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PLAGUE UPON PLAGUE: AIDS & VIOLENT CONFLICT IN AFRICA

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PROCEEDINGS

DR. BROWN: – go up to the aisle mike and ask your question there so that they can hear your questions. They will also be sending in questions to our Mac. I hope we have gotten some interest from abroad.

Also, we would like you to, once you're at the microphone, please have a short question, stay there until you finish the question and answer with whomever you're going to be speaking so that the entire discussion is captured. We will be posting this in about two weeks time, so look for it on our web site.

As a courtesy to our speakers, we ask that you please turn off your cell phones and beepers, and this is not a new rule with us; we've been doing this for quite some time.

In the meantime, I would like to introduce – it gives me great pleasure to introduce the Executive Vice President for the U.S. Institute of Peace, Harriet Hentges.

DR. HENTGES: Good morning, and welcome to the U.S. Institute of Peace. Today's briefing examines the relationship of AIDS and violent conflict in Africa. This is a topic of truly stunning magnitude. Not many years ago, we would not have anticipated that an issue of health would be on the agenda of the Institute, despite the fact that disease and violent conflict have been intertwined over history.

The scourge of HIV/AIDS, perhaps the greatest plague the world has seen since the Black Death of the 14th century, has already claimed over 21 million lives, three million in the last year alone. So far the epidemic has hit hardest in Africa where some 25 million people – 70 percent of the cases worldwide – are HIV positive. In some countries, the infection rate is as high as 35 percent or more in the adult population. Estimates are that in the absence of effective treatment and prevention measures, one-half of the 15-year-olds in Southern Africa will die of AIDS.

The devastation associated with this epidemic has prompted the Bush and Clinton Administrations to treat the AIDS epidemic as a national security issue with the potential to threaten the U.S. and American interests worldwide. A writer in last Sunday's New York Times put it this way: "AIDS is not just Africa's health crisis alone. The strains of HIV running rampant there, if left unchecked, are sure to gain novel malevolence that would allow them to spread elsewhere and overwhelm whatever resources we have devoted to defeating our western-bred strains. The rapid increase of HIV-positive numbers in many parts of the world thus confronts policymakers with a potential crisis of immense proportions."

Simultaneous with the onset of this massive tragedy, many parts of Sub-Saharan Africa have suffered from the violent conflicts that have taken the lives of millions of soldiers and civilians

during the 1990s. Weak regimes, destabilized by economic difficulties, rebellions, civil war, rival alliances of warring states, and genocidal massacres, the last decade has been a political as well as a health disaster for much of Africa. It is not hard to imagine that the AIDS epidemic will further erode social and economic structures and contribute to further instability.

In past times, there was a tight linkage between disease and violent conflict. Casualties from epidemics befalling troops and civilians in war zones often exceeded the death toll in battle. This ratio changed in the 20th century when improvements in medical science coincided with the development of more lethal weapons technology. But the 21st century may see a reversion to earlier patterns where microbes were the chief killers, and their military hosts were the human carriers.

It has been estimated that 40 percent of the military in South Africa and Angola are HIV-positive, as are many soldiers serving in African peace operation forces. Richard Holbrooke, then U.S. Ambassador to the UN, warned last year that peacekeepers need better education about AIDS. "It would be the cruelest of ironies," he said, "if people who had come to end a war were spreading an even more deadly disease."

Today's panelists will consider the linkage between AIDS in Africa and America's national security concerns, and they will

examine HIV/AIDS as both a cause and a consequence of violent conflict in Africa.

We are pleased to welcome this eminent panel as guests of the Institute. Our hope is that the discussion this morning will bring out policy recommendations to address both the prevention of conflict and contagion as well as the management and treatment of populations suffering the ravages of war and disease.

I am especially glad to welcome back to our Moderator, Princeton Lyman, who was a Senior Fellow at the Institute in 1999 to 2000. Ambassador Lyman is the Executive Director of the Aspen Institute's Global Interdependence Initiative. His distinguished career includes service as U.S. Ambassador to South Africa during that country's democratic transmission. He also served as Ambassador to Nigeria and was Assistant Secretary of State for International Organization Affairs before he joined the Institute as a Fellow.

Ambassador Lyman is completing a book on the American role in the South African transition, which we expect to be published by the USIP Press next year. This will be the latest in a long list of books and reports on Africa issues from our Fellows and staff.

Much of the Institute's effort in recent years has focused on ways to prevent the spread and recurrence of violent conflict in Africa, reflecting the conviction of our Board of Directors that the problems in Africa should continue to receive high priority attention in our working

groups, in our briefings, and in our publications.

We look forward to a stimulating discussion today, and it's clear this is a topic of keen interest, and I think we've assembled a top-notch group of experts to reflect with us.

Princeton, I'll turn it to you.

AMBASSADOR LYMAN: Thank you, Harriet. And thank you to the U.S. Institute of Peace for sponsoring this meeting this morning. I think it's extremely important.

I just came this morning, actually, from a meeting on the Hill, co-sponsored by Senator Frist and Mark Malloch Brown, the Administrator of the UN Development Program, on the subject of AIDS. And it was a rather extraordinary meeting. Secretary of Health and Human Services Tommy Thompson was there, Senator Leahy, several congressmen, people from the NGO community and from the State Department, and it signifies that there is a growing coalition around the problem of AIDS, in particular as a health issue and to some extent, more broadly, as a foreign policy issue. And I think this is all for the good.

But much of the focus tends to be, understandably, on the health aspects – on prevention, on treatment, on organizing societies to deal with that. What I think is important about the conference we're having this morning is to appreciate another side of this terrible pandemic of AIDS, and that is the potential impact on violent

conflict. And that is what we are going to be exploring this morning, and I think it is a very important subject and fits into how the world should be treating this issue all together.

We have a very distinguished panel, and I'm very pleased. And this is the way we're going to proceed: Each or our panelists will speak for about ten minutes. Then we will have some exchange among the panelists themselves as we talk particularly about policy implications. Then we're going to open it up, both to questions from our guests here at the U.S. Institute of Peace as well as obtaining questions through the wonderful technology available to us through the webcast on e-mail so that we'll get a discussion going.

Our panelists are David Gordon, followed by Thomas Homer-Dixon, and then followed by Andrew Price-Smith and Millicent Obaso. Let me begin by introducing David Gordon.

David Gordon is perhaps one of the most interesting, provocative, and intelligent people on the foreign policy scene today. He is the National Intelligence Officer for Economics and Global Issues, and a visiting professor at the Woodrow Wilson School at Princeton University. Before that he was a Senior Fellow and Director of the Policy Program at the Overseas Development Council. He has also worked for the Congress at International Relations Committee. He has worked in Africa on foreign aid issues, governance issues, democracy for the U.S. Agency for International Development. He's taught at several

universities.

Most recently, David was the inspiration behind the publication of the National Intelligence Council called "The Global Infectious Diseases Threat and Its Implications for the United States." Perhaps there's no previous report like it. It has brought the attention of the whole health area to the foreign policy community in a very new way. It's my great pleasure to introduce David Gordon.

MR. GORDON: Thank you, Princeton, for that very, very kind introduction, and I want to thank the U.S. Institute of Peace for inviting me here today, and I'll try to go quickly through my notes, because I have a lot of ground to cover.

I want to do two things. First, I want to start off by outlining very quickly how we see the national security linkages to infectious diseases in very broad conceptual terms, in broad conceptual outline. Then move on and talk a little bit more specifically about AIDS in Africa and how we look at that and the link to violent conflict.

But let me start by look at the broad security dimension of infectious diseases and why we're concerned. The first concern is the direct risk posed to U.S. public health by the importation of infectious diseases which, of course, do not respect national borders. Here we're talking about perhaps a previously unrecognized pathogen, such as AIDS, it may be a new strain of influenza developing in Asia.

Epidemiologists generally agree that it's not a question

of whether but when the next killer flu pandemic will occur. It may be a multi-drug resistant strain of a disease that we previously thought we had under control, such as TB, or, as Harriet said, the potential of an evolving strain of AIDS coming back to the United States, where we're optimistic now that we have AIDS largely under control domestically, and we do as of the moment, but that's not necessarily a permanent status. So the first issue is the direct impact on health.

The second is the link between infectious disease microbes and the increasing possibility of a biowarfare or bioterrorism attack against the United States or U.S. equities overseas, as hostile states and terrorist groups exploit the ease of travel and communications in pursuit of their goals. At least a dozen states are pursuing offensive BW programs as are some terrorist organizations.

The West Nile virus scare of 18 months or two years ago in the New York City area indicates the confusion and fear that even the possibility of a BW attack can sew. And it highlights the increasing importance of collaboration among public health authorities, law enforcement, and the intelligence community in monitoring these threats.

Third is the potential impact on U.S. troops abroad and on the readiness of foreign militaries and their ability to engage in international peacekeeping operations. Here, U.S. military personnel deployed in support of peacekeeping and humanitarian operations in

both developing countries and former communist countries will be at highest risk.

Increasingly significant is the fact that the infectious disease burden is weakening military capabilities as well as international peacekeeping efforts, as their armies and recruitment pools experience HIV rates generally double or triple the rates in broader society. The participation of militaries with high HIV infection rates complicates the recruitment of other militaries for particular peacekeeping operation and is one of a series of factors that is making the mobilization of global peacekeeping forces more difficult.

Fourth, and the leading issue for HIV/AIDS certainly, is that the worst infectious diseases – and AIDS especially among them today, but malaria as well, potentially others, such as TB – slow economic development, undermine the social structure in countries and regions of interest to the United States, challenge democratic development and institutions, potentially contributing to humanitarian emergencies and the exacerbation of military conflicts, some of which will draw on the resources of the United States.

Finally, in the economic realm, infectious disease-related embargoes and restrictions on travel and immigration is a source of friction among and with key U.S. trading partners and other states. The issue of intellectual property rights with respect to new and existing drugs is a major source of controversy in the international

community. And, more broadly, the question of the direction, scope, and resources spent on health research and the development of vaccines and other medical responses is likely to remain a major source of North/South tension for a number of years.

So these five broad reasons are why we've argued that health issues have to increasingly be seen in a foreign policy framework and have national security implications.

Let me turn to Africa and AIDS. If national security is defined as protection against threats to a country's population, territory, and way of life, then AIDS certainly presents a clear and present danger to much of Sub-Saharan Africa and a growing threat to the vast populations of Asia and Eurasia, which have the world's steepest HIV infection curves. As Dr. Hentges said, over 55 million people have been infected with HIV over the last two decades, some 35 to 40 million currently living with the virus, over five million of whom are projected to have been infected last year.

