HIV/AIDS and national security

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Published in:
AIDS and Governance

Publication date:
2007

Citation for published version (APA):
McInnes, C. (2007). HIV/AIDS and national security. In N. K. Poku, A. Whiteside, & B. Sandkjaer (Eds.), *AIDS and Governance* (pp. 93-111). Taylor & Francis. http://hdl.handle.net/2160/825

Introduction

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This volume addresses the effectiveness of global and national responses to HIV/AIDS as well as mapping out the contours of the crucial debate regarding the direction and scope for future governance. The global HIV/AIDS epidemic is a long-term event whose impact unfolds over many decades rather than months. Twenty-five years after seeing the first infection, the faces of the epidemic are increasingly the faces of women, especially young women; orphans who will have to grow up without the nurturing of parents; and the rising number of people living with HIV/AIDS. More worrying still, there is no convincing evidence to suggest that the epidemic is significantly slowing down anywhere in the world. Each day that HIV/AIDS continues to spread therefore adds to the ramifications and duration of its likely impact.

The global data as at the end of 2005 are shown in Table 1. It is tempting to hypothesise two simultaneous epidemics, one in the developed world, beginning in North American gay ghettoes and moving from there into injecting drug user and haemophilic populations, the other, far more generalised, beginning in Central Africa and spreading not into specific communities but into the 'general population'. While Africa is not necessarily the source – certainly not the only source – this latter pattern has been repeated in the Caribbean, South and Southeast Asia and the rest of Africa. This has some parallels to early mappings of the epidemic, which spoke of Patterns I, II, and III based on different epidemiological patterns. Just as these are too simple – in some parts of the world, for example, Uganda, one could find evidence for all three patterns simultaneously – so too is a divide between the developed and the developing world in terms of the political and social response. Denial and the availability of resources for prevention care and community organisation is not always linked to levels of development or affluence.

The current epidemiological data from the United Nations Joint Programme on HIV/AIDS (UNAIDS) confirms the strikingly patterned nature of the HIV epidemic. That is, it is possible to identify different forms and impact of the epidemic in different parts of the world. Despite nearly 76,000 new infections last year, HIV prevalence rates in the high income countries of Western Europe, North America and Japan remain relatively low, with infections concentrated principally among injecting drug users and men who have sex with men – although recent studies indicate that this is changing. Across Western Europe, data suggests that a larger proportion of new HIV diagnoses (59 per cent, overall between 1997 and 2001) are taking place among the heterosexual community, with infections

Table 1 Global summary of the HIV/AIDS epidemic, end 2005

		Estimate	Range
People newly infected with HIV in 2005	**Total**	**4.1 million**	[3.4–6.2]
	Adults	3.6 million	[3.0–5.4]
	Children <15	540,000	[420,000–670,000]
Number of people living with HIV/AIDS	**Total**	**38.6 million**	[33.4–46.0]
	Adults	36.3 million	[31.4–43.4]
	Women	17.3 million	[14.8–20.6 million]
	Children <15	2.3 million	[1.7–3.5]
AIDS deaths in 2005	**Total**	**2.8 million**	[2.4–3.3]
	Adults	2.4 million	[2.0–2.8]
	Children <15	380,000	[290,000–500,000]
Total number of AIDS deaths since the beginning of the epidemic	**Total**	24 million	
Total number of AIDS orphans* currently living	**Total**	**15.2 million**	[13.3–17.0]

* Defined as children who lost their mother or both parents to AIDS when they were under the age of 15.

Source: UNAIDS/WHO (2006)

occurring within the region and beyond. In the case of the United Kingdom, for example, the number of people diagnosed with HIV who were infected through heterosexual sex increased by 33 per cent between 1998 and 2001. In Ireland, to use another example, a similar trend is also visible, with the number of heterosexual transmitted HIV infections increasing fourfold between 1998 and 2001.

The position is more diverse across the developing world where most transmission occurs through sex between men and women, but there are also very high rates of infection among men who have sex with men and injecting drug users. In much of Latin America, HIV infections are confined largely to these sub-populations. This is also the case in Eastern Europe, the Middle East and North Africa. While in the rest of Africa – where over 70 per cent of the global HIV-positive population resides – the virus is spread primarily through heterosexual and perinatal transmission, with heterosexual activity being the dominant mode of transmission.

