

An immaculate construction? The securitisation of HIV/AIDS¹

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This paper follows a previous piece of research which was part of a project examining the international governance of the HIV/AIDS pandemic.² My original article examined the role of the UN Security Council in presenting HIV/AIDS as a security issue. On 10 January 2000, symbolically at its first meeting of the new millennium, the UNSC met to discuss the 'impact of AIDS on peace and security'.³ Six months later it passed Resolution 1308, stressing that the HIV/AIDS pandemic, if unchecked, 'may pose a risk to stability and security', that its spread was 'exacerbated by conditions of violence and insecurity' and expressing concerns over the risks to peacekeepers.⁴ The UN and its associated agencies have been amongst the most important players globally in increasing AIDS awareness. But the Security Council in

¹ This article draws on a number of confidential interviews and discussions held from late 2002 through to the summer of 2005. I would like to thank all those involved.

² The collection is to be published as a special issue of *International Affairs* in 2006 under the guest editorship of Nana Poku. The article from which this papers finds its origins is unimaginatively entitled 'HIV/AIDS and security'.

³ UN Security Council [UNSC] Press Release SC/6781, 10 January 2000 available at <http://www.un.org/News/Press/docs/2000/20000110.sc6781.doc.html>

⁴ UNSC Resolution [UNSCR] 1308, July 2000, p.2, available at http://www.un.org/Docs/sc/unsc_resolutions.html. HIV/AIDS has been discussed subsequently by the UNSC on a number of occasions, and has been the subject of a special session of the General Assembly.

2000 moved HIV/AIDS beyond being solely a concern for public health and international development. My article concluded that the UNSC was critical in developing the argument that HIV/AIDS was a security issue not only by providing a high profile platform in which the case could be presented but in articulating (albeit somewhat sketchily) a series of reasons to justify this assertion. The UNSC debate has become a lodestone in the subsequent literature on HIV/AIDS and security; moreover the debate has centred around the arguments presented to the UNSC in January 2000 and in UNSCR 1308. However, my article also concluded that the UNSC's case which so effectively established the parameters of the subsequent debate was neither fully supported by the empirical evidence, nor were the causal linkages between HIV/AIDS and security convincing.

This paper begins to make the next move – that what occurred was not a rational international response to a global security issue, but a case of the UNSC successfully constructing HIV/AIDS as a security issue. In so doing it uses the framework developed by the ‘Copenhagen School’ as an initial attempt to explain how this occurred. However, the reasons *why* the UNSC securitised HIV/AIDS remain under-explored. Clearly some of the UNSC's concern was on the impact of HIV/AIDS on peacekeeping missions (and indeed on peacekeepers as a vector for the spread of the disease). This was especially clear in UNSCR 1308. There may also have been genuine concern that HIV/AIDS presented a threat to international peace and stability. But there is more than a hint from interview and other unpublished sources that the securitisation of HIV/AIDS was a deliberate strategy to force action on the disease from the international community, and especially the West.⁵ By the end of the 1990s it was clear that little progress had been made in stemming the spread of HIV/AIDS. The number of people living with HIV/AIDS (PLWHA) was increasing. The overwhelming majority of these were in their 20s and 30s – usually the most productive period of people's lives. It was clear that large parts of sub-Saharan Africa faced a range of public health, social and economic problems of quite awesome severity. And there were ominous signs that the disease could soon reach epidemic proportions in the former Soviet Union, the Indian sub-continent, China and other parts of Asia. Despite a decade or more of international action therefore, the situation

⁵ The visit of Richard Holbrooke, US ambassador to the UN, to southern Africa in December 1999 appears to have been particularly important here. Holbrooke appears to have been disturbed by seeing first hand the impact of the disease and the failure of the international community to have any substantive impact in ameliorating conditions.

had got worse not better and could get a great deal worse in the years to come. Something different had to be done to force greater international action, and the best way of grabbing the attention of key players in the West (including the G8) was to convince them that this was now a security issue.

This paper does not attempt to fully develop this latter argument – it still remains speculative though intriguing. Rather the paper is the next step on this journey. What it attempts to do is two things. First, it argues that the case made by the UNSC for HIV/AIDS being an international security issue is not convincing. HIV/AIDS is not demonstrably a clear and present danger to international peace and stability. Second, it argues that the securitisation of HIV/AIDS fits the framework presented by the Copenhagen School. If both of these moves hold true, then the ground is set for the next step: that the securitisation of HIV/AIDS was a deliberate strategy to secure greater attention to the human, social and economic costs of the disease.

PART ONE: THE UNSC AND HIV/AIDS

This section of the paper focuses on the four claims made by the UNSC, especially in Resolution 1308, which constitute its case that HIV/AIDS is a security threat: that the disease poses a risk to stability, to national security and to peacekeepers, and that the spread of HIV/AIDS is exacerbated by conditions of violence.⁶

HIV/AIDS and stability

In his address to the Security Council's January 2000 session on HIV/AIDS, Kofi Annan argued that 'AIDS is causing socio-economic crises which in turn threaten political stability.'⁷ In particular the effects of the disease on economies and on governance have been consistently highlighted by the UN and other commentators as potentially destabilising. The significance of such instability might be felt beyond the confines of a failing state: the previous decade had been marked by examples of failing states creating problems for international security, while in the wake of 9/11 the link between failing states and international terrorism was drawn, notably by the Bush administration in the United States.⁸ The potential economic impact of

⁶ Although other arguments have been made – notably on grounds of human security and gender – the claims made by Resolution 1308 have been the most prominent in the securitising process.

