

Conflict Research Programme – HIV/AIDS, Security and Governance Project

HIV/AIDS: Waking up to the Challenges

Working Document

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List of Acronyms

AIDS	Auto-Immune Deficiency Syndrome
ARV	Anti-retroviral Treatment
CIS	Commonwealth of Independent States
CSO	Civil Society Organization
DDR	Disarmament, Demobilization and Reintegration
DRC	Democratic Republic of Congo
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
MSM	Men who have sex with men
NGO	Non Governmental Organization
PLWA	People Living With AIDS
PRSP	Poverty Reduction Strategy Paper
UNAIDS	Joint United Nations Programming on HIV/AIDS
UNDPKO	United Nations Department of Peacekeeping Operations
UNGA	United Nations General Assembly
WHO	World Health Organization

Executive Summary

The nature and scale of the HIV/AIDS-related security crisis varies considerably across regions and across countries. At the moment Sub-Saharan Africa is hardest hit, with more than 25 million people estimated to be living with HIV at the end of 2004. The impacts of the epidemic on society, human capital and institutions are most visible here, and many of the research findings available address the African continent. The fact that other regions and countries do not as yet experience a full-blown epidemic should not put us at rest. The major threat that HIV/AIDS poses is its invisibility in the early stages, with demographic, economic and social impacts lagging behind in time. Governments that have not yet given HIV/AIDS the sustained priority that is needed to stem the tide should be pressed ahead. This is in particular the case in China, India, Russia and other CIS countries.

This discussion paper aims at raising general awareness of the longer-term livelihood, governance and security impacts of an HIV/AIDS epidemic and calls for timely, sustained and multi-stakeholder action *across* the usual policy divides. It should provide a basis to start discussing how to develop such approaches in the fields of security and governance, taking account of current programmes/policies and how these are impacting HIV/AIDS on the ground; the major outstanding challenges; and the future agenda, instruments and 'infrastructure' that is needed to concretize such an approach.

What are the Impacts of the HIV/AIDS Crisis?

Underlying all concerns about HIV/AIDS, livelihood, governance and security is an awareness of the changes it will bring to demographic structures and the long-term undermining impacts it has on already vulnerable economies and political systems. Due to the high morbidity and mortality that is associated with the disease, HIV/AIDS hampers a country's ability to generate real economic and social development, particularly because of the effects on present and future human and institutional capacities. The main (expected) impacts of HIV/AIDS are:

- β HIV/AIDS disproportionately affects people in the working age, thereby disrupting the economic and social dimensions of livelihoods, creating new relations of dependency and destroying existing capacities.
- β HIV/AIDS disproportionately affects women, thereby reinforcing gender disparities and imbalances, transforming intergenerational relations and the organization of family and community life, and contributing to structural disruptions and (potentially) structural forms of violence.
- β HIV/AIDS greatly affects a government's resources and capacity to respond to public demands, with important consequences for public health, education, the environment and the economy, as well as affecting the relationship between states and their citizens.
- β HIV/AIDS greatly affects the armed forces and government institutions' capacity to provide security, thereby endangering an appropriate functioning of the security sector and the rule of law, with the probability of extending security threats to the region and contributing to a global spread of HIV/AIDS through peacekeeping missions.

There is great uncertainty about the full impacts of the HIV/AIDS epidemic, and some of the expected impacts as yet have not materialized. The main research and policy challenges that lie ahead of us include:

- β What evidence do we find for the expected longer-term impacts of the HIV/AIDS crisis? Are some expectations unfounded? Are there other impacts that have been overlooked? How does this inform our policy choices?
- β What are the exact consequences of HIV/AIDS on inter-group relations (gender relations, ethnic relations and inter-generational relations)? How does this affect governance structures and state-citizen relations?
- β How does HIV/AIDS *transform* states and societies? Are policy and funding mechanisms flexible enough to adjust to these changes? What is the risk of increased dependency on international funding? How to deal with this risk?

What are the Conditions that Drive the HIV/AIDS Crisis?

HIV/AIDS is of particular concern among high-risk groups such as transactional sex workers, intravenous drug users, migrants and soldiers. Young women need to be added to this risk group as they demonstrate both socially and biologically increased chances of infection. When appropriate measures are absent to contain the epidemic, HIV/AIDS will soon spread among the broad population. Existing vulnerabilities such as conditions of poverty, (gender) inequality and poor governance will further impair households, communities and states alike to deal effectively with the impacts of HIV/AIDS. The conditions that are seen to drive HIV/AIDS from a health crisis into a governance and security crisis include:

- β Existing economic and political weaknesses at the local and national level, thereby adding to poor governance and inadequate capacity to respond, and driving people into risky behaviour such as prostitution or migration.
- β Weak human resources and lacking investments in human capital (in particular the education and health sector), thereby undermining both present and future social cohesion and welfare.
- β Conditions of war and political breakdown, thereby impairing the access to health services, increasing the risk of exposure to the disease through large movements of people (including military and peacekeepers), and increasing vulnerabilities and the inability to cope with the impacts of the disease.
- β Gender ideologies and cultural practices/understandings on sexual practices and gender relations that contribute to a spread of the virus and place a stigma on HIV/AIDS-infected persons, thereby obstructing treatment awareness and openness on the disease.

Whereas these conditions are found in many developing countries, not always do they lead to a security and governance crisis. Demographic profiles, gendered attitudes, socio-economic vulnerability and political situations all matter. The available capacities and willingness to deal with the impacts appear the main critical factor. National governments are at the centre of effective AIDS-prevention and treatment efforts. The main research and policy challenges that lie ahead of us include:

- β How can we develop trend projections that better take account of the longer-term impacts of HIV/AIDS on a country's demographic profile? Can we improve projections on most affected population groups and levels of poverty and vulnerability, urban/rural ratios of HIV/AIDS prevalence, the state of health and health care, levels of malnutrition?
- β How does the disease spread within a country? How can we contain the impact of conditions of war and post-war activities on the spread of HIV/AIDS? How to tackle risk-behaviour among vulnerable groups?
- β What are likely government responses and available resources in a particular country? What role does national leadership play and what are the prevailing 'politics' of distribution and access to resources? How can we bolster political approaches and commitment to the HIV/AIDS crisis?

- β How can we better take account of cross-sectoral impacts in our cooperation frameworks? How do we link political, security, social and economic institutions? How can we better link micro-level to macro-level institutions?

What have the Responses been so far?

The HIV/AIDS epidemic has mainly been treated as a health problem. Nationally and internationally, attention to the containment of the disease has grown, which finds expression in the rise of available funds. Much progress has been made in the medical field and the availability of cheaper treatment and prevention options. However, large imbalances appear in the availability/access opportunities. It has also proven more problematic to place HIV/AIDS on the political agenda of donors and international agencies, and of national governments in affected countries in particular. So far, the number of ‘success stories’ is limited: Uganda, Senegal, Thailand and Brazil are most cited and hopefully Botswana can be added to this list shortly. The main overall recommendations on response that stand out from the literature include:

- β Finding the appropriate mix of interventions, providing tools to block various routes of infection and enable those at risk to make use of these tools.
- β A better appreciation of the impacts of sector-specific approaches and the risk of burden-shifting (e.g. the exclusion of HIV-positive from the army has safeguarded the military institution, but has increased the burden on the public health service and families).
- β Financing of HIV/AIDS programmes should not be limited to health funding and short-term emergency funding but needs to be institutionalized into foreign, development and security frameworks of operation.

How to translate such recommendations into viable policies and programmes, and whether these fit within existing paradigms of development cooperation, political and security policy needs further perusal. While searching for more concrete goals, instruments and routes, the following set of questions deserves attention:

- β What are we currently doing? What are our main standing policies in the respective fields of security, governance and livelihood?
- β How are these activities impacting on HIV/AIDS and vice versa?
- β What are the major gaps, uncertainties and obstacles we run into given the challenges that the HIV/AIDS crisis poses?
- β What should be our future agenda? What innovative ideas can we think of outside the current programmatic framework?
- β What infrastructure is needed to concretize this approach? What policies, activities and programmes can we think of for implementation? And what implications does this have for current financing rules – for HIV/AIDS as well as for the other policy fields?

The conditions, impacts and challenges/lessons for an HIV/AIDS-related security crisis to develop are summarized in the table below.

CONDITIONS	IMPACTS	CHALLENGES /LESSONS
Gender inequality	Rise dependency and sexual exploitation Structural disruption	Schooling for girls Property rights for women Improved access to treatment Gender-sensitizing rule of law, police
Difficult livelihoods	Rise mortality and morbidity Declining number of economically active members per household Decrease tax base Rise health expenditure Rise migration of workforce	Strengthening of safety nets Community-based orphanage care National and macroeconomic policy Redress malnutrition and food shortage
Weak human capital	Loss of skilled workers (incl. brain drain) Breakdown networks and institutions Loss of economic potential (productivity decline and weak investment climate)	Improve treatment to prolong the productive lives of HIV/AIDS affected Scale up education efforts Strengthening health sector Workplace prevention programmes
Political breakdown and war	Impaired access to medical care Risk of geographic spread of virus due to increased mobility Risk new mutations of virus Rise vulnerabilities and inability to cope with impacts	Targeted prevention, treatment and care programmes (e.g. refugees, DDR) Awareness programmes for high risk groups (e.g. armies, peacekeepers, regional forces) Enforce laws against rape
Taboo and stigmatization	Isolation and exclusion Hiding and negation of disease	Culture-sensitive awareness-raising National leadership National debate and openness of media
Poor governance	Missed opportunities Ineffective programs and misappropriation of funds	Political pressure Encourage transparency and accountability

I. Introduction

The HIV/AIDS crisis that we are facing today occurs against a backdrop of mass poverty, uneven economic growth and political instability. Hardest hit are the societies in sub-Saharan Africa, but the virus also spreads rapidly from hot spots in Asia, Eastern Europe, the Americas and the Caribbean. Responses to the crisis are often limited to the health field as we have until now mainly witnessed the medical and humanitarian impacts of HIV/AIDS—morbidity, mortality and personal and family crises. But the full political, economic, social and strategic implications of the pandemic lie outside our short-term visions and have yet to be realised.¹ Contrary to past epidemics as the ‘Black Death’ that killed the weak and infirm first, in the developing world HIV/AIDS has tended to claim the lives of the more productive members of society. AIDS is, consequently, an *exceptional* kind of crisis.² It is both an emergency *and* a long-term development issue.³ In the worst-case scenario, it might even pose a threat to democratic governance, political stability and state security.

β Approaching HIV/AIDS as a Security Threat

Focusing on the HIV/AIDS-related security threat is not unrealistic, as was expressed by resolution 1308 of the UN Security Council and recently confirmed by the High Level Panel Advise on major threats to global security. HIV/AIDS poses a human security challenge, as it affects personal safety and the social, economic, political and environmental spheres of activity of an individual’s life. In its epidemic form, it becomes a threat that is felt within the state institution as a whole, as it “destroys the very fibre of what constitutes a nation: individuals, families and communities, economic and political institutions, military and police forces.”⁴ Accordingly, the disease is no longer just a *symptom* of a state crisis, as usually thought, but actually a *catalyst* of it.⁵ The major incapacities of states to deal with the consequences of HIV/AIDS and the current poor state of public services should thus be an additional reason for concern. When we talk about the HIV/AIDS-related security crisis we refer in particular to its ability to

- threaten drastically and over a relatively brief span of time to degrade the quality of life for the inhabitants of a state and/or to
- threaten significantly to narrow the range of policy choices available to the government of a state or to private, non-governmental entities within the state.⁶

The *degree* of the threat that HIV/AIDS poses to a society will vary, however. Not only do prevalence rates differ substantially. The virus also spreads through different populations by different means. And national capacity and willingness to respond vary enormously.⁷ But current predictions on the spread of

¹ P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 10.

² See P. Piot (February 2005), ‘Why AIDS is Exceptional’.

³ UNAIDS (2004), ‘2004 Report on the Global AIDS Epidemic. Executive Summary’, p.3.

⁴ ICG (19 June 2001), ‘HIV/AIDS as a Security Issue’, p. 1.

⁵ P. Singer (2002), ‘AIDS and International Security’, p. 12.

⁶ See A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, pp. 14-15, referring to the work of Robert Ostergard, Barry Buzan and Richard Ullman on the concept of national security in particular.

