The HIV/AIDS Epidemic In Africa: Implications For U.S. Policy

Until the U.S. government perceived the African AIDS epidemic as a threat to U.S. interests, the U.S. response to the crisis was limited.

by Jeff Gow

PROLOGUE: The minor flap that Secretary of State Colin Powell stirred up in the Bush administration by going on MTV to endorse condom use in the developing world was a red herring. The most important thing about Powell’s outspokenness was that it signaled a growing—if belated—recognition at the highest levels of government that the horrific scale of the global HIV/AIDS epidemic now represents so great a threat to stability in Africa, Asia, and Latin America that it needs to be regarded as a national security issue.

In the following discussion of African countries’ response to the epidemic, Jeff Gow highlights another aspect of the relationship between AIDS and security. Exhibit 3 in Gow’s paper compares the level of military spending in fourteen sub-Saharan nations with their spending on HIV/AIDS. The results show how preoccupation with regional military conflicts has compounded the problem of denial and paralysis in the face of an imminent public health catastrophe.

The price of pharmaceuticals looms large in much of the discussion heard in the United States about combating HIV/AIDS around the world. Other obstacles noted by Gow may be even more intractable. Extreme poverty may increase HIV risk as well as diminish access to treatment. In its aggregated effect, poverty also reduces the human and financial resources a nation has at hand to mount an effort against the epidemic. The lack of an adequate health care infrastructure reflects both resource constraints and the pressure of competing priorities.

The notion of health policy as an instrument of international relations is not a new one at Health Affairs. Founding publisher William B. Walsh, M.D., was a firm believer in the potential synergies between the two. International assistance has been an indispensable asset to those few African countries that have mustered the will to make AIDS a priority. How soon other countries can overcome their leaders’ “lack of engagement” is a question on which millions of lives depend.

A health economist with an international pedigree, Gow is a research associate in the Health Economics and HIV/AIDS Research Division at the University of Natal in Durban, South Africa, and a lecturer in the School of Economics at the University of New England in New South Wales, Australia.
**ABSTRACT:** Political will or commitment toward the HIV epidemic has been lacking in most African countries. Although most countries are in denial, a few have moved into recognition of the epidemic. Only two countries, Senegal and Uganda, have moved into mobilization. Ineffectiveness is judged by increasing HIV prevalence rates and declining life expectancy. Countries without active national leadership to fight the epidemic have seen deterioration in these criteria. In addition to its toll in Africa, this epidemic threatens U.S. political, economic, and security interests. Political responses to manage the risks to the United States have revolved around much increased development assistance through traditional channels and financial support for the United Nations’ Global Fund to Fight AIDS, Tuberculosis, and Malaria.

The African continent is experiencing the biggest impact of the HIV/AIDS epidemic, although the epidemic and its effects are experienced differently in nearly all African countries. At the end of 2000, 25.3 million persons were infected in sub-Saharan Africa, with 3.8 million new infections in 2000 and an average HIV prevalence rate of 8.8 percent.1 Within sub-Saharan Africa the epidemic has generally moved south and west from central and eastern Africa. Eastern and central African countries have a mature widespread level of HIV infection, but southern African countries are now experiencing high levels of infection, although AIDS mortality levels there are still relatively low compared with those in eastern Africa. West African countries vary quite widely in their levels of HIV infection.

This paper has two goals. First, it focuses on the important and critical role played by political will or commitment in determining success in slowing or stopping the HIV/AIDS epidemic in sub-Saharan African countries. Second, it examines the implications for U.S. foreign policy of the African HIV epidemic, which continues to be out of control in most of these countries.

Political commitment can be defined in two ways: (1) leading politicians’ personal and public identification with the epidemic, and (2) a willingness on their part to mobilize resources and “fast-track” implementation.2 Responses to epidemics like HIV/AIDS usually follow three phases: denial, recognition, and mobilization.3 In this paper I discuss some objective criteria to examine effectiveness of responses, such as HIV prevalence rates, life expectancy, and death rates, for selected countries. I then analyze the conditions present for successful and ineffective responses, and I outline successful political actions needed to overcome the epidemic. These are predicated on the critical role of political leaders in controlling and overcoming the epidemic by making effective political and policy commitments. I also examine the level of resources committed to the epidemic by various countries. I conclude with a discussion of the implications of the epidemic for U.S. interests: I outline some political and policy initiatives to address these threats and mention recent and planned responses and resources allocated.
Patterns Of Responses To Epidemics