⁷ UNSC Press Release SC/6781, p.1. See also Lee-Nah Hsu, *HIV subverts National Security* Report from UNDP South-East Asia HIV and Development Project, August 2001, p.5.

⁸ The White House, *National Security Strategy of the United States*, p.9. Available at <http://www.whitehouse.gov/nsc/nss.html>. See also Gayle Smith, 'The global challenge of HIV/AIDS', presentation to International Film and Television Exchange and Congressional Human Rights Caucus,

HIV/AIDS includes: lost productivity due to worker illness, absenteeism and low morale; the loss of skilled labour, with their replacements perhaps less well educated and poorly trained and motivated; reduced business investment as revenues shrink or are diverted into AIDS-related healthcare schemes; reduced external investment as health costs increase and productivity falls; the flight of capital outside AIDS-afflicted countries into more productive regions; and reduced savings as money is spent on healthcare. HIV/AIDS poses particularly severe economic problems because of the cumulative effects of the disease over a number of years; because its full effects are postponed as those infected only become ill gradually but then pose an increasing economic burden on society; and because of its disproportionate impact upon workers in what should be the most productive period of their lives. In particular some of the key industries for African states – including mining, transport and agriculture – appear to be particularly susceptible to HIV/AIDS.⁹ Estimates of the impact commonly range from significant reductions in economic growth over time, to reductions in GDP. One USAID study suggests that in certain African states where HIV prevalence rates were 20% or higher, GDP declined by 2.6%.¹⁰ Such economic decline may increase income inequalities and poverty, exacerbating or creating social and political unrest.

A variety of social and political problems arising from high HIV prevalence are also commonly identified as potentially destabilising. The unusually high prevalence of HIV amongst skilled professionals, including civil servants, teachers, police and health workers, may threaten the institutions that make a state run effectively. This may undermine confidence not just in a government but in the state itself.¹¹ As teachers

20 April 2005, p.3, available at <http://www.americanprogress.org>.

⁹ UN Secretariat, *The Impact of AIDS*, Report by the Population Division, Department of Economic and Social Affairs, 2 September 2003 (New York: United Nations, 2003), pp.xiii and xiv and chapters 4 and 8; International Crisis Group (ICG), *HIV/AIDS as a Security Issue* (Brussels: ICG, 2001), pp.9-13; Robert L. Ostergard Jr., 'Politics in the hot zone: AIDS and national security in Africa', *Third World Quarterly*, 23/2 (2002), p.344; Wilton Park, p.2; S. Versteegen, *HIV/AIDS: Waking up to the Challenge* Working document prepared by Conflict Research Unit, Clingendael Institute for the Netherlands Ministry of Foreign Affairs Special Ambassador for HIV/AIDS, March 2005, pp.14-15; Mark Schneider and Michael Moodie, *The Destabilising Impact of HIV/AIDS* (Washington: Center for Strategic and International Studies, 2002), pp5-6. For an extensive review of the literature on the economic impact of HIV/AIDS, see Vinh-Kim Nguyen and Katherine Stovel, *The Social Science of HIV/AIDS: A Critical Review and Priorities for Action* Report Prepared by the Social Science Research Council Working Group on HIV/AIDS, October 2004, pp.22-38.

¹⁰ Schneider and Moodie, p.6.

¹¹ Netherlands Ministry of Foreign Affairs (MFA), *HIV/AIDS, Security and Democracy*, Seminar Report, Clingendael Institute, 4 May 2005, p.3, available at http://www.ssrc.org/programs/HIV/publications/hague2005/seminar_report.pdf; ICG, pp.1 and 14-18; Alex de Waal, 'HIV/AIDS and the military', background paper to expert seminar and policy conference *AIDS, Security and Democracy*, Clingendael Institute, The Hague, 2-4 May 2005, p.12;

become ill and as schoolchildren stay at home to work or care for HIV-positive parents, quality of education suffers; as health workers contract HIV or leave countries because of high prevalence rates, already pressurised health systems may fail; police and other security forces necessary for public order appear particularly susceptible to HIV and their number and effectiveness may decline.¹² All of these threaten what the International Crisis Group termed ‘the very fibre of what constitutes a nation’.¹³ Democratic development may also be harmed if societies become polarised as a consequence of HIV/AIDS, if disaffection with the political process sets in, or as a consequence of aid-dependency.¹⁴ The stigma of AIDS may also lead to exclusion from work and/or society, creating alienation, fatalism and anger amongst those HIV-positive. These people may become prone to criminal violence or to following violent leaders.¹⁵

However, although the argument that the ‘secondary consequences [of major epidemics] have been much more far-reaching and disorganizing than anything that could have resulted from mere numerical reduction of the population’¹⁶ is well established in the public health literature, the argument that HIV/AIDS may prove politically destabilising is much more speculative and arguably an example of worst case thinking. In particular, there is no empirical analysis to date that HIV/AIDS has led to an increased risk of conflict in a country.¹⁷ Indeed evidence for many of the claims as to why HIV/AIDS might prove destabilising appears to be lacking.¹⁸ The

Schneider and Moodie, p.6

¹²UN Secretariat, chapters 6 and 7; Report on Wilton Park Conference WPS04/21, *Health: The Rising Global Security Challenge* 10-12 September 2004, p.3; Versteegen, pp.16-17.

¹³ICG, p.1. See also Netherlands MFA, especially p.3.

