A New Crime Against Humanity:
HIV/AIDS and Security After the Rwandan Genocide

Brooke Stearns

Abstract: Since the end of the Cold War, the traditional security paradigm has been insufficient. Transnational threats and internal conflicts are gaining significance within the security framework, including HIV/AIDS. Rwanda is both an AIDS-torn and a war-torn society, and the atrocities of the Rwandan genocide have exacerbated the problems of HIV/AIDS in Africa and contributed to its risks to human, national and international security. This paper examines HIV/AIDS in Rwanda in the context of the 1994 genocide and as a threat to human, national and international security through a post-conflict lens. It considers the actions to address the problem and provide recommendations for future action.

Securitization of HIV/AIDS

HIV/AIDS is the greatest threat to mankind today, the greatest weapon of mass destruction on the earth.
– US Secretary of State Collin Powell¹

HIV/AIDS has increasingly been considered a security threat by the governments of developed countries (particularly the United States and the United Kingdom) and international organizations such as the United Nations. For example, the US National Intelligence Council’s identification of HIV/AIDS as a threat to US national security, and the human security of US citizens underscores that HIV/AIDS can be considered a security threat beyond the regions where it has the most direct impact:

New and reemerging infectious diseases will pose a rising global health threat and will complicate US and global security over the next 20 years. These diseases will endanger US

citizens at home and abroad, threaten US armed forces deployed overseas, and exacerbate social and political instability in key countries and regions in which the United States has significant interests.\(^2\)

In January 2000, the UN Security Council met to discuss the impact of AIDS on peace and security in Africa. This was the first time that the Security Council had discussed a health issue as a threat to peace and security. UN Secretary General Kofi Annan stated, “The impact of AIDS in that region [Southern Africa] is no less destructive than that of warfare itself. Indeed, by some measures it is far worse. Last year, AIDS killed about ten times more people in Africa than did armed conflict.” This meeting was an important step in expanding the definition of security to include a “human security” lens. Then US Vice President Al Gore remarked that, “We must understand that the old conception of global security -- with its focus almost solely on armies, ideologies, and geopolitics -- has to be enlarged. We need to show that we not only can contain aggression, prevent war, and mediate conflicts, but that we can work together to anticipate and respond to a new century with its new global imperatives.”\(^3\) In June 2001, the UN General Assembly Special Session on HIV/AIDS recognized that AIDS constitutes a global emergency that challenges human life, dignity and rights, and undermines socioeconomic development around the globe. The impacts occur at all levels of society – national, community, family and individual.\(^4\) In July 2001, the United Nations adopted Resolution 1308 which declares HIV/AIDS "a risk to stability and security.”\(^5\) Indeed, HIV/AIDS is having many of the same impacts on societies that conflict has. “AIDS-torn” countries resemble those who are “war-torn.” Both conflict and the HIV/AIDS epidemic pose serious threats to human security independently. The existence of both conflict and HIV/AIDS compounds the security threat.

This paper will examine HIV/AIDS in Rwanda in the context of the 1994 genocide and HIV/AIDS as a threat to human, national, and international security through a post-conflict lens. Finally, it will consider what actions are being taken to address the problem and provide recommendations for future action.

**Rwanda: War and AIDS-Torn**

*Conflict and HIV are entangled as twin evils. War is the instrument of AIDS and rape is an instrument of war. Conflict and the resulting movements of people, whether armed combatants, or refugees, fuel the epidemic.*

---


In 1994, Rwanda, which is reported to have one of the “older and more severe HIV epidemics,” became engulfed in what was arguably the fastest genocide in history – in just thirteen weeks, it made between 500,000 and 800,000 victims. Human Rights Watch estimates that at least half a million people were killed in the genocide, or three quarters of the Tutsi population. Even more shocking than the sheer magnitude of the violence and death was the brutal manner in which it was carried out – individuals armed with farm tools and machetes turning against their neighbors, friends and even relatives.

The impacts of the genocide on the Rwandan population are exacerbated by the country’s HIV/AIDS epidemic. Today, approximately 250,000 Rwandans are HIV positive. The estimated adult prevalence rate is 5.1 percent, and approximately 22,000 children are infected. Unofficial estimates have placed the HIV prevalence rate at closer to 25 percent. In 2003, AIDS caused an estimated 22,000 deaths.

The HIV prevalence rate appears to have plateaued; however, it is rising in rural areas, most likely due to “migration and acts of violence during the 1994 war.” The vast majority of Rwandans (approximately 95 percent) live in rural areas, where the HIV/AIDS epidemic neared the prevalence rates of urban centers in the years immediately following the genocide.

