In the words of Price-Smith (2002, p. 9) the spread of lethal infections such as HIV and tuberculosis throughout significantly affected societies is “comparable to the effects of a slow-acting neutron bomb that eliminates a large proportion of the population while leaving the infrastructure intact”. According to Price-Smith (*ibid.*, p. 74) the destruction of the population base of a country is a grave threat to that country’s security, by affecting its economy, educational system, military and

¹⁵ Although there have been several attempts to define human security the UNDP’s definition of the concept remains the most widely cited (Paris, 2001 p. 90).

political institutions.

According to William McNeill (1976) microbes have been persistent adversaries of humanity and human societies since time immemorial. Current anthropological evidence suggests that the expansion and collapse of various societies throughout history may have resulted in part from the transmission of lethal and/or debilitating pathogens (Price-Smith, 2002 p. 10). As we shall see there are several examples of this. Thucydides's account of the eventual fall of Athens during the Peloponnesian War pays particular attention to the devastating effect that "the plague" had on Athenian governance, and indirectly on the Athenian war effort:

The bodies of the dying were heaped one on top of the other [...] For the catastrophe was so overwhelming that men, not knowing what would happen next to them, became indifferent to every rule of religion or law. Athens owed to the plague the beginnings of a state of unprecedented lawlessness. [...] (Thucydides 1980; quoted in Price-Smith, 2002 p. 10).

McNeill (1976, pp. 101-106) argues that the collapse of the Byzantine Roman Empire in the sixth century A.D. resulted from the "plague of Justinian". According to Moore (1966, p. 6; quoted in Youde, 2004 p. 4) the Black Death, which killed approximately one-third of Europe's population, played a decisive role in bringing about the end of the feudal system and encouraging the Reformation. Garrett (2005, pp. 17-19) underlines the striking similarities between HIV/AIDS and the Black Death concerning the reshaping of the demographic distribution of societies, massive orphaning, labor shortages in agricultural and other select trades, strong challenges to military forces, an abiding shift in spiritual and religious views, fundamental economic transformations, and changes in the concepts of civil society and the roles of the state. Further on, the merging of American and European disease pools permitted the conquest of the Americas by relatively modest European military forces. According to McNeill (1976, pp. 180-181) the imported diseases led to a catastrophic population decay. In hundred years the Amerindian population had decreased from approximately 100 to 1,6 million:

[Such a disaster] carries with it drastic psychological and cultural consequences. Faith in established institutions and beliefs cannot easily withstand such disaster; skills and knowledge disappear. Labor shortage and economic regression was another obvious concomitant.

3.3 Concluding Remarks

In this chapter we have seen examples of schools that turn against traditional security, such as the *Copenhagen school*, the *human security* and the *health security*. The Copenhagen school was among the first to bring in an array of new sectors to the security discourse, and even though Buzan considers the individual as an "irreducible base unit" it was primarily the human security school that further developed the issue of personal security by focusing on the safety and well

being of the individual. Constituting a sub area of human security, the health security centers particularly on the debilitating effects that infectious diseases may have on individuals, societies and nations.

In this thesis I categorize the security threat of HIV/AIDS in four different levels – *personal*, *communal*, *national* and *international security*. Clearly, the health security approach constitutes a general theoretical framework at all these levels, but we can also easily refer to the human security and the Copenhagen school approaches, and perhaps to a certain extent even to the traditional security approach. Whereas *personal security* in its focus on the individual clearly goes hand in hand with, and forms part of the human security, *communal security* fits better with the Copenhagen school. This thesis maintains ICG's view of communal security as a function of good governance – effective operation of the institutions and people that make a state function, and the peaceful resolution of disputes (ICG, 2001 p. 15).

It is interesting to note that Buzan's concept of *societal security* focuses above all on the sustainability of identity, language, and custom and that it seems to have rather little to do with the communal security that is one of the levels for analysis in this thesis. Even though Buzan's societal security sector cannot serve as a theoretical base of the communal security in this thesis, his *political* and *economic* security sectors¹⁶ may do so (see 3.2.1).

Even though the traditional security approach does not usually consider disease a security threat, the risks that HIV/AIDS poses to *national security* by weakening “the use and control of military force” (see Walt, 3.1) suggest that we perhaps can link this level to the traditional realist approach to security. When it finally comes to the impact of HIV/AIDS on *international security*, this may perhaps in the same way as with national security also be tied to the traditional approach to security in terms of weakened peacekeeping operations (see 4.4.2), whereas the turbulence and destabilization of the international system that may follow the HIV/AIDS pandemic (see 4.4.1) is more linked to the Copenhagen school's *political* and *economic* security sectors. Furthermore Buzan's view of security as relational and interdependent may help us in understanding how HIV/AIDS can constitute an international security threat.

Finally I here wish to point out that whereas *personal* and *communal security* threats mainly refer to threats within the internal realm (such as decreased individual wellbeing and political instability) the *national* and *international security* threats have their roots in the external realm (such as weakened military forces to defend the territory from external aggressors, and weakened peacekeeping operations). Therefore this thesis will refer to the concepts of *internal* and *external* security.

¹⁶ Buzan's *political* security sector refers to the stability of states, its government, and its ideology, whereas his *economic* security sector rather focuses on a state's access to resources, finance, and markets (Buzan, 1991).

4 HIV/AIDS as a Security Threat in Sub-Saharan Africa

As we shall see in this chapter HIV/AIDS has a far reaching impact on African society, which directly, as well as indirectly has implications for the security on various levels. As U.S. Vice President Al Gore put it:

When 10 people in sub-Saharan Africa are infected every minute; when 11 million children have already become orphans, and many must be raised by other children; when a single disease threatens everything from economic strength to peacekeeping – we clearly face a security threat of the greatest magnitude” (U.S. Vice President Al Gore at the Special UN Security Council Session on AIDS in Africa, 2000; quoted in: USIP, 2001 p. 5).

4.1 Personal Security

4.1.1 Life Expectancy, Infant Mortality and Poverty

According to ICG (2001, p. 4) AIDS is almost entirely responsible for life expectancy having dropped by over twenty years in ten African countries, wiping out the gains of thirty years of development (U.S. News & World Report, February 14, 2000; quoted in: ICG, 2001 p. 4) (see Appendix 2, table 2, p. 42). Today’s world is facing the widest life-expectancy gap in human history, with the longest-living societies now surviving into their eighties, while some AIDS-plagued countries have seen their life expectancies plummet into the high twenties (Garrett, 2005 p. 12).

AIDS-related mortality also threatens to eliminate the gains made in child survival over the past twenty years in much of Africa. The epidemic makes infant mortality soar in the worst-hit countries (see Appendix 2, table 3, p. 42). In South Africa, infant mortality is already 44% higher than it would have been without AIDS, and by 2005-2010, it is expected to be 60% higher (ICG, 2001 p. 5).

UNAIDS (1998) estimates that income in poor households with an HIV-positive member may decline by as much as 40-60%, something that leads to what Price-Smith (2002, p. 86) calls “economic ‘shocks’ to household savings and consumption patterns”. This happens in several ways. As AIDS often debilitates and kills those most likely to be supporting the household financially other income earners may have to give up work to provide care. In many parts of Africa the illness of a household member also draws family labor and resources away

from subsistence agriculture, as people are either too ill to work or have their time taken up caring for the sick. However AIDS affected households do not only face losses in production, but must also find the funds necessary to pay for medication and health care during the member's illness, and the funeral after their death (Pharaoh & Schönteich, 2003 p. 9). As families have less to spend and no longer produce as much food, malnutrition rises. This was documented in Côte d'Ivoire, where family food consumption went down by 41%, whereas expenditures for health care went up 400% when a family member had AIDS (UN Security Council, 2000). The additional costs imposed on households by HIV/AIDS particularly affect the poorer ones, which indirectly means that income inequalities between the lower and upper classes are exacerbated (Price-Smith, 2001 p. 170). Socially, the disease can also sharpen divisiveness and increase group cleavages, even to the extent where one ethnic group may be targeted for blame by others (Glasgow & Pirages, 2001 p. 207).

4.1.2 Orphans

By 2003 15 million children under 18 had been orphaned¹⁷ by HIV/AIDS worldwide. About 12 million of these live in sub-Saharan Africa, and it is expected that this number will have risen to more than 18 million by 2010 (UNAIDS/WHO, 2004a). In the most heavily affected African countries, as many as one-third of all children will eventually be orphaned by AIDS (U.S. National Intelligence Council, 2000) (see Appendix 2, table 4, p. 43). When a parent becomes ill with AIDS, children often drop out of school in order to provide care and to replace the lost family income (UN Security Council, 2000). These children are also more likely to drop out of school as there is no longer money to pay for the school fees.¹⁸ According to Pharaoh & Schönteich (2003, p. 7) lost educational opportunities mean that children will have less earning potential as adults, and will therefore be at increased risk of falling into, or remaining in poverty. There is furthermore strong evidence that societies with dramatic child and youth-bulge demographics are at greater risk for civil disturbance, conflict and disorder (Garrett, 2005 p. 11; Pharaoh & Schönteich, 2003 pp. 10-11).