There is a very strong case to be made that AIDS is becoming the most serious health threat in recorded history. It has already killed more people than all the soldiers killed in the major wars of the 20th century and equals the toll taken by the Bubonic Plague in 1347. The bad news about AIDS is that unless something is done in the near future, we're on a trajectory for things to get much, much worse. Except for certain regions of the Great Lakes area in East Africa, area of

Sub-Saharan Africa, for the rest of Africa, for Eurasia, for Asia, we're at the very early stages in the AIDS pandemic, so we're on a trajectory of things getting much, much, much worse.

By 2010, many African countries will see life expectancies falling to levels not seen since the beginning of the 20th century. So an entire century's progress in improving the quality of life and the length of life is at risk of being washed away by AIDS. So there's little doubt that these countries are facing more than a health crisis, but also a threat to their very existence is viable societies and states.

Let me talk for a few minutes about how to look at the relationship between AIDS and violent conflict. It seems to me that the best way to think about this is to see AIDS as an exacerbating factor that is deepening the conditions that breed violent conflict in Africa. Let me talk about seven lines of linkage, seven lines of linkage between AIDS and conflict.

And let me start by saying that the impact of AIDS is overwhelmingly going to be indirect. We're unlike to see direct conflict breaking out as a result of AIDS. It's also going to be hard to disentangle factors. It's going to be very vulnerable to difficult counter factual analyses of what would have happened if AIDS wasn't there. And that's always a very, very, very difficult thing to judge. So I want to emphasize the tentativeness on this and the indirect nature of the linkages I'm proposing. But I think they're quite real.

The first is impoverization, and I think the data is quite good that families in households that lose a breadwinner to AIDS are at terrific risk of deepening poverty. So you have a context in societies with very, very large rates of HIV infection of massive immiseration, massive immiseration, and the returning to kinds of poverty levels that we saw in Africa in some places never, in other places only generations ago.

Part and parcel of this, again, is the breakdown of the social bonds particularly in the nuclear family as a result of losing a key breadwinner. And, again, we're seeing a lot of evidence on that the likelihood of families staying together when a main breadwinner dies of AIDS goes down dramatically. And there are very few structures in African societies that are capable, that are capable of absorbing that.

Now, in societies in which the prevalence rate is modest, in communities where the prevalence rate is modest, the effects of that can be managed. Once you get prevalence, again, at ten, 15, 20 percent, it overwhelms the structures of the extended family.

Growing out of this disruption of the extended family is the growing phenomenon of AIDS orphans, and I think as we look out over time we're looking at the potential of millions, tens of millions of orphans in Sub-Saharan Africa in fragile, poor societies undergoing increased impoverization in a context in which access to weapons is increasing, the cost of weaponry is increasing, and there are groups and individuals of various sorts interested and capable of taking

advantage of this.

Fourth is the disruption of education patterns. The importance of education in the uplifting of communities, families, and individuals is very, very well documented. Again, the likelihood of children remaining in the education system goes down dramatically when a breadwinner in the household dies of AIDS. So the disruption of education, again, is a fourth line of linkage.

Fifth is the undermining of civil society. Africa has had a very fragile but very active civil society that's played a key role in the political and economic advances that have occurred in a substantial number of African countries in the last ten or 15 years. AIDS in Africa is a socially neutral disease. It's making tremendous inroads into the professional classes – teachers, administrators, people who form the backbone of civil society. And that weakening of civil society I think leads to a context in which the maintenance and sustainability of effective governance declines dramatically.

Sixth is limited economic growth, and there's a lot of good research now coming out of the World Bank and Harvard University on the macroeconomic impact of AIDS, and there are a couple of tipping points where AIDS begins to kick in in a macroeconomic sense. At sort of five percent prevalence it kicks in a bit, and then at 15 it kicks up at a higher level, equalling losses to GDP of over one percent per year. Again, in any given year that's not a great

loss, but unlike the Bubonic Plague, AIDS is a disease that stays. So over ten or 15 years it's a tremendous loss of 20 percent or more of GDP.

Finally, AIDS will increase the conflict over power, resources, budgets that are also likely to undermine fragile structures and systems. So the picture I'm trying to paint here in this short presentation is that AIDS is a very severe health challenge for Africa, but it also will exacerbate all of the conditions that have made Africa extraordinarily vulnerable to violent conflict in the past 15 years. Thank you very, very much.

(Applause.)

AMBASSADOR LYMAN: Thank you, David. It's an excellent introduction, and it's a perfect lead to our second speaker, Thomas Homer-Dixon, because many of us have a kind of a gut feeling that the issues that David has raised have an impact on the way societies move toward conflict or possible conflict. What Professor Homer-Dixon has been doing has been looking at this very systematically and bringing to it systematic models and frameworks by which we can begin to analyze these more effectively. And I think it's extremely important for what we're talking about this morning.

Professor Homer-Dixon is Director of the Peace and Conflict Studies Program at the University of Toronto and an Associate Professor there. His research focuses on social adaptation to complex

stress and links between environmental stress and violence in developing countries and on the causes of ethnic conflict. He was Co-Director of the project on Environmental Change and Acute Conflict, a project jointly sponsored by the Peace and Conflict Studies Program and the American Academy of Arts and Sciences. And after that he became principal investigator for the project on Environmental Scarcity, State Capacity, and Civil Violence. So you can see that he is working on just exactly the kind of issues we need to understand better.

He has authored, "Environment, Scarcity, and Violence" that came out of Princeton University Press in 1999, and the "Ingenuity Gap," which came out last year. I can't imagine anyone better to put this into perspective than Thomas Homer-Dixon. Thank you.

MR. HOMER-DIXON: Thanks very much, Princeton. This is a somewhat new issue for me in some ways, because I've been focusing – as Princeton mentioned, I've been focusing on the relationship between environmental stress and violent conflict over the last decade or so. Some of you may be familiar with that work. We've looked at the relationship between water scarcity, land scarcity, fuel wood scarcity, and, say, forest scarcity and violence, such as insurgency, ethnic rebellion, and revolutions in developing countries.

Now, this work has involved about 100 researchers in 15 different countries, and we've done a lot of case studies, from the Philippines and Indonesia and China to looking at water scarcity and

how it affects the relationship between the Israelis and Palestinians, to an examination of land and water scarcity in South Africa, land scarcity in Chiapas, Mexico and the relationship between these scarcities and the conflicts in these regions.

Now, in the process of doing this work, we've learned some interesting things about the relationship between this kind of stress, environmental stress, and violence. And I think that there may be some useful lessons here for us in considering the effects of disease on violence and instability within poor countries. Now, yesterday, I went through David Gordon's "National Intelligence Estimate," which is a marvelously thorough document, but I think this particular issue could use some elaboration. And what I'm going to try to do over the next few minutes is identify some key factors and variables that we should focus on when we're thinking about the specific linkages between disease and violence.

What have we learned from the exercise of investigating environmental stress and violence that can be applied to this particular problem? That's what I'm going to talk about over the next few minutes. Now, I'm going to break my talk into a focus on two issues: First of all, the nature of the causal processes involved – I'll talk about that for most of my ten minutes – and then I'm going to say a few words about the problems of adaptation and mitigation, adaptation to disease and also mitigation of the social consequences of disease within societies.

So, first of all, on the nature of the causal processes, the linkages between disease and violence, what might those be? I think we're in the very early stages of our research on this issue, and we have a lot to learn. But we can say some things, as David has already suggested, that are reasonably assured – we can have reasonable assurance are going to be correct about the nature of these linkages.

The first, as David mentioned, is that they're going to be indirect. Disease is not going to lead directly to violence; it's going to have indirect effects that lead to violence. And we've always suggested this is kind of a two-stage process where you have the stress, environmental stress or in this case disease, leading to a series of intermediate social effects, and those effects, in turn, lead to various kinds of conflict, usually internal instability as opposed to war among countries, various kind of civil violence.

Now, in our work, we identified five intermediate social effects that we thought were particularly significant. And, actually, I think what David has done in his previous presentation is he has identified a lot of these, the potentially important intermediate social effects at the end of that, in a sense, first causal stage between disease and the social effects.

The things that we were looking at were declining agricultural production, declining economic productivity, large-scale migrations, deepened social segmentation – this basically means

deepening of class or cast or ethnic cleavages within a society. And, finally, the weakening of institutions especially the state, and we spent a lot of time looking at how various environmental stresses would affect the state.

Now, of these five intermediate social effects, I think two are particularly important or relevant to the issue of disease. One would be impoverishment or declining economic productivity, and the other is the weakening of institutions. From my review of what we understand about this issue so far, those would be the two intermediate social effects that I think would be worth most attention. And I think those were highlighted by David. The key point here, just as David suggested, is that the relationship between the disease and violence is not going to be proximate, which makes causality very difficult to determine and opens up all kinds of space for arguments and skepticism.

Now, the second thing that I'd like to say about the nature of the causal processes is that they're interactive. We have synergistic effects all over the place in these complex systems. You have, you might say, multiplicative effects where disease will interact with something else in the social, economic, political or cultural context, and that will produce a much larger effect than either one of those things would produce by themselves. In other words, the context is important. The social, political, cultural, and economic context is important, and many of the results will be unique to particular societies and particular

context.

It's difficult to draw generalizations across societies. Violence may appear in some societies and not in others because of local economic, political, and social, cultural factors. And these things can be, for example, specific kinds of market failure, failures of economic institutions, corruption, abundance of light weapons, the combination of light weapons and disease and also ethnic cleavages. That's a particularly volatile combination if you've already got serious preexisting ethnic cleavages, abundant light weapons, and then this additional social stress of disease, then you have a particularly serious situation.

What I'm suggesting is that you have to look at combinations of factors, and we can't hope to really identify the influence of disease by doing bi-variate correlations, by looking at the influence of disease just directly on violence. So look for interactions.

The third thing I'd like to say about causal processes is in these situations is that they're going to be non-linear. The relationship between disease and the social effects and between the social effects and violence will tend to be non-linear. In other words, you might get a change in the stressor, what social scientists would call the independent variable, a slow creeping change and not much apparent change in the dependent variable, the effect, and then all of a sudden, bang, you've got a sudden shift in the behavior of this system.

And that makes, again, prediction very difficult, and it makes understanding the causal relationships very difficult. But the complex systems that we have in our world today behave non-linearly, and we need to get used to that and incorporate that characteristic into our analysis of these problems.

The fourth thing that I think is important about these causal process, the fourth characteristic, is that at the second stage of this causal change between the social effects and violent conflict, violence is more likely to be caused by changes in what social scientists or political scientists would call opportunity structure than by changes in grievance.