In turn, the atrocities of the Rwandan genocide have exacerbated the problems of HIV/AIDS in Africa and contributed to its risks to human, national and international security. HIV/AIDS has spread throughout the country. Prior to 1994, the prevalence rates were significantly higher in urban than rural areas. This is no longer the case. As the quotation from Peter Piot explains, there are two main causes of the increased rate of HIV/AIDS in rural areas – rape and human displacement. UNAIDS reported that in Kigali, the capital city, HIV prevalence among pregnant women from rural areas was 24 percent in 1995, “as a result of rape and displacement during the 1994 genocide.” While rape is a threat in many African countries and in most countries in conflict, it is particularly prevalent in situations of genocide as it not only “attacks the enemy” but also diminishes the “other’s” genetic pool in the case that the rape results in pregnancy. In the case of Rwanda, rape was even more widespread due to propaganda that fueled ethnic and gender stereotypes about Tutsi women, depicting them as sexual, beautiful, desirable women who were unobtainable for Hutu men.

---

10 Adult is defined by UNAIDS as between 15 and 49 years old.
11 Children are defined as between 0 and 15 years old.
15 United States Census Bureau, “HIV/AIDS Profile: Rwanda.”
16 UNAIDS, “Rwanda Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections.”
Rape is particularly effective in transmitting HIV as the violent nature of the sexual act can cause bleeding and tearing that provide a port of entry for the virus. In the Rwandan genocide, victims were often raped by numerous perpetrators, further increasing their risk to contract the virus. Some women were even subjected to sexual mutilation “of the vagina and pelvic area with machetes, knives, sticks, boiling water, and in one case, acid.” In addition to the personal trauma and physical pain it inflicted, this mutilation made women more vulnerable to HIV/AIDS by damaging the vaginal lining and facilitating the entry of the virus.

It is extremely difficult to obtain accurate statistics on the number of women who were raped during the genocide due to survivors’ shame, trauma, and/or desire to move beyond the events of 1994. The official number of rape cases recorded by the Ministry for the Family and the Promotion of Women is 15,700. Mr. René Degni-Ségui, Special Rapporteur of the Commission on Human Rights, identified the primary reasons why the official figure underestimates the number of cases. First, the official figure only considers cases limited to the Rwandan territory during the actual conflict. It does not take into account rape “which took place after the hostilities in the refugee camps outside the country, particularly of women carried off to the camps as ‘loot’ and handed over to their tormentors.” Second, as mentioned above, rape survivors are often reluctant to confess that they were raped.

Another method to determine the number of rape cases is based on the number of pregnancies resulting from rape. One statistical model indicates that 100 cases of rape result in one pregnancy. Between 2,000 and 5,000 pregnancies are estimated to have resulted from rape in Rwanda. Applying the statistical analysis to Rwanda, the estimated incidences of rape are between 200,000 and 500,000.

Survivor testimonies confirm that rape was widespread. In addition to the individual and gang rape practices described above, many women were also subjected to sexual slavery by either a militia group or an individual member of the militia and forced to have sex under the threat of death if they refused. “Forced marriages,” as this form of sexual slavery is often called in Rwanda, reportedly lasted for anywhere from a few days to the duration of the genocide, and in some cases longer.

Dr. Odette Nyiramilimo of Le Bon Samaritain Clinic in Kigali estimated that the clinic received two rape cases a day following the genocide. Most of the survivors had vaginal infections and some tested positive for HIV. Two thousands members of the Rwandan NGO Association for Widows of the April Genocide (AVEGA) opted for voluntary HIV testing. Eighty percent tested positive. AVEGA found that most infections occurred as a result of rape and sexual violence during the genocide. African Rights conducted a series of interviews with

19 Ibid.
21 This large number "enfants mauvais souvenir" (children of bad memories) and family and societal divisions between individuals who reject these children and those who want to raise them. This particular threat to familial and community solidarity poses a threat to human security as well, although it is outside of the scope of this paper.
23 Ibid.
24 Ibid.
Rape survivors – the youngest survivor was six years old at the time of the rape and the oldest was 71 years old.\textsuperscript{26}

The true horror of the combination of conflict, rape and HIV/AIDS cannot be understood through statistics and theoretical analysis, however. To truly grasp the impact of these combined factors, it is important to consider the affected individuals. Human Rights Watch and the FIDH conducted a series of interviews with rape survivors including Maria, whose story is below.\textsuperscript{27}

While women are the primary targets of rape, it is also important to remember that men can also be victims. African Rights interviewed numerous Rwandan rape survivors including Paul who was forced by Interahamwe (the Rwandan militia responsible for a majority of the genocidal killings) to have sex with a woman they suspected to be HIV positive. He tells his story is below.\textsuperscript{28}

\begin{quote}
\underline{Maria} is a young Hutu woman who was a student in Gikongoro before the genocide. Two years later, she is still so traumatized from her experience that she cannot look up when recounting what happened to her. According to the medical personnel who treat her, Maria continues to suffer hallucinations and frequently has weeping fits. She does not like to see or to be near men. On April 15, 1994, the Interahamwe came and killed her grandparents, her two aunts and her brother. As she was fleeing, she was caught by five militia who raped her.