⁷ UN Millennium Project (February 2004), ‘Interim Report of Task Force 5 Working Group on HIV/AIDS. Executive Summary’, p. 5.

the disease are worrisome. It is, for example, expected that by 2010 Asia will outstrip Southern Africa in absolute numbers of HIV/AIDS infected.

β **Substantiating Calls for Prevention**

Fortunately, we have not (yet) witnessed states collapsing due to HIV/AIDS. Predictions as the one just mentioned above nevertheless call for stepping up preventive measures. When the disease builds up momentum it will be difficult to turn it around. Health services will be inadequate and the costs of education and treatment will be overwhelming. There is, in fact, “far too little attention to the central challenge of how to sustain democracy, basic social services and economic growth in a country suffering the onslaught of a full-blown HIV/AIDS epidemic.”⁸ Such concerns should lead to a push for greater investment in treatment *and* prevention. Prevention is therefore a major challenge, but alike prevention strategies in other fields, runs into major difficulties of implementation.

β **Designing Broad Responses to the HIV/AIDS-related Security Crisis**

There is a need for continued efforts to contain the epidemic by targeting high-risk groups –sex workers, intravenous drug users, military- and to increase efforts of treatment and care for those already affected.⁹ Money and drugs are moreover needed to ensure that people actually have access to appropriate means of protection and treatment. But there are other important drivers of the epidemic and its impacts that are much harder to control: conflict and war, poor governance, migration and trade. To tackle these drivers, HIV/AIDS approaches need to extend from the health and emergency field to other areas of foreign and security policy. The HIV/AIDS-related security crisis, in short, requires action *across all sectors*.

Understanding the potential implications of HIV/AIDS on national security and stability will thus raise an additional set of challenges for governance, security and development strategies and requires timely and innovative responses. While still preventable and containable the fight against HIV/AIDS requires support to those who are facing the hard issues of AIDS, while encouraging others that still shirk their duties to respond. The instruments of development co-operation, foreign and security policy have to combine efforts to ensure the leverage and efficiency needed. How to do this, is still insufficiently clear. There seem to be some imbalances in current aid paradigms that require debate so as to begin translating high aspirations and rhetoric into suggestions for practical action.¹⁰

β **The Objective and Structure of this Discussion Paper**

This discussion paper stipulates major issues in the debate on how HIV/AIDS, a major threat on its own, is related to concerns of insecurity and instability in a broader context. Its ultimate objective is to find ways of how to integrate HIV/AIDS and its impacts within existing governance and security frameworks. Reaching this objective requires a greater awareness of the disease and its consequences, a major shift in priority setting, as well as a clear political and financial commitment to address the challenges of treatment and prevention.

⁸ Justice Africa/GAIN (October 2004), ‘HIV/AIDS, Democracy and Governance in Africa’, p. 1.

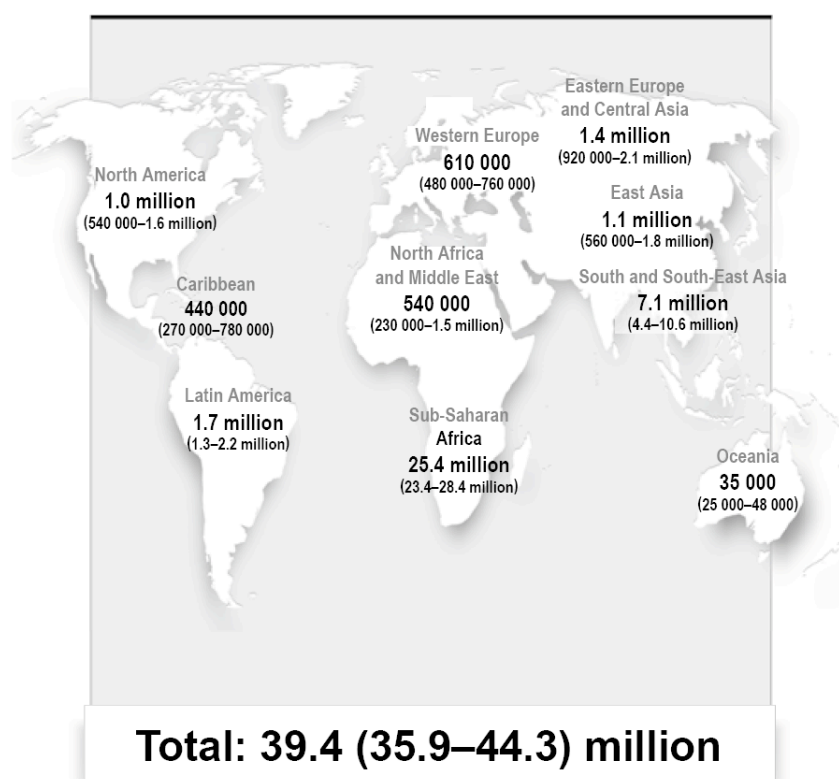
⁹ In the document the role of drugs and other new technology to prevent or to combat the Aids virus in the human body are not brought up. Although anti-retroviral treatments (ARV) have become widely available worldwide (also for poorer people) and efforts have intensified to find a vaccine and microbicides to apply vaginally, the expectations on the effect now and on the longer term are not as optimistic as some time ago. For example, experience learns that fighting ARV resistance will be a continuing struggle, particularly for Africa. Experts are very pessimistic about the possibility to develop a vaccine, due to the diversity and the continuing change of the HIV-virus and the fact that one person can be infected by different types of the HIV-virus. The microbicides might create a kind of opportunity, but the applicability proofs to be as difficult as the use of condoms and the by-effects are not yet known.

¹⁰ See also UN Millennium Project (February 2004), ‘Interim Report of Task Force 5 Working Group on HIV/AIDS. Executive Summary’, p. 6.

This paper expounds the nature, scope and impacts of the HIV/AIDS pandemic and reflects on the ways and likelihood it may develop into a full-blown security crisis. Evidence from various disciplines and policy fields is used and illustrations are given for different country cases. Much of the work found in the literature, however, is still preliminary and sometimes speculative. It is nonetheless relevant and deserves careful consideration and critical assessment. Chapter II therefore looks into the scope and magnitude of the current crisis, highlighting the main impacts on state and society. Chapter III focuses on susceptibility to HIV/AIDS and patterns of vulnerability that incapacitate effective responses and hence create the conditions for a governance and security crisis. Chapter IV tries to bring these two strands together and looks into the contribution of HIV/AIDS to processes of breakdown in fragile and failing states. Chapter V summarizes the major overall challenges that HIV/AIDS poses to national and international response capacities.

II. Scope and Magnitude – What Kind of Security Threat do we Face?

While talking about the scope and magnitude of the HIV/AIDS¹¹ pandemic, one most commonly starts with the numbers. And these numbers are dazzling. “In 2003, almost five million people became newly infected with HIV, the greatest number in any one year since the beginning of the epidemic. At the global level, the number of people living with HIV continues to grow—from 35 million in 2001 to 38 million in 2003. In the same year, almost three million were killed by AIDS; over 20 million have died since the first cases of AIDS were identified in 1981.”¹² The figure below demonstrates the number of adults and children estimated to be living with HIV as of the end of 2004.¹³



Disaggregation of the numbers, however, is needed. “The epidemic varies in scale or impact within regions; some countries are more affected than others, and within countries there are usually wide variations in infection levels between different provinces, states or districts, for example.”¹⁴

HIV/AIDS and related diseases as tuberculosis has become one of the leading causes of death in Sub-Saharan Africa. It now accounts for about 20 percent of all deaths in the region and more than half of the deaths in some countries. But also in regions where national infection rates are presently low, these rates often mask serious regional epidemics, such as in China and

India.¹⁵ The raising concern on ‘next wave countries’ (see box 1) particularly focuses on Nigeria, Ethiopia, Russia, India and China, given their strategic position and for the fact that, together, they make up 40% of

¹¹ The literature sometimes clearly differentiates between HIV (carriers of the virus) and AIDS (carriers of the virus that have fallen ill), but in most cases is less specific. In the paper we have therefore opted to refer to HIV/AIDS without making the distinction. Exceptions are citations.

¹² UNAIDS (2004), ‘2004 Report on the Global AIDS Epidemic. Executive Summary’, p. 5.

¹³ Taken from UNAIDS/WHO (December 2004), ‘AIDS Epidemic Update 2004’, p. 77.

¹⁴ UNAIDS (2004), ‘2004 Report on the Global AIDS Epidemic. Executive Summary’, p. 5.

¹⁵ “Although no signs have yet emerged of a generalized epidemic in many of the countries in Asia, the conditions are ripe for a rapid spread of HIV.” B. Epstein (November 2004), ‘The Demographic Impact of HIV/AIDS’, p. 13.

the world population. These countries are still in the early-to-mid stages of the epidemic, with governments that have not yet given HIV/AIDS the sustained priority that is needed to stem the tide.¹⁶

Box 1 – Future Scenarios on the Spread of HIV/AIDS in ‘Next Wave Countries’

β *National Intelligence Council* (2002: 4): “We project China will have 10 to 15 million HIV/AIDS cases, and India is likely to have 20 to 25 million by 2010 – the highest estimate for any country. By 2010, we project Nigeria will have 10 to 15 million cases, Ethiopia 7 to 10 million, and Russia 5 to 8 million.”

β *National Intelligence Council* (2002: 5): “In Russia, the rise in HIV/AIDS will exacerbate the population decline and severe health problems already plaguing the country, creating even greater difficulty for Russia to rebound economically. These trends may spark tensions over spending priorities and sharpen military manpower shortages.”

β *National Intelligence Council* (2004: 10): “Russia faces a severe demographic crisis resulting from low birth rates, poor medical care, and a potentially explosive AIDS situation. To the south, it borders an unstable region in the Caucasus and Central Asia, the effects of which – Muslim extremism, terrorism, and endemic conflict- are likely to continue spilling over into Russia. While these social and political factors limit the extent to which Russia can be a major global player, Moscow is likely to be an important partner both for the established powers, the United States and Europe, and for the rising powers of China and India.”

Note: there is a degree of uncertainty with regard to the ‘numbers’ on HIV/AIDS prevalence. UNAIDS statistics have proven most comprehensive, but work with official government statistics from each country only.¹⁷ Although much of the work is based on estimates by experts with a high level of consensus, there is a major gap in evidence-based research. Such research suffers from the stigma that rests on the disease, costs involved in detection and the long incubation period. And even when the statistics are available, these are not always made public due to the impact this might have on the security and economy (e.g. prevalence of HIV/AIDS in the national army; impact on investors climate). The lack of reliable data on what is actually happening obstructs the ability to measure progress and the impact of interventions for the future.¹⁸

β **Demographic Impacts and Changes in the Population Structure**

The impacts on morbidity and mortality associated with HIV/AIDS are enormous. In some of the worst-affected countries average life expectancy has declined by more than 20 years (see figure on top of next page). HIV/AIDS typically strikes people of childbearing, childrearing and working age, **seriously**

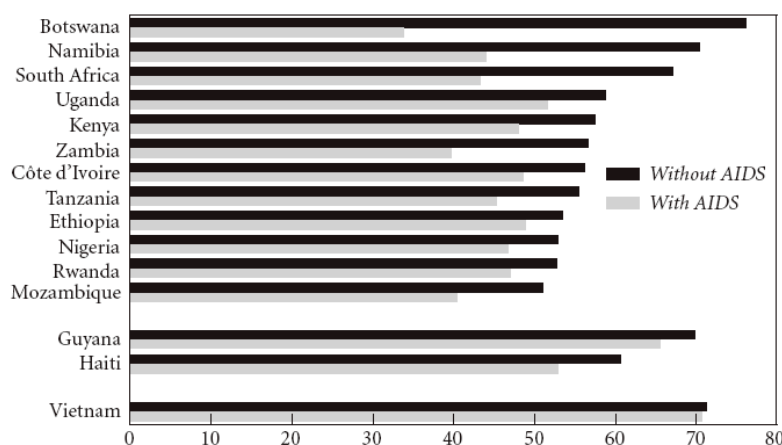
¹⁶ See National Intelligence Council (2002), p. 1.