Now, standard theories of revolution and rebellion suggest that civil violence, revolution, and rebellion is caused by a combination of factors: Rising frustration or grievances within a society and also a change in the balance of power within a society that gives opportunities to challenger groups to confront the state. This is what is usually called a change in the opportunity structure.

Now, it would seem that environmental scarcity would influence grievances most, and I suggest that disease will have its principal effect on the balance of power within societies and in particular on the capacity of the state. And the reason I think there's a difference here is because environmental scarcity is often a function, in significant part, of what we would call structural scarcity, distributional imbalances

of resources within society. Some groups control a lot of the water, whereas other large groups have very little access to water. Some groups control a lot of the good land; other groups have little access to land. And this means that there are, for those who are on the short end of the stick, who are suffering serious resource scarcity, there are people to blame and there are people to be angry with and people to express your grievances towards and to think of as, in a sense, exploiters within the system.

It's not so clear that that's the case when you're dealing with disease. And I suspect that disease's principal effect will be on the state and will have a tremendous capacity to weaken the state and reduce its ability to deal with abhorrent social behavior and breakouts of violence within the society – outbreaks of violence.

And this is because of its effect on – disease's effect on human capital and on the fiscal resources of the state. As human capitalists degraded within the society, as a lot of the educated people become sick or die, the state is going to be – is going to suffer serious consequences in terms of its ability to make decisions, in terms of coherence among the various elements of the state – the bureaucracy, the bureaucratic elements, the judiciary, and other components of the state.

And also disease will effect fiscal resources, as David suggested, by increasing fiscal demands on the state. The state is

going to be under tremendous pressure to try to deal with the consequences of disease. But at the same time, disease will be undermining the tax revenues of the state. It will actually be decreasing or contributing to a decrease in the flow of funds into the state to meet the increased demands its facing. And so that is a prescription for a serious weakening of the state.

Now, just a couple of quick words, because I'm just about out of time, on this issue of adaptation and mitigation. This is the focus of my most recent work on the ingenuity gap. Basically, what disease will do is it raises the requirement for ingenuity – and by ingenuity I mean ideas applied to solve our practical, social, and technical problems – while at the same time, disease can undermine the capacity of societies to deliver and supply those ideas in response to the rising requirement. In fact, the evolving pathogens in our environment are one of the best examples of a race between our requirement for ingenuity, our requirement for increasingly sophisticated and complex solutions to the problems we face and our apparently inadequate ability to supply solutions to those problems.

On the supply side of this problem, looking at the supply of ingenuity in response to disease, there are four factors that deserve attention, and I'll just mention quickly because I'm into my last minute here. We can analyze the problem of adaptation and mitigation according to the factors of human capital. Can society deliver the brain

power at the local and community and national levels to address the problem effectively? From the point of view of a scientific establishment, are there the labs, the clinics, the researchers, the technicians and scientists available to address the issue? From the point of view of the economic structure of the society involved, are there incentives for entrepreneurs to respond to the problem at hand? And, finally, from the point of view of the political system, can the political system cope with the collective action problems that are introduced by serious disease problems?

I can't say much specific about these factors at the moment. There's much more in my most recent book, "The Ingenuity Gap," but I would say that many of the societies we're looking at are at risk of entering a downward spiral, essentially a feedback loop, in which disease and its consequences undermine the very adaptive capacity of the societies – the adaptive capacity that they need to cope with the diseases that they're facing.

By weakening human capital and by especially threatening scientists, technicians, and also the entrepreneurs who need to respond to disease and also by weakening the state, it makes it harder for societies to actually cope with the diseases that they're facing, and this possibility of a vicious circle or downward spiral is something that I think we need to address directly. Thank you.

(Applause.)

AMBASSADOR LYMAN: Thank you very, very much. I think that was just excellent in terms of moving this subject forward. I took my degree in political science many years ago, because I thought it was a license to dabble in almost anything. And what we have on the panelists today are people who don't dabble; they do this very systematically and brilliantly.

And Andrew Price-Smith is in that same category. He is the Director of the Project on Health, Environment, and Human Security at the University of North Dakota. And having subjected himself to the terrible last winter, he's moving now to the University of South Florida.

(Laughter.)

I have had the pleasure to listening to Professor Price-Smith on the direct effects or the effects – I'll let him describe them – particularly of health and the impact on society, the state, and possible conflict. And I think he brings a special expertise and approach to this that is quite relevant. He is the author of the "Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development," which is coming out of MIT Press. And I am absolutely delighted that he is able to join us on the panel.

MR. PRICE-SMITH: Well, thank you very much for having me down here, and thank you, Prince.

At the Council on Foreign Relations last year in New York City, former Ambassador Richard Holbrooke said that, in his

opinion, the HIV/AIDS pandemic was perhaps the greatest threat facing humanity – the greatest challenge facing humanity in the 21st century. And I agree that it is certainly up there on the radar screen in terms of one of the greatest challenges that we will have to face.

I've studied this issue now for five years, going on six years, and tried to really flesh out some of the types of relationships that Tad laid out for us here. And I'm here to report today several key findings of these many years of study that are going to be forthcoming in the book, "The Health of Nations," so there's my plug for my book. I'm not going to sell as many copies as Tad, but I'm going to work on it.

The first finding, which is novel and surprised even me, was that we have preliminary evidence of what you might call an asymmetrical feedback loop between population health and state capacity. And let me just define state capacity here. State capacity is a concept originally elaborated by Tad and the teams up at the University of Toronto, but let me sum it up as really the capability of the state to govern effectively. And so what we see here is, in effect, the population has a greater statistical effect on state capacity over a 15-year period in the obverse. So that's the first finding.

Now, what are the ramifications of that? Well, the rapid deterioration of population health can in fact generate a significant negative effect on a state's capacity to govern effectively. In other words, HIV/AIDS has the potential to seriously destabilize societies over the

long-term, from five to 15 years.

How does this relationship play out in the real world, aside from inventing statistical indexes and comparing population health against that? Well, once again, I want to mention that all the studies that I've done over the past five years do in fact collaborate the findings of the National Intelligence Council. And, basically, the relationship between HIV/AIDS and conflict is in fact indirect; we know that now.

How does this function? Well, a, increasing levels of AIDS will weaken the economy primarily thorough the destruction of the 15- to 45-year-old portion of the demographic curve, which, as you know, is the backbone of the work force. David Bloom and others at Harvard University estimate that every five-year decline in life expectancy will equal a negative 0.5 percent drag on the growth rate of national GDP. Now, of course, that's going to vary from state to state, but that was in a recent paper, I believe, published in Science back in last fall. And in fact what we're now beginning to see is HIV-induced economic decline in Sub-Saharan Africa. Now, Tad's point, in which he focused on non-linearity, is very important here, because what we may see in fact is a gradual erosion of economic power and suddenly a real, real rapid decline. So that's a very well-taken point.

Now, HIV/AIDS also drains government coffers, and it forces governments to divert resources to the health sector and away

from other productive sectors, such as teaching, for example. So increasingly scarce economic resources will lead to increased friction between elites as they try to control a declining resource base. But it's also important to recognize the disease imposes much greater relative costs on the poor and on the middle classes because they bear a relatively greater burden.

For example, malaria medication is extremely expensive to the poor – sorry, HIV/AIDS triple therapy is much more expensive to those who are in the middle class or who are poor than it is to the elites. So the relative burden of the cost of treatment is much greater upon the poor and middle classes.

What does this mean? Well, it may foster what we call class polarization, and it will certainly increase economic deprivation upon the poor and middle classes throughout Sub-Saharan Africa.

The second part, b, the second part of the argument is the effect of HIV/AIDS on human capital. And it's already been mentioned by the others, those who preceded me, so I'm not going to belabor the point. But AIDS basically depletes the reservoir of human capital in a given society, and it also impedes the development and consolidation of human capital within the young, because the young teachers are dying, their parents are dying, they're pulled out of school, it impedes their capacity to learn and acquire skills effectively.

Over time, the depletion of human capital – and of

course this also we're looking at the death of judges, lawyers, policemen, teachers, doctors, entrepreneurs, managers – over time, it's going to generate an effect that we call institutional fragility; in other words, increasing weakness in the structures of governance.

C, so when you look at this simultaneously as increasing deprivation on one hand and coupled with increasing fragility of the state, you in fact see a synergy here wherein it raises not only the incentive for conflict on the part of those who are deprived but also the opportunity for violence either between elites or between classes. And particularly when you have a situation where there are ethnic cleavages, this becomes rather dangerous. So the best way to think of this is that HIV/AIDS is in fact a stressor on state capacity.

Another additional point I want to make is what is the relevance of this? Okay. Well, states with lower initial levels of endogenous capacity are in far greater danger of falling into what Tad referred to as a disease-induced negative spiral. Why? Well, because they have lower levels of resources available to them to counter the HIV/AIDS threat. They have lower levels of endogenous human capital at the outset of the pandemic with which to generate solutions. And at this point, Tad's ingenuity argument becomes very important, because the pandemic's negative effect on human capital will simultaneously erode the state's capacity to supply ingenuity even as the demand for ingenuity rises. So with a nod to Tad, it might be a good idea to go out

and read his book, because it's a very important work that has in fact influenced many of my ideas on the pandemic.

Now, let's turn to policy ramifications, because we haven't really talked about this yet, and I'll try and get through this. How am I doing for time, Prince?

AMBASSADOR LYMAN: You've got about five minutes.

MR. PRICE-SMITH: Okay, great. Policy ramifications. Well, the balance of evidence suggests, number one, HIV will continue to debilitate and destroy the population base of seriously affected states. In Botswana, if you haven't heard already, it is perhaps – demonstrates the highest levels of infection – over 35 percent of all adults within that country are now infected. Number two, HIV will increase poverty and misery throughout these societies. Number three, we know it will erode human capital and undermine the economy in the state as well.

Number four, the combination of all the above I've just mentioned, including the increasing probability of social unrest, ethnic violence, governance problems, and even organized political violence, may occur in seriously affected states. But, again, we have to consider the contextual variables involved in terms of state/society relations.

And this doesn't mean that every country with high HIV prevalence is going to display violence, and I want to be very, very firm on that. Otherwise, obviously, Botswana would be engulfed right now,

perhaps, with increasing violence. We're not seeing that, but we are seeing increasing tensions within South Africa and Zimbabwe. So it's important to keep these contextual variables in mind when we're looking at this problem.