Young people that lack job and income, and that have no family to support them are also at risk of joining, or being abducted by, local militias. Whereas the militias constitute a source of food, shelter and identity for many of these children, the children in their turn are a low-cost source of labor for the militias, and can be induced to undertake the most horrific of missions (ICG, 2001 p. 7). It should not be denied that a vast amount of orphans can become a threat to the

¹⁷ According to UNAIDS, WHO and UNICEF an AIDS orphan is a child who loses his/her mother to AIDS before reaching the age of 15/18 years (AIDS Orphans in sub-Saharan Africa, 2005).

¹⁸ According to a UNDP study of Zambian households that had lost a member to HIV/AIDS, 21% of the girls and 17% of the boys dropped out of school (Pharaoh & Schönteich, 2003 p. 9).

internal security of a country. Atwood (1997) predicts that:

(w)ith children who have lost their parents eventually comprising up to a third of the population under 15 in some countries, this outgrowth of the HIV/AIDS epidemic will create a lost generation – a sea of youth who are disadvantaged, vulnerable, undereducated and lacking both hope and opportunity. What we are seeing here are the seeds of crisis. The creation of such large and disaffected demographic “youth explosion” could propel some of these societies to significant unrest and destabilization over the long term. The threat to the prospects for economic growth and development in the most seriously affected countries is considerable.

4.2 Communal Security

According to ICG (2001, p. 15) communal security is a function of good governance – effective operation of the institutions and people that make a state run, resolve disputes peacefully, and create a sense of national unity. Rousseau and Hobbes argued that a social contract has historically existed between the state and the governed.¹⁹ By this they meant that the citizen declares his or her fealty to the state that in return guarantees to protect the citizen from internal (i.e. criminals), as well as external (i.e. foreign armies) threats (Price-Smith, 2002 p. 118). But what happens when the state, due to diminishing financial, as well as human capital, is so weak that it can no longer do this? Under these circumstances the risk for instability and conflict seems to increase considerably.

According to Price-Smith (*ibid.*, p. 120) there exist two principal hypotheses that link demographic change to intra-state violence: the *relative deprivation hypothesis* and the *state weakness hypothesis*. The *relative deprivation hypothesis* argues that certain demographically related processes may lead to increasing deprivation that eventually translates into increasing frustration, which in turn generates increasing aggression by disaffected individuals and collectivities. Hence, greater deprivation may increase the probability of social violence and political chaos.

However the deprivation hypothesis by itself cannot explain political violence. It is easily falsified by all those poor countries which are not characterized by chronic internal violence. Kahl (1998; quoted in Price-Smith 2002 p. 120) argues that conflict appears to occur more frequently when mounting deprivation is combined with declining state capacity. Thus the *state weakness hypothesis* suggests that intra-state organized violence tends to occur when stressor variables (e.g. poverty, environmental scarcity) create both opportunities and incentives for citizens to engage in collective violent action against the status quo. According to Price-Smith HIV/AIDS may be a significant contributor to the preconditions for sub-state violence and state failure by causing considerable deprivation, and by

¹⁹ See Hobbes' *Leviathan* and Rousseau's *Social Contract*.

simultaneously weakening the state capacity of the affected countries. How does the HIV/AIDS weaken the state capacity then?

4.2.1 Economy

The economic effect of AIDS is felt at various levels and to various degrees. The individuals who fall ill and die are all economic actors – producers and consumers. The effect of an infection is felt first and most immediately by the persons who fall ill and by their families. It then spreads like a ripple through the household, community, and then through the country as a whole (Nevin, 1998 p. 16). AIDS puts at risk human capital and natural resource development, and business investment, which form the foundation of national economies (ICG, 2001 p. 9). According to the U.S. National Intelligence Council (2000) AIDS has already cut 1 percentage point off of GDP in Africa's worst-hit countries. In South Africa, where 20% of the population is HIV-positive, the World Bank (2000) estimates that GDP will be 17% lower by 2010 than it would have been without HIV/AIDS.

AIDS assaults the human capital by infecting the workers, who consequently are less efficient, less able to do manual labor, and more absent. As workers begin to die firms face an overall labor shortage. HIV/AIDS disproportionately targets skilled workers²⁰, such as middle and senior management, educated urban professionals, and government officials (Copson, 2001). AIDS harms business by taking its toll far faster than the professional ranks can be replenished with fresh trainees (Garrett, 2005 p. 10). Furthermore the epidemic increases the costs for business – for replacement hires, recruitment and training, insurance, health care and funeral expenses. A number of key sectors in African economies are already being decimated by AIDS, including agriculture, mining and transport. According to the Food and Agriculture Organization (FAO, 2001) AIDS has killed almost 13% of the agricultural workforce in the most-affected countries. In South Africa the industry hardest-hit by HIV/AIDS is the most central to the country's economy – the mining. Studies of the sector have shown infection rates from one-quarter (The Economist, February 8, 2001; quoted in: ICG, 2001 p. 11) to one-half (Daily Mail & Guardian, July 26, 2000; quoted in: ICG, 2001 p. 11) of the country's miners.

HIV/AIDS also has an impairing effect on business investment in that it, due to reduced productivity and rising costs, shrinks businesses' revenues and savings, and thereby diminishes the ability to invest in the future. Studies show that a negative impact on business investment is already taking place as individual

²⁰ This might be explained by the fact that these employees have relatively high salaries and travel more, which make them prime targets of the commercial sex trade (New York Times, November 15, 1998; quoted in: ICG, 2001 p. 10).

companies shift out of Africa determined that HIV/AIDS would so significantly affect their potential regional market that they would be better off investing elsewhere (British House of Commons, 2001).

4.2.2 Governance and Policing

According to ICG (2001, p. 15) AIDS is undermining the governments of Africa and attacking civil servants in disproportionately greater numbers than the population at large.²¹ High prevalence rates within the domain of governance undermine the capacity of political leaders and their respective bureaucracies to govern effectively (Price-Smith, 2001 p. 171). Ultimately the loss of senior officials weakens state institutions (ICG, 2001 p. 15).²² Given that the epidemic is still in its infancy in many parts of the world, and at least 39 million people now infected with HIV are expected to perish over the next five to ten years, this depletion of elite workers, professionals, political leaders, and managers is expected to reach crisis proportions in many countries by 2010, challenging the ability of the state to perform even rudimentary aspects of governance (Garrett, 2005 p. 11).

According to Price-Smith & Daly (2004, p. 13) there exists a strong relationship between population health and state capacity, where public health is a major driver of state capacity. Significant declines in population health will therefore generate significant declines in state capacity over the long term. States with lower state capacity find themselves severely impaired in responding to the HIV/AIDS epidemic. In his “Ingenuity model” Homer-Dixon (1995, p. 589) argues that “resource scarcity can simultaneously increase the requirement and impede the supply of ingenuity, producing an ‘ingenuity gap’”. According to Price-Smith (2001, p. 172) the negative economic and social effects of disease can also increase the requirement for ingenuity while limiting its supply. Thus the AIDS tragedy continues to grind forward, weakening economies and political systems that hold the key to effective remedial action.

According to Price-Smith (2002, p. 124) disease also generates a negative effect on political polarization and promote competition between elites for political power within a climate of declining fiscal resources and increasing deprivation. Therefore, Price-Smith argues, the probability of intra-elite conflict will increase as a result of the absolute decline in resources available to the state, carrying with it grave risks, such as coups, collapse of governance and planned genocides.

²¹ Earlier mentioned factors such as frequent travel and high incomes increase the risk for HIV.

²² 1964-84 Zambia held fourteen by-elections for reason of the deaths of incumbents. In 1984, Zambia officially noted its first AIDS case, and between that time and 2003, the number of necessary by-elections soared to 102; thirty-nine of them due to the death of an incumbent. Each of these special elections represented the loss of political experience and enormous monetary expense to the government (Garrett, 2005 p. 40).

As the burden of disease increases on the population of a state, the resulting poverty and physical destruction may over time also erode governmental legitimacy and increase the risk for social unrest: “Evidence suggests that in societies facing economic crisis and lack of clear political leadership the presence of AIDS with its associated stigma may cause instability. The citizens are aware of the increase in illness and death, the stigma associated with it; and the lack of leadership leads to blame” (British House of Commons, 2001).²³ This may in turn contribute to repression and the collapse of democracy as a weakening state seeks to maintain order while the government’s legitimacy erodes and as governmental institutions become increasingly fragile (Price-Smith, 2001 p. 171).