¹⁷ How these figures can be enriched by incorporating academic and NGO assessment is still open. (A. de Waal ??) New estimates on the status of the epidemic, as published yearly by UNAIDS, indicate that the prevalence in the general population in Africa is lower than previously thought. One reason for this is that AIDS deaths are rapidly increasing. Another is that previous estimates appear to have been too high. See Justice Africa/GAIN (August 2004), ‘HIV/AIDS, Democracy and Governance in Africa’, pp. 2-3.

¹⁸ A high level of uncertainty about prevalence estimates will remain until assessment methodologies are improved. In fact, it is argued that it will always remain impossible to know the exact number of people living with HIV/AIDS (PLWA), and that it is therefore best to identify *trends over time* rather than ‘correct’ prevalence levels at a given time. See Justice Africa/GAIN (August 2004), ‘HIV/AIDS, Democracy and Governance in Africa’, p.4.

affecting productive age groups. In countries with projected negative population growth, AIDS mortality is likely to produce population pyramids of a pattern never seen before: National population distribution is expected to transform from a pyramidal shape to a chimney-type form, with similar numbers of adults of different ages perched on a large base of children and adolescents.¹⁹ There will be a substantial increase in orphans and other vulnerable children, subsequent changes in the composition of households, decreasing labour force and increases in demand for (and costs of) social services.²⁰

Figure 1.12. Life Expectancy at Birth With and Without AIDS in Selected Countries, 2005
(Years)



Source: U.S. Census Bureau, International Programs Center, HIV/AIDS Surveillance Data Base (2004) and unpublished tables.

There are also **demographic imbalances in gender ratio.** Women demonstrate a younger average age of infection. “Women, and especially young women, have multiple vulnerabilities to HIV transmission: biological, cultural, social, and economic. (...) Economic dependency on men, a cultural preference for high fertility, lack of power to negotiate safe sex practices, and lack of access to information and health care all combine to make it difficult and undesirable for women to be proactive in safe sex negotiation.”²¹ (see also chapter III) Whereas the global distribution of HIV by sex is nearly 50-50, in sub-Saharan Africa women account for 57% of HIV infections.²² The biological vulnerability of women,²³ consequently, leads to a *structural* disruption.

β **Socioeconomic Impacts – in Present and Future**

The changed demographic structure (fewer adults and shortened lifespan, increased dependency ratios) will also produce economic distortions. **HIV/AIDS disrupts the production process and thereby affects**

¹⁹ A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, p. 16.

²⁰ B. Epstein (November 2004), ‘The Demographic Impact of HIV/AIDS’, pp. 30-31.

²¹ B. Epstein (November 2004), ‘The Demographic Impact of HIV/AIDS’, pp. 15-16.

²² UNAIDS (2004), ‘2004 Report on the Global AIDS Epidemic’, p. 100.

²³ “Physiologically, the greater concentration of HIV in semen than vaginal secretions, the penetrability of the female genital tract, and for young women the particularly vulnerable character of the cellular structure of the uterine cervix, all mean that transmission is more likely from an infected man to a woman than vice versa. The likelihood of transmission between an infected male to another male or female through anal intercourse is even higher because the membrane lining the rectum is less able to resist absorption of HIV into the bloodstream. In Africa it is estimated that less than 1% of infections have occurred through men who have sex with men (MSM).” J. Putzel (May 2003), ‘Institutionalizing an Emergency Response’, pp. 8-9.

the macro-economy. The increase of ill-health will have direct costs, such as increased spending on health care, lower savings, shifting consumption patterns and low productivity. Impacts will also arise in the labour force, as HIV/AIDS has a disproportionate impact on the most productive part of the labour force. It will reduce the number of people at working age, but also change the structure of the working age population.²⁴ By skimming off the most skilled workers in the economy (earlier than necessary if treatment would be available), HIV/AIDS threatens to forestall the emergence of a critical mass of these workers.²⁵

The AIDS epidemic is likely to have a dramatic effect not only on domestic saving (through the foreshortening of time horizons and the increased demand for present consumption to finance medical care), but also on the attractiveness of foreign investment. It is expected to worsen the investment climate, as “Investors are more likely to wait (defer investment) when they have information indicating that the spread of HIV/AIDS will affect adversely the cost structure of any investment they are contemplating.”²⁶ “These effects together are likely to erode the physical capital stock in many of the hardest-hit countries. Insofar as this in turn reduces the skill premium, it will reduce incentives for households to invest resources and time in the education of their children beyond the basic, primary level.”²⁷

Other features arise from a look at the micro-household level or to related **impact on human capital** (existing abilities and capacities of the victims) and social fabric (the formation of human capital in the next generation and beyond). “It is one thing when 11 percent of 20-year-old males, and 4 percent of 20-year-old females, will fail to see their fortieth birthday (the case in South Africa in 1990); it is a problem of an altogether different kind when those proportions are 36 and 54 percent, yet this is the appalling prospect confronting South Africa in the coming two decades. Seen in this light, the loss of workers in their most productive years signals only the beginning of the damage the epidemic will eventually wreak upon the economy and society.”²⁸

It is the postponed impact of the HIV/AIDS crisis that causes greatest concern. “This threat of a progressive collapse of the economy is particularly insidious because the effects will not be felt immediately. Thus estimates of the economic impact of AIDS that look only at the short- to medium-term effects of reductions in labor supply are dangerously misleading. They risk lulling policymakers, especially those concerned with short-term economic fluctuations, into a sense of complacency. (...) it is possible to avert the downward spiral, but only with an aggressive set of policies aimed at shoring up the faltering mechanisms of human capital transmission between generations—policies that prevent AIDS, prolong the lives of its victims, and support the education of their children. These policies are expensive, but, when viewed against the spectre of a collapse of the economy and possibly of society itself, they seem like a bargain.”²⁹

²⁴ AIDS-induced debilitation and mortality is *not* expected to lower unemployment rates, because the contraction of the macro-economy will also lower the general demand for labour. However, the epidemic is expected to exacerbate the pre-existing shortage of *skilled* workers. See A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, p. 19.

²⁵ N. Birdsall, A. Hamoudi (November 2004), ‘AIDS and the Accumulation and Utilization of Human Capital in Africa’, p. 159.

²⁶ McPherson cited in A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, p. 24.

²⁷ N. Birdsall, A. Hamoudi (November 2004), ‘AIDS and the Accumulation and Utilization of Human Capital in Africa’, p. 161.

²⁸ C. Bell, S. Devarajan, H. Gersbach (November 2004), ‘Thinking About the Long-Run Economic Costs of AIDS’, pp. 100-101.

²⁹ C. Bell, S. Devarajan, H. Gersbach (November 2004), ‘Thinking About the Long-Run Economic Costs of AIDS’, p. 129.

β Impacts on Governance

The impacts on governance, more or less, run parallel to the effects on the economy. **The loss of human resources greatly affects institutional capacities.** Experience and formal and informal networks are lost, and so is efficiency. The loss of staff is also expected to affect the ‘democratic infrastructure’ of, for example, civil society organizations (CSOs) and local government. Some speculations exist on how HIV/AIDS might affect overall democracy, e.g. the loss of interest in politics, elections and reduced political participation due to personal concerns.³⁰ Whether political instability becomes a real potential consequence remains unsure, and is addressed more substantially in chapter IV.

The implications of HIV/AIDS will be substantial for public and fiscal policy. HIV/AIDS will require prevention policies, treatment and care policies, social and economic policies, but at the same time greatly affects government revenue.³¹ Increased levels of death and illness among the population will reduce the tax base from which governments finance their budgets, while the HIV/AIDS pandemic simultaneously will raise public demands for increases in public health expenditure.³² The likely **increase in dependency on external finance** to redress the pandemic should be taken note of.

β Impacts on the Security Sector

HIV/AIDS has a significant draining effect on skilled positions within the military forces, and the police and corrections system. **Soldiers in particular are susceptible to HIV/AIDS**, since they are highly mobile and belong to a sexually active age group.³³ The higher prevalence rates in sub-Saharan Africa make HIV/AIDS a more immediate and acute issue for the armed forces than in, for example, Asia.³⁴ Factors that are thought to contribute to the weakening of the armed forces include poor morale and discipline, a diminished pool from which to recruit, loss of experience and expertise, impaired cohesion of units, and a weakening of command and control.³⁵ “The loss of personnel furthermore compromises combat readiness, and upsets the continuity of command and the efficacy of detachments. This raises the risk of un(der)skilled people taking up these positions. HIV/AIDS will furthermore raise direct costs by providing health care for soldiers who are sick. Training new recruits also absorbs already scarce resources.³⁶ Without being specific on the exact mechanisms, some also fear that the weakness of a country’s national defence system and governance institutions may shift existing power balances, leading to **new security threats within and between countries.**

Box 2 – HIV/AIDS among the Kenyan Security Forces

³⁰ M. Haacker (November 2004), ‘HIV/AIDS: The Impact on the Social Fabric and the Economy’, p. 65.

³¹ See also M. Haacker (November 2004), ‘The Impact of HIV/AIDS on Government Finance and Public Services’, p. 199.

³² R. Mattes (April 2003), ‘Healthy Democracies?’, p. 4.

³³ In that sense, they also serve as agents for the transmission of HIV/AIDS. See e.g. R. Bazergan (November 2004), ‘HIV/AIDS: Policies and Programmes for Blue Helmets’; A. de Waal (2002), ‘Fucking Soldiers’.

³⁴ Some care with the statistics cited in the literature is warranted, however. There is a lack of reliable evidence on HIV/AIDS in the security sector because of a culture of state secrecy on matters related to the security. “A much-repeated factoid of this nature is the claim that HIV prevalence in armed forces is 2-5 times higher than in the general population. While this may have been true in some places at an early stage of the epidemic (e.g. when the overall prevalence rate was 3% and among soldiers it was 6-15%), but it is no longer plausible when the epidemic has matured and general population rates are above 10-15%.” Justice Africa/GAIN (August 2004), ‘HIV/AIDS, Democracy and Governance in Africa’, p. 5.

³⁵ P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 14.

³⁶ R. Bazergan (November 2004), ‘HIV/AIDS: Policies and Programmes for Blue Helmets’, p. 3.

Lt. Gen. John Koech, deputy chief of the Kenyan general staff, said that between 50 and 60% of the beds at the Forces Memorial Hospital in Nairobi were now occupied by HIV/Aids sufferers. General Koech warned that HIV is affecting the armed forces at all ranks. He said the effects of the virus were causing loss of continuity at command levels and within the ranks and, in turn, increasing the costs of recruiting and training replacements. Kenya's armed forces now lose between 6 and 10 soldiers a week. Voluntary counselling and testing has been introduced on an anonymous basis within the army.

Source: "Aids burdens Kenya prison warders", BBC News, (20 June 2003) & "Kenya—From Moi to Kibaki: Assessing the Transition" Ambassador Johnnie Carson, Woodrow Wilson International Center for Scholars (September 11, 2003).

There are related concern for the regional and global impacts on the military apparatus, in particular through participation in **peacekeeping missions**. These missions employ multi-country military (and civilian) personnel. In the case of UN missions extensive efforts have been taken by UNDPKO to reduce the risk of HIV/AIDS spread between populations and armed forces, but less clarity exists for regional peacekeeping missions of, for example, AU or ECOMOG.

Whether the uniformed services (military, police, customs, border and prison guards) will be decimated by the pandemic³⁷, is debatable. Some years ago there was clear evidence that HIV/AIDS rates among the military were considerably higher than among the broader population. Evidence now arises that the military institution has started to safeguard itself from these impacts, mainly by keeping out of its ranks HIV infected. Whereas the military institution no longer decays, some related effects should be noted such as the burden shifting of HIV/AIDS care and impacts to the public sector. Some fear that, where military institutions remain strong while civic institutions are further weakened, new political and legal challenges might arise for **civil-military relations**.³⁸

B Uneven Spread of Impact

The effects of HIV/AIDS do not hit evenly.³⁹ Most profoundly, it affects people living with HIV/AIDS (PLWA) and their households. Most figures on HIV/AIDS spending, however, ignore so-called 'out-of-pocket spending' by directly affected individuals and families.⁴⁰ Such out-of-pocket expenses can represent a substantial share of total health expenditure on AIDS. In Kenya (2002) this added up to 41%, whereas this was 93% in Rwanda (1998). **These figures provide alarming evidence of the financial burden of AIDS on households.**⁴¹ Much of the burden of AIDS-related care also falls on women. This is even more so in rural communities, where many women play a significant role in economic activities in addition to their household work. Carrying for the sick disrupts this work.⁴² When the partners or fathers of women die of AIDS, many are left without inheritance – land, housing or other assets.⁴³The uneven

³⁷ J. Mendelson Forman, M. Carballo (July 2001), 'A Policy Critique of HIV/AIDS and Demobilisation', p. 3.