Past epidemics of infectious or communicable diseases like HIV/AIDS have resulted in fairly similar response patterns. With HIV/AIDS this chronological pattern can be divided into three stages: (1) denial—that the new epidemic is present within the country, reflected either by an absence of any preventative or treatment measures or by any border restrictions; (2) recognition—that the epidemic is present in the country (a country will admit that cases of the epidemic are occurring and will adopt measures to find out how widespread the epidemic is); and (3) mobilization—a country gets active at the levels of society and government to prevent the further spread of the epidemic.4

In the early (mid-1980s) and middle days of the epidemic in Africa, denial was widespread, and physical evidence of HIV (ill people) was lacking. Most political leaders in sub-Saharan Africa would still be considered to be in a state of denial, but most are in the process of moving toward recognition as evidence of the impacts of the epidemic is becoming increasingly hard to avoid. Examples are the leaders of Kenya, Zimbabwe, and South Africa. Fortunately, the underresourced health systems in these countries have responded to the treatment needs of HIV-positive persons despite denial by politicians. These systems, though, have frequently been overwhelmed by the epidemic.

Only recently (in the past five years) have some countries moved out of denial into the recognition phase: Botswana, Nigeria, Namibia, and Malawi are examples. Botswana and Nigeria have moved rapidly toward the mobilization phase, but evidence of their efforts is not yet present. Only two countries in sub-Saharan Africa could be considered to have moved fully into the mobilization phase: Senegal and Uganda.

Criteria Used To Examine Response Effectiveness

Use of objective criteria provides evidence with which to evaluate the effectiveness of countries’ responses. These criteria include trends in HIV prevalence rates, death rates, life expectancy, and increasing levels of social dislocation (for example, numbers of orphans). Data on these and other criteria indicate that political efforts to ameliorate the epidemic have been ineffectual (Exhibits 1 and 2).

Prevalence data. Data on prevalence rates indicate the wide variability both within sub-Saharan Africa generally and in the three subregions as well. Senegal has a low rate, below 2 percent, while Botswana has the highest in the world at more than 35 percent. Seven of the eight countries with the world’s highest rates of HIV prevalence are located in southern Africa (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe). They, along with all other sub-Saharan African countries except Senegal and Uganda, experienced increasing levels of HIV prevalence during the 1990s. The number of persons with HIV is increasing rapidly in sub-Saharan Africa. South Africa is the country with the highest absolute number of its citizens infected with HIV in the world. Four other countries in southern and
central Africa have more than one million HIV-positive citizens. Regarding other indicator data, orphan numbers are already large in all of these countries and will continue to rise. Uganda, which experienced the worst of the epidemic earlier than elsewhere, has the highest absolute number of orphans.

The effect of high prevalence rates is to dramatically reduce life expectancy in individual countries. Countries with extremely high prevalence, such as Botswana, have seen the largest drops in life expectancy, and this is expected to continue. The impact of untreated mother-to-child transmission of HIV is clearly evident in the child mortality rates when one compares scenarios with and without AIDS. HIV/AIDS will raise 2010 child mortality rates by anywhere from 50 percent to 500 percent compared to the year 2000.5

**Responses to the epidemic.** The three-part typology of response patterns is not a hard-and-fast rule by which to judge a country’s efforts in addressing the epidemic. The time lag from contracting HIV to death is approximately six to ten years. Therefore, any recent or current efforts against the epidemic will not result in declines in prevalence rates for several years into the future. The rate of these declines will also be influenced by a country’s current position within the epidemic—that is, whether it is at an early or an advanced stage.