D – well, actually, let's move on here since I'm running out of time. Policy prescriptions. If I might make some suggestions, and I'm sure we'll all get into this later. Sub-Saharan Africa is an example of the persistent lack of political will among many political elites to deal with the problem. And we've seen evidence of this throughout the region but particularly in places such as Zimbabwe and until recently within the state of South Africa.

As many of you probably know, President Mbeki of South Africa was tortuously slow to accept the HIV/AIDS hypothesis, having doubted that for quite some time. The persistent culture of denial and shame within Sub-Saharan Africa, in general, doesn't allow for open discussion of the issues throughout Sub-Saharan Africa civil society. And it fosters a culture of fear where those who test positive are in fact shunned or in some cases even killed. A similar lack of leadership, I might put it that way, has also been shown by President Mugabe in Zimbabwe and particularly Daniel Arap Moi of Kenya who all basically refuse to accept the fact that HIV/AIDS was a serious issue confronting their societies.

Let's spin the problem back, though, away from these

really nasty cases. What are some success stories, and what can we use to build upon here? Well, several countries, namely Brazil, Uganda, Thailand, are good examples of countries that can in fact effectively adapt to the HIV/AIDS problem. Why? Because political elites in these countries have realized the long-term potential for HIV/AIDS to destabilize their economies and their societies. Active intervention by political elites in the nations I've just mentioned has led to decreasing infection rates. And even to the provision of low-cost, antiretroviral therapy to infected citizens in Brazil, which is a wonderful, wonderful example of a country that's dealing with this in a very proactive way.

What are some lessons we can take from this, just to open up the policy discussion? Number one, the lack of political will and the culture of denial are the major barriers, in my opinion, to controlling the spread of the pandemic. Without the political elites on board, we're basically going to go nowhere on this issue, and we've seen that for the last ten years in Sub-Saharan Africa. HIV will continue its spread. I've seen the trajectory curves, as I'm sure David has as well, and Tad as well. HIV will continue to spread into India where already one percent of the adult population is HIV-seropositive. It will continue its spread into China, Ukraine, Russia, and the Caribbean. And it jeopardizes the long-term stability of these societies.

The lack of transparency, political transparency is also a major hindrance here. Some states such as China will not issue

accurate reports of HIV seroprevalence, and I've had some problems lately with South Africa in terms of getting accurate measures on infection rates in their military.

We need to invest in better global surveillance regimes also, and I'm going to make – this is my call. I'm going to make the call on this. The pandemic will continue its expansion throughout Sub-Saharan Africa over the next five years, in my opinion. We're going to see increasing numbers of orphans, we will see increasing economic destabilization, we will see increasing political stability in the years to come if the political elites do not get on board for this.

And in my opinion, the pivotal issue is limiting transmission, not seeing AIDS as a chronic condition. There is, as you know, no vaccine, there is no cure, these antiretroviral therapies are not a cure. And the one thing that I confront constantly is people saying, "Well, now it's a chronic illness." No. This pathogen has the capacity to evolve and mutate rapidly. And there are already several clades, or varieties, of HIV, and if the drugs are used improperly, it will continue to mutate beyond the capacity of those drugs to regulate the pathogen, and we will in fact likely see in the future resistant strains of HIV coming back to North America. Thank you.

(Applause.)

AMBASSADOR LYMAN: Andrew, thank you very much. It was a very sobering presentation. We've talked a great deal about

these impacts, and I think we need now to focus on exactly how African societies and African populations and communities are in fact adapting to, responding to, and coping with this.

And therefore we're fortunate to have with us Millicent Obaso, who is Manager of the Africa Initiative at the American Red Cross and the Special Advisor on International Women's health issues there. She has worked for seven years in Swaziland on HIV/AIDS programs. She has worked previously in Kenya, and she focuses in particular on the social and economic empowerment of particularly vulnerable women and youths. And she is currently working on measures to improve community health education. I think this focus is going to be extremely important when we talk about what are the policy implications of this. So, Ms. Obaso, it's my pleasure.

MS. OBASO: I don't know where to begin after having such eloquent speakers, but I want to talk about the Africans and the African situation. Africa, as a continent, is devastated. You saw the title. It says, "Plague Upon Plague," and sometimes we wonder which plague should be given priority. War is going on all the time. When you think of war in Congo we are not just talking about the Congolese. You have Ugandans there, you have Namibians there, you have Zimbabweans there all in one place. You are not thinking of one country. Then you also have people from the international community. You have peacekeeping force. Then you have the two warring parties or

three warring parties sometimes. You never know whether they are increasing or decreasing.

And this is just endless suffering. In those situations, the magnitude of insecurity, particularly for the local people, the most vulnerable, the women and children, is just beyond imagination. The internally displaced people in African countries are colossal. Worldwide we have 18 countries with internally displaced people, and seven of these are in Africa. Africa is just a small continent. So in your own country you are not at home, you are not comfortable, and then there is AIDS on top of this.

And therefore we must think of ways of addressing HIV issue beyond borders. Let's remove all the borders. When we talk about Congo, we have Americans there. But there are specific factors in conflict situations that increase the spread of HIV/AIDS and I want to talk about this, because unless we are able to deal with those, our efforts to address HIV/AIDS even in stable situations will be undermined. What do we call stable? You are stable, but because of conflict and external migration, you are also at risk.

Some of the problems is movement from internal. Let's talk about what is happening in country first. Movement from urban to rural areas. As soon as war strikes, urban areas become extremely unsafe, and people feel comfortable where their ancestors are, where their grandmothers are. Even a man is not looking for his wife; he's

looking for his mother, and he goes to the village. And in the village the HIV prevalence tends to be lower than the urban areas, and these movements really impact the rural areas. And this happens not only internally but if you look at the situation, countries that have been at war and now returnees are coming back, the soldiers are coming back, the peacekeeping soldiers. Then you get another influx not only of people but of the virus and also of different strains.

We have an example of Rwanda. I have to talk about this. I'm from Kenya, but my country too has problems, so we Africans we have to be open minded, and we have to talk about these things with a straight face if we expect to get solutions. Rwanda, many years after the war it was discovered that HIV prevalence in the rural areas really went beyond double, and they said, "Why is this so?" And the general feeling was that the returnees and the soldiers contributed to this increase. And this is an example of how conflict can affect HIV/AIDS.

Then there are other issues like lack of health services. Whenever there is war the first thing there is chaos. Everybody is disconnected. You are disconnected from your bank; ATM card is no good. You are disconnected from your school where you take your children. You are disconnected from your doctor, from your health facility. And this is amazing. Sometimes you move just with these clothes that you have.

And what does that mean in terms of HIV/AIDS? We

have people who are sick who need to be taken care of. The systems break down completely. In Africa, people who are sick in the rural areas, and even in towns, are taken care of by women, because there are some gender roles, and apparently this one has been the role of women. And when people move and when there is war, the systems break down and families also disintegrate -- social controls. So you don't have home-based care for people with AIDS. You don't have counseling. There are no condoms and you can imagine then what happens.

The young people are particularly impacted under these circumstances. Mainly because young people have hope. They want to go to school, they want to feel they have a future and when there is so much chaos and they can't go to school. Particularly, those in high school and universities because they are old enough to know and they already have their own visions.

A lot of them are turning to drugs and violent sex, so rape is rampant. Women are raped by the soldiers, by young people, by men, by the enemies --

(END OF TAPE 1, SIDE A.)

(BEGINNING OF TAPE 1, SIDE B.)

MS. OBASO: -- soldiers -- had some refugees had killed somebody in their local community. Maybe they were in search of food or in search of something. That's the time when the food ration

went down and in revenge the local population conducted mass rape. Fifteen women were raped, more than 15, in fact, in one afternoon and it was sad.

Then there is also blood transfusion, if you think of conflict situation, that's where you need blood. Most people hurt all of the time and injured and the circumstances don't allow for proper screening, don't allow -- it's really like life-saving operation. And we don't have the statistics, but definitely there must be some kind of relationship.

Then universal precaution on HIV/AIDS where those who provide care – nurses – are supposed to be protecting themselves but also protecting the patients and vice versa so there is no transmission from the caregiver to the patient and the patient to the caregiver. But they lack simple things like gloves, so when you go to some of those situations you want to help but you don't have the wherewithal to do this. So sometimes people become victims of HIV/AIDS.

Another thing is because when you hear the soldiers have returned home, sometimes people think it is the bad conduct of the soldier, but it is the situation that they find themselves in.

And when we look at external migration, when internally to become so secure there's some individuals who feel their lives are threatened so they close borders. They come as far as the United

States. The major problem here, wherever they go, key concern they want to replace their relatives who are dead. Therefore, they want to have many children, and there will be no use of condom. Maybe we need to find ways and means of spreading the gospel.

Then sex industry also is a big thing in refugee situations. Refugees have become big towns, and one of the contacts between the local community and the refugees is prostitution. As I've mentioned, sometimes condoms are not available or people don't want to use them, and STD is quite high. I remember when I was walking in the Kagome (phonetic) in one of the camps, the syphilis prevalence among pregnant women was 19 percent. Now if you think of the men, then it must be higher because of multiple partners and polygamy and rape and so on and so forth.

Then what can we say? The AIDS orphans in Africa are increasing by numbers, from war and from HIV/AIDS. Unless we take care of them, then conflict will never end. There will be a war between the haves and the have-nots.

In conclusion, I make several recommendations. One, remove factors that lead to conflict, and involve women in conflict resolution. Men are busy fighting. Maybe if we bring in more women, we might be able to find that soft spot in the mind that can turn on war and turn it off. Advocate policies which will reduce transmission of HIV/AIDS in conflict and refugee situations. Harmonization of policies

which govern HIV prevention and control and also that address issue of the AIDS orphans.

All governments, I think, should be approached so that they can give proper briefing to the soldiers, to the peacekeeping force, first, for themselves so that they can take better care of themselves but also so that they can behave in such a manner that they uphold the human dignity, respect for the women. And the last one is economic empowerment for women to be able to free themselves and not depend on men economically and for security.

(Applause.)

AMBASSADOR LYMAN: Thank you very, very much. We have a very rich set of issues here. I want to take a few minutes with the panel on the policy implications, and then we'll open it up. And it seems to me that several different ways of looking at this have been put on the table, not only the broad scope of it and its many implications, but as Tad Homer-Dixon has said, there isn't necessarily a linear approach to this; there's many synergies to it. Some of the effects are indirect and over long-term.

And Andrew Price-Smith has added to this by focusing us, I think, a little bit more on the short-term versus the long-term implications. Do you address, it seems to me, one of the questions, do you go after the shorter-term issues, the problems that you see on the horizon, the clash over access to, let's say, drugs that is one of the

things that deepens class divisions? Do you go after the problems immediate to the problem or do you deal more with these longer underlying things, because this pandemic is going to go on for such a long period of time?