³⁸ Elbe cited in A. Price-Smith, J. Daly (July 2004), 'Downward Spiral', p. 30.

³⁹ C. Bell, S. Devarajan, H. Gersbach (November 2004), 'Thinking About the Long-Run Economic Costs of AIDS', pp. 96-97.

⁴⁰ Though systematic information collection is scarce, in 2003, AIDS out-of-pocket spending is likely to have exceeded US\$ 1 billion worldwide. Regional differences are inversely related to government health-care expenditure: when public health sector infrastructure is weak, individual households are likely to pay out of their own pockets. UNAIDS (June 2004), '2004 Report on the Global Aids Epidemic', pp. 136-137.

⁴¹ UNAIDS (June 2004), '2004 Report on the Global Aids Epidemic', p. 137.

⁴² UNAIDS (June 2004), '2004 Report on the Global AIDS Epidemic', p. 130.

⁴³ UNICEF, for example, reports that in a Ugandan survey one in four widows reported their property was seized after their partner died. "A women may also be prevented from using her property or inheritance for her family's

impact of HIV/AIDS across individuals and households requires more attention and should inform distributional aspects in policy design. Most notably this is of relevance to aspects of *access* to treatment and care.

Box 3 – Impacts of HIV/AIDS on the Livelihoods of PLWA

“A study of AIDS-affected households in Zambia shows that in two thirds of families where the father had died, monthly disposable income fell by more than 80%. A similar study in Côte d’Ivoire found that income in AIDS-affected households was half that of the average household. In Botswana, where the infection rate is exceptionally high, per capita household income for the poorest quarter of households is expected to fall by 13% over the next 10 years, while every income earner in this category can expect to take on four more dependents because of AIDS.”

Source: UNAIDS (2005), ‘AIDS in Africa: Three Scenarios to 2025’, p. 31.

β Summary Findings - Key Features that Make HIV/AIDS a Potential and Real Security Threat

There is currently no foreseen halt to the spread of HIV/AIDS. The long incubation period of the virus as well as the stigma that rests on the disease might imply there is more in store for the future. The following characteristics of HIV/AIDS are considered to be key factors of influence to the governance and security setting. They are therefore of relevance to all sectors that make up a foreign and security policy:

- β HIV/AIDS disproportionately affects people in the working age, thereby disrupting the economic and social dimensions of livelihoods, creating new relations of dependency and destroying existing capacities.
- β HIV/AIDS disproportionately affects women, thereby reinforcing gender disparities and imbalances, transforming intergenerational relations and the organization of family and community life, and contributing to structural disruptions and (potentially) structural forms of violence.
- β HIV/AIDS greatly affects a government’s resources and capacity to respond to public demands, with important consequences for public health, education, the environment and the economy, as well as affecting the relationship between states and their citizens.
- β HIV/AIDS greatly affects the armed forces and government institutions’ capacity to provide security, thereby endangering an appropriate functioning of the security sector and the rule of law, with the probability of extending security threats to the region and contributing to a global spread of HIV/AIDS through peacekeeping missions.

The impacts of HIV/AIDS are complex, structural and far-reaching, reaching well beyond the individual and household level. But many uncertainties about the full impact of HIV/AIDS remain. These impacts still lie in the future or are less visible. Not only do statistics on deaths and infection rates matter. The out-migration of skilled and affluent people from AIDS-affected regions, for example, will also strongly impact on a society.⁴⁴ One could also think of a ‘subjective demography’, where expectations of dying

benefit. This in turn hurts her ability to qualify for loans or agricultural grants.” In UNDP/UN-OHRLLS (2005), ‘Hope Building Capacity’, p. 8.

⁴⁴ Accurate statistics on the problem of brain drain do not exist. One of the worst examples of the regional brain drain is Zambia. A few years ago the country had 1600 doctors, in 2002 there were only 400 in practice. Although brain drain isn’t limited to the health sector or the African continent, this is where it is being felt the most. A study by the World Bank reported that some 70.000 highly qualified African scholars and experts leave their home countries every year in order to work abroad. See H. Luring (2002), ‘Action Needed on Brain Drain’.

early affect social behaviour.⁴⁵ And how will scarcity of adult women affect their power situation or influence the behaviour of adult and unmarried men?⁴⁶ At present we can only ask questions about these processes. Different scenarios are open to challenge on numerous grounds, but they pose questions that cannot be ignored.⁴⁷

⁴⁵ See for example the work of P. Richards.

⁴⁶ How sex ratios (a surplus of men) affect behaviour and security is a real issue in China, but also in some other Asian countries. See V. Hudson, A. Den Boer (2002), 'A Surplus of Men, A Deficit of Peace'.

⁴⁷ A. de Waal (2003) 'How Will HIV/AIDS Transform African Governance?', pp. 4-6.

III. Susceptibility and Vulnerability – Which Conditions Feed into the Crisis?

Fortunately, HIV/AIDS does not always pose a national security threat. It is therefore necessary to make a distinction between high prevalence and low prevalence cases. In Asia, for example, the disease is still concentrated in high-risk groups (sex workers, intravenous drug users), which might facilitate containment. It is however also seen to be spreading quickly to wider circles, through heterosexual transmission, migrant workers and rising prostitution. **Shorter-term containment should therefore not hide longer-term vulnerabilities.** In all cases, HIV/AIDS should be given appropriate reflection, factoring in cross-border issues of spread and the long incubation period that may hide consequences until full-blown eruption. Timely and effective prevention of this epidemic state requires a capacity for early recognition of the major symptoms. So which conditions deserve particular attention because they are known to form a ‘breeding ground’ or ‘vectors’ for spread of the disease? And which conditions sharply reduce the capacities of a society to absorb the impacts of HIV/AIDS?

B Existing Vulnerabilities and Shifting Vulnerability Patterns

To get a better grip on the conditions that feed into the crisis, it is first of all important to look at the susceptibility of a society to HIV/AIDS, that is, “those aspects of a society which make it more or less likely that an epidemic will develop”.⁴⁸ Particular conditions such as poverty and lacking economic opportunities, war, weak rights protection and public services, unfortunately found in many parts of the developing world, intensify the hostile conditions that support the spread of the virus. Unsafe medical, sexual and cultural practices add to this risk.⁴⁹ A health crisis, however, can also develop into a security crisis. One should therefore also **be aware of the existing vulnerability of a society**, that is, “those aspects of a society which make it more or less likely that an epidemic will have a serious impact on social and economic organizations”.⁵⁰ This very much depends on governance and the adaptive and coping capacities present both at the governmental and at the societal level (see also chapter IV).⁵¹

It is extremely difficult to separate the causes of the epidemic from its consequences. Many countries demonstrate a quick development of the epidemic *because* they have weak social and economic organizations in the first place. Yet in others the presence of social, economic and political capacity will be able to avoid negative impacts on security *despite* the spread of the epidemic. Two key factors that seem to modulate the level of susceptibility and vulnerability of a society are the level and distribution of wealth and income, and the degree of social cohesion. The observation that HIV/AIDS disproportionately affects people in their productive years should therefore be a major concern. **This will lead to shifting**

⁴⁸ Decosas cited in P. Fourie, M. Schönreich (2002), ‘Die, The Beloved Countries: Human Security and HIV/AIDS in Africa’, p. 5.

⁴⁹ The most common patterns of transmission include unsafe sex; transmission from infected mother to child; the use of infected blood and blood products; intravenous drug use with contaminated needles; and other blood related modes of transmission. See e.g. J. Putzel (May 2003), ‘Institutionalizing an Emergency Response’, pp. 8-10.

⁵⁰ Decosas cited in P. Fourie, M. Schönreich (2002), ‘Die, The Beloved Countries: Human Security and HIV/AIDS in Africa’, p. 5.

⁵¹ Some, for example, argue that the security impact will most likely be limited in China and other Asian countries, because of strong government capacity. Others, however, point out the fact that the epidemic at one point develops its own dynamic, which even with the best of intentions cannot be contained in the shorter term. This might after all lead to a loss of legitimacy of government when appreciated increasingly as ineffective.

vulnerability patterns,⁵² affecting not only the weak but also the strong and skilled workers, who are so desperately needed for a society's long-term development, security and stability.

The conditions that are described below should be seen as both cause and consequence of an HIV/AIDS crisis. They pose a heightened risk for the spread of HIV/AIDS and for a sharpening of the impacts of the crisis. Where such conditions are present, HIV/AIDS should be given appropriate consideration and, if necessary, be assigned priority attention.

⁸ **Poverty, Weak Human Capital and Limited Alternative Economic Opportunities**

The spread of HIV/AIDS first of all is related to patterns of vulnerability that again relate to poverty and powerlessness. **Poverty affects people's vulnerability to HIV/AIDS, both by increasing the risk of contracting the virus and by reducing one's ability to deal with the economic and social consequences.**⁵³ The fact that the disease takes the lives of skilled workers, among which school teachers,⁵⁴ adds to these long-term consequences. And although the problem of Africa's small human capital stock (e.g. measured by average years of schooling) predates the arrival of the epidemic, it is also affected profoundly in the process. Years/decades of investments in development, consequently, are easily lost.

There are some widely cited examples of poverty forcing people to accept high-risk areas of employment. The lack of alternative economic opportunities, for example, drives many women into the commercial sex industry. One could think of Cambodia and Thailand, but similar problems arise in the former soviet republics and Estonia. Current migration patterns, human trafficking and illegal prostitution raise concerns for a renewed wave of HIV/AIDS in Europe. Also seasonal migration, often instigated by temporary lack of employment opportunities, is highly correlated to increased risks of HIV/AIDS for example in China. In Afghanistan, where the HIV/AIDS crisis is mainly related to intravenous drug use, the problem seems of a different nature, but the underlying causes that drive the crisis are similar. It is not just the lack of opportunities, but also particular development patterns in transforming economies that might increase the incidence of HIV infection. Such projections are for example expected as a result of an increase in rural-urban transport infrastructure and the urbanisation associated with export-oriented industries. Trade routes often are correlated to increased incidence rates. Hence, **it is not so much the size of the economy that seems to matter most in providing conditions for spread of the crisis, but the structure of the economy.** A relevant question then would seem to be "how to harness the resources generated by economic growth and capitalise on the broad improvement in household welfare to reduce the rate of spread of HIV."⁵⁵

Some development patterns also erode the economic power base of women, making them more dependent on their husbands' incomes and giving them less decision-making power. Increasing poverty and dependency also pushes women to resort to commercial or consensual sex;⁵⁶ or causing greater under-nutrition which further reduces their immunity and causing early death from AIDS.

⁵² The concept of 'shifting vulnerability pattern' is taken from A. de Waal.

⁵³ M. Haacker (November 2004), 'HIV/AIDS: The Impact on the Social Fabric and the Economy', p. 80.

⁵⁴ In Uganda and Malawi, for example, nearly one third of all teachers are HIV-positive. See World Bank (2002), 'Education and HIV/AIDS: A Window of Hope', p. 12.

⁵⁵ C. Jones (1998), 'Does Structural Adjustment Cause AIDS?', p. 62.

⁵⁶ Studies conducted in 2001 in Kisumu, Kenya and Ndola, Zambia report that 40% of women, most of them single, had had sex in exchange for money or gifts in the previous year. Female-headed and orphaned-adolescents headed households are particularly vulnerable to offers of economic support from so-called 'sugar daddies' who pay school fees and food in return for sex. See UNAIDS (2005), 'AIDS in Africa: Three Scenarios to 2025', p. 43.