Following the rape, eighteen-year-old Maria's vagina was severely slashed with knives by the militia who shouted "we are going to kill you so you will want death. When the RPF comes, there will be no one left alive." She knew one of the men. The next day, Maria was found by a Red Cross team who transported her to a hospital. The rape and mutilation had resulted in extensive damage to her vaginal area. She was taken to Kigali Central Hospital where a doctor who remained on duty performed surgery, amid the pandemonium caused by the killings. She was hemorrhaging because the mutilation had destroyed the wall between her vagina and rectum. She stayed in the hospital until July 1994 when the RPF came. In January 1995, Maria was sent to Belgium for reconstructive surgery. At that time, the doctors who treated Maria discovered that an infection had spread to her uterus and a hysterectomy had to be performed immediately. The doctors also found that the rectal/vaginal wall and the anal sphincter had been irreparably damaged. They attempted as best as possible to perform reconstructive surgery, but Maria will never be able to be sexually active for the rest of her life. The doctors also discovered that she is carrying the AIDS virus.

Rwandans who fled the country faced risks as well. A second factor that contributed to HIV transmission during (and immediately after) the genocide and its spread to rural areas is refugee camps, which provide an environment particularly conducive to the spread of HIV/AIDS.\textsuperscript{29} For example, individuals have little opportunities to earn money and this desperation can lead women and children in particular to resort to sexual acts in exchange for food, clothing, money or other necessary or personal items. In addition, the particularly cramped quarters facilitate multiple sexual partners, another factor that increases the risk of HIV infection. Young girls are particularly vulnerable. Men in the camps do not have outlets for their
\end{quote}


\textsuperscript{28} Binaifer Nowrojee, “Shattered Lives: Sexual Violence During the Rwandan Genocide and Its Aftermath.”

frustrations and become more prone to commit acts of violence and abuse, particularly when alcohol is involved.  

UNAIDS and UNHCR conducted a survey at two Rwandan refugee camps in Tanzania to analyze HIV/AIDS in these camps. One of their primary conclusions was that prevalence rates could rise substantially due to the mix of refugee populations. At that time, there were much higher prevalence rates of HIV infection among urban Rwandans (around 35 percent) than among rural Rwandans (5 percent) and the host populations of Hgara District in Tanzania (7 percent). Surveys among pregnant women indicated high prevalence rates of Sexually Transmitted Illnesses (STIs); 5 to 10 percent for cervical infections and up to 40 percent for vaginal infections. STIs increase the risk of HIV transmission by providing a port of entry for the virus.

Clearly the conflict in Rwanda contributed to the spread of HIV/AIDS through rape and the displacement of Rwandans. This has created a particular context in which HIV/AIDS poses a threat to the human security of Rwandans on a personal and national level, as well as a potential threat to international security.

**HIV/AIDS and Human Security in Rwanda**

The direct outcomes of the spread of HIV in conflict and post conflict situations are psychological and social trauma, illness and death. As this epidemic increases, the ensuing adverse impact on social relations and productive capacity leads to destitution, insecurity, lawlessness, political unrest, violence, and even conflict. Elizabeth Reid, UNDP

On the most basic level, HIV/AIDS threatens human security by increasing mortality rates and reducing life expectancy. AIDS-related illnesses are one of the three leading causes of death in Rwanda. By 2005, the crude death rate will be 40 percent higher due to AIDS than it was in 1990. As in many other parts of Africa, HIV/AIDS has contributed to a decline in population growth in Rwanda: the annual growth rate from 1990 to 1998 was negative 0.7 percent. AIDS has also had a significant impact on life expectancy in Rwanda. In 2002, life expectancy was 39.5 years compared to an estimated 51.5 years without HIV/AIDS, or a loss of 12 years. Many Rwandans either do not have access to or money for antiretroviral drugs.

According to Survivors Fund (SURF), approximately 8,000 female rape survivors are known to be HIV-positive but only 22 are receiving medication. Ironically, individuals who are receiving

---


32 It is also possible to address community security; however, this area can be incorporated into both human and national security.


35 UNAIDS, “National Response Brief,”


41
free antiretroviral medications from foreign assistance are those accused of genocide at the UN Tribunal’s detention center in Arusha, Tanzania, and those who are convicted will receive full medical care in serving out their prison terms.  