And Millicent Obaso has given us a different perspective. She turned it around. She says conflict contributes to the spread of this problem, and therefore poses another set of policy issues. Do you deal with conflict and the conditions in conflict that are adding to the pandemic?

Now, if you're sitting in the policy positions in the NSC or the State Department, et cetera, and you get this whole array of things, where do you start and how do you organize? What are the priorities if you were the policymaker, if I can ask our panel, as to how you focus the efforts, not only of the United States but also the international community? Anyone want to take a crack at that? David?

MR. GORDON: Let me make some points here. These are my personal judgments and views, so I'm just reflecting myself here rather than a U.S. government position. I heard in this discussion four central policy points. I think the – one is that this linkage back to state capacity in a context of a continent that's already in a crisis of governance I think is a major theme. And I think suggests a focal point for foreign aid efforts in trying to reduce the pressures on governance to combat that increasing pressure that the pandemic will put.

I mean it's a very interesting theme, because a lot of the themes certainly in the U.S. foreign aid discussion have focused not on government but on building the capacities of non-governmental organizations. So I think that we may need to recalibrate a little bit back to a focus on state capacities and trying to minimize the negative impact on state capacities. That's point number one.

A second point is that prevention of the spread of the disease is the goal here. And so I think that mitigation efforts have obviously a humanitarian motivation, and they're important, but I think that strategically we have to focus on the potential links between mitigation and prevention and to always have our eyes on the prize of prevention.

Now, I actually think that there's some hidden very good news here, that mitigation and the ability to mitigate I think will make it easier to destigmatize the disease. It will given an incentive for testing. It will give the ability of governments and the international community to offer hope in what had previously been a hopeless situation. So that's the good news.

The bad news is that there's a risk, that the politics of the disease is likely to have intense pressures on the mitigation side of the equation. And I think that it's going to be a very difficult task to keep the eye on the prize of prevention.

A third point, I think, and it was Andrew's point that I think

it absolutely correct, that the record shows that a scene aquanon (phonetic) for effectively dealing with AIDS in a country context is strong political leadership from the very top. I think that creates a diplomatic goal; that is, have we thought creatively enough on how we can enhance the commitment of governments to AIDS?

I actually think that Andrew was a little bit overly negative. I think that there has been the beginnings of a dramatic shift on this issue in the last 18 months to where governments are beginning to be much more active in addressing this issue. President Moi is not in the same camp as President Mugabe anymore, and that's the good news. But we have to go much farther in that.

The fourth point is that in conflict resolution efforts, and I think Millicent's point is absolutely correct, that the major impact of the military on the spread of the pandemic is after conflict. It's after their demobilized, after they go back to the villages. And so I think that building AIDS consciousness and special programs into conflict resolution and post-conflict reconstruction efforts is the fourth theme. And let me stop there.

AMBASSADOR LYMAN: Andrew, did you want to say something? And then Tad.

MR. PRICE-SMITH: Sure, yes. Well, first of all, yes, I didn't – I do accept the fact that – what I was trying to refer to, David, actually, with respect to Moi and Mbeki is that there have been problems

over time in terms of getting these political leads to mobilize on the issue. And so you're right, I mean there definitely has been significant movement, in my opinion, really within the last, I'll put it, as a year.

But there is still a relative amount of intransigence within the elites as a whole, in terms of getting behind it. Now, this is, of course – it's moved, it's gotten a lot better, but I'm still having some problems with getting transparency on these issues, particularly out of South Africa and Zimbabwe.

I think you're right, I think you're absolutely right on the need for increased political involvement by the elites. The one thing that I really want to focus on is that the political elites – and this is the key to what I'm trying to say here – if the political elites don't get involved in changing what we might know as the tenor of civil society within their countries, that tenor of civil society will continue to remain negative. In other words, there will continue to be a culture of denial and fear.

We have seen in Uganda, we have seen in Thailand, we have seen in Brazil political elites get on board and change the tenor of the debate within their societies which allows people to more effectively use the resources, such as prophylaxis in terms of condoms and education, and even the empowerment of women, which was a central point of Millicent's presentation that I think is very important. And it's the change in the tenor of the debate in civil society that can only really be produced by changing positions of the political elites. And

that's the central point I was trying to make on that issue. But I'm going to turn it over to the rest of the table for now.

MR. HOMER-DIXON: Thanks. I have, I guess, four points I'd like to make. And, again, I come to this issue sometimes from the outside from the point of view of what we've learned about the relationship between environmental stress and civil violence. And these four points certainly apply in that domain, and I think they apply here.

First of all, early intervention is much better than late intervention. So try to start addressing these problems before you even get close to the kind of downward spiral that Andrew and I were talking about where disease is causing an evisceration of states and social relations, and that is further exacerbating the disease problem. And that means we should be proactive looking for places where this disease is about to take off, and it looks like South Asia is one place that deserves a lot of attention at this point. Prevention is key. So that's the first point.

The second point is that we shouldn't use the indirectness of the causation as an excuse for inaction or denial. And I think it's very easy because the linkages are uncertain, unclear, and indirect to suggest that this is not really going to be a national security issue or an issue for the security – the military and national security of these countries, but it is. And that should increase the profiles of disease on our policy agendas as a result. So let's not use the

indirectness of causation as an excuse for inaction or denial.

The third thing is that we can play the synergies or interactiveness of these systems to our advantage, which means that we should not look for a silver bullet, but we should be engaging in multiple interventions. Because you can sometimes get much more from a series of interventions than you could from just single interventions from the – again, the whole is going to be more than the sum of the parts.

This might mean, for instance, that you go after not just the disease directly, but you go after some of the contextual factors that are interacting with the disease to produce serious social instabilities, such as the proliferation of light weapons and the availability of light weapons in these societies, corruptions within the state, economic pressures, external economic pressures on these societies, such as collapsing commodity prices that can produce a decline in state revenue and make it more difficult for the state to respond to the disease problem that they're facing.

So, again, we can play synergies to our advantage. Synergies don't always work to our disadvantage. We can sometimes get a real bang from multiple interventions rather than just aiming at single interventions.

And the fourth point is that – and this goes along with what other people have been saying, David in particular – is capacity-

building. We have to try to reduce human capital flight from these societies. AIDS is one more reason for the educated and the technocrats and the skilled people within the bureaucracy to leave the country – the people with money, the people with knowledge and skills. And there's been just a hemorrhaging of talent out of Africa over the last couple of decades. I think something like 60,000 mid- and senior-level managers left Africa between 1985 and 1990 alone.

Now, what can we do on the capital-building front – sorry, the capacity-building front? We can intervene to make sure that there are financial incentives for people to stay within these societies. And we can think about that as a policy approach. We can try to build indigenous research capacity in the area of disease prevention. And I'm thinking of something such as an analog to the CGIAR System within agricultural research, the Consultative Group on International Agricultural Research, which is a distributed set of research centers around the world that have more or less single-handedly fed probably one or two billion people on this planet as a result of the research they've produced. The advantage of this is that these research centers are familiar with local conditions, and they attract and hold in the third world, in poor countries, the researchers and scientists that they need. So we need to provide resources for a major distributed network of research centers to deal with not just AIDS but I think a whole range of emergent and reemergent infectious diseases in poor countries.

And, finally, there's a huge unmet need for condoms and contraceptives in the developing world. I mean even if we're just talking about family planning and fertility rates, we know that there's an unmet need of 20, 25 percent. And there really is no excuse for the fact that people don't have condoms available to them. And that's something where we can focus our resources immediately. Of course, there are problems of civil instability, sometimes getting contraceptives into regions, but that should be a priority for us.

AMBASSADOR LYMAN: I'm going to come back to you, Millicent, and I'm going to open it up and then come back, if I can. But I'm going to let you think about one other issue that nobody has raised, and that is the impact on the military and the capacity of states to wage war. You could argue that the demographic impact of this disease may reduce the size of armies and access to people, but I think it's going to have another deleterious effect, which is more and more use of child soldiers, reaching down deeper into the population for that person. But I'll put that out there for people.

And I'm going to open it up now, and I'm going to alternate between here and this wonderful machine here, if I manage it right. But I want to start here. When you stand and – do we have a microphone at all? There and then give your name. And start with this gentleman and – oh, okay, start with that gentleman right there. And give us your name and where you're from, and then we'll go from there.

MR. WOOLERY (phonetic): My name is Chuck Woolery (phonetic). I'm on the Action Board of the American Public Health Association and also the Issues Director of the World Federalists Association. And I want to compliment, first, the Institute on putting together this incredible panel. I mean this has been a very, very informative and I wouldn't say inspiring, maybe frightening, and it's interesting there's not a whole lot of controversy in a lot of these issues.

My concern is that there seems to be an obsession with HIV/AIDS, and you've mentioned about the importance of other diseases. And, actually, many other diseases have even more of an impact on the economy and kill as many people, and there are solutions for those, but yet we don't apply them. So my concern is that.

Second is the idea of a United Nations Rapid Deployment Force to go in and stop some of these problems before they get out of hand. The situation being Rwanda. Basically, the situation in the Congo right now is a spillover of what happened in Rwanda. It would have cost us about $120 million to put in a Rapid Deployment Force into that situation to stop that, but now it's $20 billion later, the Congo, seven nations involved, diseases continue to spread, and that's actually the heart of where HIV/AIDS and ebola come from. The national security ramifications of that are extraordinary, and I would suggest a policy consideration being looking at creating some kind of Rapid Deployment Force to stop these kinds of genocides before they

get out of hand.

And the question is the role of the United Nations. You know, the very first time nations ever came together in world history was in the 1850s around the spread of disease, and it wasn't because people were dying, it was because of the loss of trade and the quarantines. And the United Nations, with the World Health Organization, its development efforts, its environmental efforts, all of its efforts together seem to play an extraordinarily important role in the control of disease, but yet our government is doing less and less for it.

AMBASSADOR LYMAN: I'm going to take several questions, then we'll open it up to the panel. I have a question here from a reporter from Bulgaria. This is a very concrete question. I don't know if we have the answer, but if anybody does, two years ago, six Bulgarian doctors and other medical staff were detained in Libya and charged with intentionally infecting about 400 children in Bagasi Hospital (phonetic) with AIDS. And last week, Colonel Gadhafi made a public speech at the Pan Am African AIDS Conference in Nigeria and once again accused the Bulgarians that they were ordered by the CIA and Mossad to cause this devastation. The trial will be held on the 13th of May. What do you think about that case? I don't know if anybody has information on it, but take that note, and I'll take a couple more questions. Yes?