B A Weak and Decaying Health Infrastructure

HIV/AIDS requires large investments in epidemiological research, medical and technical treatment and care, as well as preventative measures to change individuals and group behaviour. Where resources are scarce, such investments fall behind. **Among the already existing capacity constraints the most serious would be the lacking availability of human resources.** Even if sufficient financing were available, the prevailing shortage of trained personnel cannot be made up for in the short term.⁵⁷ “Not only are health professionals in short supply, but they are being lost to the private sector, to international migration, and to AIDS itself. ‘We are going to run out of people before we run out of money’ reads an article on the subject in South Africa (SAPA 13 December).”⁵⁸

It is worthwhile to note that some claim a relationship between structural adjustment and HIV/AIDS infection resulting from reform prescriptions that require cutbacks in health financing and other public services. Although it is hard to substantiate such claims, there is some evidence that at the least ‘hard core’ poverty among the poorest of the poor as well as the level of inequality tends to increase due to these policies. “These findings could have worrisome implications for the spread of HIV, if an increase in urban poverty or a decrease in household expenditures of the poorest segment of the population increases the risk of contracting HIV.”⁵⁹ A rise in inequality “could lead to an increased prevalence of AIDS if it increases the depth or severity of poverty and those members of the population who are adversely affected are more likely to engage in behaviour that puts them at greater risk for contracting HIV. Another channel through which increasing inequality could affect the prevalence of HIV is if greater inequality reduces educational or health services to the poor that lower their risk of infection.”⁶⁰ In addition to AIDS-specific treatment, the WHO therefore stresses the need for general health system support, improvements in the physical infrastructure, programs to address the increased mortality and morbidity of health workers,⁶¹ improved procurement and distribution systems, and measures to stimulate demand through community mobilization.⁶² **“The benefit of investing early to avoid higher costs later is particularly obvious in the case of AIDS.** Most industrialized countries will need to propose bold increases in their direct assistance to poorer countries for HIV and AIDS programmes. For maximum impact, these must be additional resources, and not funds diverted from other priority development programmes aimed at reaching the Millennium Development Goals.”⁶³

B Poor Governance and Poor Leadership

Lacking capacities and the scarcity of resources greatly obstruct an effective and timely treatment and prevention of HIV/AIDS. But it is most often poor governance and poor leadership that provide the ground for its development into epidemic forms—with all related security consequences. The data on funding for HIV/AIDS spending in low-income countries⁶⁴ seem to suggest “that governments that offer a

⁵⁷ M. Haacker (November 2004), ‘The Impact of HIV/AIDS on Government Finance and Public Services’, p. 231.

⁵⁸ A. de Waal (15 October 2004), ‘British Government Policy on AIDS: Analysis for African Civil Society’, p. 7.

⁵⁹ C. Jones (1998), ‘Does Structural Adjustment Cause AIDS?’, p. 61.

⁶⁰ C. Jones (1998), ‘Does Structural Adjustment Cause AIDS?’, pp. 61-62.

⁶¹ UNAIDS estimates indicate that in some countries illness and death rates among health workers have increased five- or six-fold as a result of AIDS. See UNAIDS (2005), ‘AIDS in Africa: Three Scenarios to 2025’, p. 31.

⁶² In M. Haacker (November 2004), ‘The Impact of HIV/AIDS on Government Finance and Public Services’, p. 232.

⁶³ UNAIDS (June 2004), ‘2004 Report on the Global Aids Epidemic’, pp. 137-138.

⁶⁴ In 2003, there was an estimated availability of 4232 millions of dollars for low-income economies, including 1000 million from the governments of the affected countries themselves, 2015 million from bilateral donors, 200 million from foundations and other NGOs, 470 million from UN agencies and the World Bank, and 547 million from the Global Fund. See Summers and Kates in M. Haacker (November 2004), ‘HIV/AIDS: The Impact on the Social Fabric and the Economy’, p. 63.

convincing and comprehensive HIV/AIDS program can raise a substantial proportion of the necessary funds from external grants.”⁶⁵ Unconvinced of the urgency, or out of disinterest in public affairs, the issue of HIV/AIDS is often neglected by national leadership. Some argue that politicians just do not have much incentive to place AIDS at the forefront of the political agenda. For politicians it is not a successful campaigning theme as the impacts are long-term and the broad population still largely considers HIV/AIDS a private matter.

There is consensus in the literature that leadership is the single most important factor in a successful tackling of HIV/AIDS and its related impacts. Whereas leadership is warranted at both state and societal level, state action in the HIV/AIDS policy domain is absolutely crucial. **“Governments must be at the center of AIDS-prevention and treatment efforts.** Experiences from the past fifteen years show that where governments fail to act, the disease spreads faster, the eventual costs of dealing with it are higher, and the negative effects on development are more far-reaching and intractable. Conversely, governments that *do* respond forcefully to the issue of AIDS have registered successes in bringing HIV infection rates down, such as in Uganda and Senegal.”⁶⁶ Governments that have “registered successes in responding to AIDS have adopted the following set of common policies: early and aggressive action; involving community groups and other realms of civil society; political leadership at the top levels; extensive data collection and dissemination; distributing low-cost, high-quality condoms; and targeting interventions to high-risk groups such as migrant workers or prostitutes.”⁶⁷

Unwillingness and lacking capacities, however, are not always easily and neatly separable. Ineffective management of funds, for example, can be due to lacking human and institutional capacities. And “managing the aid flows, catering to the specific needs of different donors, and coordinating the activities of numerous agencies and NGOs, some of which are directly financed from abroad, can be a challenge for a government whose human resources are already stretched thin by the epidemic.”⁶⁸ So, even if the money is made available, the capacity to spend might be in question. The absorption capacity of recipient governments or organizations therefore is a major concern.

⁸ **Stigmatization and Lack of Rights and Protection for High-risk Groups**

The stigma and taboo that rests on HIV/AIDS in many societies is a real concern. Not only are carriers of the virus hidden from the eye, the disease is also given the opportunity to linger on. Where the disease is linked to ideas of unacceptable practices, the consequences for a person’s life are far-reaching, excluding them from the usual networks and protection mechanisms. The existence of taboos and stigmatization furthermore puts a strain on effective treatment, prevention and awareness raising.

Gendered aspects of the HIV/AIDS spread are often overlooked in policies, whereas power relations between men and women (and between groups of women) greatly impact on the likelihood of spread of the virus, the access to treatment and care, and the capacities to withstand the negative consequences of the disease. Whereas a functioning rule of law should protect the well-being of vulnerable groups and reduce discrimination of HIV positive persons, such rights-based protection mechanisms are often absent. In absence of such enforceable rights to, for example, treatment and care, it is not to be expected that more HIV/AIDS infected will come forward voluntarily.

⁶⁵ M. Haacker (November 2004), ‘HIV/AIDS: The Impact on the Social Fabric and the Economy’, p. 64.

⁶⁶ C. Boone, J. Batsell (2001), ‘Politics and AIDS in Africa’, p. 11.

⁶⁷ C. Boone, J. Batsell (2001), ‘Politics and AIDS in Africa’, p. 7, referring to a study by the Worldwatch Institute (1999).

⁶⁸ M. Haacker (November 2004), ‘HIV/AIDS: The Impact on the Social Fabric and the Economy’, p. 64.

Social protection mechanisms take different shapes, are often related to traditional, cultural or religious practices and play a key role in absorbing shocks. **Exclusion from such social services and networks**, whatever form or shape these take, is an important dimension of vulnerability. Of major concern is the large cohort of orphans. This becomes a severe drain on state resources in the years to come, but also falls upon extended family members, threatening to overwhelm existing support systems.

β Conditions of War and Post-War

Wars have both facilitated the spread of HIV/AIDS and hampered efforts to control and treat it. This was acknowledged by the UN Security Council when it adopted resolution 1308 in July 2000, recognizing that the HIV/AIDS pandemic is “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”.⁶⁹ In countries that already experience rising incidence rates of HIV/AIDS the “added harm of war is that valuable windows of opportunity, in nipping diseases before they reach critical stages, are lost.”⁷⁰

The **conditions in refugee and IDP camps** might seriously affect the spread of HIV/AIDS. Increased risks are, for example, related to changing behaviour of particular actors and increases in gender violence and transactional sex. Also the reduction in resources and services –health care, education, community services, protection and food—provide conditions for the disease to fester. Some intermediate factors that influence the level of risk include the HIV/AIDS prevalence in the area of origin of the refugees and IDPs; the HIV/AIDS prevalence among the surrounding host population; and the length of time of lingering of conflict and existence of the camp.⁷¹

In various recent conflicts (Bosnia-Herzegovina, DRC, Liberia, Rwanda) combatants have also used **rape as a weapon of war**. This not only affected women and girls, but also young men and boys.⁷² Even more common is to find military detachments accompanied by/attracting large numbers of commercial sex workers. A 1997 study found a correlation between HIV clusters in Northern Namibia and the proximity of military bases.⁷³ Soldiers therefore are both a high risk group and a key ‘bridging’ group, acting as a conduit for the spread of HIV into the wider population. “Armies are generally composed of young men of a sexually active age, imbued with a risk-taking ethos and deployed on tours of duty away from home with money in their pockets.”⁷⁴ Some factors are known to affect **the behaviour of military personnel**. “These include whether their presence results from conscription or voluntary enrolment, the level of disposable income, length of deployment, effectiveness of disciplinary regimes, perceived differences in terms of gender and sexual culture between home and new environments, knowledge and perceptions of condoms and willingness to use these, reflecting in turn attitudes towards sexuality (including those relating to sex between men and women and between men), risk and danger.”⁷⁵ Such understandings have relevance for the behaviour of national armies, but also for international peace-keeping missions. The perception that peacekeepers may spread HIV/AIDS has crystallised debate around the complex issue of mandatory testing. Many troop-contributing countries, in fact, have a policy of mandatory testing prior to

⁶⁹ (include reference).

⁷⁰ P. Singer (2002), ‘AIDS and International Security’, p. 22.

⁷¹ See figure ‘HIV risk factors for conflict and displaced persons camps’, originally provided by Speigel/UNHCR in UNAIDS (June 2004), ‘2004 Report on the Global AIDS Epidemic’, p. 180.

⁷² UNAIDS (June 2004), ‘2004 Report on the Global Aids Epidemic’, p. 176.

⁷³ See R. Bazergan (November 2004), ‘HIV/AIDS: Policies and programmes for blue helmets’, p. 2.

⁷⁴ R. Bazergan (November 2004), ‘HIV/AIDS: Policies and programmes for blue helmets’, p. 2.

⁷⁵ P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 5.

deployment, whereby they exclude those who are HIV-positive. The rigour with which such policies are implemented varies enormously, however.⁷⁶

Concerns of HIV/AIDS prevalence among soldiers and combatants also arise during the phase of demobilization. Some studies on **the effects of demobilization** in Uganda, for example, “revealed devastating results for the rural areas where the demobilized HIV-positive troops retired.”⁷⁷ Similar concerns existed for the case of Ethiopia that has experienced a large cutback in the number of troops. Together with the related commercial sex workers, these soldiers are dispersed around the country. In cases where HIV/AIDS prevalence was largely limited to particular regions and high-risk groups, fear exists for a quick spread of the disease.

Conflicts, through uprooting large population groups and the involvement of various warring groups and peacekeeping forces, thus bring groups into contact that otherwise would be less likely to mix. “Such mixing may potentially be the most dangerous aspect of AIDS’s heightening of the impact of war, as **it facilitates the emergence of mutations in the virus itself**. Researchers have found that the conflict in the DRC has created a veritable witch’s brew of AIDS, bringing together various strains from around the continent.”⁷⁸ But there are also known cases where conflict has acted as a break on the epidemic, through the virtual isolation of the area, e.g. limiting cross-border migration and trade, and movement within the country.⁷⁹ Overall, however, it seems realistic to expect that the “ultimate dynamic of warfare and AIDS is that their combination makes both more likely and more devastating.”⁸⁰

B Summary Findings - Key Factors affecting a Country’s Vulnerability to HIV/AIDS

Although currently much attention focuses on the HIV/AIDS pandemic in Africa, other parts of the world also face a projected increase of HIV/AIDS with undoubtedly significant economic, social, and political impacts. “But the impacts of the disease over the coming decade will vary a lot from one region to another, given the large number of differentials. These include different projections and actual trajectories of the disease, different demographic profiles, different socio-economic and political situations, different capacities and responses of governments and leaders in affected countries, and, on the part of donors, different perceptions of strategic interest and responses.”⁸¹ The HIV/AIDS epidemic thus takes radically different forms in different communities, countries and regions. How states and societies in the longer term will be affected by the epidemic is therefore an issue that requires context-specific assessment. The following factors should be taken into consideration when assessing the nature of a country’s vulnerability to HIV/AIDS and the likelihood it will take crisis-like proportions.