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**EXHIBIT 1**
HIV Prevalence, Infections, And Orphans In 1999 And Life Expectancy In 1993, 1995, And 1998 In Selected Sub-Saharan African Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated adult prevalence (percent)a</th>
<th>Number of adults and children living with HIV/AIDS (thousands)a</th>
<th>Estimated number of orphans (thousands)a</th>
<th>Life expectancy (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1993b</td>
</tr>
<tr>
<td>Angola</td>
<td>2.78%</td>
<td>160</td>
<td>98</td>
<td>46.8</td>
</tr>
<tr>
<td>Botswana</td>
<td>35.80</td>
<td>280</td>
<td>66</td>
<td>65.2</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>10.06</td>
<td>700</td>
<td>420</td>
<td>50.9</td>
</tr>
<tr>
<td>Dem. Rep. of Congo</td>
<td>5.07</td>
<td>1,100</td>
<td>680</td>
<td>52.0</td>
</tr>
<tr>
<td>Lesotho</td>
<td>23.57</td>
<td>240</td>
<td>35</td>
<td>60.8</td>
</tr>
<tr>
<td>Malawi</td>
<td>15.96</td>
<td>760</td>
<td>270</td>
<td>45.5</td>
</tr>
<tr>
<td>Mozambique</td>
<td>13.22</td>
<td>1,200</td>
<td>310</td>
<td>46.4</td>
</tr>
<tr>
<td>Namibia</td>
<td>19.54</td>
<td>160</td>
<td>67</td>
<td>59.1</td>
</tr>
<tr>
<td>Senegal</td>
<td>1.77</td>
<td>75</td>
<td>42</td>
<td>49.5</td>
</tr>
<tr>
<td>South Africa</td>
<td>19.94</td>
<td>4,200</td>
<td>420</td>
<td>63.2</td>
</tr>
<tr>
<td>Swaziland</td>
<td>25.25</td>
<td>130</td>
<td>12</td>
<td>57.8</td>
</tr>
<tr>
<td>Tanzania</td>
<td>8.09</td>
<td>1,300</td>
<td>1,100</td>
<td>52.1</td>
</tr>
<tr>
<td>Uganda</td>
<td>9.51</td>
<td>930</td>
<td>1,700</td>
<td>44.7</td>
</tr>
<tr>
<td>Zambia</td>
<td>19.95</td>
<td>870</td>
<td>650</td>
<td>48.6</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>25.06</td>
<td>1,500</td>
<td>900</td>
<td>53.4</td>
</tr>
</tbody>
</table>

**Sources:** See below.

In very recent times, the leaders of Botswana and Nigeria have shown committed leadership and support for effective interventions. Following the examples of the leaders of Senegal, Uganda, and Thailand, the presidents of both countries have made the epidemic their special responsibility. This has resulted in extra resources flowing to HIV/AIDS prevention, treatment, and care activities.

**Conditions Present In Successful Responses**

Another way of benchmarking the performance of sub-Saharan African countries in fighting the epidemic is to examine the conditions present in those countries that have made improvements in the objective criteria. Senegal and Uganda are good examples.

Strong prevention programs have stabilized HIV prevalence rates in Senegal and have turned around a major epidemic in Uganda. It is important not to attribute this success too much to the existence of political will, however it may be defined. The factors that influence success are many and varied, ranging from the individual to the collective.

**Senegal.** Senegal contained the spread of HIV/AIDS through a combination of early and aggressive control efforts, including (1) an effective epidemiological surveillance system; (2) the involvement of all leaders: religious, political, and traditional; (3) intensive information campaigns; and (4) widespread provision of preventive measures, such as condoms.6

A large measure of Senegal’s success is attributable to strong political leadership and the country’s high level of social cohesion. The government worked...
quickly with civil society and the religious structures to address HIV/AIDS from the mid-1980s onward. Further, a long tradition of community involvement in health and development issues was mobilized around AIDS prevention issues. The emphasis on treating sexually transmitted diseases also contributed to the success of the Senegalese campaign. In essence, Senegal has managed to contain HIV/AIDS to incredibly low levels, despite high poverty levels, as a result of an organized and committed response by all sectors of society to the issue.

**Uganda.** During the 1990s Uganda reported success in reducing HIV prevalence rates. In Kampala HIV prevalence among tested prenatal clinic patients rose from 11 percent in 1985 to 31 percent in 1990 and declined to a stable 15 percent in 1996. Many HIV/AIDS interventions have contributed to slowing the epidemic—not because they were about AIDS, but because they were about building civil society and taking responsibility. If the relative economic improvement experienced during the 1990s continues and if civil society can continue to build itself, then Uganda may well be able to continue reversing its HIV prevalence levels.

**Summary of successful responses.** Lessons from successful responses to HIV/AIDS like those in Senegal and Uganda include the need to (1) mobilize widespread community support in the fight against HIV/AIDS; (2) overcome stigma, denial, and silence to make progress; (3) change sexual behavior to embrace safer-sex practices; (4) showcase examples of sustained actions at the national level; (5) develop committed leadership at all levels; (6) develop partnerships at different levels; (7) mobilize resources, set priorities, and adequately finance initiatives; and (8) use local institutions, communities, and the public and private sectors efficiently.