Post-conflict Rwanda also faces the potential of an increasing rate of HIV/AIDS transmission due to psychological impacts of the genocide. For example, upon conducting an AIDS focus group with women, Human Rights Watch facilitators discovered that rates of sexual activity outside of marriage appeared to be notably higher among women since the genocide, in large part because women were looking for "affection and protection." Both conflict and HIV/AIDS can create a sense of recklessness and a disregard for the fear of death that could promote risky behavior. Thus, there is potential that the HIV/AIDS crisis could worsen due to the emotional impact that the genocide has had on many of the survivors.

While the emotional or psychological impacts on individuals are hard to measure the economic costs are not. Households with an HIV positive member have significantly higher medical needs and expenses. The annual per capita use of outpatient services in Rwanda was 11 visits per year for people living with HIV (PLWH) versus 0.3 in the general population and annual per capita health expenditures were $63 in households with HIV/AIDS patients versus $3 for households on average— that is more than 20 times more. Less than 30 percent of Rwandan households were able to meet the costs of health care from their own resources. Often HIV/AIDS results in the loss of the primary breadwinner’s salary as s/he becomes too sick to work, or eventually is killed by the disease. A study in three countries, including Rwanda, has calculated that AIDS will not only reverse efforts to reduce poverty, but will increase the percentage of people living in extreme poverty (from 45 percent in 2000 to 51 percent in 2015).

The economic strain on the households whose primary breadwinners either becoming too ill to work or are killed by HIV/AIDS also has a significant impact on the children. In addition to the psychological trauma of caring for or losing a parent, the human security of children is also threatened by HIV/AIDS. Often they are forced to drop out of school to take care of their ill parents or find jobs to meet the economic void caused by ill or deceased parents.

In addition, many children whose fathers are imprisoned on charges of participating in the genocide not only suffer from the absence of their father, but are also relied upon for their incarcerated parent’s survival. In addition to being expected to contribute to providing food or income for the family (and thus unable to attend school), these children also suffer from the stigma of being the child of an accused genocidaire.

UNICEF estimates that 67 percent of primary school-age boys and 68 percent of girls were enrolled in school in 2001. These numbers provide a deceptively positive impression of the situation of education in Rwanda, however, as some students will be expelled due to an inability

---


to pay school fees and others, particularly girls, will not pass their courses due to excessive demands on their time outside of school. The 1997-1998 primary school completion rate was only 23 percent, and the number of Rwandan children who enroll in secondary school is approximately 6 percent. In addition, the quality of primary education is often poor, with less than half the teachers possessing basic qualifications.42

This situation is worsened by the distorted age distribution of the Rwandan society. There were approximately 160,000 AIDS orphans in Rwanda in 2003.43 An additional 340,000 Rwandan children were orphaned from a cause other than HIV/AIDS, primarily the genocide.44

In general, HIV/AIDS creates a situation in which there are large numbers of orphans and elderly people, placing the burden of caring for children on their grandparents or other older relatives, neighbors or friends. In Rwanda, the genocide also significantly reduced the number of middle age members of society. Thus, the population distribution by age is not only distorted in the middle, productive years (as is typical in countries with high rates of HIV/AIDS) but also both in the earlier and later years. The largest percentage of the Rwandan population is four years or younger.45

This distorted age distribution in the population in Rwanda could be furthered as “public opinion is not very favorable to family planning, given the psychological trauma resulting from large scale loss of human life, genocide and massacres.”46

While HIV/AIDS is virtually decimating an entire generation of parental age, the Rwandan genocide has seriously reduced the overall adult population. Thus thousands of Rwandan children have neither parents nor grandparents to rely on, and are forced to live with other relatives, in foster care or on their own. Without guidance from older generations, children are more prone to prostitution, drug abuse, crime, or becoming child soldiers. Orphans are at a higher risk of contracting HIV/AIDS because they are often impoverished and/or malnourished. In addition, they suffer psychologically and mentally as they are denied “normal” childhoods and often forced to “grow-up” prematurely. A report produced by World Vision and UNICEF found that 95 percent of child-headed households do not have access to education or healthcare. Also, most live in sub-standard housing.47

The negative impacts of being orphaned are compounded for children who experienced the Rwandan genocide. In addition to not having their basic needs met, many Rwandan children witnessed genocidal atrocities, including the murder of family members and escaping their own deaths.48 While the Rwandan government’s policy of “one family, one child” has resulted in many children being placed with relatives or in foster homes, these situations are not always ideal. The Rwandan News Agency reported that some children in foster homes are exploited,

42 Human Rights Watch, “Lasting Wounds: Consequences of Genocide and War on Rwanda’s Children.”
48 Human Rights Watch, “Lasting Wounds: Consequences of Genocide and War on Rwanda’s Children.”
tortured and discriminated against by the very people who are supposed to care for them. Often the children are treated as domestic labor and the girls are highly vulnerable to physical or sexual abuse, and thus contracting HIV/AIDS. This mistreatment has led to some children choosing to be on their own rather than in the care of an adult who may take advantage of them.