¹⁴ National Intelligence Estimate [NIE] 99-17D, *The Global Infectious Disease Threat and its Implications for the United States* January 2000, available at:

<http://www.cia.gov/cia/publications/nie/report/nie99-17d.html>; Justice Africa, *HIV/AIDS and the Threat to Security in Africa*, submission to the UN Secretary General’s High-Level Panel on Threats, Challenges and Change, 2 May 2004, Addis Ababa, p.2, available at http://www.justiceafrica.org/aids_mainpapers.htm; Peter Fourie and Martin Schonteich, ‘Africa’s new security threat: HIV/AIDS and human security in Africa’, *African Security Review* 10/4 (2001), p.5, available at: <http://www.iss.co.za/Pubs/ASR/10No4/Fourie.html>, accessed 17 June 2005; Versteegen, p.16.

¹⁵ Ostergard, p.342; Justice Africa, pp.1-2.

¹⁶ Zinsser, quoted in Stefan Elbe, *The Strategic Implications of HIV/AIDS*, Adelphi Paper 357 (Oxford: OUP for IISS, 2003), p.44

¹⁷ de Waal, p.10; Netherlands MFA, p.8.

¹⁸ The exception to this is the ‘poverty fuels conflict’ argument, where a body of evidence does appear to exist which is suggestive of such a link. As Alex de Waal has commented, ‘The association is small but robust. Insofar as HIV/AIDS contributes to poverty, inequality and economic downturn, it also increases the risk of conflict.’ de Waal, p.11. However Paul Collier has argued ‘When the main grievances - inequality, political repression, and ethnic and religious divisions - are measured objectively, they provide no explanatory power in predicting rebellion. These objective grievances and hatreds simply cannot usually be the cause of violent conflict.’ For Collier it is access to resources that is critical in fuelling and maintaining a civil conflict, implicitly suggesting that high HIV prevalence is

argument for example that high HIV prevalence rates might lead to a disaffected group prone to criminal violence and capable of undermining the state remains contested; indeed evidence to date suggests that states are coping with increased criminality from HIV. Direct evidence that young people with HIV become fatalistic, prone to violence and susceptible to ‘entrepreneurs of violence’ is also lacking.¹⁹ Nor is it clear in what ways high HIV prevalence will transform societies, what intervening variables will determine the nature of such transformations, and how significant such transformations will be.²⁰ For example there appears to be a fundamental disagreement over how instability might occur. For some, economic collapse and poverty creates the potential for political violence to flourish,²¹ for others, the issue is one of weakening institutional structures creating a ‘fading state’ which would go out not with a bang but with a whimper.²²

This disagreement reveals the difficulty in establishing a causal link between HIV/AIDS and state failure. A more nuanced attempt at establishing a relationship is the Jaipur paradigm of Tony Barnett and Alan Whiteside. This begins by making a distinction between susceptibility (those factors which make a society more or less likely to experience high prevalence rates of HIV/AIDS) and vulnerability (the extent to which a society will be affected by HIV/AIDS). Crucially it is not susceptibility which determines vulnerability, but two other factors: social cohesion, and the level and distribution of wealth and income.²³ If this is correct, then large numbers of states which have a high prevalence of HIV may not be at risk from instability. It is only if such states also have *both* low social cohesion *and* high levels of poverty/unequal distribution of wealth that they may be at high risk of instability. But even if the Jaipur paradigm is incorrect, then it remains unclear the extent to which HIV may only prove destabilising if it can exacerbate existing tensions in a state, and if so how serious such tensions must be for HIV/AIDS to trigger instability. A further

likely to be at best a marginal contributory factor Paul Collier, *Economic Causes of Civil Conflict* available at <http://www.worldbank.org/research/conflict/papers/civilconflict.htm>. Collier’s thesis, although influential from his position in the World Bank, is nevertheless controversial. See for example Roland Marchal, *The Economic Analysis of Civil War according to Paul Collier*, available at http://www.ssrc.org/programs/gsc/publications/gsc_activities/globalization_conflict/marchal.doc.

¹⁹ Wilton Park, p.10; de Waal, p.11.

²⁰ Versteegen, p.6.

²¹ For example, Paolo Tripodi and Preeti Patel, ‘The global impact of HIV/AIDS on peace support operations’, *International Peacekeeping*, 9/3(2002), p.55.

²² Netherlands MFA, p.3.

²³ Tony Barnett and Alan Whiteside, ‘The Jaipur Paradigm: a conceptual framework for understanding social susceptibility and vulnerability to HIV’, *South African Medical Journal* 90 (2000), pp.1098-1101.

complicating factor is that the impact of HIV is not immediate but cumulative. On the positive side, this provides the opportunity for states and international donors to react and adapt to meet emerging social and political problems; on the negative, it may be that the onset of such problems is so gradual that they are not noticed, or that social cohesion and/or wealth may be eroded over time creating a situation of vulnerability where none previously existed. A key variable therefore appears to be whether policy and international funding mechanisms are sufficiently sensitive to identify and flexible to adjust to these challenges.²⁴

HIV/AIDS and national security

It has become an ‘accepted assumption ... that the rates of HIV are higher among the military and other uniformed forces than among the general population.’²⁵ The figures most often cited are those of two to three times, or two to five times that of the general population. In sub-Saharan Africa in particular, infection rates amongst the military are often cited as being especially high, with a number of militaries experiencing rates above 50%, those of Malawi and Zimbabwe believed to be in the order of 75-80%, and elements of the South African military believed to be perhaps 90%.²⁶ Moreover, during periods of conflict it is believed that the risk of infection may be as much as 50-100 times that of the civilian population. The reasons offered for this greater vulnerability are fairly standard across the literature. In particular the majority of the military are drawn from the age group at greatest risk from infection, namely sexually active 15-24 years olds. Young soldiers have money in their pocket and ready access to sex workers and illicit drugs. Peer pressure to engage in casual sex may be an important factor in some units, but more generally working in the military creates an environment where risk taking is endemic due to the nature of the profession, and this is reflected in attitudes towards sex. Moreover deployments away from home create loneliness, stress and the build-up of tensions which seek release either in casual sex or illicit drug use.²⁷ UNAIDS cites the example of Dutch navy and

²⁴ Versteegen, p.6

²⁵ ICG, *HIV/AIDS as a Security Issue in Africa: Lessons from Uganda* (Kampala/Brussels: ICG, 2004), p1.