There is no quick, easy, straightforward answer to overcoming the HIV/AIDS epidemic in sub-Saharan Africa. Senegal and Uganda have been successful in reducing prevalence rates mainly by changing individual behavior. To what extent the political process and politicians achieved this is debatable. However, it is clear that without top-level political commitment and the mobilization of resources, HIV prevalence will not decline. Political will is a necessary condition for the epidemic’s growth to be capped or, better still, reversed.

**Conditions Present In Ineffective Responses**

The HIV/AIDS epidemic has been present in sub-Saharan Africa for the past fifteen years. The reaction time of most African political leaders to address the most challenging issue facing their countries has been slow. Countries with widespread evidence of the epidemic, such as South Africa and Zimbabwe, are still in the denial phase. This is indicative of the lack of importance given the epidemic by political leaders in these countries.

Earlier I listed some of the conditions present in countries that have shown progress toward containing or reversing their HIV epidemics. There also are conditions that influence failure. These include lack of public dialogue, lack of resources, and lack of government capacity. Positive political discussion and action...
“Without political commitment from the top, good intentions and plans of action remain mainly rhetoric and ideas, rather than deeds.”

about HIV is relatively scarce outside of Uganda and Senegal. Little political discourse about the epidemic is taking place in many African countries. Political elites remain disengaged from what should be their top public policy issue.

Denial, stigma, and discrimination lie behind African political leaders’ silence. This is still the norm in the majority of African countries. As long as HIV is not discussed openly, denial will continue to exist. It is critically important for leaders to overcome silence and stigma in addressing HIV. Without political dialogue, the problems that arise from HIV and AIDS will continue to be surrounded by ignorance, myths, and, of course, denial that the epidemic exists in the first place.

Why then the reluctance of African politicians and political elites to “notice” the epidemic and place it on the political agenda and to undertake activities to ameliorate its effects? Possible explanations for the slow and ineffective response include the following.

■ The “invisibility” of the disease. HIV transfer can occur without either the transmitter or the receiver of the virus being aware. Also, the virus may not manifest itself in the infected person for five to seven years. Further, the physiological effects on the infected person are not directly related to the virus but are the result of opportunistic diseases such as pneumonia and tuberculosis, which arise as a result of weakened immune systems.

■ Other pressing political problems. Leaders confront numerous other political problems that have much more immediate currency. The most visible is widespread poverty, particularly in rural areas. Desmond Cohen has outlined how poverty leads to outcomes that expose the poor to increased probabilities of HIV infection.9

■ Lack of resources. Both physical and human resources, to improve countries’ education, welfare, and general population health, are greatly lacking. The economic performance of many countries is fair to poor, with static or declining incomes leading to reduced consumption possibilities and reduced government revenues and thus the capacity for expenditure.

■ Capacity of the state to respond. The infrastructure required for the increased levels of illness is often lacking. Hospitals, clinics, health staff, and consumables were already in short supply before the epidemic. The epidemic merely places more pressure on overstretched resources.

African Political Leaders’ Appropriate Role

Countries like Uganda and Senegal that have succeeded in containing or reversing their HIV epidemics demonstrate that political will or commitment is a key ingredient in mounting an effective campaign against HIV/AIDS. Without political
commitment from the top, good intentions and plans of action remain mainly rhetoric and ideas, rather than deeds. This substitution of rhetoric for action has served the majority of countries of sub-Saharan Africa poorly in the past.

Mark Malloch Brown has outlined four ways that political leadership can manage and reduce the impacts of the epidemic: (1) Most importantly, break the silence once and for all, to alter permanently the norms, values, and traditions that are fueling the epidemic. (2) Ensure that the full power and authority of the state are brought to bear on the crisis. National AIDS plans, coordinated at the highest level of government and involving all relevant actors and institutions, are proving to be a particularly successful way to respond. (3) Scale up efforts to mobilize adequate human and financial resources to effectively confront the epidemic. (4) Acknowledge—and work to mitigate—the tremendous impact of the epidemic on governments’ ability to provide basic social services.10

The focus on leadership in the fight against HIV/AIDS is appropriate. Strong political commitment is a fundamental prerequisite to setting up a national strategic response to HIV/AIDS, which includes multisectoral participation and action at the community level. The actions or inaction of political leaders through government is the glue, which brings together an integrated and effective response. If political leaders do not display commitment and governments do not take the leading role in committing to ameliorative actions, then failure is almost guaranteed.