A study by ACORD estimated that as many as 227,500 Rwandan households (equivalent to 13 percent) are headed by children. Human Rights Watch identifies that females in this situation are likely to trade sex for school fees or otherwise be sexually exploited. Thus, they are putting themselves at risk of contracting HIV/AIDS and perpetuating this vicious cycle.

The ongoing HIV/AIDS pandemic and the legacy of the genocide clearly have a serious impact on the human security of Rwandans. As individual Rwandans are insecure, a breakdown in community and weakening of national security are also likely.

HIV/AIDS and National Security in Rwanda

The national security dimension of the virus is plain: it can undermine economic growth, exacerbate social tensions, diminish military preparedness, create huge social welfare costs, and further weaken already beleaguered states. And the virus respects no border.

- George Tenet, Former Director of the CIA

It is extremely difficult to study or quantify the social and psychological impacts of the HIV/AIDS epidemic and the genocide on Rwandan society; however, it is evident that the task of establishing a solid sense of community built on trust is a long process after the indescribable atrocities committed by friends, relatives and neighbors against each other. Efforts such as the gacaca courts and the elimination of ethnic identity cards are steps along the path of rebuilding Rwanda; however, testimonies of survivors and accused alike show that there is still much work to be done. The threat that HIV/AIDS poses to national security may serve as an obstacle for the very reconciliation and rebirth that Rwanda is working towards achieving. A highly pervasive HIV/AIDS epidemic such as the one found in Rwanda, can attack the very foundations of a nation on the individual, familial, community, institutional and security force levels. In this context, broader security consequences are likely for not only the nation itself, but also its neighbors, trading partners and allies.

Having addressed the concept of human security (and thus the impacts on the family and community), it is important to examine the economic and defense threats HIV/AIDS poses to national security.

---

50 Human Rights Watch, “Lasting Wounds: Consequences of Genocide and War on Rwanda’s Children.”
51 Agency for Cooperation and Research in Development, Research into the Living Conditions of Children who are Heads of Households in Rwanda, March 2001.
52 Human Rights Watch, “Lasting Wounds: Consequences of Genocide and War on Rwanda’s Children.”
54 The gacaca courts represent a form of community justice that strives to promote community healing with time and cost efficient means of punishing genocide perpetrators. The gacaca courts involve victims and witnesses in interactive court proceedings presided over by citizens who were elected by their peers to serve as judges.
First, HIV/AIDS poses a serious threat to the labor force. Rwandan President Paul Kagame identified that HIV/AIDS will continue to erode Rwanda’s human capital. HIV/AIDS disproportionately impacts youth, women and people in their productive years. This further destroys Rwanda’s human capital base, which was already severely impacted by the genocide.\textsuperscript{56}

While specific data was not available for Rwanda, according to SAfAIDS, “deaths from AIDS typically peak in women in their 20s and in men in their late 30s and early 40s.\textsuperscript{57} The fact that HIV/AIDS impacts most significantly members of society in their productive years, has devastating results that are not experienced by other diseases which spread more rapidly among old and infirm members of society.

The decrease in skilled, trained, or experienced professionals could be exacerbated in the future as the current generation of orphaned children which often lacks education (see above) becomes the resource pool for these jobs. Thus, Rwanda faces a potential human capital crisis than is even greater than what it is currently experiencing. Frighteningly, as the children who are not currently HIV positive become sexually active, the risk of even higher HIV prevalence rates increases. Without significant intervention, the AIDS crisis in Rwanda could rapidly worsen.

In the field of public health, the impacts of HIV/AIDS are two-fold. HIV/AIDS could seriously undermine the Rwandan government’s ability to provide basic services to its population at the same time that demand for these services, particularly in the field of public health, is increasing. In the late 1990s, there was only one doctor for every 20,000 people in Rwanda.\textsuperscript{58}

The impacts on human capital also have an economic cost. Whether infected individuals work in the private or public sector, HIV/AIDS can result in absenteeism due to poor health. For instance, a person with HIV/AIDS can be absent up to 50 percent of their working days in his/her final years.\textsuperscript{59} Debilitating illness or death can lead to higher rates of turnover, which involve additional costs and reduced productivity (due to a lack of experience) and higher recruitment and training costs. High rates of turnover are particularly detrimental to sectors such as government ministries and big businesses that depend on staff with professional skills, years of experience and extensive networks of contacts.\textsuperscript{60}

In addition, businesses and the government may also face higher expenses in areas such as health care or insurance, funeral costs, or retirement plans. Faced with decreased productivity and rising costs, businesses’ ability to invest is diminished. These higher costs associated with conducting business in Rwanda are compounded by the unstable post-conflict environment and potentially serve as serious deterrents for foreign direct investment.