²⁶ NIE 99-17D, *The Global Infectious Disease Threat*; Lindy Heinecken, ‘Facing a merciless enemy: HIV/AIDS and the South African armed forces’, *Armed Forces and Society* 29/2 (2003), p.784; Ostergard, p.343; ICG, *HIV/AIDS as a Security Issue*, p.ii and *HIV/AIDS as a Security Issue in Africa*, pp.2-3; Schneider and Moodie, p.2; Tripodi and Patel, p.54 table 1;

²⁷ NIE 99-17D, *The Global Infectious Disease Threat*; ICG, *HIV/AIDS as a Security Issue*, pp.20-1; Ostergard, p.343; Peter Chalk, ‘Infectious disease and the threat to national security’, *Jane’s Intelligence Review* September 2001, p.49; 79; Alan duPont, *HIV/AIDS: A Major International Security Issue*, Asia Pacific Ministerial Meeting October 2001 (Canberra: Commonwealth of Australia, 2001), p.7; Versteegen, p.16; Duane Bratt, ‘Blue condoms: the use of international peacekeepers in the

marines personnel on peacekeeping duty in Cambodia, 45% of whom had sexual contact, often unprotected, with the local population (including sex workers) during a five-month tour.²⁸

There is a similar degree of consistency in the arguments as to why this is a security problem. In particular, combat readiness and military performance may be affected. There is evidence for example that flight times in African militaries have been significantly affected because crew have been too ill to fly, while there is concern that soldiers may be wary of helping comrades with blood injuries in combat due to fear of infection. Unit cohesion may suffer if some are HIV positive and others are not. The high rate of infection amongst the officer corps and NCOs will not only affect leadership and experience, but may mean the loss of informal networks crucial to the efficient operation of complex institutions such as the military. The loss of officers and NCOs may also affect discipline. Morale may deteriorate as workloads are increased to cover for the ill, as the progressive deterioration of comrades due to AIDS is witnessed, or due to the fear of infection and the stigma associated with it (although this latter point appears paradoxical given claims that soldiers are willing to risk contracting HIV through their sexual behaviour). The pool of recruits may diminish as HIV positive youngsters are turned away, while the cost of treating those in the military may pose a major burden on defence budgets (and one which may not be eligible for international aid). If military effectiveness is reduced as a result of HIV/AIDS, or even if it is perceived to have been affected, then states may be at risk from internal conflict or external aggression.²⁹

The argument that HIV levels are significantly higher in the military and that this is therefore a concern for national security needs to be treated carefully however. In particular the statistical evidence is not clear cut. The assertion that the military experiences significantly higher prevalence rates than the general population is largely drawn from limited evidence from the mid-1990s. A decade later this pattern is no

fight against AIDS', *International Peacekeeping* 9/3 (2002), p.71; Schneider and Moodie, p.6; Tripodi and Patel, pp.54-7; Stefan Elbe, 'HIV/AIDS and the changing landscape of war in Africa', *International Security* 27/2 (2002), p.164.

²⁸ UNAIDS, *HIV/AIDS and uniformed services*, available at:

http://www.unaids.org/en/in+focus/hiv_aids_security+and+humanitarian+response/hiv_aids+and+unif+armed+services.asp.

²⁹ Elbe, *Strategic Implications*, chapter 2 and 'Africa', pp.163-6; Heineken, op. cit.; Ostergard, p.344; NIE 99-17D, *The Global Infectious Disease Threat*; ICG, *HIV/AIDS as a Security Issue*, pp.ii and 19-21; Hsu, p.5; Schneider and Moodie, p.2; Tripodi and Patel, pp.54 and 61.

longer apparent, partly because in sub-Saharan Africa (where much of the original data originated) levels in the general population have risen.³⁰ In addition there is evidence that prevalence rates may be case dependent and subject to a number of variables, including age, rank structure, deployment patterns and military culture.³¹ Thus not all militaries appear equally susceptible to HIV. Moreover HIV/AIDS is preventable and there is a considerable body of evidence to suggest that not only have militaries been acting to prevent the spread of HIV, but that they have been successful (Ghana and Thailand being two significant examples). In particular the structured, disciplined nature of militaries may make them susceptible to AIDS awareness programmes. In 2003 the UN General Assembly launched a global initiative to improve AIDS awareness in militaries. Within two years UNAIDS had undertaken programmes in over 50 states while a number of states have undertaken programmes in advance or independent of UNAIDS.³² HIV prevalence may also be affected by screening recruits to ensure that they are HIV negative. In the South African military for example, 'No person is recruited or contract renewed unless the specified health standards, which includes an HIV negative status, are met.'³³ When this is coupled to AIDS awareness programmes within the military, prevalence may be sharply reduced. Whether there will be a sufficient pool of HIV negative recruits also appears to be highly case sensitive, with some states experiencing 'youth bulges' which will probably provide necessary numbers of HIV negative recruits. Moreover, in conscript armies many recruits are from rural areas where HIV prevalence rates tend to be lower.³⁴

The stereotype of highly mobile young men with money to burn is also questionable. Many soldiers, particularly conscripts, are poorly paid, largely stationary and may be based in remote rural areas where HIV prevalence is low. Moreover evidence suggests that sex workers operate in a similarly hierarchical manner, with a particular group being identified with for example the lower ranks, another with NCOs, and another with junior officers. This creates a relatively closed group which limits the spread of HIV. Nor are the effects of HIV necessarily as dramatic as those portrayed

³⁰ de Waal, , p.3; Heinecken, p.285. A good example of the tendency to use dated evidence from the mid-1990s is duPont, pp.7-8.