**African Resources To Fight The Epidemic**

Most African countries have not provided adequate resources to fight the impacts of the epidemic and prevent further infections. This can be shown in absolute terms by their fiscal commitment to HIV/AIDS programs and in comparative terms with other government activities such as military spending. Spending on war, civil violence, or preventive security measures vastly outweighs spending on health generally and HIV/AIDS specifically.

Exhibit 3 provides an incomplete overview of the relative commitment of sub-Saharan countries to HIV and military spending in 1996. Two facts stand out here: First, national government spending on HIV is pitifully low, and second, military spending is much larger than HIV spending. Uganda, the African success story, commits relatively few of its resources to the HIV effort. International donor expenditure is fourteen times higher there than national government expenditure on HIV, although its absolute commitment is high in comparison with that of other countries. Examining the ratio of HIV to military spending, Zimbabwe stands out with a rate of military spending 6,782 times larger than spending on HIV/AIDS. This is in a country with an adult prevalence rate of 25 percent and more than 1.5 million HIV-positive citizens. The situation has also worsened recently, as Zimbabwe’s involvement in the war in the Democratic Republic of Congo dramatically raised its military spending.

In addition to their monetary costs, conflicts and wars bring about total up-
heaval of societies and greatly increase the probability of HIV transmission. Witness the current or recent conflicts in Burundi, Eritrea, Democratic Republic of Congo, and Sierra Leone. Countries in eastern and southern Africa that engaged in or experienced wars or major civil violence during the 1970s and 1980s are the countries now experiencing the most severe epidemics. War and civil violence increase countries’ susceptibility to HIV/AIDS via soldiers’ increased risky sexual behavior (especially rape) and the breakdown of civil society. Displaced females are subject to sexual abuse, and soldiers and guerrillas have been very efficient carriers of sexually transmitted diseases.

Recently, the trends in African military spending have been rising dramatically, with an increase in real terms of 37 percent between 1998 and 2000—from $6.5 billion to $9.8 billion, in constant 1998 prices. This is the result of large increases in the military budgets of countries involved in wars on the continent, mainly Democratic Republic of Congo. Similar increases in national health or specifically HIV budgets have not occurred. It would seem from this case study of military

**EXHIBIT 3**

**HIV/AIDS And Military Spending In Selected Sub-Saharan African Countries, In Constant 1996 U.S. Dollars (Millions)**

<table>
<thead>
<tr>
<th>Country</th>
<th>National government</th>
<th>International donors</th>
<th>National government military spending</th>
<th>Ratio of military to national HIV/AIDS spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>$0</td>
<td>$0.4</td>
<td>$975.0</td>
<td>–</td>
</tr>
<tr>
<td>Botswana</td>
<td>2.7</td>
<td>0</td>
<td>195.8</td>
<td>72</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>0.7</td>
<td>6.5</td>
<td>10.9</td>
<td>15</td>
</tr>
<tr>
<td>Dem. Rep. of Congo</td>
<td>0</td>
<td>3.6</td>
<td>214.3</td>
<td>–</td>
</tr>
<tr>
<td>Lesotho</td>
<td>–e</td>
<td>0</td>
<td>35.5</td>
<td>–e</td>
</tr>
<tr>
<td>Malawi</td>
<td>1.1</td>
<td>5.2</td>
<td>15.5</td>
<td>13</td>
</tr>
<tr>
<td>Mozambique</td>
<td>0</td>
<td>2.9</td>
<td>65.4</td>
<td>–</td>
</tr>
<tr>
<td>Namibia</td>
<td>0.4</td>
<td>0.7</td>
<td>98.3</td>
<td>225</td>
</tr>
<tr>
<td>South Africa</td>
<td>–e</td>
<td>0</td>
<td>2,696.5</td>
<td>–e</td>
</tr>
<tr>
<td>Swaziland</td>
<td>–e</td>
<td>0</td>
<td>27.9</td>
<td>–e</td>
</tr>
<tr>
<td>Tanzania</td>
<td>0.1</td>
<td>2.3</td>
<td>–e</td>
<td>–e</td>
</tr>
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<td>Uganda</td>
<td>2.5</td>
<td>35.0</td>
<td>127.3</td>
<td>50</td>
</tr>
<tr>
<td>Zambia</td>
<td>0.2</td>
<td>6.0</td>
<td>38.3</td>
<td>200</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>0.1</td>
<td>13.9</td>
<td>297.1</td>
<td>6,782</td>
</tr>
</tbody>
</table>