The civil service ranks are also being thinned, rendering some previously rocky bureaucracies marginally functional. Surviving civil servants are likely to suffer frequent absenteeism due to funerals and the exigencies of caring for relatives. In South Africa as many as one in seven civil servants were thought to be HIV-positive in 1998 (New York Times, November 15, 1998; quoted in ICG, 2001 p. 15). AIDS affects governments not only by decreasing its productivity, but also by increasing government costs for health benefits and pensions, and additional spending on recruiting and training replacement staff. Consequently fewer funds are left for the very services the ministries are supposed to provide the public (ICG, 2001 p. 16).

Some of the most heavily affected sectors of public employment are among the most important: teachers and health care workers. Due to their relatively high education these employees are also among the most difficult to replace. In South Africa, as many as a third of the teachers are HIV-positive, whereas in Zambia the rate is at 40%, with five teachers dying daily from the disease (Panafrican News Agency, December 6, 2000; quoted in ICG, 2001 p. 16). According to ICG (2001, p. 16) health is arguably the most AIDS affected sector. Whereas the British House of Commons (2001) have reported that health care staff in some countries are dying faster than they can be trained, a study in Malawi 2000 estimated that between 20 and 50% of all health workers would be dead from AIDS in 2005 (Foreman & Scalway, 2000 p. 4).

At the very basic level of communal security we must also consider the impacts of HIV/AIDS on policing. According to ICG (2001, p. 14) anecdotal evidence suggests that Africa’s police forces are suffering heavily. In South Africa, AIDS permeates the police and military to such an extent that neither group is permitted to donate blood (Daily Mail & Guardian, March 14, 2000; quoted in: ICG, 2001 p. 14). According to Kenyan police AIDS accounted in 2000 for 75% of all deaths reported in the force in the last two years (The Nation, November 27, 2000; quoted in: ICG, 2001 pp. 14-15). Further evidence comes

²³ In Kenya during a demonstration concerning the epidemic one protestor displayed a sign that addressed the 2003 elections, saying: “Don’t worry about the elections, we’ll all be dead” (The Economist, February 7, 1998; quoted in: Glasgow & Pirages, 2001 p. 208).

from Namibia, where a spokesman for the police admitted that “HIV/AIDS had become a heavy burden for the police’s coffers and administration load (The Namibian, March 7, 2001; quoted in: ICG, 2001 p. 14). If we for a brief moment recall the *relative deprivation* and *state weakness hypotheses* it seems like the HIV/AIDS epidemic creates not only incentives, but also opportunities for citizens to engage in collective violent action against the status quo.

4.3 National Security

4.3.1 Military Forces

Even though the available data for prevalence rates in armed forces are considerably patchy and at times hard to obtain²⁴ HIV prevalence rates in many armed forces seem to be significantly higher than in the surrounding civilian population, with some troops with rates perceived as high as 50-60% (see Appendix 2, table 5, p. 43). There are several reasons as to why armed forces are affected by higher prevalence rates when compared to civilian populations. According to Elbe (2003, p. 20) soldiers’ duties require them to be geographically mobile, and to be away from home for extended periods, whereby troops may engage in casual sexual relationships while on tour. Furthermore large concentrations of soldiers may attract a high number of sex workers (Yeager & Ruscavage, 2000; quoted in: Elbe, 2003 p. 20).

According to Elbe (2003, pp. 23-25) HIV/AIDS poses challenges to a country’s armed forces in several ways. Firstly, high prevalence rates mean increased costs for the militaries in terms of the training and recruiting of more soldiers in order to replace soldiers who fall ill. Secondly, HIV will affect personnel and staffing. The pandemic means that the available volunteer pool decreases significantly. HIV will also affect the senior level of command, and less experienced soldiers might have to be promoted to fill these positions (Center for Strategic and International Studies Working Group on Global HIV/AIDS, 1994; quoted in: Elbe, 2003 p. 24). HIV/AIDS can also lead to the loss of highly specialized or technically trained staff that is not easily replaced. Finally, HIV/AIDS can also damage the morale of armed forces, in that soldiers know that some of their comrades will die slow and painful deaths, especially so if they suspect that they might suffer the same predicament in the near future. Soldiers may also resent receiving an increased duty load while other troops are ill.

²⁴ For example the Deputy Defense Minister of Namibia refused to divulge exactly what percentage of the country’s military was HIV-positive, saying “this information is a sensitive intelligence issue” (The Namibian, February 13, 2001; quoted in: ICG, 2001 p. 21).

According to ICG (2001, p. 21) there is moreover a strong risk that with the likelihood of early death from AIDS so high, soldiers indulge in more risky and more criminal behavior on the battle field, and they and their commanders may be less likely to support peacemaking efforts.²⁵

According to the U.S. National Intelligence Council (2000) “given that a large number of officers and other key personnel are dying or becoming disabled, combat readiness and capability of such military forces is bound to deteriorate”. Col. Wale Egbewunmi, co-coordinator of Nigeria’s Armed Forces Programme on AIDS Control says that: “The deadly disease is deadlier than war. HIV/AIDS impairs military readiness... Valuable experience and skills will be lost, shortage of officers and troops may result, and less experienced personnel may have to take on more responsibilities (Tempo, April 12, 2001; quoted in: ICG, 2001 p. 20).

4.3.2 The AIDS-Conflict Continuum

According to ICG (2001, p. 21) the perception that a neighbor’s military is suffering from an AIDS epidemic, suggesting a tactical advantage, may trigger wars. Elbe (2003, p. 27), far more cautious in his conclusions, points out that there is no evidence that the impact of HIV/AIDS on armed forces is having strategic implications in a way that inspires or forecloses the outbreak of armed conflicts. According to Elbe this suggests that the strategic ramifications of the impact of HIV/AIDS on armed forces may be more complex than is commonly assumed, and its long-term effects dependent on a number of wider variables.²⁶ Also USIP (2001, p. 4) argues that even though AIDS and conflict contribute to each other the relationship between them is far too complex to be expressed in simple cause-and-effect terms.

Although some might question the significance of AIDS as a contributor to conflict, few deny the role of conflict in the spread of the virus. Price-Smith (quoted in: USIP, 2001 p. 8) underlines warfare as an amplifier of disease, creating ideal conditions for its spread, such as poverty, famine, destruction of health and other vital infrastructure, large population movements, and the breakdown of family units and thus protective networks for women.

²⁵ There is evidence from the Congo conflict that supports this hypothesis (ICG, 2001, p. 21).

²⁶ According to Elbe (2003, pp. 28-29) a decrease in military capabilities will only become strategically significant if the environment is hostile, and there is a realistic chance that the armed forces will need to be fully used. Other variables Elbe sees in the level of HIV prevalence; the number of people with AIDS; the type of armed forces involved; levels of specialization; the size of the armed forces and the level of leadership and resources available to address the problem.

4.4 International Security

4.4.1 Turbulence and Destabilization

Even though the HIV/AIDS epidemic may create an environment in which outside aggressors may be tempted, this scenario seems rather unlikely. However, it is a fact that *major* weakened powers may lead to increased turbulence and minor violence in the international system (ICG, 2001 p. 21). The larger the country, the larger the potentially destabilizing impact on the international arena. Thus countries like Russia, India and China, which are all characterized by a rapidly increasing HIV prevalence rate, may have a seriously destabilizing impact on the international system. What is more, state chaos and disintegration may have grave consequences for neighboring countries in terms of economic dislocation and refugee flows. According to ICG (*ibid.*, p. 22) this is already a concern for many of the countries seriously affected by the epidemic. The potential for economic collapse in African powerful states, such as Nigeria or South Africa, could thus bring with it severe concerns about migration and broader destabilization.

It should also be pointed out that the pandemic have indirect links to the security of less affected, wealthy nations. An ever increasing life-expectancy gap, along with the tremendous disparity in access to life-extending anti-HIV drugs, are fueling anti-Western sentiments that could provide fertile ground for anti-Western violence, possibly terrorism (Garrett, 2005 p. 12). Other security concerns for countries in the West are seen in the fact that the HIV/AIDS pandemic drives up the cost of mining for precious metals. As many wealthy countries shift toward greater dependence upon African and Russian oil supplies, mounting HIV rates in those regions pose concerns (*ibid.*, p. 11; see also Burton, 2004).