³¹ Netherlands MFA, p.5

³²UNAIDS, *UNAIDS Initiative on HIV/AIDS and Security: Third Quarterly Report* (2002), available at http://www.who.int/hac/techguidance/pht/UNAIDS_initiative_HIV_security/en/ ; duPont, p.8; ICG, *Uganda*, pp. 3, 8-9 and 14

³³ Heinecken, p.286. See also de Waal, p.3; Netherlands MFA, p.6.

³⁴ de Waal, p.3

in much of the literature. The pyramid structure of all regular militaries means that there are always more candidates for promotion than there are places providing a degree of redundancy against 'hollowing out'. Equally, discipline is common to all militaries with well-established methods of maintaining it even under significant pressure. Therefore HIV is unlikely to pose a significant disciplinary problem except in those militaries with a propensity for poor discipline. Indeed there is little evidence that discipline has been undermined because of HIV in previously well ordered militaries.³⁵ Moreover the loss of personnel is something militaries should be prepared because of combat. In this respect, HIV/AIDS is less of a problem because of the time allowed for replacements to be brought into units. Nor is it apparent that the weakness of a state's armed forces is a causal agent in either internal or external aggression. It appears far more likely to be a contributory factor, and even then secrecy over combat readiness and HIV prevalence may limit the impression of weakness.

HIV/AIDS and peacekeeping

Three concerns are frequently expressed over the impact of HIV/AIDS on peacekeeping.³⁶ First, that peacekeepers may be at increased risk from HIV. This argument is linked to the perception that many of the world's conflicts are in regions with a high prevalence of HIV. Concerns over infection appear to have originated with the deployment of UNTAC to Cambodia in the early 1990s, but it was in Sierra Leone where these concerns received prominence. In July 2000 Richard Holbrooke highlighted the international security consequences of this by stating that the US would refuse to support any UN peacekeeping resolution which did not take the risk of HIV/AIDS into account.³⁷ Second, there are concerns that peacekeepers may act as vectors for the spread of HIV. This appears to have occurred in both Sierra Leone and Cambodia, where concerns over peacekeepers being at risk from HIV have also been prominent.³⁸ Significantly, the top 10 contributory nations to peacekeeping operations include states with high HIV prevalence rates such as Kenya, Nigeria and Ghana, as well as a number perceived to be at high risk such as Ukraine, Bangladesh Pakistan and India. Christen Halle, chief medical support officer in the UN's Department of Peacekeeping Operations, described a state 'perceiving itself as low endemic,

³⁵ de Waal, p.3.

³⁶ 'Peacekeeping' here is used in a broad sense, encompassing what are sometimes termed 'peace support operations' and humanitarian interventions as well as the more traditional monitoring of peace agreements.

³⁷ UNSCR 1308; Ostergard, p.342; Chalk, p.49; Schneider and Moodie, p.8; Bratt, p.73; ICG, *Uganda*, p.4

³⁸ Bratt, p.68; Schneider and Moodie, p.8; Chalk, p.49;

[demanding] a guarantee that all deployed peacekeepers would be HIV negative. The fact that the UN cannot give such a guarantee could lead to a situation where a member state, reluctant to accept a peacekeeping force, might resist pressure to do so and reject the presence of UN troops on its territory.³⁹ This concern over peacekeeping acting as a vector for HIV was further exacerbated by allegations of sexual exploitation and abuse by UN peacekeepers in the DRC. The UN's report acknowledged that exploitation and abuse were 'widespread' in the DRC and had occurred elsewhere. Ironically, the ready availability of condoms to peacekeepers - distributed as a means of protecting them against HIV - was seen by some soldiers as an unofficial endorsement of sexual exploitation.⁴⁰ Finally HIV may make it difficult for some armies to deploy peacekeeping forces, especially at short notice. In particular the attempt to devolve peacekeeping to regional powers may be hamstrung by high HIV prevalence, particularly amongst key African armies such as South Africa and Nigeria.⁴¹

However, the UN has itself been prominent in attempting to reduce these concerns. Security Council Resolutions 1308 and 1325 both address the link between peacekeeping and the spread of HIV, while in January 2001 UNAIDS and the UN's Department of Peacekeeping Operations (DPKO) formally agreed to co-operate to reduce the risk of HIV/AIDS in peacekeeping operations. The key to the UN's approach has been to raise awareness of HIV/AIDS amongst peacekeepers and other workers in humanitarian emergencies (including, for example, those engaged in disaster relief after the December 2004 tsunami). A million awareness cards have been distributed to all UN peacekeepers as well as humanitarian workers and national militaries; awareness training has been provided to UN mandated operations such as those in Haiti, Burundi and the Sudan; a senior HIV officer is appointed to each UN peace support operation; and awareness training has been established and supported in national militaries, with programmes established in over 60 countries by the middle of 2005.⁴² Because of this awareness training, the potential for peacekeepers to prevent

³⁹ Christen Halle, address to conference *HIV/AIDS as a Threat to Global Security*, International Conflict Research Group, Yale University, 8-9 November 2002 p.18

⁴⁰ United Nations, *A Comprehensive Strategy to Eliminate Future Sexual Exploitation and Abuse in UN Peacekeeping Operations* Report A/59/710 (New York: United Nations, 2005), paras 3-10, 44 and 62. See also UNSC Press Release SC/8400, 31 May 2005, available at <http://www.un.org/News/Press/docs/2005/sc8400.htm>.