**SOURCES:** See below.

**NOTES:** Military expenditure values have been converted to 1996 prices and exchange rates using the World Consumer Price Index (1995 = 100). Numbers used for ratio calculations have been rounded.


b Stockholm International Peace Research Institute, SIPRI Military Expenditure Database (various countries), first.sipri.org/non_first/result_milex.php? (19 October 2001).

c Author’s calculation.

d Not calculable.

e No data available.
spending that the issue of resources to fight the HIV epidemic in many African countries is not one of availability but one of priorities.

**Threats To U.S. Interests, And The U.S. Response**

Until the late 1990s the African epidemic received little direct U.S. attention outside of health-based organizations such as the National Institutes of Health (NIH) and development organizations such as the U.S. Agency for International Development (USAID). The perception of HIV/AIDS as primarily a health problem was replaced by a more holistic view, as the negative consequences for all aspects of severely affected African societies were increasingly witnessed and documented. This was evidenced by USAID's programs, which began in health and later expanded to include a more development-oriented approach, by attempting to ameliorate the social, economic, and governance impacts of the epidemic.

During the 1990s, as the scale of the epidemic’s societywide effects became apparent, the epidemic also came into clearer focus for U.S. intelligence and security. With increasing globalization, the expanding epidemic and its effects posed increasing risks to the United States and its interests. The threat of HIV transmission has increased with migration, as many people from adversely affected countries came to the United States during the economic upswing of the 1990s. Also, low-cost international travel enabled more Americans than ever to travel overseas and potentially come into contact with HIV.

The onset of new infectious diseases over the past twenty years, such as HIV and Hepatitis C, and the resurgence of “traditional” infectious diseases, such as tuberculosis and malaria, claimed around twenty million lives worldwide in 1999.12 The U.S. death rate from infectious diseases has doubled since 1980, and treatment of these diseases costs $120 billion (in 1995 dollars) annually, or 15 percent of total U.S. health spending.13 These diseases are brought into the United States by both foreign immigrants and traveling citizens. Disease does not stop at the U.S. border. This transmission threat, of which HIV is now the largest communicable disease source, is a clear challenge to U.S. interests.

The HIV epidemic has the potential to destabilize societies, economies, and governments. Infectious diseases reduce length and quality of life, economic productivity of individuals and countries, and the capacity of the state to cope and respond. Andrew Price-Smith correlates declining health status with a decline in state capacity, leading to instability and unrest through reduced prosperity, increased inequality, and reduced human capital.14

Research began in the late 1990s that attempted to outline the risks and strategic implications of the burgeoning worldwide communicable diseases epidemic to U.S. interests. In 2000 the National Intelligence Council and the Congressional Research Service both produced public reports that examined in detail the threats of the growing HIV epidemic and the implications for the United States.15
tional Intelligence Council concluded:

New and re-emerging infectious diseases will pose a rising global health threat and will complicate U.S. and global security over the next 20 years. These diseases will endanger U.S. citizens at home and abroad, threaten U.S. armed forces deployed overseas, and exacerbate social and political instability in key countries and regions in which the U.S. has significant interests.

In response, the focus of U.S. government activities toward HIV/AIDS has shifted away from a domestic orientation toward an increasingly international focus. The Office of National AIDS Policy now has an explicit international focus. Although the African epidemic is now the worst, the potential exists for an epidemic of similar magnitude in Asia over the next decade. Emerging epidemics in the Caribbean and Latin America are smaller in scale but closer to home.

The threat from HIV/AIDS to U.S. interests will continue to grow over the next twenty years. The African AIDS crisis will be exacerbated by a rapid spread of the disease in India, Russia, China, and Latin America, which make up almost 40 percent of the world’s population. UNAIDS projections are that by 2010 the number of absolute infections in Asia alone (mainly India and China) will be likely to outstrip that number in sub-Saharan Africa; at the end of 2000, twenty-five million Africans were estimated to be living with HIV. Looking to 2010, and without meaning to sound alarmist, the HIV epidemic and its burden could reach catastrophic proportions, given the existing level of infection, the poor prospects for stemming the transmission of HIV, and the unlikelihood of developing a preventive or curative vaccine. This worst-case scenario of increasing worldwide infectious disease threat, especially HIV/AIDS, is considered by the National Intelligence Council to be the most likely scenario over the next ten years.