Furthermore, the loss of adults both from the genocide and HIV/AIDS weakens Rwanda’s tax base, thus reducing the government’s ability to finance public expenditure. The increasing costs in the field of health also divert necessary resources away from other important


\textsuperscript{59} Ibid.

\textsuperscript{60} Alex de Waal, “How Will HIV/AIDS Transform African Governance?,” \textit{African Affairs} (2003), vol 102, pg. 12.
sectors such as education and police forces.\textsuperscript{61} By the mid-1990s, 66 percent of Rwanda’s health budget was spent on treating people with HIV/AIDS.\textsuperscript{62}

These economic impacts will only worsen the underdevelopment of Rwanda, which had a Human Development Index rank of 158 in 2003.\textsuperscript{63} This economic burden threatens to further weaken the Rwandan state, which is already tasked with the challenge of rebuilding the country after the genocide. According to research conducted by the US Central Intelligence Agency, infant mortality levels are one of the best variables for predicting state failure.\textsuperscript{64} UNAIDS believes that HIV/AIDS will further raise Rwanda’s already high infant mortality rate of 96 deaths per 1,000 live births.\textsuperscript{65}

In addition to a loss of human capital from genocide or AIDS-related incapacity or death, a large portion of the young, adult Rwandan population is currently being detained as they await their trial for crimes committed during the conflict. During the genocide, a significant portion of the civilian population was mobilized to participate in the killings. In theory, states have a monopoly on the legitimate use of force, and as such, traditional conflicts were fought primarily between armies. The high level of civilian involvement in the Rwandan conflict – not only as victims but also as perpetrators of the violence – has created a serious strain on Rwanda’s judicial system and further diminished the potential labor supply\textsuperscript{66}. There are currently approximately 80,000 Rwandans awaiting trial for genocide-related crimes. The government estimates that it could take 100 years to try everyone.\textsuperscript{67}

Thus HIV/AIDS exacerbates the diminished labor force that is a legacy of the Rwandan genocide (both in terms of lost lives and those in the justice system) and threatens the future labor force as Rwandans’ children are at extremely high risk for contracting HIV if they are not already seropositive.

In addition, HIV/AIDS further threatens Rwanda’s national security by diminishing its military forces. UNAIDS conservatively estimates that militaries tend to have two to five percent higher HIV infection rates than their civilian counterparts, and that during conflict, members of the military can be 50 times as likely to contract sexually transmitted diseases, including HIV, as their civilian counterparts.\textsuperscript{68} The Rwandan military does not allow quantitative data collection, but according to Human Rights Watch an estimated 35 percent of the Rwandan army was HIV positive before the genocide. This is 10 percent higher than estimates for the general population.\textsuperscript{69} Estimates on the HIV prevalence rate in the Rwandan

\begin{thebibliography}{9}
\bibitem{65} UNDP, “Human Development Indicators 2003: Rwanda.”
\bibitem{66} The role of the Gacaca Courts in the judicial process is an attempt to ease the burden on traditional courts and bring about reconciliation in Rwanda. While this is an extremely interesting aspect of human security in Rwanda, it falls outside the domains of this paper.
\bibitem{67} CNN, “Rwandan Genocide 10 Years Later,” Aired on Insight, 6 April 2004 at 11 pm, \url{http://www.cnn.com/TRANSCRIPTS/0404/06/i_ins.00.html}, (10 April 2004).
\bibitem{68} UNAIDS, “AIDS and the Military.”
\bibitem{69} Binaifer Nowrojee, “Shattered Lives: Sexual Violence During the Rwandan Genocide and Its Aftermath.”
\end{thebibliography}
military were as high as 65 percent in 1994. Furthermore, UNDP consultant John Gordon has reported that very few officers were left alive due to high HIV infection rates before the 1994 genocide. In 1999, the Rwandan Ministry of Defense declared HIV/AIDS a security problem due to its impacts on the national security forces. Members of the military are particularly prone to contracting HIV/AIDS given their demographic make-up (generally young men, often from poorer socioeconomic backgrounds) and the fact that they frequently must spend large periods of time away from home. Nigerian Colonel Wale Egbeunmi has commented that, “The deadly disease is deadlier than war. HIV/AIDS impairs military readiness… Valuable experience and skills will be lost, shortage of officers and troops may result, and less experienced personnel may have to take on more responsibilities.” The International Crisis Group also identifies that anecdotal evidence from conflicts such as Congo that indicates that soldiers engage in higher risk and more criminal behaviors due to the high probability of early death.