⁴¹ Heinecken, p.291; Elbe, 'Africa' pp.166-7; Schneider and Moodie, pp.4 and 7; and Justice Africa, p.2.

⁴² See UNSC Resolutions 1308, 1325, 1542, 1545, and 1590, all available at <http://www.un.org/documents/scres.htm>. See also the quarterly reports from UNAIDS Office on AIDS,

or contain the spread of HIV has also been recognised. In the January 2000 meeting of the Security Council, Peter Piot, the Executive Director of UNAIDS, made the case that ‘military and police forces that are well trained in HIV prevention and behaviour change can be a tremendous force for prevention as long as it is made one of their priorities’.⁴³ However others have questioned whether this task would be better left to health professionals, whether it might confuse the role of peacekeepers, and whether such a task might be an example of how peacekeeping missions become overextended.⁴⁴

Although the UN’s initiatives on HIV/AIDS awareness training have been hailed as having a ‘positive impact’,⁴⁵ there are a number of limiting factors. Peacekeepers remain under national jurisdiction and the UN is reliant upon national authorities to ensure that awareness training is properly implemented. Reports suggest that this does not always happen and, even when it does, its impact is sometimes limited. Militaries have spent decades attempting to educate soldiers on the dangers of sexually transmitted diseases, not always with success even when diseases such as syphilis were life threatening and had no known cure. Although it is conceivable that the social stigma of HIV/AIDS may in this instance be beneficial in encouraging soldiers to take precautions, there is little available evidence that this is the case. Moreover, not all nations are willing to screen peacekeepers for HIV (including the UK),⁴⁶ raising concerns not only amongst other national contingents involved in a peacekeeping operation but with the recipient country. Mandatory testing however raises questions of civil liberties in certain states and may in some instances be harmful in driving the disease underground (as has happened with other infectious diseases when mandatory testing has been implemented). Nor is education on its own sufficient – as the UN itself implicitly recognises in issuing condoms to peacekeepers. Finally, UN initiatives do not apply to peacekeeping operations undertaken by regional security organisations (such as ECOMOG), and although it may be hoped that the UN’s best practice may be emulated there is no guarantee of this.⁴⁷

Security and Humanitarian Response, published by UN Nordic Office, Copenhagen; Statement by Sir Jeremy Greenstock, Permanent Representative of the United Kingdom, in the Security Council, 19 January 2001, ‘The impact of HIV/AIDS on peace and security’, available at <http://www.ukun.org>, p.2; Halle, p.19.

⁴³ Peter Piot, *Statement to the Security Council by the Executive Director, UNAIDS* 10 January 2000.

⁴⁴ For example, Bratt, pp.80-1.

⁴⁵ Wilton Park, p.6.

⁴⁶ Letter from Dean Gargano, Defence Medical Services Department, UK Ministry of Defence, to author, 22 August 2005.

⁴⁷ Bratt, pp. 68 and 77-9; Versteegen, p.17; Tripodi and Patel, pp.59-60; Wilton Park, p.6.

HIV/AIDS and conflict

There is a strong advocacy consensus that conflict acts as a vector for HIV/AIDS. This was reflected in UNSC Resolution 1308, but originates from several years earlier. In particular the first major epidemic of HIV/AIDS, in Uganda, coincided with the invasion of that country, while there appeared to be a strong link between the deployment of peacekeepers in Cambodia in the early 1990s and the spread of the disease there. Moreover links have been drawn between the fact that southern Africa, where HIV is most prevalent, was also an area of high instability during the 1970s and 1980s.⁴⁸ There is similarly broad consensus as to the reasons for this: that soldiers, already a high risk group, are willing to engage in risky behaviour in conflict regions; that incidents of sexual violence increase in conflict; that combat injuries may be treated in the field with blood donated by comrades which has not been screened; that civil society and government may break down releasing some of the limitations on behaviour, while prolonged conflict may induce a sense of fatalism and willingness to engage in risky activities; health education and surveillance may be poor in zones of conflict; soldiers returning from conflicts may bring HIV with them; conflicts create migration which may also lead to the spread of HIV; and refugee camps may have poor health education and access to condoms, but are also areas where sexual violence is rife.⁴⁹

Despite the strength of this advocacy consensus, the link between conflict and the spread of HIV is far from straightforward. Some long conflicts have demonstrated little change in HIV prevalence (for example during the conflict in Angola), while a number of conflicts have seen HIV prevalence reduce suggesting that that conflict actually limits the spread of HIV. Not least, if conflict isolates regions and reduces mobility, then one of the most significant vectors for the spread of the disease – human mobility – is directly affected. Nor are refugee camps necessarily catalysts for an increase in HIV prevalence. In some camps, better health education, together with improved security preventing sexual exploitation or abuse, may act to reduce the spread of HIV. Furthermore the post-conflict phase may witness increased prevalence

⁴⁸ Examples of this consensus are: UNSC Press Release SC/7086, 28 June 2001 available at <http://www.un.org/News/Press/docs/2001/sc7086.htm>, p.2; UNSCR 1308; Greenstock, p.2; Bratt, p.72; Versteegen, p.24; Jeff Gow, 'The HIV/AIDS epidemic in Africa: implications for US policy', *Health Affairs* 21/3 (2002), p.65; Gayle, pp.1-2; Fourie and Schontech, p.6.