In many countries, infection rates have increased from 3 to 10 per cent in adult populations in less than a decade. In South Africa, for example, the level of infections has risen roughly tenfold in just the last 10 years. Thus, before people are even aware that infected families and friends surround them, their communities have been deeply penetrated. Take the case of India, its national adult HIV prevalence rate of less than 1 per cent offers little indication of the serious situation facing the country. An estimated 3.97 million people were living with HIV at the end of 2001 – the second-highest figure in the world, after South Africa. HIV prevalence among women attending antenatal clinics was higher than 1 per cent in Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu. This figure is expected to more than quadruple in the next decade – thus making the country one of the most infected countries in the world.

In the heavily affected societies, the epidemic is leading to a deterioration in indicators that had been improving, such as life expectancy, infant mortality, literacy and primary school enrolment. It is reducing capacity in all social and economic sectors, as a result of the illness and death of highly skilled and experienced people who cannot be replaced quickly or easily, but only after long periods of training and skill acquisition. It is lowering general levels of education as enrolments fall among children who lose parents as a result of HIV/AIDS and as educational capacity is lost because of mortality among teachers, educational administrators and teacher trainers. It is leading to a retreat into subsistence production in agriculture as a result of reductions in the economically active population – the group most likely to be HIV-positive. It is reducing productive capacity in all sectors because of the decline in key categories of skill, especially managerial capacity. These declines in economic activity in turn are reducing levels of tax revenue, which lowers the capacity of the public sector to undertake its functions at a time of dramatically increased demand for public services in health, education and training.

The process is insidious, since the full effects of the epidemic will be felt only over the long-term, although the broad patterns of change are clearly evident.

These patterns are not felt uniformly across the world, but significant numbers of countries in the developing world, particularly Africa, are now experiencing a reversal of development gains as a direct result of HIV/AIDS, even countries which had been manifesting evidence of improvements in general living standards of their people.

It has, for sometime, been the position of many observers of this grotesque crisis that politics, not medicine, holds the key to effective response. This was formally confirmed in 2001 when the United Nations General Assembly Special Session on AIDS called for 'greater political leadership' in the fight against the epidemic with the donor community's acquiescence. Since then, new programmes of mitigation, treatment and care, funded increasingly by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, private foundations, corporations, bilateral donors and national governments have transformed the opportunities for developing and implementing effective responses to the HIV epidemic. The expanded level of funding together with dramatic reductions in the costs of drugs has led to a rapid expansion of programmes providing antiretroviral therapy (ART) in many countries. These new programmes offer the potential for dramatically changing the lives of those infected with HIV and the families and communities of those affected, while at the same time generating social and economic benefits for societies in general.

But major challenges remain, and countries are at present only at the start of the process whereby they will be able to provide comprehensive programmes. Finance is far from assured for these expanded programmes and it is by no means clear that the necessary resources will be forthcoming. At the present time the various funding sources are only a fraction of what will be needed for sustained programmes of ART, and hence the need to ensure that innovation take place both in programme development and in service delivery. This is essential if costs are to be confined within the envelope of resources likely to be forthcoming. It seems highly unlikely that the scale of resources currently estimated as needed – US$18 billion for 2007 and US$22 billion for 2008 – will be available, and hence the urgency to identify less resource intensive ways of making services available, including ART, to those in need.

The chapters ahead elaborate these themes and issues. The quality and contributions are of the highest order and they offer, together, a comprehensive account of the power relations driving the HIV/AIDS epidemic in the most affected regions, frustrating the possibility of alleviation, care and recovery – and operating not just to marginalise people living with HIV/AIDS (PLWHA), but to relegate entire regions to a vulnerable and bleak future. The volume is divided into two parts. Chapters in the first part of the book map the nature and forms of impacts of AIDS on governance. The impact is explored in respect of key areas of political and economic life; including education, health, security, democratic accountability and representation. Although attempts at countering the impact of HIV/AIDS have been made through reforms of state organisation, multiple factors, such as ownership, existing capacities and unintended consequences of

reforms may aid or in the worst case jeopardise the overall national strategies of fighting HIV/AIDS. These are the themes of the chapters in the second part of this volume. Collectively, they explore the role of leadership, civil society organisations, and global institutions in confronting the epidemic. Crucially, they provide a critical assessment of the challenges and opportunities encountered in the two and half decades of living and confronting HIV/AIDS.