In addition, identity entrepreneurs or rebel leaders have a large pool of easy-to-recruit militia members. Rwanda’s orphan population is at high risk for joining or being abducted by a militia who could offer food, shelter, and a sense of identity. Randy Cheek of the US National Defense University describes that, “the uneducated, malnourished, and purposeless mass of children represents a potential army in search of a leader.” Given the instability of the Great Lakes Region, and particularly neighboring Burundi, there is a significant risk that Rwanda’s orphans could go from victims to perpetrators of violence.

According to Paul Collier, post-conflict societies are particularly prone to experience another conflict. Collier found that in the first decade after conflict, a country’s risk of conflict is double what pre-conflict risk factors would predict. Rwanda recently passed this milestone under intensive attention of the international community on peace building and bringing about justice through the UN International Tribunal for Crimes in Rwanda.

**HIV/AIDS in Rwanda and International Security**

AIDS has had unquestionably severe effects on the security of individuals, economies, institutions and militaries within states. But the disease also has the potential to strike at the security of the international system – and at the interests of states more removed from the epidemic.

— International Crisis Group

By weakening the Rwandan state and providing potential militia soldiers, HIV/AIDS can also threaten regional and international security. In the Great Lakes Region, which is ripe for further conflict given the instability of the majority of the countries in the region (particularly Burundi and the Democratic Republic of Congo, and Uganda to a lesser degree), Rwanda’s
weakened state may make it more vulnerable to foreign aggression or serve as a base for other rebels groups, including those from Uganda. Given that many of the other states in the region face similar threats; however, HIV/AIDS may not heighten the threat to regional and international security in this already insecure region.

Another population group that Rwanda’s post-conflict HIV/AIDS situation may threaten is international peacekeeping troops. Former US Ambassador to the UN, Richard Holbrooke, remarked that, “AIDS is being spread, among other people, by peacekeepers.” The National Intelligence Council ascertains that, “US military personnel deployed at NATO and US bases overseas, will be at low-to-moderate risk. At highest risk will be US military forces deployed in support of humanitarian and peacekeeping operations in developing countries.”

Similar to national militaries, peacekeeping troops are often stationed far from home and particularly susceptible to risky sexual behaviors such as having intercourse with sex workers. Dr. Christen Halle, Head of the UN Department of Peacekeeping Operations describes how military culture “tends to exaggerate male behaviour” as young men in their sexual prime are removed from family and community constraints that might otherwise regulate their sense of risk-taking and invincibility. As peacekeeping troops move around the world, they are not only being infected, they are also spreading infection. Elizabeth Reid identifies several compounding factors including one women having sex with multiple soldiers, soldiers infecting others through seminal fluids that may remain in the woman’s vaginal tract and the rotation of multiple companies of troops into the same area.

In addition to the threat it poses to international peacekeeping and foreign military forces, the underdevelopment due in part to HIV/AIDS can threaten the international community by diminishing security in more “human” ways as well. While the underdevelopment and human security issues in Rwanda could impact the region and the international community through migration, a high need for foreign assistance and a weakening of its ability to be a viable economic partner, Rwanda’s relatively low international strategic importance minimizes these threats. Much has been written on the impact of HIV/AIDS in the Southern Africa region, and particularly South Africa, which plays an important role in stabilizing the region. The arguments for Rwanda’s threat to international security are more general – regardless of the relative “strategic importance” of a country, the greater the inequality in the world, the farther we are from a peaceful global community. Furthermore, the high risk of HIV infection among international peacekeepers and foreign militaries in the region arguably threaten to spread HIV/AIDS and weaken these forces to maintain or uphold stability in pre-conflict, conflict or post-conflict societies.

Conclusion: The Way Forward

People are coming more often for preventive care, which decreases further disease complications. The mutuelles unify the population, creating an assembly that promises a better quality of life.