MS. MENDELSON-FOREMAN (phonetic): Hi. My name

is Johanna Mendelson-Foreman (phonetic), and I am a Senior Fellow at the World of American Military Power, which is a project of the Association of the U.S. Army. But in very recent lives I've been very engaged at the United States Agency for International Development in Civil Military Relations and was a founder of the Office of Transition Initiatives. So all of these issues come back to me, but I have a specific question, especially the one that you raised, Princeton, about military capacity. Because I think it's critical, but I also think we overestimate the capacities of some of the militaries that we're dealing with in warfighting capabilities.

But I think we underestimate the capacity of the governance issues that the other panelists meant for the immediate need to deliver services. And this is an issue which I think we've overlooked, in part, because the development community resists working with armed institutions in some cases both legislatively but in other cases culturally, but it's an area we're going to have to overcome if we're going to work on the disease in Africa.

And I say this because in many countries, as we know, the military is the only institution with capable infrastructure to, a, deliver services and to provide education instruction whether we like it or not. And I think we have to start working very carefully identifying people who are bad actors and not working with bad actors but using this as our immediate line of defense in some of the HIV areas.

And I cite a very specific example, a conference that was sponsored by USAID in Tulane University had a Namibian officer who came to the conference, a very talented woman, who, on her own, got the High Command of Namibia, not the civilian government, to invite people back who are already doing HIV briefings and using that institution as a education and distribution means.

And I just want to make one other point because Ms. Obaso made it so clearly. We ignore frequently the role that women play in the prevention as well as in the care. And I think in looking at policy remedies we need to be much more focused on that aspect of civil society which I feel has been overlooked in much of the distribution. Thank you.

AMBASSADOR LYMAN: Let me take one more question from the e-mail, and I think the first four tie together, or at least three of the four. And this comes from no name affiliation here. Why is AIDS in Africa a U.S. problem and not something best addressed by the United Nations? It goes back to a question earlier about the role of the United Nations.

So we have really several things here. We have the idea of Rapid Development Force, which relates to the UN, other UN roles. The question here about working more with the military, and I wonder if our panelists might want to comment on these set of questions, and if anybody has an answer to our Bulgarian inquiry.

Andrew, you want to start?

MR. PRICE-SMITH: Okay. Well, first of all, let's address the question of military capacity, and I think, David, you probably have something to say on this well. It's increasingly apparent, at least in my opinion, that high infection rates within the military, within Africa, will substantially deplete their ability both to defend their borders and probably more importantly to project power.

Now, what does this mean? Well, what I think it means is that among states in the Southern Cone, for example, there will be less and less incentive to engage in conflict between states, because they will be less and less capable of projecting their power. But as I've said before and I think the other people on the panel concur, there is probably more ability for states to be subject to processes of fragmentation within them. So I see – in terms of violence, I see a focus on intrastate violence as opposed to interstate violence.

David, do you want to comment on that?

MR. GORDON: Yes. Let me make a couple of comments on these questions. The military capacity issue is a very tough one. I think it's not easy to make a hard and firm argument that we've seen a lot of loss of military capacity directly as a result of AIDS, but, again, we're in this difficult counter factual issue of what would have happened if.

I do think that in the most technically advanced

militaries, we are looking at diminished capacities for a number of reasons, and the South African military is obviously the one that comes to mind the most. I agree with Andrew that the most likely result of this is a further disincentive for state-on-state warfare, which has not been the dominant pattern of warfare in Africa in recent years. So it's a tough one.

On your question of the military as an institution to do some of this delivery of services, that's a tough question. I've got to say I'm a skeptic on that. Now, in a few societies, yes, particularly in Southern Africa where you've had militaries that have been quite professional, militaries that have good relations with civil society, et cetera.

I think, in general, I'm skeptical about the role of the military as doing this in the civilian sector. I think there's a crucial role for African militaries on this issue within the military, and that's going to be – particularly in post-conflict situations, that's going to be a very, very large task in and of itself and a very significant task in and of itself. So I don't want to toss out the military all together as a tool, but I've got to say I'm a little skeptical outside of a handful of countries that we could probably generally agree to quite easily.

On the question of other diseases, yes, of course there are lots of other diseases there. And I think – I mean there is a crowding out danger here in the focus on AIDs, but let's remember that

it was this argument that other diseases are more important that dominated organizations like the World Health Organization and led to their absolute virtually criminal neglect of AIDS up until very, very, very recently, up until the most recent leadership change in that Organization.

I remember being at a WHO Conference about a decade ago in which people were lambasting the United States as imposing the anti-AIDS agenda on Africa when other health issues were really the dominant issues of concern. And I mean I think the evidence is absolutely there. That was a wrong perspective. The international community, particularly the key institutions, avoided this disease until very, very, very late in the game. And people can be critical about the U.S. government. Maybe we didn't do enough, but we were, for many, many years, virtually the only game in town in terms of active efforts to try to combat this.

AMBASSADOR LYMAN: Millicent, did you –

MS. OBASO: Yes. I have two comments to make. One about the, not strictly military, but if you include there the police force and the prison officers, this group has very high prevalence rate. Maybe there is need to do some kind of discrete study to find out why and how they can be helped. We need security. If you don't have the police and you have some of your associates outside and they're having some difficulties, maybe we need to find out and design the best mechanism of getting services to them.

The second one is on capacity-building in the case of HIV/AIDS. I see two-prong approach in Africa. One is capacity-building for leadership. People in the community talk about AIDS; they bury their dead very openly. But there is silence in Millicent Obaso and ourselves. We don't talk about it, and we don't admit it. We don't everyone take responsibility for it that it is important for our country.

So if one prong can build the leadership for senior people to come out and talk about it, not just the presidents, but all corporation leaders, the government leaders, private sector leaders, this probably would move us forward. But more importantly, it's capacity-building in the community so that the community takes responsibility for themselves.

Why haven't we addressed malaria? Because the woman in the rural area has not been educated or the man or the women to take responsibility, go door to door campaign. This is the only way I think we are going to overcome this problem. It is expensive, and many people shy away from it, but let us empower the communities.

The last one, some governments have come out and now said HIV/AIDS is a disaster. Where is the disaster response? We are all responding in a development mode. How long will it take us to cover all the countries and bring down the infection rate? We are saying prevention is the key thing. Thank you.

AMBASSADOR LYMAN: Tad?

MR. HOMER-DIXON: Okay. Just a quick point on other diseases. I was fairly careful to talk about diseases, because I think this is an important issue that we could see a number of new pathogens affecting human beings in coming years. And the ones we're experiencing right now many of them are diseases that we thought we'd dealt with, and it turns they're rebounding on us. And also that there seem to important interconnections among these diseases, especially between tuberculosis and AIDS from what I understand, that AIDS is weakening people's immune systems and making them increasingly vulnerable to TB, and that's one of the reasons that antibiotic-resistant TB is becoming more prevalent around the world.

But the thing I wanted to – there are two things I wanted to stress. I actually wanted to return to this issue of intentional infection in Libya, because I have something – just a story to tell about that.

But, first of all, on the UN role, I'm always struck by the fact that when there's an outbreak of an disease, and now we're not talking about HIV/AIDS, but, say, something like ebola that the first thing that happens in there's a team mobilized at the CDC that is sent off to some distant part of the Africa in the remote jungle or something like that to try to identify what's happening and respond to it. I don't at all understand why this is left in the hands of the CDC, and that's an obvious thing that the United Nations should be doing, perhaps through

the World Health Organization.

Not to sound apocalyptic about it, basically there's an ongoing war, and there always has been an ongoing war between pathogens and the human species on this planet, and we have a responsibility to develop our immune system. And the immune system is not only going to consist of medicines, it's going to consist of social responses of various kinds. And one of the important social responses surely is some kind of international agency that's dedicated to the rapid deployment of expertise in situations where there is an outbreak of a disease of some kind. Again, this would help on the prevention side because we'd get to things early. We need some kind of UN agency that can lead the way on the identification, tracking of diseases and also the rapid deployment of specialists to areas where we see outbreaks.

The final thing I wanted to talk about was this issue of intentional infection. Now, I don't know about this specific story, but I received an e-mail from a colleague in South Africa last week, and he said there's a rumor spreading across South Africa that white doctors have been intentionally infecting blacks by giving them injections, and white doctors are now being threatened with necklacing in South Africa's response.

And I think one thing we haven't addressed here is the kind of social hysteria that can develop within a population in a situation of such extreme stress, where old animosities and alliances reemerge,

and that further contributes to the breakdown of these societies. Obviously, this kind of situation in South Africa is going to be a further spur for experts and doctors who have the capacity to deal with this disease, in part, or respond to it to leave the country.

MR. GORDON: Let me make a couple of comments on this, Princeton, two comments. One, on the surveillance issue, that there is an increasing effort on global surveillance. It's one of the very promising foci of multilateral cooperation in the world today. The center of it is in the WHO, in the disease surveillance operation that they have. They have very close links to national public health authorities. Their utilization of CDC and the French Pasteur Institute is a function of the extraordinary technical capabilities, both here in the U.S. in our CDC and in particularly in the Pasteur Institute.

It doesn't derive from any imposition of an American approach to the issue. So this is something that increasing resources are going to. I think it's a harder one to mobilize resources on than particular diseases that the particular diseases are easier to run international campaigns that mobilize resources on. But this is one of, I believe, the most important and the most promising foci for collaboration.

On the question of Gadhafi's speech and other stories, I think this goes back to one of the last major Soviet disinformation campaigns was a very extensive disinformation campaign in the late

1980s in Africa about the origins of HIV/AIDS and about the U.S. as infecting Africa. And it was a scurrilous campaign there. Colonel Gadhafi made an absolutely scurrilous speech at the Abuja meeting last week, and it's just very, very unfortunate.

AMBASSADOR LYMAN: Let me make two quick comments on health and then the UN. On health, I think that one of the things that, if we don't make a mistake on the AIDS strategy, try and just go at it with retrovirals or something, it will lead to addressing the basic health infrastructure issues in Africa. It's the only way one's going to be able to deal with a lot of it. And that opens the door to addressing a broad range of diseases.

Let me just say a couple of things on the UN. First on peacekeeping. The UN Is now struggling with a major problem, and that is can they ask countries that contribute peacekeepers to screen their peacekeepers for HIV/AIDS? What it now is is a voluntary program. They do not enforce it. And that raises some very serious questions about the use of UN peacekeepers, including a Rapid Development Force.