- A country’s demographic profile and trend projections– e.g. most affected population groups, levels and patterns of poverty and vulnerability, urban/rural ratios of HIV/AIDS prevalence, the state of health and health care, levels of malnutrition;
- The current development pattern/mode of spread of the disease within the country – e.g. through conditions of war and post-war activities, through migrant populations, heterosexual transmission, intravenous drug use;
- The likely government responses and available resources – including the ‘politics’ of distribution and access to resources as well as the prevalence of strong national leadership.

⁷⁶ R. Bazergan (November 2004), ‘HIV/AIDS: Policies and Programmes for Blue Helmets’, p. 4.

⁷⁷ R. Bazergan (November 2004), ‘HIV/AIDS: Policies and programmes for blue helmets’, p. 2.

⁷⁸ P. Singer (2002), ‘AIDS and International Security’, p. 22.

⁷⁹ See UNAIDS (June 2004), ‘2004 Report on the Global Aids Epidemic’, p. 178.

⁸⁰ P. Singer (2002), ‘AIDS and International Security’, p. 3-4.

⁸¹ P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 11.

IV. Processes of Breakdown – How are Fragile States Affected by the Crisis?

Prevalence rates alone tell us relatively little about the strategic implications of HIV/AIDS.⁸² Many studies often examine only one facet of the epidemic's impact, but much is to learn from how HIV/AIDS operates simultaneously across various domains—demographic, economic, and governance—to destabilize states and threaten their national security.⁸³ The particular contribution of HIV/AIDS to political instability, insecurity and violent conflict, however, is largely indirect and cumulative. Downward spirals of state breakdown happen with and without the presence of an HIV/AIDS epidemic. Though hard evidence is lacking, there is an emerging consensus that the longer-term economic, political, governance and social implications of the HIV/AIDS epidemic, together with the impact on security forces, are such that **at a certain level of prevalence, HIV could significantly increase the risk of conflict** – especially the kind of internal conflict associated with weak and failed states.⁸⁴ It has the potential to accentuate exactly those weaknesses and problems that are usually identified as sources of conflict. Yet it is not clear that these impacts will necessarily materialise at a certain level of HIV/AIDS prevalence, and if they do, whether they will actually lead to conflict.

^B **HIV/AIDS in Fragile and Failing States**

Many states still face the challenges of state formation, such as establishing a monopoly on the legitimate use of force; the functioning of a governing elite and the development of a property-owning middle class; the functioning of a revenue, expenditure and financial system; and the provision of public goods including health, education, law and order. In absence of such capacities states are inherently fragile, for internal and external contestation as well as for demographic catastrophes such as famines and epidemics. The HIV/AIDS-related threats that stand out include:

- ^B A dramatic decrease in life expectancy and quality of life (high morbidity and mortality, increase in disease-related poverty)
- ^B A systematic erosion of economic strength of a country (shrinking productivity, decline in savings, diminishing human capital)
- ^B A systematic erosion of institutions of governance (police, military) and state capacity.

“Unfortunately, many African countries are already highly vulnerable to these structural reverses, and some have already experienced them in one form or another. HIV/AIDS only heightens that susceptibility. It also inhibits countries’ ability to recover from these shocks.”⁸⁵ “These factors combine to produce both the motive and the opportunity for intrastate violence between political elites, or ethnicities and may even generate state failure.”⁸⁶

All in all, fragile states demonstrate a fundamental lack of capacities to avoid shocks. The breakdown of capacities can result from decreasing state effectiveness as well as decreasing state legitimacy.

⁸² S. Jensen (2004), ‘Fatal Years’, pp. 2, 7.

⁸³ A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, p. 5.

⁸⁴ P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 10.

⁸⁵ A. de Waal (2003), ‘How Will HIV/AIDS Transform African Governance?’, p. 17.

⁸⁶ A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, p. 5.

Institutional factors play a key role in shaping the dynamics of the crisis as well as the governmental response to it.⁸⁷ So what are the variations in state responses to the spread of HIV/AIDS, and what explains these differences in governmental response?⁸⁸ Why did Uganda and Senegal prove successful in stemming the spread of the epidemic, whereas Zimbabwe and South Africa did not? Here, one has to go beyond seeing governance as a checklist of policies. Any programmes or assessments of governance in the developing world need to take account of political processes of on-going 'state formation'.⁸⁹

β HIV/AIDS under Conditions of Weak and Decaying State Effectiveness

Combating HIV/AIDS often is a proclaimed objective, which does not necessarily imply it is given priority attention and resulting in effective strategy design. Behind the surface many problems may arise with a common strategy. Obstacles that are found include the lack of acknowledgement of the medical background of the disease; denial, silence and stigmatization of the disease; disagreement on prevention and treatment strategies; and **competition with other policy objectives and challenges which makes the necessary long-term commitment difficult**. The impacts are particularly worrying in the face of lacking strong political institutions. "The dominant characteristic of political institutions across the region, and indeed most of sub-Saharan Africa, is one of neo-patrimonialism whereby 'strong man' political leaders use patronage to gain and maintain political loyalty. (...) A civil service characterised by a high degree of staff turnover and growing proportions of inexperienced personnel will be even less likely to develop and enforce institutional boundaries and autonomy. Conversely, such a civil service is more likely to succumb to patronage or corruption payoffs by a neo-patrimonial executive branch, party officials or business people."⁹⁰ Africa's governance institutions, hence, are not in a good shape to face the challenges of HIV/AIDS. The pandemic is likely to further undermine the effectiveness of bureaucracies and bureaucratic norms and could severely damage the process of political institutionalism in several ways as state institutions will face a shrinking proportion of civil servants, policy-makers and legislators. Rapid decline in effectiveness, capacity and integrity of state and non-state institutions is also recognized as a major structural cause of conflict.⁹¹

β HIV/AIDS under Conditions of Weak and Decaying State Legitimacy

There are expressed doubts about whether democracy can survive in an era of HIV/AIDS. **HIV/AIDS will be detrimental to central elements of democracy** (inclusion, opportunity for effective participation), **but also to factors that are believed to help sustain democracy** (economic growth; essential political institutions and service delivery institutions, strong civil society).⁹² But even without the presence of HIV/AIDS the future of democracy in many regions, Africa in particular, is far from certain.⁹³ Especially in the face of economic crises, these are apt to breakdown.⁹⁴ As the disease reduces a government's capacity, public confidence and state legitimacy may be further undermined.⁹⁵ Such a loss of legitimacy

⁸⁷ C. Boone, J. Batsell (2001), 'Politics and AIDS in Africa', p. 1.

⁸⁸ C. Boone, J. Batsell (2001), 'Politics and AIDS in Africa', p. 4.

⁸⁹ J. Putzel (2003), 'Institutionalizing an Emergency Response', p. 5.

⁹⁰ R. Mattes (April 2003), 'Healthy Democracies?', p. 5.

⁹¹ Yet, such ineffective regimes have also survived low levels of legitimacy, even hostility, and failure to deliver public services and economic development. A. de Waal (2003), 'How Will HIV/AIDS Transform African Governance?', pp. 15-17.

⁹² R. Mattes in Nelufule (2004), 'AIDS and Democracy', pp. 21-22.

⁹³ Even countries in Africa that demonstrate political competition and a full range of political freedoms and civil rights (Botswana, South Africa, Namibia), the existence of single dominant political parties may over time affect the workings of the system. Opposition parties hardly play a role here and the political systems are characterized by highly hierarchical structures.

⁹⁴ See R. Mattes (April 2003), 'Healthy Democracies?', pp. 1-2.

⁹⁵ Nelufule (2004), 'AIDS and Democracy', p. 20.

might eventually lead to political instability, violence and state collapse, further obstructing an effective HIV/AIDS strategy. The literature, for example, describes the likely decrease in citizen support for democratic government, a decrease in citizen participation, damage to civil society, and even the creation of an ‘uncivil’ society (decreasing popular compliance with the law, increasing violent protest, social intolerance and criminal activity).⁹⁶ “[W]here factors combine to give rise to either conflict or the epidemic—depending upon prevailing socio-economic, political and epidemiological vulnerabilities—the *opportunity* is created for the other, not only to emerge, but also to thrive.”⁹⁷

β **The ‘Politics’ of HIV/AIDS**

It has proven difficult to put HIV/AIDS at the forefront of political agendas. However, ‘historically, those who occupy positions of authority within states have undertaken their most radical reforms in the face of threats to their power or to the existence of the state’.⁹⁸ Threats are commonly known to provide a basis for community organization. In this way it could be speculated that HIV/AIDS could serve as a basis for governments to increase their legitimacy, as was seen in Uganda. The social issues related to the HIV/AIDS crisis (in comparison to the politics of food and ecological crises) can thus lead to political mobilization, while at the same time constraining societies’ capacities for mobilization.⁹⁹

It could however also trigger authoritarianism and political entrepreneurship, where desperation leads to scapegoating around arguments of personal immorality, religious transgressions, minority groups or external forces.¹⁰⁰ It is not uncommon to find perceptions that certain groups may be carrying and spreading the virus; that certain groups are being denied treatment; that a government is not doing enough to deal with the epidemic; or that the military preparedness of the adversary may have been undermined by HIV/AIDS.¹⁰¹ If resources are limited, governments will be confronted with decisions about where, and for whom, to prioritise access to drug therapy. And regardless of whether or not governments actually do this, the *perceptions* of politically expedient preferences might be significant. This can be affected by on-the-ground realities, e.g. that South Africa’s highest HIV rates are located in KwaZulu-Natal, political heartland of the opposition; that Zimbabwe’s non-Shona population suffer higher HIV infection rates and have less adequate health care than the largely pro-government Shona people; or that Namibia’s Herero and Damara populations have less access to government resources and health care. **“Thus, political decisions around AIDS treatment hold the potential to aggravate tensions and political conflict between workers and unemployed; urban and rural populations; or between different ethnic groups.”**¹⁰²

The combination of decreasing economic opportunities, decaying social safety nets and large cohorts of HIV/AIDS orphans should raise particular concerns for state breakdown. Conflict studies have found strong evidence that young and unemployed men constitute an important base for recruitment for various (warring or criminal) factions. A U.S. National Intelligence Council report in 2000: “With as much as a

⁹⁶ So far, however, “little is known about why or how children, citizens, elites and institutions infected, affected or threatened by HIV/AIDS change their social and political behaviour.” See R. Mattes (April 2003), ‘Healthy Democracies?’, pp. 7, 9.

⁹⁷ P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 19.

⁹⁸ J. Putzel (2003), ‘Institutionalizing an Emergency Response’, p. 5.

⁹⁹ A. de Waal (2003), ‘How Will HIV/AIDS Transform African Governance?’, pp. 11-13.

¹⁰⁰ Manning and Mattes in Nelufule (2004), ‘AIDS and Democracy’, p. 20.

¹⁰¹ P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 10.

¹⁰² R. Mattes (April 2003), ‘Healthy Democracies?’, p. 8.

third of the children under fifteen in hardest-hit countries expected to comprise a ‘lost orphaned’ generation by 2010 with little hope of educational or employment opportunities, these countries will be at risk of further economic decay, increased crime, and political instability as such **young people become radicalized or are exploited by various political groups for their own ends**; the pervasive child soldier phenomenon may be one example”.¹⁰³

B Summary Findings – Key Mediating Mechanisms of State Security in the wake of an HIV/AIDS Crisis

The looming security implications of AIDS, particularly within Africa, are now a baseline assumption of the disease’s danger. The *mechanisms* by which experts claim that the landscape of war has been changed by HIV/AIDS is nevertheless barely understood. It is, in fact, an extremely complicated matter to trace the effects of the HIV/AIDS epidemic in the presence of other factors contributing to a country’s malaise (e.g. corruption, political instability, poverty and famine). But it is clear that in the context of poor governance (lacking political will and state capacity) HIV/AIDS reinforces a vicious spiral within affected countries.¹⁰⁴ The direct and indirect impact of the disease on an already weak starting position leads to worrying future scenarios. There are projections for 2020 that “weak governments, lagging economies, religious extremism, and youth bulges will align to create a perfect storm for internal conflict in certain regions.”¹⁰⁵ Two components of government response and state capacity in effective containment of the crisis require particular attention:

- B Variations in state response to the epidemic – **the role of leadership and strong, centralized state-imposed strategies**. Yet, state capacity to do this does not exist and international donors would not countenance such an approach. Public action by the state has also lost importance in large-scale promotions by Bretton Woods institutions of the privatization of state companies/tasks.¹⁰⁶
- B Variations in the relationship between governments and NGOs – **the ability of NGOs to pressure for policy reform and political opening**.¹⁰⁷ A wide range of local and international NGOs are seen to develop innovative grassroots and community-based programmes for education, prevention and care. Positive has been principles of gender equality and human rights that often guide these projects. Less favourable is the voluntary nature, and limited impact these have made on encouraging a significant behavioural change.¹⁰⁸

¹⁰³ Cited in A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, p. 17.