4.4.2 Peacekeeping

As it becomes increasingly well known that peacekeepers are at special risk of contracting and spreading HIV, the epidemic poses additional logistical and political problems for these operations, and thereby presents challenges for the maintenance of international peace and security (Elbe, 2003 p. 39). It is estimated that 11% of the UN force totals come from high prevalence countries, whereas 37% come from countries nearing such high prevalence yields (UN, 2001; quoted in: ICG, 2001 p. 23). Since the 1980s, more peacekeepers have actually succumbed to AIDS-related illnesses than to battle injuries (Heinecken, 2000).

Elbe (2003, p. 39) mentions five major ways in which HIV/AIDS has begun to affect international peacekeeping. Firstly, peacekeepers have acted as vectors of

HIV, spreading the virus among populations in areas of deployment.²⁷ It is indeed a great irony that UN peacekeepers “[...] in the cause of peacekeeping [...] spread a disease which is killing ten times as many people as war” (Holbrooke, 2000; quoted in: Elbe, 2003 p. 40). Secondly, the risk of forces contracting HIV while on deployment may reduce a state’s willingness to participate in peacekeeping operations.²⁸ Thirdly, HIV/AIDS prevalence among contributing forces may make it difficult to staff operations. Fourthly, states may become less willing to host peacekeeping missions. Finally, the constrained capacity of states to contribute to peacekeeping missions may create additional resource difficulties as the earning potential of such operations is reduced.

The fact that many of the armed forces that contribute to international peacekeeping are severely affected by AIDS is not only a concern of the individual countries affected, but also of Western countries. If countries such as Nigeria or South Africa experience difficulties in the long term, this will have important implications for the stability of the region more generally, given the contribution these countries could make to peacekeeping in Africa.²⁹ Even though the blow is most serious for peacekeeping operations in Africa it may also have grave effects on peacekeeping more broadly (ICG, 2001 p. 22).

4.5 Summary

We have in this chapter looked at how HIV/AIDS can be seen as a threat to *personal, communal, national and international security* in sub-Saharan Africa. If we for a brief moment recall Rousseau’s notion of the social contract it seems clear that HIV/AIDS, through its weakening of the state capacity, constitutes a grave hindrance for the state to fulfill its part of the agreement by protecting the citizen from internal, as well as external threats. By lowering the life expectancy, increasing the infant mortality, spreading poverty, increasing the number of orphaned children and seriously affect the economy, as well as governmental institutions the HIV/AIDS epidemic seems to create the incentive for instability and violence (*relative deprivation hypothesis*). Furthermore the weakening of a country’s police and military forces makes this instability and violence, and even external aggression and turbulence possible (*state weakness hypothesis*). HIV/AIDS thus has the potential to threaten *internal*, as well as *external* security.

²⁷ In Sierra Leone and Liberia, peacekeepers have been among the main agents for spreading HIV (Atlanta Journal-Constitution, April 11, 2001; quoted in: ICG, 2001 p. 22).

²⁸ The British Minister of Defense predicts that HIV/AIDS will become an “increasingly important consideration” for soldiers that are deployed abroad (Sieff, 2001 p. 5; quoted in: Elbe, 2003 p. 44).

²⁹ According to a South African military analyst many countries, including South Africa, will soon be unable to participate in peacekeeping operations unless the spread of AIDS among African armies is stopped soon (San Jose Mercury News, April 8, 2001; quoted in: ICG, 2001 p. 22).

5 Case Studies

5.1 Zimbabwe

Zimbabwe is currently enduring its worst humanitarian situation since independence a quarter of a century ago. And even though declining economic performance, political polarization and unfavorable environmental conditions play an important role in the country's crisis the HIV/AIDS pandemic does too.

The first case of AIDS was identified in 1985 and by 1990 HIV prevalence was estimated to already exceed 10% (UNAIDS, 2005 p. 5). By the end of 2001 prevalence rates had reached 34%. Figures released in Zimbabwe in 2003 suggested that national adult HIV prevalence had dropped to 25% and that the country was turning its epidemic around. Unfortunately the new figures merely represented a statistical correction of the 2001 estimate, which had relied on erroneous data. There was thus no actual decline in HIV prevalence in the country. The current prevalence rate in the country remains approximately 25%, but new evidence shows a declining trend in national adult HIV prevalence. However it is still the case that at least one in every five adults in Zimbabwe is infected (*ibid.*, p. 4).

5.1.1 The Impact of HIV/AIDS

Let us start out with the *personal security*. Zimbabwe has witnessed a dramatic reversal in life expectancy, which has declined from 52 years in 1970 to 40 years in 1999 to 36 years for women and 37 years for men in 2003 (WHO, 2003). UNICEF predicts life expectancy to fall to a meager 27 years by 2010 (Price-Smith & Daly, 2004 p. 16). The depleted capacity in the social service sectors has given way to that Zimbabwe now, according to UNICEF (2005a), has the world's fastest rise in child mortality, and has created a vast amount of orphans, whose cumulative number, in 2003 was estimated at 980,000 (Avert³⁰, 2005a). UNICEF (2005a) talks about a "catastrophe in orphans unlike any the world has seen" and underlines that almost one in five children in Zimbabwe has been orphaned by

³⁰ Avert is an international HIV/AIDS Charity based in the UK with the aim of averting HIV/AIDS worldwide.

HIV/AIDS. According to Schönteich (1999, p. 57) the growing population of AIDS orphans will directly increase the frequency and severity of crime in Zimbabwe in the decades to come.

As we have seen HIV/AIDS brings poverty to a large number of affected households. Furthermore, widows in Zimbabwe may lose their land when their husbands die of AIDS, as male relatives may lay claim to the dead individual's belongings, according to custom (Price-Smith & Daly, 2004 p. 18). According to Price-Smith & Daly (*ibid.*, pp. 20-21) HIV/AIDS affects smallholder farms to a greater extent due to their labor intensive nature. This might in turn exacerbate existing income inequality, increase resentment among the poor and add fuel to the burgeoning racial conflict between white and black landowners in the country. (For further illustration of the impact of HIV/AIDS on the Zimbabwean *personal security* read the story of a grandmother, Appendix 4, p. 47.)

Let us move on to consider the effects of HIV/AIDS on *communal security*. How has the pandemic affected the Zimbabwean economy, its governmental institutions and police force? According to Haacker (2002, p. 35), the HIV/AIDS epidemic in Zimbabwe will result in a loss of output per capita of 7,3% per annum. Bonnel (2000, p. 16) estimates that current levels of HIV prevalence reduce the GDP growth by approximately 1,5% per annum. Even though it is difficult to determine empirically what proportion of Zimbabwe's economic decline is a direct result of the pandemic and what proportion is attributable to the Mugabe government's increasingly poor management of the economy it is clear that HIV/AIDS contributes to the country's economic malady (Price-Smith & Daly, 2004 p. 23).

HIV/AIDS is seriously affecting Zimbabwe's labor supply, debilitating and killing skilled employees and generating a decline in human capital that impedes worker productivity. At the macro level HIV is diminishing the stock of endogenous human capital in Zimbabwe, as it takes time and money to train workers over jobs vacated by their infected peers. One company in Zimbabwe reportedly trains three new hires for every job: "We expect to lose two of them within a year's time" (Jeter, 2000; quoted in: Boone & Batsell, 2001 p. 20).

The impact of HIV/AIDS is felt in various sectors. There has been a 25% loss of manufacturing capacity since 1998, a 20% loss of the mining output since 1999, and a 50% decline in tourism earnings since 1999 (Robertson, 2002). Even though HIV/AIDS hardly is solely responsible for such declines it is clear that the epidemic significantly limits the productive possibilities of the Zimbabwean economy (Price-Smith & Daly, 2004 p. 20). Furthermore a seriously affected agricultural sector endangers the food security of Zimbabwe. Although this may be explained by the Mugabe regime's policy of coercive land redistribution and by the widespread drought that has plagued the country, the effects of HIV/AIDS should not be excluded from the picture. Other sectors where the pandemic is painfully noted in Zimbabwe are the health and education sectors. In July 2002 it was estimated that 25% of the country's teachers were infected with HIV (Machipisa, 2002 p. 1).

According to Price-Smith & Daly (2004, p. 26) Zimbabwe's HIV/AIDS epidemic affects the nation's ability to sustain and deliver quality public services

for its citizens. With anticipated professional losses looming as high as 40% there is a great concern about sustaining a viable professional staff in the Zimbabwean government. Professional losses also result from the voluntary retirement of talented public servants who are not HIV-positive, but who fear that their pension plans will be whittled away, before they can enjoy them, by the high costs of paying retirement benefits to individuals who retire early because of HIV/AIDS (*ibid.*, p. 27). According to Price-Smith, Zimbabwe is caught in a vicious cycle where the HIV/AIDS epidemic progressively takes its toll and thereby reduces Zimbabwe's state capacity. As the country's state capacity declines, so the nation's ability to come up with creative HIV/AIDS intervention strategies diminishes (*ibid.*, p. 27).