⁴⁹ Paul B. Spiegel [UN High Commissioner for Refugees], 'HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action' *Disasters* 28/3 (2004), p.325; Ngoyen and Stovel, pp.11-12; Elbe, 'Africa', pp.172-4; Bratt, pp.70-2; ICG, *Uganda*, pp.5-6 and 17.

as confidence returns, mobility within a region increases and foreign workers begin to appear (as has happened in Mozambique, Angola and Afghanistan). The epidemiology of HIV/AIDS and conflict therefore appears to be complex. Although a key variable appears to be differences in HIV prevalence between the conflict region and that of troops or humanitarian workers from outside the region - if one is high and the other low, then conflict may act as a vector for the disease – even this is only one variable in a complex mix.⁵⁰ Nor is conflict the only vector for the disease. The Ivory Coast in the 1990s for example was relatively peaceful and stable, but nevertheless experienced increased HIV prevalence; in Asia, trade, drug use and human trafficking (including for the sex industry) appear to be much more significant vectors; in China, a key vector may prove to be the blood supply; while in the former Soviet Union drug use is a major cause of HIV infection.⁵¹ Thus by focusing on conflict as a vector for HIV, not only is the epidemiology of the disease oversimplified but other major vectors may be ignored or not given sufficient attention.

A case built on sand?

As Lindy Heinecken has pointed out, HIV/AIDS is not in itself a security problem. Rather, '[i]t is the collective impact of the disease on the social structure of society and on state strength that creates the problem'.⁵² In the early years of this millennium, an advocacy consensus emerged that HIV/AIDS not only created security problems, but that the spread of the disease was affected by violent conflict. The January 2000 Security Council debate and Resolution 1308 were crucial in legitimising and promoting these arguments. But the evidence supporting the Security Council's four key arguments is not clear cut but complex and case sensitive. Moreover the causal links between HIV/AIDS and insecurity are far from robust. It is tempting to argue that some of the dangers identified have been averted through preventative action, not least AIDS awareness programmes and the issuing of condoms; but in retrospect the case made in 2000 was at best somewhat speculative, while worst case thinking and snowballing subsequently led these concerns to a position of orthodoxy.

PART 2: HIV/AIDS AND THE COPENHAGEN SCHOOL

⁵⁰ Spiegel, pp.322-5; Netherlands MFA, p.6; de Waal, pp.8-9.

⁵¹ Hsu, p.6; Chris Beyer, address to conference *HIV/AIDS as a Threat to Global Security*, International Conflict Research Group, Yale University, 8-9 November 2002, pp.32-3.

⁵² Heinecken, p.296.

But if the successful presentation of HIV/AIDS as a security issue was not a rational response to a clear and present danger to international peace and stability, then what was going on? The next step of my argument therefore is to use the Copenhagen School's framework for analysis to demonstrate how an issue may successfully be presented as a security issue – in their terms, how an issue is 'securitised'. My argument therefore is that HIV/AIDS was securitised in the early years of this decade *not* because it was a clear and present danger to international peace and stability, but because it could be successfully presented as one.

The 'framework for analysis' produced by Buzan, Waever and de Wilde⁵³ and which has formed the basis for what is referred to as the Copenhagen School begins by raising the problem that, once analysis moves beyond a narrow definition of security as solely a military issue, then how is an issue defined as a security issue? They acknowledge that this problem has led some to argue against expanding the agenda away from its narrow focus – that in broadening security it loses definition - but defend their broadening of the agenda, arguing that what is needed is a means of defining issues as security issues not a retreat into orthodoxy. Their project is to 'explore the logic of security itself to find out what differentiates security... from that which is merely political' (pp.4-5). They do admit however to two problems with the widening agenda (p.4). First, that applying the security label to a wide range of issues risks state involvement where that might prove 'undesirable and counter-productive'; and second that security is in danger of being '[elevated] into a kind of universal good thing – the desired condition toward which all relations should move... this is a dangerously narrow view. At best, security is a kind of stabilization of conflictual or threatening relations, often through the emergency mobilization of the state.'

Buzan *et al* then identify a number of conceptual tools which are used in their framework. Of specific importance to my argument is *securitization*. Here the hand of Waever's post-structuralism is most apparent. Buzan *et al* argue that labelling an issue as a 'security' issue takes it beyond the realm of normal political discourse and allows exceptional actions to be undertaken. As Buzan *et al* state, '[in] depicting a threat the securitizing agent often says something cannot be dealt with in the normal way' (p.26). Security becomes a 'self-referential practice... **[an] issue becomes a security**

⁵³ Barry Buzan, Ole Waever and Jaap de Wilde, *Security: A New Framework for Analysis* (Boulder, COLO: Lynne Rienner, 1998).

issue... not necessarily because a real existential threat exists but because the issue is presented as a threat.' (p.24, emphasis added) This process is securitization.