Beyond that, on the UN, after the kind of problems with WHO that David mentioned, there was created UNAIDS, which is a coalition of seven UN agencies to build up their programs addressing AIDS, and that program has developed. There is a UNAIDS Secretariat that provides, largely, technical advice to the whole program.

It's not perfect, but right now in the Congress where we're coming up with various kinds of funds, we have a trust fund idea, a global fund idea, everybody understands that sooner or later this has to be an international effort, and it will be lodged somewhere in the UN system – the World Bank or somewhere else – and hopefully coordinated under UNAIDS to be effective. But, obviously, it is a very broad effort.

Now, let me take four questions over here, and then we'll come back to the panel.

MR. ERVIS (phonetic): John Ervis (phonetic), a freelance political consultant and a writer in D.C. My question is about the national security implications of AIDS. And going back to Mr. Gordon, what you were saying at the beginning, I think I can quote this, I hope I got it right, but you're defining national security as "protection against threats to a nation's population, territory, and way of life." To me, that engenders two questions and only a part of that's been answered, I think, today.

One, does AIDS threaten the national security of the countries involved? And, two, does a country's AIDS problem affect the national security of other countries? And I think today we've heard that AIDS certainly affects the national security of the countries in Africa that have AIDS, in terms of that definition. But I'm curious, do you, in particular, and do the other panelists think that AIDS in Africa is it a

threat to the national security of other countries outside of Africa, particularly the West? B, is AIDS in Asia, China in particular, India and then the former Soviet Union, a threat to the national security of the former Soviet Union and Asia?

And the final question, if there is a risk to national security in Asia or the former Soviet Union, again, is that a national security issue for the West? But I think we've answered the Africa question, but I'm still curious is Asia a national security to other questions, either internally or vis-a-vis their relations with others?

AMBASSADOR LYMAN: Okay. We'll come back to that question. Next question.

MR. SINIGLUAS (phonetic): My name is Vince Sinigluas (phonetic), journalist and Executive Director of the Council on Diplomacy's Global Issues Awareness Initiative. We all know that the visitation caused by AIDS poses a clear challenge to long-term U.S. economic and security interests. Solutions and prevention to this problem requires funding. That's what Ambassador Lyman stated to our panel of experts, and I would appreciate if Ambassador Lyman can share his opinion considering his recent meetings with the policymakers this morning?

My question is in reference to America's financial commitment in international AIDS relief efforts, which I believe have an impact on preventing conflict as well as this disease. Treasury

Secretary Paul O'Neil (phonetic) said last week, and I quote, "That the Bush Administration might be open to increasing its commitment but only if there was convincing evidence the extra money would be used effectively."

My question is were the infrastructure problems in the past higher than the success cases? If so, what are the success cases that you can think of where modest amount of money have yielded significant results that would convince the Administration to increase America's commitment of $1 billion a year, as laid out in the Senate's budget plan? Thank you.

AMBASSADOR LYMAN: Good question. Next gentleman.

MR. FOOT (phonetic): Yes. May name is Mel Foot (phonetic), and I'm the President of the Constituency for Africa, which is led by former Congressman Ron Dellums (phonetic). We're primarily focused on building public and private support to address the pandemic in Africa.

First, I want to compliment the panel. I think you provided some excellent information and insight. But I was initially looking at it and said, okay, you said that HIV/AIDS causes conflict or leads to conflict. And Millicent, you talked about the fact that conflict also can lead toward the spread of AIDS, and I think you're right on the mark there. I would like to hear more about what are some of the

recommendations that you have for the U.S. government and Western powers in a real sense? Given the projected devastation in Africa, what will be the impact on the globe? A lot of conflicts in Africa are fueled by outside forces, i.e. arms dealers, diamond merchants and such, so it's not just an African problem, it's a global problem.

You say Africa's leadership is a factor, a negative factor, and I would agree with that. We also think the Western leadership also has been very negligent. Last year, at the National Summit, President Clinton stood up and said, "We're going to commit $300 million to Africa," and people applauded when they should have been throwing eggs. So I don't think that the Western leadership is any better than Africa leadership, quite frankly.

Last year, we passed The AIDS Marshall Plan Trust Fund, and it got allocated, I think, at $150 million. Twenty million actually got – well, $20 million actually got allocated out of the $150 million request, but so far zero has been spent. The money is stuck over at Treasury, and every day 7,000 people a day die. Who's negligent and what is the U.S. response?

Also, what about race and class? Do you think race and class are going to be a factor in how the Western countries will respond. Because these people are black and of color, does that mean the U.S. and other countries are going to be less willing to respond appropriately?

In terms of where AIDS comes from and that sort of thing, it's principally a factor among African-American leaders. They think it's a conspiracy. Horowitz has a book on emerging viruses, you know, talking about chemical weapons and this sort of thing. Is there – well, I don't even want to go there, but I think it's more than just a – Jeffrey Sachs (phonetic) says it's going to take $10 billion a year to treat AIDS, and I think that's about $4 billion for the U.S., that sort of thing, and it would be allocated out. Is that a realistic kind of thing?

And, Dave, you talked about the fact that prevention is more important than treatment, and I was kind of shocked by that, because you're talking about 25 million people who are infected. Are we writing those people off or – I know you didn't mean that, but how do you go about balancing treatment versus prevention?

AMBASSADOR LYMAN: Very good question. Thanks, Mel. I'm going to take the rest of the three people who are in the line, and then we'll open it up for the panel to comment across the board on this. The lady is next.

MS. MCGINN (phonetic): Hi there. My name is Colleen McGinn (phonetic) from Tulane University's Pacen Center (phonetic), and we've talked a lot this evening about the negative spiral feedback loop between how conflict and AIDS can reinforce each other. But what's also not always recognized is how health programs can be used in peace building and in conflict resolution by bringing groups together

around a common purpose and by directly addressing the fear and prejudice in communities. So I was interested in your comments on that.

Secondly, my office recently sponsored a symposium for African practitioners working on HIV/AIDS in post-conflict countries, and their consensus declaration is on the table outside. They echoed a lot of your comments about how critical it was to devise interdisciplinary, multifaceted approaches to dealing with the disease. It's not just health, it's about culture, it's about – there are so many intervening and contributory factors.

However, they also reported that the key problem or one of the key problems in actually implementing operational, multidisciplinary programs was lack of funding from Ministries of Health but also the international communities. When you start talking about the impact of conflict on trauma, how that contributes to high-risk behavior, how that contributes to a breakdown in families, there's no health funding – there's no funding for a program that addresses these psychological issues, because it's written off as not health. How can we address the political will within the international community to actually put funding into interdisciplinary approaches to HIV/AIDS prevention, particularly in conflict-affected societies where that's especially important?

AMBASSADOR LYMAN: Thank you. Next?

MS. UMA (phonetic): My name is Beldina Uma (phonetic). I'm from the Foundation for the AIDS Campaign in Africa. The Foundation for the AIDS Campaign in Africa is an NGO, which was formed at the request of the African NGOs last year at the UN Special General Assembly on Women. Their request was that the Foundation should be formed to help them with their campaign on AIDS, especially with coining, developing culturally best messages.

Their concern is that there's a lot of information out there on AIDS, but there's something that seems to have been overlooked, that each culture understands the AIDS issue differently or doesn't understand it at all or understand it from their own cultural perspective. And so they call that messages should be formed according to – should be developed according to the cultures.

And so what the Foundation has done so far is to form a module, which, if used in each culture, would bring out the right kind of messages that will help a specific culture. But this is a mammoth task. I mean the Foundation was started six months ago. There's very little response to assisting the Foundation, and yet all over everybody's talking about prevention. And this is one of the key issues in prevention. Thank you very much.

AMBASSADOR LYMAN: And the last question here, please.

MR. LESTEMO (phonetic): My name is Frank Lestemo

(phonetic) of the George Washington Center for International Health. I have a very brief question, but before I start my question I wanted to point out a comment that you mentioned about the CDC, because it's important to understand the organizational setup there.

The CDC is part of the Public Health Service, which is a wonderful, marvelous mechanism that allows us to deploy what we call the uniformed services. These are the professionals who are trained, and they can be deployed anywhere in the world where they're asked to be brought in. Now, that's the key. They have to be asked by the country. And not only that, many of these individuals are trained by, whether it's CDC or other parts of the Public Health Service, NIH, or so forth.

And one of the strongest programs CDC has, as you many know, is the Epidemiology Information and Surveillance Program. So when they go to a country, they usually already have a few trained counterparts who've already been through the program, so this makes a wonderful partnership at the country level with the CDC.

Now, the reason I mention this – and I'm going to get to my question – this Public Health Service model was created over 200 years ago. I mean our creators of the Public Health Service envisioned a marvelous model that was based on two things. One was the commission corps, which was the uniformed services. The other was the civil servants.

Now, the difference was the Surgeon General and his

key officials could deploy those commissioned officers anywhere in the world. In other words, he could put them in harm's way. They would go to places like Anaktuvak Sound or McMurdo Sound or Alaska or the Indian Reservations or wherever they were needed, and they had to go, because they were part of the uniform corps. So that's the same thing that holds true when they go to other parts of the world.

And the key to this model is they recognized 200 year ago public health is not defined by the country; it's defined by the diseases you have to attack. And as was mentioned here, we're in a real war against diseases. We can't just focus on HIV alone. Although HIV will consume a lot of our attention, we have to be worried about the next influenza virus that could be equally as devastating in the future if we aren't careful.

So my question is this: How could we utilize this marvelous mechanism that has been slowly, over the last two decades, I would say, broken, debilitated, cut, and reduced as a mechanism for national security? For example, my previous organization – I'm going to cut this real short – with our advocacy efforts raised the level of having a health person in the National Security Council. That person has already been removed. Now, how can you have health and public health as part of these decisions if they're not even present to help with their prevention strategies?

So I think if you want to utilize that mechanism –

because what's the most important priority in any country? The military. And here's a role for military officers who are trained to deliver health services and also therefore contribute to their country's development rather than just going to war. Thank you.

AMBASSADOR LYMAN: Thanks, Frank. I'm going to comment a little on the funding, and then I'm going to let our panelists finish up on all these questions. Let me say several things on the funding issues. It cuts across several questions.

I think Friday there will be an announcement from the Administration on its contribution to the Global AIDS Fund. My guess is, from the combination of the Administration and Congress, there will be a substantial, if not the level that people want, but it will be a significant contribution. However, at the same time, Congress has just in the budget resolution reduced foreign affairs spending by $700 million, so the implication is that the increase in funding for AIDS may in fact come out of other foreign aid programs.