Furthermore, the epidemic intensifies the risks for intrastate political violence and state failure. Rival political elites in Zimbabwe may attempt to seize power from the government. It is also possible that deprivation combined with a weakened state foster the deliberate use of violence by the state against its own citizens in an attempt to retain control. Price-Smith & Daly (*ibid.*, p. 28) predict an intensification of authoritarian rule as the Zimbabwean government grows less able to meet the demands of the population and more desperate to hold on to power. With regards to the impact of AIDS on Zimbabwe's law enforcement personnel, the pandemic furthermore cuts critically into law enforcement's capacity to maintain the peace at the community level (*ibid.*, p. 26).

Let us now finally consider the impact of HIV/AIDS on Zimbabwe's *national security*. A well functioning fighting force needs a substantial national economic engine to power it. The HIV/AIDS epidemic, putting considerable constrain on the Zimbabwean economy, is also increasingly limiting Zimbabwe's military power (*ibid.*, p. 24). What is more there is evidence that Zimbabwe's armed forces are highly infected. According to Heinecken (2001, p. 11), Zimbabwe's armed forces exhibit an aggregate seroprevalence rate of 55%, whereas HIV seropositivity levels among the Zimbabwe servicemen returning from the DRC have been estimated to run as high as 80% (Price-Smith & Daly, 2004 p. 31). According to Price-Smith & Daly (*ibid.*) AIDS losses in the Air Force of Zimbabwe (AFZ) over the next decade can be expected to range between a low of 1,300 and a high of 2,600 personnel. AIDS-induced mortality has a greater impact in the AFZ than in the Zimbabwe National Army (ZNA), due to the greater challenge to sustain the former's higher level of professional competency.

According to Price-Smith & Daly (*ibid.*) Mugabe's military strength, which serves as an instrument of control over legitimate democratic processes, will slowly and almost invisibly erode over the next decade. Losses of more seasoned military staff through HIV/AIDS will provoke institutional fragility in the apparatus of coercion and thereby reduce ZANU-PF control over the governance process in Zimbabwe. The epidemic may also affect the country's relative power (i.e. its power relative to other states), where HIV/AIDS may have a greater negative effect on the relative power of Zimbabwe than on neighboring states with lower prevalence rates, such as South Africa and Mozambique (*ibid.*, pp. 31-32).

5.1.2 The Government's Response

According to WHO no country in southern Africa is as far behind in treating AIDS as Zimbabwe (Timberg, 2005). President Mugabe recently acknowledged that the HIV/AIDS epidemic constitutes a significant threat to Zimbabwe, and he has begun to give the issue a higher priority on the regime's agenda. This was demonstrated by the adoption of a strategic framework on HIV/AIDS, as well as a National AIDS Policy, and the creation of the National AIDS Council (NAC) in 2000 (USAID, 2002a p. 1). Furthermore, in 2000 a 3% tax was imposed on companies and individuals to raise funds for HIV/AIDS programs. Monies collected by the NAC have been distributed to various entities, such as the Zimbabwean National Army, the Zimbabwe Republic Police, the Ministry of Health and Child Welfare and the district AIDS action committees (Price-Smith & Daly, 2004 p. 34). There have nevertheless been persistent accusations for money having been distributed primarily to government supporters through the district AIDS action committees, which are aligned with the government (Financial Gazette, July 4, 2002; quoted in: Price-Smith & Daly, 2004 p. 34). Most of the monies collected through the tax have been mired in bureaucracy. According to then deputy health minister P. David Parirenyatwa, speaking in August 2001, at least 25 million USD were waiting to be spent, but the disbursement was held up by bureaucratic inefficiency (Cauvin, 2001).

In 2003 Harare began to improve its record on delivering antiretroviral (ARV) therapies to recipients, and in 2004 Parirenyatwa told Zimbabwe's parliament that the AIDS levy had amassed approximately 15 billion USD for the National AIDS Trust Fund, of which 8,9 billion USD had been distributed to those in need. However Parirenyatwa pointed out that certain AIDS service organizations had abused their positions of power. He stated that "the Zimbabwe National Network for people living with HIV and AIDS abused 96 million USD allocated to it and part of the money was used to buy property". Even though the government has been successful in recovering much of these funds the case illustrates the widespread problem of corruption within the service providers (Herald Reporter, January 30, 2004; quoted in: Price-Smith & Daly, 2004 p. 35).

Due to President Mugabe's reputation as one of the most undemocratic and anti-Western African leaders, a viewpoint held by some powers, the international funding for HIV/AIDS has bypassed Zimbabwe almost entirely. Whereas UNICEF estimates the average amount of international funding each year in southern Africa is 74 USD per person infected with HIV, the corresponding amount in Zimbabwe is 4 USD (Timberg, 2005). In Zimbabwe being seropositive for most people is the same as being sentenced to death.

5.2 Botswana

Like Zimbabwe Botswana is one of the countries in the world that has been hardest hit by the HIV/AIDS epidemic. Botswana has made many notable social

and economic gains since its independence in 1966. However these impressive standards are being threatened by the HIV/AIDS pandemic, the most devastating emergency in the nation's history. Botswana's first AIDS case was reported in 1985. By the end of 2003 there were approximately 350,000 people in Botswana living with HIV. In a country with a total population of 1,6 million the prevalence rate was 36,5%, and is today slightly over 37% (UNAIDS/WHO, 2004b), the second highest in the world after Swaziland³¹. Even though Botswana is severely affected by the epidemic there seems to be hope. Botswana has become the first African country to aim to provide ARV therapy to its citizens on a national scale.

5.2.1 The Impact of HIV/AIDS

Let us start by having a look at the impact that HIV/AIDS has had on Botswana's *personal security*. Life expectancy in Botswana has dropped considerably due to the epidemic, and is today 37 years for men and 36 years for women (the same as in Zimbabwe) (WHO, 2003). According to USAID (2002b) life expectancy would in 2002 have been 72 had it not been for AIDS. According to ICG (2001) it is furthermore estimated that life expectancy could fall to an almost medieval age 29. There is moreover a sharp upward trend in child mortality which, according to UNICEF (2005b), is attributed to the HIV/AIDS epidemic. According to the U.S. Census Bureau, by 2002 infant and child mortality in Botswana soared by 44.8% for infants and 76.5% for children under five (Garrett, 2005 p. 44). By 1999, over 37,000 children under five years old were infected with HIV, acquired primarily through mother-to-child transmission (*ibid.*). Some 9,500 babies will become HIV-positive from their mothers each year in Botswana if preventive measures are not in place.

Due to HIV/AIDS household incomes are reaching unsustainable levels as family resources are reallocated to assist AIDS patients. Moreover most AIDS deaths occur in adults of child-bearing age. These parents leave behind orphans dependent on aged grandparents or relatives. Botswana has the highest rate of orphaning in sub-Saharan Africa, with 20% of its children orphaned (UNAIDS/UNICEF/USAID, 2004 p. 8). In 1990, only 7% of all children in Botswana were orphans, but by 2003, one out of five children in the country was an orphan and 77% of all orphans had lost one or both parents to HIV. The government reckons that by 2010, one out of four children will be an orphan (Garrett, 2005 p. 45).

Let us now turn to the country's *communal security*. How does HIV/AIDS affect Botswana's economy and state capacity, and thereby its *internal security*? For sixteen years Botswana had a budget surplus; in 2001, the once economically successful country recorded its second deficit in a row. The government finds that

³¹ According to UNAIDS estimates Swaziland has a prevalence rate of 38,8% (UNAIDS/WHO, 2005a).

it must devote more and more of its budget to hospitals, medicines and other costs associated with the epidemic. In a recent report, the Botswana Institute for Development Policy Analysis predicted that HIV/AIDS will reduce government revenue by 7% at the same time as expenditure on the epidemic increases by 15%. Government spending on HIV/AIDS may reach 20% of the total government budget by the end of the decade and Botswana's economy may shrink by as much as 30% as a result of the epidemic. Furthermore foreign investment will likely continue to be constrained (ICG, 2001). A good illustration of the country's economic decline can be taken from the mining sector. In Botswana diamonds account for 80% of export earnings and half of the government's revenue. It is not hard to imagine the economic impact of the epidemic when considering that a third of the industry's employees is estimated to be HIV-positive (*ibid.*, p. 11). Agriculture has also been hard hit, with more than one in seven farm workers killed and labor shortages expected to be increasingly acute. Some companies in Botswana are even importing cheap labor from Far East to make up for local workforce shortages (British House of Commons, 2001).