¹⁰⁴ A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, p. 9.

¹⁰⁵ National Intelligence Council (December 2004), ‘Mapping the Global Future’, p. 14.

¹⁰⁶ A. de Waal (2003), ‘How Will HIV/AIDS Transform African Governance?’, pp. 18-19.

¹⁰⁷ “Investigating AIDS NGOs in Africa suggests the importance of factors like NGOs organizational structure, political capacity, ideology, and positioning vis-à-vis the state. Research in this area could contribute to better understanding of the conditions under which positive partnerships between regimes and civil organizations can develop.” C. Boone, J. Batsell (2001), ‘Politics and AIDS in Africa’, p. 4.

¹⁰⁸ A. de Waal (2003), ‘How Will HIV/AIDS Transform African Governance?’, pp. 18-19.

V. Recognizing and Responding to the HIV/AIDS Crisis – What are the Challenges?

HIV/AIDS is not a short-term problem. It will be affecting countries many years from now. However, it remains uncertain in what way, and by how much, the future will be shaped by AIDS.¹⁰⁹ At the least, it is seen to multiply already worrying phenomena of fragile states, youth bulges and weak human capital and social protection mechanisms. Fighting HIV/AIDS should therefore be seen as a number-one priority of Africa's leaders (and elsewhere). Some of the major challenges are summarized below.

β **Breaking the Downward Spiral – Promoting ‘Good’ Governance**

There is nothing inevitable about the impacts of HIV/AIDS. This is a matter of governance, and hence the impacts of HIV/AIDS can be shaped by political action.¹¹⁰ While the challenges to contain the disease and its impacts on state, society and the economy are huge, **good governance can compensate to some degree for the relatively low levels of state capacity.**¹¹¹ Other lessons are:

- β Sensible, consensus-based and transparent decision-making could break the negative spiral associated with the HIV/AIDS security crisis. It will improve the sharing of information around HIV/AIDS and possibly contribute to better leadership on the issue.¹¹² Mechanisms for accountability for leaders are necessary to come out of a process of politicians making unrealisable promises.¹¹³ A fair electoral system with participation by both genders moreover facilitates greater female representation in government.
- β A strong civil society is essential in combating HIV/AIDS and pushing government. A credible and competitive political process may make HIV/AIDS an election issue, thereby fostering leadership around HIV/AIDS.
- β A comprehensive response to the epidemic requires prevention and treatment & care to go hand in hand as two essential elements. Equitable access to resources is a key concern. **Failure of governments to set appropriate treatment and prevention priorities can be a political choice and should be appreciated as such.**

β **Lifting Bottlenecks to Effective Spending**

A major bottleneck remains the lack of human and institutional capacity. Others include the persistent negative effects of stigmatization and discrimination, shortfalls in political commitment, the slow transfer of funds from the international and national to local and community levels, inadequate accounting and auditing mechanisms, and inconsistent bureaucratic funding processes of the global donor community.¹¹⁴ Critical assessments argue that the past several years have witnessed dramatic increases in the level of resources available in international health, including HIV/AIDS. More problematic is the issue whether or

¹⁰⁹ See for example UNAIDS (2005), ‘AIDS in Africa: Three Scenarios to 2025’.

¹¹⁰ A. de Waal (2003), ‘How Will HIV/AIDS Transform African Governance?’, p. 3.

¹¹¹ A. Price-Smith, J. Daly (July 2004), ‘Downward Spiral’, p. 6.

¹¹² Nelufule with reference to work of A. Whiteside and S. Willan (2004), ‘AIDS and Democracy’, pp. 3-4.

¹¹³ Justice Africa/GAIN (August 2004), ‘HIV/AIDS, Democracy and Governance in Africa’, p. 2.

¹¹⁴ UNAIDS (June 2004), ‘2004 Report on the Global AIDS Epidemic’, p. 131.

not (and how) developing countries can make effective use of these large sums of new money.¹¹⁵ Getting the effects of the efforts out in the open is important, as “A remarkable window of opportunity is opening up and needs to be taken advantage of now. Making the money work, including through increased coordination, will be a critical part of mobilizing more resources, both domestic and international.”¹¹⁶ Other lessons are:

- β The capacity to spend might be in question due to the impact of HIV/AIDS on human capital. Absorption capacity is therefore a major concern.¹¹⁷ Calls for ‘scaling up’ available resources should also make us reflect on how to administer. Already we see struggles to control resources, between different departments and between different interest groups. Policy differences and ‘turf battles’ also exist within and among donor agencies.¹¹⁸
- β Better coordination and a clear division on roles and responsibilities between the multiple stakeholders is key to any effective strategy. **Parallel structures should be avoided.**
- β Obstacles to effective spending on HIV/AIDS can also arise from other (non-HIV/AIDS addressing) development strategies. Well-known examples include the restrictions on public sector spending and hiring imposed by IFIs. **Creative ways need to be found to reconcile substantial increases in spending on health and other social services with macroeconomic stability.**¹¹⁹
- β Even if more resources are devoted to AIDS programmes, implementation is likely to miss significant portions of the population, given the weak/limited governance institutions and the uneven coordination between the local and the national level.¹²⁰ Local level governance plays a crucial role in implementation, but is hardly strengthened in today’s development approach that focuses on the national level.

β Targeting Aid and Investments

A good understanding of both the short-term and long-term consequences of the epidemic will help in formulating policies and in allocating scarce resources. Such well-crafted programs designed to fight the epidemic and mitigate its impact can offset or reduce some of the serious social, political and economic consequences of HIV/AIDS, thereby breaking a vicious cycle of vulnerability, desperation and breakdown.¹²¹ At the moment, however, the fight against HIV/AIDS is being conducted too much in a business-as-usual manner, with incremental programmes, but lacking the levels of both funding and leadership that are warranted. Decision-making on what to do is relatively short-term, narrowly-focused and apt to fashionable topics.¹²² Putting prevention, treatment and care programmes in place is a good starting point, but any serious effort to tackle AIDS has to go beyond health.¹²³ Other lessons are:

¹¹⁵ In that regard, it might prove fruitful to learn what has been the impact of the new and innovative financing mechanisms at the country level. See *Report on Wilton Park Conference WP751 ‘Scaling Up Health Investments in Developing Countries: Lessons About what Works’*, 16-18 June 2004, <http://www.wiltonpark.org.uk/web/papers/pdfs/pdfreports/WP751/WP751.pdf>

¹¹⁶ UNAIDS (2005), ‘AIDS in Africa: Three Scenarios to 2025’, p. 14.

¹¹⁷ Some argue that most of the available capacity is absorbed by donors themselves.

¹¹⁸ A. de Waal (2003), ‘How Will HIV/AIDS Transform African Governance?’, p. 20.

¹¹⁹ Millennium Project (February 2004), ‘Interim Report of Task Force 5 Working Group on HIV/AIDS. Executive Summary’, <http://www.unmillenniumproject.org>, p. 10.

¹²⁰ National Intelligence Council (2002), p. 5.

¹²¹ See also M. Haacker (November 2004), ‘The Macroeconomics of HIV/AIDS’, p. xii.

¹²² A. de Waal (2002), ‘Fucking Soldiers’, pp. 87, 92.

- β The type of threat that the HIV/AIDS pandemic poses to state security is contingent upon time and scope. “From a short-term perspective, the pandemic poses the greatest threat to political and military institutions whereas from a long-term perspective, the pandemic’s threat is centred on entire populations and state economic performance.”¹²⁴
- β **Prevention programs should distinguish between low-prevalence and high-prevalence settings.** In low-prevalence settings measures are targeted at key populations at risk, to keep the epidemic from spreading through the general population. Such programs are among the most efficient preventive interventions. In high-prevalence settings, these measures are complemented by strategies aiming at broader segments of society, tackling socio-economic and political factors that construct vulnerability and determine impact.¹²⁵
- β A sustainable response to the epidemic requires **a vigorous financial and political commitment to health systems.**¹²⁶ “Poverty, misplaced priorities, and years of externally imposed restriction on social spending have left health systems for over 2 billion people dysfunctional, non-existent, or too expensive.”¹²⁷ Equitable access to basic services is key, as is equitable access to ARV treatment to highly vulnerable and often stigmatized groups.
- β Soldiers, both in national armies and in peacekeeping missions, remain a prime vector of transmission. This could allow for well-targeted prevention campaigns. How to target non-regulatory armed forces is a greater challenge. **HIV/AIDS should be given priority attention during the aftermath and reintegration of former combatants and soldiers into communities.**
- β The vulnerability of women to HIV/AIDS is disproportionately high (biologically, socially and economically). **Gender-sensitive access to treatment** needs to be assured as the social and economic power imbalances between men and women raise fears that women are being denied equitable and timely access to treatment options.
- β High levels of out-of-pocket spending reveal that the main costs of HIV/AIDS are carried by PLWA. Their **coping mechanisms need strengthening** in order to avoid further impoverishment and irrational choices that further endanger spread of disease.

β **Summary Findings – Key Challenges to Improve Policy Coherence and Effectiveness**

More work should be undertaken to identify the scale of the problem and the impact of the response so far.¹²⁸

Key is not only donor coordination and harmonisation, but also policy coherence, i.e. “the extent to which HIV/AIDS policies are meshed with other key policies, notably poverty reduction, macroeconomic

¹²³ See also DfID (2004), ‘Taking Action. Summary of the UK’s Strategy for tackling HIV and AIDS in the Developing World’, p. 7.

¹²⁴ Ostergard and Tubin in Nelufule (2004), ‘Aids and Democracy’, p. 28.

¹²⁵ P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 19.

¹²⁶ “In some countries, the creation of national AIDS commissions has weakened the core programmes and infrastructure of the Ministries of Health by diverting scarce personnel and resources to more diffuse programmes across ministries, the nongovernmental sector, and poorly resourced local governments.” UNAIDS (2005), ‘AIDS in Africa: Three Scenarios to 2025’, p. 33.

¹²⁷ Millennium Project (February 2004), ‘Interim Report of Task Force 5 Working Group on HIV/AIDS. Executive Summary’, <http://www.unmillenniumproject.org>, p. 7.

¹²⁸ UK Mission to the United Nations (17 November 2003), ‘Security Council: Open Briefing on HIV/AIDS and Peacekeeping Operations (SCR 1308 – 2000)’, http://www.ukun.org/articles_show.asp?SarticleType=17&Article_ID=714

stability and good governance.”¹²⁹ What is needed is less ambitious but more concrete goals and regional frameworks for action.¹³⁰ The basis of such frameworks should reflect the following considerations:

- β Effective prevention requires a combination of interventions, providing tools to block various routes of infection and enable those at risk to make use of these tools. *Medical/technical and social/political/economic measures go hand in hand.*
- β Prevention and care programs will fail if they ignore the underlying determinants of the epidemic: poverty, gender inequality, and social dislocation. *It is important to build mutually reinforcing strategies for reaching the various development goals.* The most powerful answers to social vulnerability will be those that transcend HIV/AIDS: (girls) education, guaranteeing equal property rights and economic opportunity, and combating violence against women.¹³¹

Although there is no sound evidence that efforts to mitigate or prevent HIV/AIDS reduce the build-up towards conflict, there are some reasons to at least believe that they *could*. **Both conflict and HIV/AIDS share common drivers in the form of poverty, inequality, discrimination, exclusion and insecurity.** Efforts to address these (whether primarily intended to tackle conflict or HIV/AIDS) seem likely to have secondary benefits in terms of the other. Also, both conflict and HIV/AIDS erode the social capital upon which societies depend for mutual cooperation and survival. Again, efforts to increase and strengthen this are likely to be of mutual benefit.¹³²

¹²⁹ A. de Waal (15 October 2004), ‘British Government Policy on AIDS: Analysis for African Civil Society’, p. 4.