Now that gets to the question of how you deal with the indirect effects, the multiple addressing of it that Tad has talked about, and that worries me a great deal. Because it's one thing to address it as a health issue, which is very important and with the Global Fund we'll probably do. And I'm not sure how fast the money can be spent, because it depends a lot on individual countries. I know countries where you can't spend anymore because the leadership isn't there. But,

nevertheless, the Fund is important.

But if we reduce our capacity – our ability at the same time to address state capacity, the indirect effect, someone talked about psychological trauma, we had Millicent's comments about the impact of conflict. If we don't have a multiplicity of resources to address those questions, then I think the increasing contribution just to the AIDS Fund is not going to help us as much as we would like it to be.

Now, I'm going to turn to the panel. I think I'll just take them in the order, because you only have a few minutes, and you can cover all the questions, as well as other comments. The last question that we got on the machine, which we discussed, which you can think about is, again, what are the first three policy steps you would recommend for the U.S. and others?

So we'll start with David and then go in the same order.

MR. GORDON: Okay. Let me respond to the question of national security. In our national intelligence estimate, we've never used the phrase "threat to national security," because we basically didn't want to get into a religious talmudic argument about when something becomes a threat to national security. We did say that infectious diseases broadly have strong national security implications for the United States, and I think that's right.

Now, is AIDS in Africa a threat to U.S. national security? Well, it's a very, very tough call. I mean I think it's clear, as you said, that

it's a threat to the national security of African countries; that, I think, is an open and shut case. But let's take a worse case scenario now, take a worse case scenario. The two countries that have the highest increase of HIV/AIDS in Africa are the two countries that we're most concerned about, generally, in Africa – South Africa and Nigeria – the two most significant largest countries in Africa. If you begin to have some of the effects that we've talked about here today, a collapse in governance in these two countries, the potential for increased humanitarian emergencies, atrocities, the penetration of these countries by criminal networks, by drug networks, by terrorists, all of that leverages up.

I mean if you look at where these other things thrive that have very direct national security implications for us, it's in societies that fail – in your Sudans, in your Samolias. There is a threat here potentially in a worse case scenario. There clearly – if the global community doesn't get its arms around global AIDS and you have anything like the rise in prevalence elsewhere – in Asia, in India, particularly, or in Russia, the Ukraine – these effects, again, magnify, and it also dramatically increases the likelihood of all sorts of negative health impacts blowing back on the United States.

I think it's an open question. I mean, clearly, Russia and other parts of the former Soviet Union and India have the highest trajectories up. It's still not absolutely clear if we're going to get into mass heterosexual transmission of the disease, and that's really

everything, that's everything. Now, the numbers are going to increase very dramatically. Whether they begin to have the kinds of national security implications for these countries that they do in Africa, I think is a real uncertainty. I don't think it's by any means inevitable, but I certainly wouldn't want to say that it's not going to happen.

Let me just make one final comment to Mel's very good question. I'm certainly not against mitigation of the disease. I said that. I think mitigation is very important. It creates huge opportunities. What I did say is that I think mitigation efforts have to be seen in a strategic context in which the ultimate goal is prevention.

And there are, basically, two ways to get from here to there. One way is through behavioral change; the other way is through creating a vaccine. And I think both the focus – the social focus on behavioral change and the scientific focus on a vaccine rather than antiretrovirals are both very, very significant and shouldn't be lost, and I think there's a danger that they might be.

AMBASSADOR LYMAN: We are scheduled to end at noon. We're going to run a little bit over. I know that some people may have to leave, but we're only going to run a few minutes over, because several of us do have to leave right after. So I'm going to turn to Tad.

MR. HOMER-DIXON: Very quickly, on the national security implications, I agree wholeheartedly with what David was saying. You seem to be looking for some kind of specific probability,

and it simply – it's going to be impossible to provide.

PARTICIPANT: (inaudible)

MR. HOMER-DIXON: Yes, absolutely. I mean but we've gone through a whole bunch of reasons, which I'm just going to reiterate, because I think otherwise it gets a bit tired, but I'll do it very quickly. As societies start to disintegrate, they become the basis for crime, for terrorism, as David suggested. They become a dead weight on the world economy, and that affects everybody's well-being. They often demand – there are crises, conflicts, humanitarian emergencies in these societies that demand military intervention by external forces or some kind of military mitigation.

But, perhaps, most importantly, to the extent that the health care infrastructure in Africa disintegrates, Africa can become an epidemiological pump, can basically become a source for disease for the rest of the planet. Now, if that isn't a national security implication, I don't know what is.

But then you go on to India, right? Now, if we see even two-thirds, let's say a half to two-thirds of what we see in Africa in India, we're talking about a truly critical situation at the global level at that point, because we have the nuclear power, we have a billion people involved, we have chronic conflict in the neighboring states, and a fundamentally fractioned society already with serious internal tensions that has been able to hold things together by sustaining a modest growth rate for the

first few decades of its existence.

(END TAPE 1, SIDE B)

(BEGIN TAPE 2, SIDE A)

MR. HOMER-DIXON: – the propagation of these diseases. What I'm suggesting is we should extend this marvelous CDC capacity to the international level, and there should be an international operation under international authority with labs of equivalent competence and quality and technicians of equivalent competence that are under international authority, because then it will be seen as an activity of humanity as a whole, rather than something that seems to, a lot of the time, have an American label on it.

AMBASSADOR LYMAN: Andrew?

MR. PRICE-SMITH: Okay. Thanks. Well, I've been quiet for a while now, so I want to address a couple of issues. First of all, with respect to the mitigation issue, it's very important to understand that mitigation is in fact important, because what it does is it reduces what we call the viral load within the human host, and this brings down the probability of infection. In other words, if you use antiretroviral therapies effectively, you can reduce the viral AIDS load within the human host, which makes the risk of transmission to non-infected individual far, far less. So that's very important to address mitigation as well, but it's bound up with the whole probability of transmission. So, in a sense, mitigation becomes prophylaxis.

The other important epidemiological point here is that increasing spread of disease within Africa – this goes back to Tad's point on Africa as a possible pump for the rest of the world – increasing spread of disease will increase both the virulence of illnesses, in general, not just HIV/AIDS, and the mutation rate of those organisms, because, in general, as the organisms, there are more of them, and statistically it gives a higher probability of mutation and virulence. If you want to read a great book on that, read Paul Ewald's (phonetic) work, which has been out since 1994 with Oxford University Press, "The Evolution of Microorganisms," something like that. Anyway it's a great book.

A little comment about capacity-building here. When I was a graduate student at the University of Toronto, there was an economist there named Jerry Holeiner (phonetic). And what they did at the Center for International Studies where I was a grad student is they brought over 20 African agro-economists and trained them over a period of five to six years to go back to their countries, to build endogenous capacity within those countries.

Now Jerry Holeiner (phonetic), who was in charge of this project, spoke with me back in 1997, and he said that of those 20 who were trained nine had died within two years of going back to Africa from HIV/AIDS infection. Now you talk about trying to build capacity within societies that are on this downward spiral. It just ratchets up the

requirements to a level that it may be, in some cases, such as Botswana, extremely, almost incredibly difficult, to address the question of endogenous capacity-building, which is why international intervention is so important.

And this goes back to the question raised about Wester governments. Have Western leaders been effective in a leadership role on this issue? No, they haven't been. Are we being effective right now, in terms of the money allocated to dealing with AIDS in Africa? Absolutely not. And I never meant to paint the picture that only African elites were responsible for this. No, we have been extremely deficient, and the departure of Ken Bernard (phonetic) from the NSC is a major blow to U.S. policy in this area, and we need someone on the NSC dealing with these issues, absolutely.

Following on your question, again, whether race and class are an issue in the Western response, I think Ambassador Holbrooke put it rather well when we discussed this at the Council on Foreign Relations in New York. He said explicitly that there is a subtext here to the lack of an effective response by the West to these issues. And I have encountered many people throughout my studies and lectures on this issue who say, "Well, why should we care about Africa?" The obvious subtext to that is racism, period.

And, let's see, finally, the question of is HIV/AIDS a threat to other countries? Absolutely, absolutely. I'm not going to

address the question of whether it's a direct threat to the U.S., because of course the rest of the panel's already done that. But with respect to India, we already know that one percent of the adult population is infected. We already know that mass transmission is occurring through heterosexual contact. This has been going on now for three years. In Nagaland and Manipur, infection rates of the adult population are over seven and eight percent within those respective territories.

India will, in all probability, follow a similar path as we've seen in Sub-Saharan Africa unless we get on this issue and unless the political elites there get on the issue very rapidly. And Tad's point about India being possibly destabilized by this and the fact that it is a nuclear power and there are enormous ethnic frictions underlying the social structure within the country there is enormous potential for destabilization in India.

But let's just not look at India. Russia has enormous problems on the horizon; Ukraine as well. And there are a lot of key states that could be undermined by the progression of the pandemic, and I think I'll leave it at that.

AMBASSADOR LYMAN: Millicent, you have the last word.

MS. OBASO: I think we must target behavior change. HIV/AIDS is going to overwhelm all of us. The world has become very small. When we talk about security to the U.S., no one lives in isolation.

American have businesses overseas where Africans are the employees. The impact of HIV/AIDS on the work force is colossal. Most companies now have to recruit three senior officers for one position. If you lose one, then the others will take over. I can name Zwaziland, I can name Kenya. They are already doing the same. So I call for partnerships and strategic alliances to address this problem.

How should we go about it? Africa needs capacity-building, but that doesn't mean that the African culture will not be taken into account. The Africans must provide the leadership. They must sit on the driver's seat and define how this whole process should move forward, and our partners from America, from the West should help us to build the capacity. There is the issue of corruption and accountability.

I think AIDS is emergency. When there is emergency we don't have to wait for the governments to have the money in their Treasury and pass it over. Why don't we use disaster approach to HIV/AIDS? When we had bomb blast people came in. Those who wanted to help came in. You form strategic alliances with the people who are credible and definitely want to help and want to move forward.

Women want to move forward. We have one lady here who was saying that they are committed to HIV/AIDS. Get women, get young people. They will bring new leadership. If our governments are not ready, they will join us, because we must do something today. And I thank you all for inviting me to come here and speak on behalf of the

Africans.

AMBASSADOR LYMAN: Thank you, Millicent.

(Applause.)

AMBASSADOR LYMAN: I want to thank the panel. I think it's been a fascinating discussion, and I want to thank all of you for being here and those who were on the webcast. Again, let's give a hand to the panel. I thought they were terrific.

(Applause.)

(Whereupon, the United States Institute of Peace Briefing on AIDS and Violent Conflict in Africa was concluded.)

END TRANSCRIPT

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