Botswana's educated labor force, particularly civil servants, has been particularly affected by the epidemic, draining the country of some of its most valued leadership and making sure that it will have an ever decreasing number of qualified managers as the pandemic wears on. Indeed, 50% of the students at the University of Botswana – the only university in the country – are seropositive or have already died from AIDS (ICG, 2001). The fact that Botswana's police force is also severely affected by the epidemic seriously impairs its capacity to maintain order.

Let us now finally turn to the impact that the HIV/AIDS pandemic has on Botswana's *national security*. According to Heinecken (2001, p. 11) the HIV-prevalence rate in Botswana's army is 33%, which is lower than that in the surrounding population (37%). Nevertheless this means that as much as one-third of the country's forces suffer from HIV/AIDS. Such attrition causes loss of continuity at command level and within the ranks, increases costs for the recruitment and training of replacements, and reduces military preparedness, internal stability and external security (ICG, 2001).

5.2.2 The Government's Response

Botswana's response to the HIV/AIDS epidemic can be divided into three stages. The early stage (1987-89) focused mainly on the screening of blood to eliminate the risk of HIV transmission through blood transfusion. The second stage (1989-97) introduced the first Medium Term Plan (MTP), and saw the introduction of information, education and communication programs. During this stage, in 1993, the government adopted the Botswana National Policy on AIDS. During the third stage (1997-2002), the response to HIV/AIDS was expanded in many different directions to include education, prevention, and comprehensive care, including the provision of ARV treatment (Avert, 2005b). The aim of this plan (known as MTP II) was to involve many stakeholders who had previously been excluded, with the

overall aim, not only of reducing HIV infection and transmission, but also reducing the impact of HIV/AIDS at all levels of society (UNDP, 2001a p. 41).

In 2000 the National AIDS Coordinating Agency (NACA) was set up. NACA is chaired by the President and is also the secretariat for the National AIDS Council. NACA has the responsibility to mobilize and co-ordinate a multi-sectorial response to HIV/AIDS (UNDP, 2001b). There is an array of different HIV/AIDS initiatives and programs taking place in Botswana. One of the most high profile initiatives is the African Comprehensive HIV/AIDS Partnerships (ACHAP), which is a collaboration between the Government of Botswana, the Bill & Melinda Gates Foundation and the Merck Company Foundation. The aim of ACHAP is to support the goals of the Botswanan Government in decreasing HIV incidence and increasing the rate of diagnosis and treatment (Avert, 2005b). The Bill and Melinda Gates Foundation and the Merck Company Foundation have each committed 50 million USD over five years towards the project. Merck & Co. Inc. is also donating two ARV drugs (ACHAP).

In 2001 President Mogae announced that the Botswanan government would provide ARV medication for all those who needed it, before the year end. However it successively became clear that enrolling people was a lengthy and complicated process. Furthermore, the introduction of ARV in Botswana requires a broadening of the infrastructure (testing centers, storage facilities etc.) and the training of more medical personnel (Avert, 2005b). By March 2005 UNAIDS/WHO (2005b) estimated that 42,000 people were receiving ARV treatment, which is well over half of the 75,000 believed to be in need.

5.3 Summary

In this chapter we have seen how the HIV/AIDS pandemic threatens the *personal*, *communal* and *national security* in two of the world's most affected countries – Zimbabwe and Botswana. Both countries show evidence of dwindling life expectancy, increasing infant mortality, explosion in numbers of orphans, weakening economy and state capacity and seriously affected police and military forces. Even though the impact of the HIV/AIDS epidemic is severe in both countries the governments have dealt with it to different extents. Whereas President Mugabe only recently acknowledged that the HIV/AIDS epidemic constitutes a significant threat to Zimbabwe, Botswanan President Mogae's early response to the epidemic dates back to as early as the late 1980s. Moreover there are great differences between the two countries with regards to international funding, with Zimbabwe nearly bypassed, whereas Botswana receives considerable funding. Zimbabwe and Botswana therefore remain painful evidence that AIDS relief is arriving in a profoundly uneven way, dividing the African continent into areas where AIDS is survivable and areas where it is not. Whereas there in Botswana is a 50% chance that an HIV-positive person gets ARV treatment, the corresponding rate for a person that happens to live across the border in Zimbabwe is close to zero.

6 Discussion

6.1 Results

There should by now remain little doubt with regards to the serious implications that the HIV/AIDS pandemic has on the *personal*, *communal*, *national* and *international* levels of security in sub-Saharan Africa. All these levels are intimately linked to each other as weakened *personal security* may lead to weakened *communal security*, which in turn may lead to weakened *national* and *international security*. By depleting the population health HIV/AIDS seriously weakens the state's capacity to act effectively to stem the pandemic. And even though we do best in perceiving HIV/AIDS as a mere stressor among others we should not deny its strong negative impact, not least so on already weak states.

Price-Smith (2002, p. 10) criticizes Pirages and Garrett for failing to address "whether the resurgence of disease will have different impacts on different societies". In the following discussion about the two case studies the aim is therefore to examine more closely to what extent the HIV/AIDS pandemic may have different impacts on the two case studies.

According to Price-Smith (2001, pp. 169-170) the state's ability to adapt in order to mitigate the effects of diseases on state capacity is limited by several factors. Firstly, the initial level of state capacity (*endogenous state capacity*) will determine the amount of resources that can be mobilized to deal with the epidemic. States with higher initial capacity will have greater technical, financial and social resources to adapt to crises. Secondly, state adaptation is also affected by *exogenous inputs*, capital and social and technical ingenuity, as well as courtesy of international organizations. Thirdly, a state's capability to adapt may also be impaired by *other intervening variables*, such as war, famine and ecological destruction.

Let us now turn to our two case studies. What can we say about their respective capacity to mitigate the effects of HIV/AIDS? Not surprisingly the difference is striking. Zimbabwe has a moderately low level of *endogenous state capacity* to combat the HIV/AIDS epidemic and it remains, according to Price-Smith & Daly (2004, p. 33), unclear whether the country has enough endogenous capacity to stop the epidemic within its own borders. As the prospect is that the epidemic will cross threshold at which demand for state capacity will exceed supply (*ingenuity gap*), it will be impossible for Zimbabwe to stop the epidemic using endogenous resources alone. However *exogenous inputs* do not seem to be forthcoming in the nearest future, at least not to the needed extent. Furthermore,

one might describe an array of *other intervening variables* that further compromise Zimbabwe's capability to adapt. The country is suffering its worst humanitarian situation since independence a quarter of a century ago, characterized by declining economic performance, political polarization and unfavorable environmental conditions.

The prospects for the Zimbabwean state to adapt seem rather meager. However there is also, according to Price-Smith & Daly (*ibid.*, p. 33; 6), another key to successful adaptation by the state – the mobilization of *political will*. Thus good governance³² can compensate to some degree for relatively low levels of state capacity. “Success stories” such as Thailand and Uganda have shown how political elites mobilize in an effort to initiate widespread behavioral change throughout their populations. According to Price-Smith & Daly even countries with lower levels of state capacity may be able to contain the spread of HIV/AIDS by adopting such “low-tech strategies”. However apart from diminishing state capacity, the greatest impediments to Zimbabwe's ability to stem the spread of the epidemic have been the persistent lack of political will on the part of ZANU-PF to mobilize the country effectively against the epidemic (*ibid.*, p. 33).

Let us now turn to our other case study, Botswana. To start with, the *endogenous state capacity* of the country may not be very high, but it seems plausible to argue that it, even while fairly low, is somewhat higher than that of Zimbabwe due to its relatively rich diamond resources. What is more, Botswana receives considerable *exogenous inputs* in its struggle to combat the epidemic. With regards to *other intervening variables* it is an exaggeration to say that these are non-existent. However in a comparison with Zimbabwe the country stands out as considerably stable and peaceful, and has in fact enjoyed a period of unbroken peace since 1966 (Avert, 2005b). If we finally consider Botswana's *political will* it is obvious that the country's leaders through their efficient acting have been able to compensate for relatively low levels of state capacity with good governance. In comparison with Mugabe, Mogae shows evidence of being a relatively strong and committed leader. Departing from this comparison between Zimbabwe and Botswana it seems quite reasonable to suggest that HIV/AIDS constitutes a greater security threat if the country, like Zimbabwe, is characterized by: 1) *low endogenous state capacity*; 2) *low exogenous inputs*; 3) *other intervening variables* and 4) *low or non-existent political will*.