¹³⁰ See A. de Waal (15 October 2004), ‘British Government Policy on AIDS: Analysis for African Civil Society’, p. 6.

¹³¹ Millennium Project (February 2004), ‘Interim Report of Task Force 5 Working Group on HIV/AIDS. Executive Summary’, <http://www.unmillenniumproject.org>, p. 9.

¹³² P. Gordon, R. Jacobson, T. Porteous (February 2004), ‘A Study to Establish the Connections Between HIV/AIDS & Conflict’, p. 18.

References

Alastair, R. (2004), 'Governance and AIDS in West Africa: An Overview', *Justice Africa Issue Brief*, <http://www.eldis.org/subtemp/docs/3260/West%20Africa%20Issue%20Brief.doc>

Bazergan, R. (November 2004), 'HIV/AIDS: Policies and Programmes for Blue Helmets', *ISS Paper 96*, <http://www.iss.org.za/pubs/papers/96/96.pdf>

Bell, C., S. Devarajan, H. Gersbach (November 2004), 'Thinking about the Long-Run Economic Costs of AIDS', in M. Haacker (ed.), *The Macroeconomics of HIV/AIDS*, Washington D.C.: International Monetary Fund, pp. 96-133.

Birdsall, N., A. Hamoudi (November 2004), 'AIDS and the Accumulation and Utilization of Human Capital in Africa', in M. Haacker (ed.), *The Macroeconomics of HIV/AIDS*, Washington D.C.: International Monetary Fund, pp. 134-166.

Boone, C., J. Batsell (2001), 'Politics and AIDS in Africa: Research Agendas in Political Science and International Relations', in *Africa Today* 48(2), <http://iupjournals.org/africatoday/aft48-2.html>

Epstein, B. (November 2004), 'The Demographic Impact of HIV/AIDS', in M. Haacker (ed.), *The Macroeconomics of HIV/AIDS*, Washington D.C.: International Monetary Fund, pp. 1-40.

Fourie, P., M. Schönteich (2002), *Die, The Beloved Countries: Human Security and HIV/AIDS in Africa*, http://www.sarpn.org.za/documents/d0000177/P170_Security_HIVAIDS.pdf

Germann, S. (December 2004), 'Call to Action: What Do We Do?', in R. Pharoah (ed.), *A Generation At Risk? HIV/AIDS, Vulnerable Children and Security in Southern Africa*, ISS Monograph no. 109, Pretoria: ISS, pp. 93-114. <http://www.iss.org.za/pubs/monographs/no109/chapter5.pdf>

Gordon, P., R. Jacobson, T. Porteous (February 2004), *A Study to Establish the Connections Between HIV/AIDS & Conflict*, London: John Snow International, http://www.jsiuk.com/docs/hiv_aids_conflict_2004.pdf

Greener, R. (November 2004), 'The Impact of HIV/AIDS on Poverty and Inequality', in M. Haacker (ed.), *The Macroeconomics of HIV/AIDS*, Washington D.C.: International Monetary Fund, pp. 167-181.

Haacker, M. (November 2004), 'HIV/AIDS: The Impact on the Social Fabric and the Economy', in M. Haacker (ed.), *The Macroeconomics of HIV/AIDS*, Washington D.C.: International Monetary Fund, pp. 41-95.

Haacker, M. (November 2004), 'The Impact of HIV/AIDS on Government Finance and Public Services', in M. Haacker (ed.), *The Macroeconomics of HIV/AIDS*, Washington D.C.: International Monetary Fund, pp. 198-258.

Hudson, V., A. Den Boer (2002), 'A Surplus of Men, A Deficit of Peace; Security and Sex Ratios in Asia's Largest States', in *International Security* 26(4), pp. 5-38.

International Crisis Group (19 June 2001), *HIV/AIDS as a Security Issue*, ICG Report, http://www.icg.org/library/documents/report_archive/A400321_19062001.pdf

International Crisis Group (16 April 2004), *HIV/AIDS As A Security Issue in Africa: Lessons from Uganda*, ICG Issues Report nr. 3, http://www.icg.org/library/documents/issues/03_lessons_from_uganda.pdf

International Crisis Group (16 December 2004), *Myanmar: Update on HIV/AIDS Policy*, ICG Asia Briefing, http://www.icg.org/library/documents/asia/burma_myanmar/041216_myanmar_update_on_hiv_aids_policy.pdf

Jensen, S. (March-April 2004), 'Fatal Years: How HIV/AIDS is Impacting National and International Security – A Desk Review of the Literature and Analytical Approaches', technical officer UNAIDS SHR (status of document unknown).

Jones, C. (1998), 'Does Structural Adjustment Cause AIDS? One More Look at the Link between Adjustment, Growth, and Poverty', in M. Ainsworth, L. Fransen, M. Over (eds) *Confronting AIDS: Evidence from the Developing World*, Brussels: European Commission, pp. 53-64, <http://www.iaen.org/limelette/html/limcontents.htm>

Justice Africa/GAIN (August 2004), 'HIV/AIDS, Democracy and Governance in Africa: A Retrospect of Recent Developments', *GAIN Issues Brief* nr 2, http://www.justiceafrica.org/gain_issue_%20brief2.htm

Justice Africa/GAIN (October 2004), 'HIV/AIDS, Democracy and Governance in Africa: A Retrospect of Recent Developments', *GAIN Issues Brief* nr 3, http://www.justiceafrica.org/civil_society_homepage.htm

Lauring, H. (2002), 'Action Needed on Brain Drain', [http://manila.djh.dk/global/stories/storyReader\\$98](http://manila.djh.dk/global/stories/storyReader$98)

MacFarlan, M., S. Sgherri (2001), 'The Macroeconomic Impact of HIV/AIDS in Botswana', http://www.grc-exchange.org/info_data/record.cfm?id=650

Mattes, R. (April 2003), 'Healthy Democracies? The Potential Impact of AIDS on Democracy in Southern Africa', *ISS Occasional Paper* 71, <http://www.iss.co.za/pubs/papers/71/paper71.html>

Mendelson Forman, J., M. Carballo (July 2001), *A Policy Critique of HIV/AIDS and Demobilization*, Red de Seguridad y Defensa de América Latina (RESDAL), <http://www.resdal.org.ar/art-mendelson.htm>

National Intelligence Council (September 2002), *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China*, http://www.odci.gov/nic/PDF_GIF_otherprod/HIVAIDS/JCA_HIVAIDS20092302.pdf

National Intelligence Council (December 2004), *Mapping the Global Future*, <http://www.foia.cia.gov/2020/2020.pdf>

Nelufule, M. (July 2004), *Aids and Democracy: What Do We Know? A Literature Review Update*, paper prepared for the 'Democracy, Governance and HIV/AIDS in Africa' Roundtable, Pretoria, 19-20 July 2004, <http://www.nu.ac.za/heard/papers/RTLitRev2004.pdf>

Nguyen, V., K. Stovel (October 2004), *The Social Science of HIV/AIDS: A Critical Review and Priorities for Action*, working draft prepared by the Social Science Research Council Working Group on HIV/AIDS, SSRC: New York.

Overseas Development Institute/Humanitarian Policy Group [ODI-HPG] (2003), *HIV/AIDS, Food Security and Humanitarian Action: A Resource Guide*, <http://www.odi.org.uk/hpg/aidsresources.html>

Patterson, D. (2001), 'Political Commitment, Governance, and HIV/AIDS', in *Canadian HIV/AIDS Policy and Law Review* 6(1/2), <http://www.aidslaw.ca/maincontent/otherdocs/newsletter/vol6nos1-22001/politicalcommitment.htm>

Piot, P. (February 2005), 'Why AIDS is Exceptional', speech given at the London School of Economics, London, 8 February 2005.

Price-Smith, A., J. Daly (July 2004), 'Downward Spiral. HIV/AIDS, State Capacity, and Political Conflict in Zimbabwe', *Peaceworks* no. 53, Washington, DC: Unites States Institute of Peace, <http://www.usip.org/pubs/peaceworks/pwks53.pdf>

Putzel, J. (May 2003), *Institutionalising an Emergency Response: HIV/AIDS and Governance in Uganda and Senegal*, report submitted to the Department for International Development, <http://www.crisisstates.com/download/HIV/Putzel.pdf>

Report on Wilton Park Conference WP751 'Scaling Up Health Investments in Developing Countries: Lessons About what Works', 16-18 June 2004, <http://www.wiltonpark.org.uk/web/papers/pdfs/pdfreports/WP751/WP751.pdf>

Singer, P. (2002), 'AIDS and International Security', in *Survival* 44(1), pp. 145-158, http://www.brookings.edu/dybdocroot/views/articles/fellows/2002_singer.pdf

Waal, A. de (September 2001), 'AIDS-Related National Crises. An Agenda for Governance, Early-Warning and Development Partnership', *Justice Africa AIDS and Governance Issue Paper no. 1*, <http://www.justiceafrica.org/publications/papers/AIDS%20related%20National%20Crises%20sept%20%2001.doc>

Waal, A. de (2002), 'Fucking Soldiers', *Index on Censorship* nr. 4, pp. 87-92.

Waal, A. de (October 2002), 'HIV/AIDS and Famine: A Framework', (*status of document unknown*).

Waal, A. de (2003), 'How Will HIV/AIDS Transform African Governance?', in *African Affairs* 102, pp. 1-23.

Waal, A. de (12 February 2004), 'HIV/AIDS and Security in Africa: An Agenda for the Netherlands Presidency of the EU, Late 2004' (*status of document unknown*).

Waal, A. de (15 October 2004), 'British Government Policy on AIDS: Analysis for African Civil Society', *GAIN Briefing Note*, http://www.justiceafrica.org/britisch_policy.htm

Policy Documents and Policy-related Information Sheets

DfID (May 2001), 'HIV/AIDS Strategy', <http://www.dfid.gov.uk/pubs/files/hivaidsstrategy2001.pdf>

DfID (2004), 'Taking Action. Summary of the UK's Strategy for Tackling HIV and AIDS in the Developing World', <http://www.dfid.gov.uk/pubs/files/HIVAIDStakingactionssummary.pdf>

DfID (3 August 2004), *draft* 'Working in Partnership with UNAIDS (the Joint United Nations Programme on HIV/AIDS) – Institutional Strategy Paper', <http://www.dfid.gov.uk/pubs/files/draft-ispunaidspdf.pdf>

Ministerie van Buitenlandse Zaken (2003), *AIDS Notitie*, http://www.minbuza.nl/default.asp?CMS_ITEM=C8507864E43F468E8FD0657D9CE4207AX3X54212X1

Ministerie van Buitenlandse Zaken (2003), *Aan Elkaar Verplicht*, http://www.minbuza.nl/default.asp?CMS_ITEM=03872577FA7E424781602DC1982C7AA6X3X56893X14

UK Mission to the United Nations (17 November 2003), 'Security Council: Open Briefing on HIV/AIDS and Peacekeeping Operations (SCR 1308 – 2000)', http://www.ukun.org/articles_show.asp?SarticleType=17&Article_ID=714

UNAIDS, 'HIV/AIDS and Peacekeeping Operations', http://www.unaids.org/en/in+focus/hiv_aids_security+and+humanitarian+response/hiv_aids+and+peacekeeping+operations.asp

UNAIDS (2005), 'AIDS in Africa: Three Scenarios to 2025', http://www.unaids.org/unaidresources/HomePage/images/AIDSScenarios/AIDS-scenarios-2025_report_en.pdf

UNAIDS (June 2004), '2004 Report on the Global AIDS Epidemic', http://www.unaids.org/bangkok2004/report_pdf.html

UNDP (s.a.), 'Chapter 4 HIV/AIDS. CSOs as a First Line of Defence', http://www.undp.org/cso/resource/documents/partnershd/partnershd_ch4.pdf

UNDP/UN-OHRLLS (2005), 'Hope Building Capacity', <http://www.allafrica.com/sustainable/resources/view/00010393.pdf>

United Nations General Assembly (26 October 1987), 'Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS)', 48th plenary meeting, A/RES/42/8, <http://www.un.org/documents/ga/res/42/a42r008.htm>

UN Millennium Project (February 2004), 'Interim Report of Task Force 5 Working Group on HIV/AIDS. Executive Summary', <http://www.unmillenniumproject.org>

World Bank (2002), 'Education and HIV/AIDS: A Window of Hope', Washington D.C., <http://www.worldbank.org>