– Sister Yvette Vincent, Director of the Bungwe Health Center

78 Paul Collier, “Economic Causes of Civil Conflict and Their Implications for Policy.”
80 Michael Fleshman, “AIDS Prevention in the Ranks.”
81 Elizabeth Reid, “Challenge of the HIV Epidemic.”
82 This research was conducted in 2004. As a result, it does not reflect recent developments in HIV/AIDS activities in Rwanda including the US President’s Emergency Plan for AIDS Relief, under which Rwanda is a focus country.
In recognition of the potentially devastating impact that HIV/AIDS could have on human, national and international security, the Rwandan government released its Strategic Plan for HIV/AIDS in 2002. The five-year plan addresses prevention, mitigation, and care and treatment. The National Commission Against AIDS and Treatment and Research AIDS Center, which are based in the Ministry of Health, are responsible for overseeing the implementation of the strategy. The acknowledgement of the impact of HIV/AIDS and dedication to prevent its spread and mitigate the impacts of this deadly disease are an essential first step in combating HIV/AIDS, as is seen in the progress made by countries such as Uganda. It is important to assess the effectiveness of this strategy and make necessary adjustments when developing a continuation of the strategy in 2006. In addition, the Rwandan First Lady is actively supporting the Protection and Care of Families Against HIV/AIDS initiative and Rwanda is an important partner in the Alliance of First Ladies Against HIV/AIDS.

In addition to the efforts by the Rwandan government, the United Nations is actively involved in the field with ten UN agencies implementing HIV/AIDS-related projects. These agencies, as well as co-sponsoring agencies, which include the Food and Agriculture Association, the World Health Association, the Economic Commission for Africa, and the World Food Program, meet through a UNDAF/UNAIDS Theme Group on HIV/AIDS and Reproductive Health. The coordination of these agencies’ strategies is essential in order to effectively and efficiently counter the HIV/AIDS pandemic in Rwanda, and should incorporate activities of the Rwandan government, non-governmental organizations, and civil society organizations working in the field. The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria requested nearly $90 million in its efforts to fight against HIV/AIDS in Rwanda. In general, the Global Fund faces a financial crisis with inadequate support from governments. Still, it represents an opportunity to truly coordinate a holistic campaign to combat HIV/AIDS and should be supported to ensure its success, and thus, our success in addressing the problem of HIV/AIDS in Rwanda and across the globe.

There are also more community-focused approaches such as USAID-supported pre-payment health insurance schemes that not only address the health needs of people living with HIV/AIDS but also work to build social safety nets and a greater sense of community. In this particular program, Rwandans pool their resources in order to receive health care services. Similar community-based programs exist and can be further developed in other areas such as micro-credit loans to enable Rwandans to participate in small, income-generation activities and build their own micro-enterprise. This type of social safety network can be developed to provide for other aspects of human development such as the education of Rwandan children.

85 UNAIDS, “National Response Brief: Rwanda.”
86 UNAIDS, “National Response Brief: Rwanda.”
87 Ibid.
In addition to a holistic strategy to combat HIV/AIDS, there are several groups that require special attention in order to effectively mitigate the human, national, and international security threats of HIV/AIDS in post-conflict Rwanda:

Victims of Rape: Support is needed for organizations such as the Association for Widows of the April Genocide to ensure that rape survivors have access to HIV testing and counseling as well as general support to enable them to cope with their trauma as well as find safe and productive ways of continuing their lives.

Populations in Refugee Camps: AIDS intervention such as that in the Benaco refugee camp in Northwestern Tanzania, which is the first large-scale HIV/AIDS intervention undertaken in a refugee population,\(^90\) must be expanded to all refugee camps. These programs must incorporate prevention education, condom distribution, testing, and care for those who are already infected.

Orphans: While the government’s “one family, one child” program effectively places children in a home environment, these placements must be screened and monitored to ensure that the child is protected. In addition, government policies that provide funding for orphans to attend school must be restructured to effectively administer these benefits and ensure that children whose parents are currently imprisoned are included as well as those who lost their parents during the genocide. Safe centers should be established for orphans who are currently taking care of themselves.

Members of the Military and International Peacekeeping Operations: Training about HIV/AIDS awareness and prevention based on the existing UN Department of Peacekeeping Operations’ booklet on HIV/AIDS\(^91\) should be incorporated as an integral part of UN Peacekeeping training. The increased condom distribution “not just in the medical tent, but wherever soldiers congregate -- in the bathrooms, dining halls, bars and recreational facilities” that is being implemented in the UN Peacekeeping Operations\(^92\) should be replicated among national militaries.

Although many positive steps have been taking to address the HIV/AIDS problem in Rwanda since the end of the genocide, there remains much work to be done. Cultural and contextual adaptations are necessary; however, an effective strategy to combat HIV/AIDS cannot be limited to one country or sub-population. The HIV/AIDS pandemic is not restricted by national boundaries and threatens the security of all citizens of the world. Significant progress has been made in the global fight against HIV/AIDS and further coordinated efforts are necessary to work towards a world in which global citizens are free from fear and want.

---


\(^{91}\) Michael Fleshman, “AIDS Prevention in the Ranks.”

\(^{92}\) Ibid.