According to Price-Smith & Daly (2004, pp. 33-34) the risk for HIV/AIDS to cause a society to experience state collapse may depend on various factors, such as whether the populace has access to effective ARV therapies and on whether the government will provide such therapies to infected populations in a comprehensive and nonpartisan manner. Other influential factors may be to what

³² According to ICG (2001, p. 15) good governance can be defined in terms of effective operation of the institutions and people that make a state run, resolve disputes peacefully, and create a sense of national unity.

extent the economy and governmental institutions and legitimacy have been damaged by the epidemic, as well as regime type. According to Price-Smith & Daly (*ibid.*, p. 34) nascent democracies and authoritarian regimes are more vulnerable to disease-induced economic and political destabilization, whereas established democracies seem to be more resistant in responding to such disease-induced stresses. Again it seems plausible to conclude that HIV/AIDS constitutes a considerably greater security threat to Zimbabwe than to Botswana.

6.2 Material

There are mainly two remarks I wish to make with regards to the material used in this thesis. Firstly, the fact that relatively little has been written about the nexus between HIV/AIDS and security has to a fairly large extent made me rather dependent on a limited number of sources, the most important one being Andrew Price-Smith. However the fact that Price-Smith (2002) has based his theories about public health and state capacity on an empirical cross-national study of twenty nations, drawing on forty years of data, and including a wide array of variables seems to make it a rather stable basis for my thesis. While looking for critics (which naturally would make the basis even more stable!) it once more became apparent that the field is rather new and unexplored.

Secondly, naturally more time and deeper research (as well as access to sensitive information) would be needed to get a more just and a more profound picture of who is carrying out the research for whom, and whose vested interests are represented. A case in question would be the research carried out on Zimbabwe by Price-Smith & Daly (2004). Perhaps the use of more diverse sources with regards to the AIDS crisis in Zimbabwe would have given a slightly different opinion of how the Mugabe regime is handling the country's HIV/AIDS epidemic.

6.3 Future Research

It is obvious that more research is needed within the field, not least so by political scientists, who unfortunately have appeared rather absent in the health-security nexus. Just like Price-Smith (2002, p. 180) I can therefore only call for scholars to explore this research in greater depth, and to refine our understanding of the hypothesized relationships. Doubtlessly there is also a great need for more country-specific research in order to better understand why some countries may suffer to a greater extent than others. Particularly more research is needed to explore the complex links between HIV/AIDS and conflict.

7 Conclusions

There is a war going on in Africa. A war that is having a serious impact on the people and the countries of the continent. But the war in Africa is not a war in traditional terms. It's a bloodless war without bullets. A silent war, named HIV/AIDS. HIV/AIDS threatens the security of sub-Saharan Africa at *personal*, *communal*, *national* and *international* levels. The pandemic firstly attacks *personal security*. Death rates rise, life expectancies dwindle and infant mortality rates soar. As HIV/AIDS primarily strikes at the most productive members of society, breadwinners and adults of child-bearing age it gives rise to poverty and a vast array of orphans.

Like a parasite that slowly sucks the blood from the veins of all governmental institutions, HIV/AIDS also constitutes a considerable threat to *communal security*. As workers die or become ill productivity decreases, the costs of business raise and investment rates drop. In the long run this has serious implications for the country's economy. A declining population base in turn constitutes a serious blow for the state capacity. Human capital drops as highly educated persons, such as: managers, decision-makers, civil servants, doctors and teachers die. With the financial, as well as human resources dwindling, the state finds itself entrapped in an *ingenuity gap*, where the negative economic and social effects of disease increases the requirement for ingenuity while simultaneously limiting its supply. The declining resources and increasing deprivation will increase the risk for violence, instability and intra-elite conflict, such as coups and collapse of governance. Whereas the increased deprivation gives incentive to violence, the seriously weakened police force seems to give opportunity for it.

However HIV/AIDS does not only constitute a threat to *internal*, but also to *external* security. By weakening a country's armed forces considerably the epidemic reduces military preparedness and thereby puts the country's *national security* at risk. HIV/AIDS can also have serious consequences for *international security* by seriously impairing peacekeeping operations and by giving rise to turbulence that might have a destabilizing impact on the international system. By looking at the two cases of Zimbabwe and Botswana it seems plausible to suggest that HIV/AIDS constitutes a greater security threat if a country, like Zimbabwe, is characterized by: *low endogenous state capacity*; *low exogenous inputs*; *other intervening variables* and *low or non-existent political will*.

HIV/AIDS is linked to poverty in a vicious cycle where the pandemic gives rise to poverty, which in turn constitutes a fertile ground for the spread of the pandemic. Doubtlessly HIV/AIDS has become a security issue, with the potential to undo decades of human, economic and national development and progress in sub-Saharan Africa. This needs to be acknowledged and examined critically with a view to taking the steps necessary to ameliorate the impact of the epidemic.

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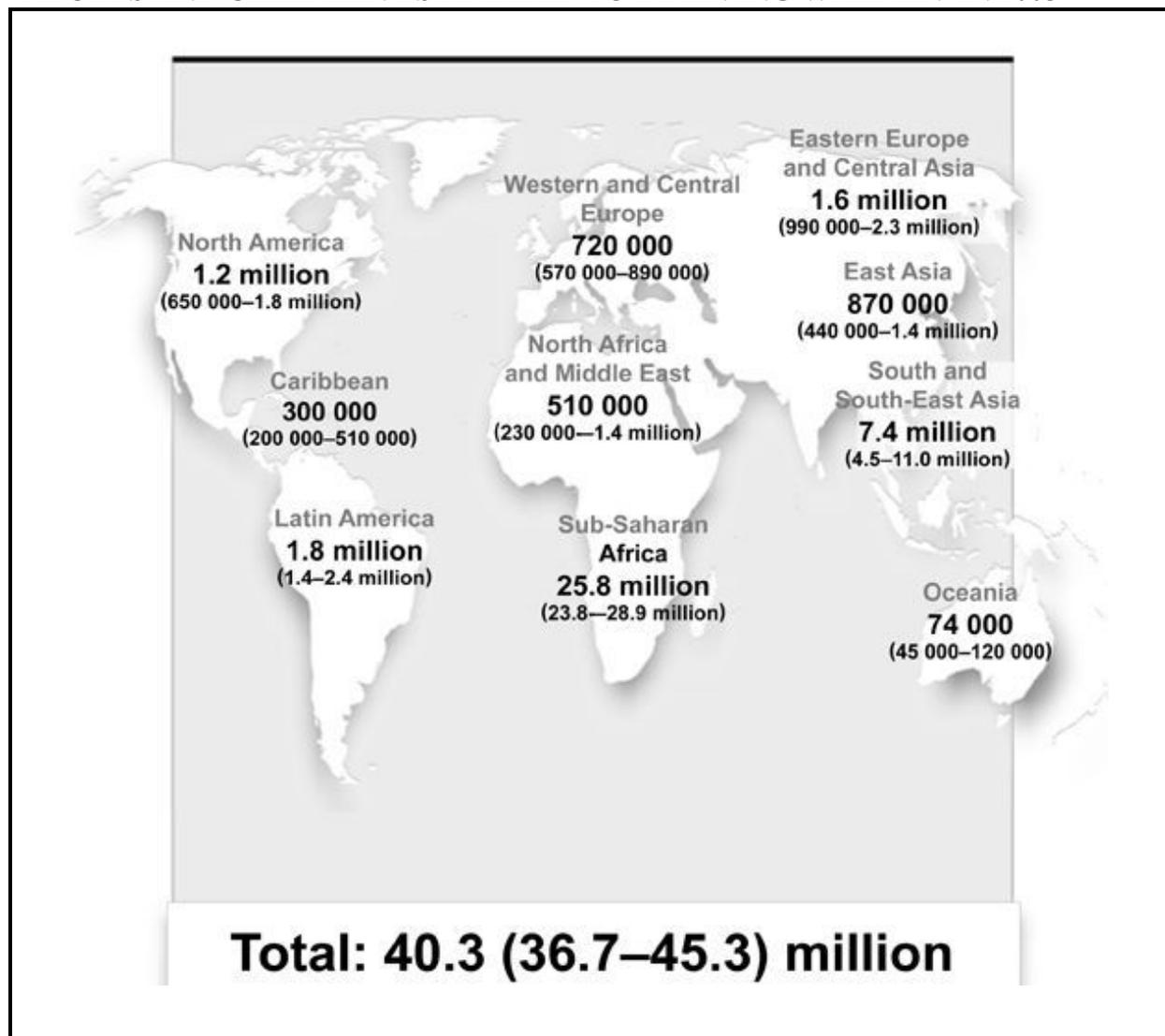
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Appendix 1 (World AIDS Statistics)

ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV IN 2005



Source: UNAIDS/WHO, 2005a

Appendix 2 (Statistical Tables)