For Buzan *et al*, the character of security in an international relations context is different from the 'everyday' meaning of security. In the IR context, security is about survival. It is 'when an issue is presented as posing an existential threat to a designated referent object'. (p.21) There is no satisfactory objective measurement of what is/is not a security issue, nor can we usefully differentiate between 'real' and 'imagined' security issues. What may seem imagined to one state may nevertheless be very real to another. An 'imagined' security issue might also lead to 'real' actions which then make it a real issue for other states. But Buzan *et al* do not wander into the trap of arguing that security is simply subjective. Rather they present a more complex argument:

The label *subjective*... is not fully adequate. Whether an issue is a security issue is not something individuals decide alone. Securitization is intersubjective and socially constructed: Does a referent object hold general legitimacy as something that *should* survive, which entails that actors can make reference to it, point to something as a threat, *and* thereby get others to follow or at least tolerate actions not otherwise legitimate? This quality is not held in subjective and isolated minds; it is a social quality, a part of the discursive, socially constituted, intersubjective realm. (p.31)

A key element of this is that the special nature of international security warrants extraordinary measures to handle them. Gaining acceptance for such measures requires approval and therefore a consensus that this is a legitimate security issue warranting extreme measures. Hence security is intersubjective.

The idea that security is intersubjective and that issues are created as security issues through speech acts raises a problem: who are the actors who, through their speech acts, can create security issues? Clearly this power is not universal but biased towards certain actors who are 'generally accepted voices of security' (p.31). Three facilitating conditions are necessary for a speech act to be successful in the process of securitization:

- it must follow the accepted grammar of security (that is, use accepted terminology and concepts);
- it must come from an actor in a position of authority to pronounce on security (eg a state);
- and that it helps (but may not be necessary) if the object can be generally held to be threatening.

As Buzan *et al* argue, the ‘definition and criteria for securitization is constituted by the intersubjective establishment of an existential threat with a saliency sufficient to have substantial political effects’ (p.25). So, in defining health issues as security issues, they do not need to meet external criteria but rather be agreed upon intersubjectively as constituting an existential threat which cannot be dealt with in the normal way, and which has a political impact. Thus HIV/AIDS infection has been agreed upon and has political effect and is therefore a security issue, but obesity has not.

Finally for the purposes here, Buzan *et al* discuss actors and referent objects: the question of ‘whose security?’ (p.35ff). They usefully distinguish three types of actor:

1. Referent objects, which are defined as ‘things that are seen to be existentially threatened and that have a legitimate claim to survival’ (p.36). In principle any actor can be a referent object; in practice referent objects are limited by the three facilitating conditions above. Buzan *et al* argue that size is important here. Too large and the referent object loses focus and therefore finds difficulty in attracting legitimacy (eg ‘humankind’, ‘the working class’). Too small (individuals) ‘can seldom establish a ‘wider security legitimacy in their own right’ (p.36). Although this latter argument is presented in a somewhat flimsy manner, if the analysis is correct then it offers a solution to the problem of health’s focus on individual security and foreign and security policy’s on the state. In other words, individuals would have to establish intersubjectively a legitimate claim as referent objects against specific threats. Or as Buzan *et al* put it: ‘referent objects must establish security legitimacy in terms of a claim to survival’ ((p.39). Buzan *et al* therefore accept the argument that human security may be a legitimate security concern and that the individual may be a

referent object (by this they mean individuals, not a named person), but only if they meet the facilitating conditions.

2. Securitizing actors: actors who have the necessary level of accepted authority to declare a referent object threatened. Although a complicated category to pin down, Buzan *et al* argue that this is usually government officials, pressure groups and lobbyists, political leaders etc.
3. Functional actors: neither of the above, but who may nevertheless have an ability to influence decisions in the relevant sector. The example given is that of a polluting company in environmental security. Pharmaceutical companies would be an obvious analogue in the health sector. But this is a difficult category since a company might also become a securitizing actor or a referent object under different circumstances (or even in the same situation).

What is striking is how well HIV/AIDS fits the above, specifically:

- The disease could be credibly presented as existential threat to societies where prevalence rates were high. For Buzan *et al* ‘existential’ does not mean ‘existence’, but rather a threat to social and economic stability. HIV/AIDS could easily be presented in this manner, but in extreme cases could also threaten the very existence of whole societies.
- The threat from HIV/AIDS could be presented using the traditional grammar of security (instability, violence, military force, etc).
- The securitising move was made by an actor in a position of authority – the UNSC. But it was also echoed by a variety of other credible actors, ranging from US Secretary of State Colin Powell to influential NGOs such as the International Crisis Group to quasi-academic think tanks such as the IISS.
- The object was held to be threatening not only to life but to social and economic order.
- The referent object could be clearly identified as societies with high HIV prevalence rates.

If, as Buzan *et al* argue, the ‘criteria for securitization is constituted by the intersubjective establishment of an existential threat with a saliency sufficient to have

substantial political effects' (p.25), then this clearly occurred with HIV/AIDS in the first half of this decade.

CONCLUSION

This paper is intended as the first step in making the next move in an argument. The argument is that HIV/AIDS was presented as a security issue in the first half of this decade not because it represented a clear and present danger to international peace and stability, but because of the failure of the international community to halt the spread of the disease and to ameliorate its impact upon societies worst hit. During the 1990s, HIV/AIDS had been presented as a public health issue and a matter for international development. With the failure of this approach, something new was needed. By constructing HIV/AIDS as a security issue, a new series of concerns could be articulated which might galvanise the West (and in particular the G8) into action.

What this paper does is to suggest that the argument that HIV/AIDS represented a clear and present danger to international peace and stability was weak. The empirical evidence was lacking and the reasoning suspect. However, by using the framework of analysis developed by the Copenhagen School, it is possible to understand the mechanisms whereby issues can be successfully presented as security issues. This is what happened to HIV/AIDS: it was securitised. What now needs to be better understood are the reasons why it was securitised: was it a genuine belief that it was a security issue, or was security a Trojan Horse to get HIV/AIDS back on the top table?