U.S. And International Resources—Pledged And Required

The U.S. government, through USAID, has been the largest international donor to African countries throughout the 1990s. From 1986 to 2001 USAID has spent $1.6 billion on programs to address the HIV/AIDS epidemic in the developing world. The vast majority of this money has gone to sub-Saharan Africa. During 1996–1999 an average of $135 million per year was committed to HIV/AIDS spending, $80 million per year in Africa. In the late 1990s President Bill Clinton and congressional leaders expanded their political interest in the African epidemic, and the flow of funding subsequently increased. In July 1999 Vice-President Al Gore proposed $100 million in additional funding for the global LIFE (Leadership and Investment in Fighting an Epidemic) AIDS initiative for African countries, which commenced in 2000. In July 2000 the U.S. Export–Import Bank made available a total of $1 billion in loans to African countries to purchase HIV/AIDS medications and infrastructure from U.S. firms.

Legislation enacted during the 106th Congress increased HIV/AIDS funding worldwide and initiated several African AIDS programs. In June 2001 the Global Access to HIV/AIDS Prevention, Awareness, Education and Treatment Act (H.R.
2069) passed the House International Relations Committee, authorizing large increases for international HIV/AIDS programs. H.R. 2069 authorized $560 million in both fiscal years 2002 and 2003 for USAID activities and a further $750 million in 2002 for contributions to a global fund and other multilateral efforts.\textsuperscript{22}

Total direct U.S. government spending in 2001 and 2002 on HIV/AIDS initiatives in Africa was to increase to $168 million and $234 million.\textsuperscript{23} These increases were to be channeled through USAID, the Centers for Disease Control and Prevention (CDC), the NIH, and the Departments of Defense and Labor. The Bush administration has clearly taken the epidemic seriously, with Secretary of State Colin Powell stating in a 4 February 2001 interview that “AIDS is a national security problem. It’s an economic problem. It is a devastating problem, especially in [sub-Saharan] Africa.”\textsuperscript{24} The largest monetary initiative for the epidemic is the United Nations’ Global Fund to Fight AIDS, Tuberculosis, and Malaria. The goal of this program is to reverse the spread of HIV/AIDS and other infectious diseases by 2010. UN Secretary-General Kofi Annan estimates that $7–$10 billion per year is needed to fight HIV/AIDS and to combat tuberculosis and malaria.\textsuperscript{25} On 11 May 2001 the United States, through President George W. Bush, pledged a donation of $200 million.\textsuperscript{26} As of March 2002 total commitments from all sources topped $1.9 billion.\textsuperscript{27} The Bill and Melinda Gates Foundation was an early contributor, with $100 million, and the initial U.S. government contribution was increased by another $100 million on 24 July 2001 and by $200 million on 28 January 2002.\textsuperscript{28} Total international health-related aid to low- and middle-income countries now runs at $2–$3 billion annually, which is a fraction of these countries’ $250 billion annual health bill.\textsuperscript{29} Comparing these resources with the burden on African countries and also the effects on Western nations indicates that even more resources should be forthcoming to fight the HIV epidemic.

The countries of sub-Saharan Africa have been most adversely affected by the HIV/AIDS epidemic. Nearly all but Uganda and Senegal have lacked the political will or commitment of resources to halt the spread of HIV in their population and to address the epidemic’s many negative impacts. African political leaders’ lack of engagement with the epidemic confronting their countries is worrisome. The commitment of resources by sub-Saharan countries to fight the epidemic is small, especially in the face of dramatically rising military spending. The international community and in particular Western countries have committed many more resources to the epidemic than the sub-Saharan countries have themselves.

Since the late 1990s U.S. interests have been increasingly at risk from an African HIV epidemic that is essentially out of control. Infectious diseases like HIV do not respect borders, and the HIV epidemic increases the risks facing U.S. political, security, and economic interests. It is in the self-interest of the United States and other Western countries to attempt to reduce the worst impacts of the epidemic.
NOTES
4. Ibid.
5. Author’s calculation from Exhibit 2.
16. Ibid., 5.
17. UNAIDS, Epidemiological Fact Sheet on HIV and Sexually Transmitted Infections.
19. Ibid.
21. Ibid.
22. Ibid.
23. USAID, USAID Combating HIV/AIDS.
28. Ibid.