Table 1: Adult HIV-Prevalence Rates (%) in Continental SADC States, 1997-2001

	Dec. 1997	Dec. 1999	Dec. 2001	% change in HIV-prevalence rate, 1997-2001
Angola	2.1	2.8	5.5	+162
Botswana	25.1	35.8	38.8	+55
DRC	4.4	5.1	4.9	+11
Lesotho	8.4	23.6	31.0	+269
Malawi	14.9	16.0	15.0	+1
Mozambique	14.2	13.2	13.0	-9
Namibia	19.9	19.5	22.5	+13
South Africa	12.9	19.9	20.1	+56
Swaziland	18.5	25.3	33.4	+81
Tanzania	9.4	8.1	7.8	-17
Zambia	19.1	20.0	21.5	+13
Zimbabwe	25.8	25.1	33.7	+31

Source: UNAIDS 1998, 2000 and 2002; adapted in: Pharaoh & Schönteich, 2003 p. 3

Table 2: Years of Life Expectancy Lost to AIDS

Country	% Adult HIV/AIDS Rate (end 1999)	2010-2015	2010-2015	2010-2015
		Life Expectancy at Birth	Life Expectancy at Birth	Years of Life Expectancy Lost
		Actual (with AIDS)	Hypothetical (without AIDS)	
Namibia	19.54	41.5	67.7	-26.3
Botswana	35.80	48.9	73.0	-24.1
South Africa	19.94	47.2	67.4	-20.1
Zimbabwe	25.06	50.4	69.8	-19.4
Kenya	13.95	51.0	69.8	-18.8
Mozambique	13.22	39.6	56.7	-17.1
Zambia	19.95	51.5	63.7	-12.3
Cameroon	7.73	55.3	66.2	-10.9
Tanzania	8.09	52.4	63.2	-10.8
Malawi	15.96	48.1	57.3	-9.2
Lesotho	23.57	59.2	68.3	-9.1
Côte d'Ivoire	10.76	54.8	62.8	-8.0
Nigeria	5.06	53.6	58.4	-4.7

Source: United Nations Development Programme (UNDP), 1999

Table 3: AIDS and Infant Mortality Rates

Country	% Increase in Infant Mortality Due to AIDS
Botswana	121
Namibia	58
South Africa	44
Nigeria	7
Côte d'Ivoire	14
Zambia	31
Kenya	25
Mozambique	14
Malawi	16

Source: HIV/AIDS Country Profiles, U.S. Census Bureau, June 2000

Table 4: AIDS and Orphan Rates

Country	Orphans Due to AIDS as a Percentage of All Orphans, 2003
Zimbabwe	78%
Botswana	77%
Swaziland	63%
Zambia	60%
Lesotho	56%
Malawi	48%
Namibia	48%
Uganda	48%

Source: Avert, 2005a

Table 5: HIV Prevalence Rates in Selected African Militaries

Country	HIV prevalence	Date of Estimate
Angola	50%	1999
Botswana	33%	1999
DRC	50%	1999
Lesotho	40%	1999
Malawi	50%	1999
Namibia	16%	1999
South Africa	15-20%	2000
Swaziland	48%	1997
Zambia	60%	1998
Zimbabwe	55%	1999

Source: Heinecken, 2001 p. 11

Appendix 3 (Resolution 1308)

United Nations

S/RES/1308 (2000)

Security Council

Distr.: General 17 July 2000

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Resolution 1308 (2000)

Adopted by the Security Council at its 4172nd meeting, on 17 July 2000

The Security Council,

Deeply concerned by the extent of the HIV/AIDS pandemic worldwide, and by the severity of the crisis in Africa in particular,

Recalling its meeting of 10 January 2000, on “The situation in Africa: the impact of AIDS on peace and security in Africa”, taking note of the 5 July 2000 report from UNAIDS (S/2000/657) which summarizes follow-up actions taken to date; and recalling further the letter of its President dated 31 January 2000 addressed to the President of the General Assembly (S/2000/75),

Emphasizing the important roles of the General Assembly and the Economic and Social Council in addressing HIV/AIDS,

Stressing the need for coordinated efforts of all relevant United Nations organizations to address the HIV/AIDS pandemic in line with their respective mandates and to assist, wherever possible, in global efforts against the pandemic,

Commending the efforts by UNAIDS to coordinate and intensify efforts to address HIV/AIDS in all appropriate forums,

Recalling also the 28 February 2000 special meeting of the Economic and Social Council, held in partnership with the President of the Security Council, on the development aspects of the HIV/AIDS pandemic,

Welcoming the decision by the General Assembly to include in the agenda of its fifty-fourth session an additional item of an urgent and important character entitled “Review of the problem of HIV/AIDS in all its aspects”, and encouraging further action to address the problem of HIV/AIDS,

Recognizing that the spread of HIV/AIDS can have a uniquely devastating impact on all sectors and levels of society,

Reaffirming the importance of a coordinated international response to the HIV/AIDS pandemic, given its possible growing impact on social instability and emergency situations,

Further recognizing that the HIV/AIDS pandemic is also exacerbated by conditions of violence and instability, which increase the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care,

Stressing that the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security,

Recognizing the need to incorporate HIV/AIDS prevention awareness skills and advice in aspects of the United Nations Department of Peacekeeping Operations’ training for peacekeeping personnel, and welcoming the 20 March 2000 report of the United Nations Special Committee on Peacekeeping Operations (A/54/839) which affirmed this need and the efforts already made by the United Nations Secretariat in this regard,

Taking note of the call of the Secretary-General in his report to the Millennium Assembly (A/54/2000) for coordinated and intensified international action to reduce the HIV infection rates in persons 15 to 24 years of age by 25 per cent by the year 2010,

Noting with satisfaction the 13th International AIDS Conference, held from 9 to 14 July 2000 in Durban, South Africa, which was the first conference of this type to be held in a developing country and which drew significant attention to the magnitude of the HIV/AIDS pandemic in sub-Saharan Africa, and further noting that this Conference was an important opportunity for leaders and scientists to discuss the epidemiology of HIV/AIDS and estimates of resources needed to address HIV/AIDS, as well as issues related to access to care, mother to child transmission, prevention, and development of vaccines,

Bearing in mind the Council's primary responsibility for the maintenance of international peace and security,

1. Expresses concern at the potential damaging impact of HIV/AIDS on the health of international peacekeeping personnel, including support personnel;
2. Recognizes the efforts of those Member States which have acknowledged the problem of HIV/AIDS and, where applicable, have developed national programmes, and encourages all interested Member States which have not already done so to consider developing, in cooperation with the international community and UNAIDS, where appropriate, effective long-term strategies for HIV/AIDS education, prevention, voluntary and confidential testing and counselling, and treatment of their personnel, as an important part of their preparation for their participation in peacekeeping operations;
3. Requests the Secretary-General to take further steps towards the provision of training for peacekeeping personnel on issues related to preventing the spread of HIV/AIDS and to continue the further development of pre-deployment orientation and ongoing training for all peacekeeping personnel on these issues;
4. Encourages interested Member States to increase international cooperation among their relevant national bodies to assist with the creation and execution of policies for HIV/AIDS prevention, voluntary and confidential testing and counselling, and treatment for personnel to be deployed in international peacekeeping operations;
5. Encourages, in this context, UNAIDS to continue to strengthen its cooperation with interested Member States to further develop its country profiles in order to reflect best practices and countries' policies on HIV/AIDS prevention education, testing, counselling and treatment;
6. Expresses keen interest in additional discussion among relevant United Nations bodies, Member States, industry and other relevant organizations to make progress, inter alia, on the question of access to treatment and care, and on prevention.

Appendix 4 (The Story of a Zimbabwean Grandmother)

At my homestead, I have four graves. One is for my daughter, two are for my sons, and one is for my daughter-in-law. My sons were working in the mine. They used to look after me. They were both married. Two years ago, one fell ill and was excused from work. He came home with his wife and four children since they had to vacate the mine house. For a whole year, my son was very sick. I never left my homestead and neither did my daughter-in-law. In the end, she started getting sick as well, and her brothers came to take her to her home. My divorced daughter and I remained taking care of my sick son, whose savings and unemployment package were now finished. My daughter became very stressed and fell ill. Other village women especially from my church used to come and help me take care of both my son and daughter. A teenage daughter had to drop out of school to help me look after the two patients. That year, I did not even have time to work in the fields. My neighbors tried to help me but the harvest was very poor. Within two weeks of each other, the two had died. After coming to the funeral of his brother, my other son did not go back to the mines. He had TB³³. His wife also had TB. He died six months later and his wife remained in my care until she died two months ago. So all the four graves are within two years of each other. I now have 14 grandchildren in my care. Four of the teenagers have had to drop out of school because we had no school fees and we needed them to work (Maposhere, 2001 p. 15).

³³ Tuberculosis kills more HIV-infected people in Africa than any other AIDS-related disease (Cohen, 2000).