THE HIV/AIDS – NATIONAL SECURITY NEXUS: A HISTORY OF RISKS AND BENEFITS

Submitted by Harley Feldbaum to the London School of Hygiene and Tropical Medicine, for the degree of Ph.D.

Abstract

The links between HIV/AIDS and national security have played a major and under recognized role in impacting efforts to fight the pandemic. To date, critical studies of the HIV/AIDS – national security nexus have been limited. Using 27 semi-structured interview and extensive literature review, this thesis creates the first global history of the nexus, from 1985-2007. This long-timeframe analysis allows a novel examination of the risks and benefits of this politically potent linkage, an assessment of the role of global health actors in the nexus, and a testing of the published conceptual frameworks that seek to explain the relationship between global health and national security.

This thesis examines the history of the HIV/AIDS – national security nexus in three parts. First, the early and beneficial securitizations of the epidemic in Uganda and Thailand are examined. Two other events, the U.S. and USSR intelligence community interest in HIV/AIDS and the likely spread of HIV/AIDS by the United Nations peacekeeping mission in Cambodia, illustrate hazards of the nexus and complete this section. Second, the factors and events that led to the securitization of HIV/AIDS at the United Nations Security Council and within the U.S. are evaluated. Third, the consequences of securitization are considered, including the impact on global priority and funding, Security Council Resolution 1308, the U.S. President's Emergency Plan for AIDS Relief, and military HIV/AIDS programs.

This thesis finds that where policymakers have framed HIV/AIDS as a direct threat to national security and prioritized the disease, clear benefits in fighting the epidemic have resulted. However the role of global health actors in these political events has been limited, and hazards of the nexus include the classification of public health data and the divergent interests of the global health and national security communities.

Dedication

For my family: Nicole, Maddox, Nora, Mom, Dad, Mia, Jimbo, Max, Craig, Austin, Maureen, Matt, Alan, Carol, Sam, Julia and Sue.

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Statement

I hereby declare that, except where explicit attribution is made, the work presented in this thesis is entirely my own.

Harley Feldbaum

Chapter 1: Introduction

"No war on the face of the earth is more destructive than the AIDS pandemic. I was a soldier. But I know of no enemy in war more insidious or vicious than AIDS. An enemy that poses a clear and present danger to the world."

- Colin Powell (2001: para. 16) to the UN General Assembly Special Session on HIV/AIDS

1.1 Rationale for the study

This statement by the U.S. Secretary of State Colin Powell in 2001 describes HIV/AIDS as one of the world's most critical security threats. This represents a staggering transformation of the political response to the 25 year-old pandemic that has been accurately characterized as "glacial" (Barnett and Whiteside 2004: 5). Fidler (2004: 45) describes the rise of HIV/AIDS, and other select global health issues, to the top of the international agenda as a "revolution" unprecedented in the history of global health.

Powell's statement directly stemmed from two events in 2000 that framed HIV/AIDS as a threat to national and international security. The first was the declassified publication of a 1999 U.S. National Intelligence Council (NIC) report that examined global infectious diseases, including HIV/AIDS, and their implications for U.S. national security. The second was the United Nations Security Council (UNSC) meetings on the impact of HIV/AIDS on peace and security in Africa, and the resulting UNSC Resolution 1308 on HIV/AIDS and UN peacekeeping forces. Together these events dramatically increased the political stature of HIV/AIDS, and contributed to a massive increase in international funding available to fight the pandemic. The response to HIV/AIDS was moved from ministries of health and aid organizations, to the highest levels of national and international politics, and now included ministries of defense and heads of state. Looking back to 2005, the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Peter Piot said that the UNSC meetings on HIV/AIDS and Resolution 1308:

> transformed how the world views AIDS. I say 'transformed' because many now view AIDS as a threat to national security and stability… because of that transformation that I believe today, for the first time ever, we have a real opportunity to halt and begin to reverse this devastating epidemic… (UNSC 2005: 5)

This is not the first time a disease has impacted what we today call foreign policy and national security. The black death of the fourteenth century had a radical impact on European society, and contributed to the decline of the feudal system (Garrett 2005). The spread of smallpox by Spanish soldiers in the Americas led to the decimation of the Aztec and Incan empires, and paved the way for European colonization (McNeill 1976). These infectious disease epidemics had major impacts on political, economic and social stability. As such, they were major security threats of their time, influencing the survival of civilizations and shaping the demographic composition of the modern world.

In more recent history, International Sanitary Conferences were held between 1851-1938 to limit the impact of cholera, plague, yellow fever and other diseases on trade and commerce through improved health cooperation (Fidler 2001; King 2002). Public health was also closely linked with the interests of European colonial powers through efforts to maintain the health of soldiers and civil servants in colonial states (King 2002). Disease control efforts were critical to U.S. success in overcoming the malaria and yellow fever epidemics that had stymied previous French efforts to build a canal through Panama (Stern 2005). Success over these infectious diseases allowed the U.S. to control commerce and travel through the strategic passage for the remainder of the twentieth century. In these cases, public health control of diseases played an important role within the traditional realm of national security, enhancing the preservation and projection of military power, and facilitating the expansion of trade and commerce (Fidler 2003).

This close link between the management of infectious diseases and the national security of powerful states became more tenuous in the latter half of the twentieth century. The causes of this de-linking were multifactorial. Successful sanitary reforms in industrialized countries reduced the impact of cholera, typhoid and other infectious diseases on major population centers. The advent of antibiotics and vaccines gave industrialized countries new tools that contributed to the successful control of polio, tuberculosis and other diseases (Fidler 2001b). These advances thus reduced the immediate threat that infectious diseases posed to citizens of industrialized countries.

Concurrently, decolonization reduced the European and American presence in many parts of the developing world, further reducing the relevance of infectious diseases to the strategic interests of powerful states. The link between public health and national security had been temporarily broken.

By the 1950s, the field of international health[1] operated independently from the strategic concerns of the great powers. During the Cold War, international health was largely operationalized through international institutions such as the World Health Organization (WHO) and non-governmental organizations (Fidler 2004). International health became strongly associated with "improving health conditions and services in poor, developing countries;" efforts that rarely affected the strategic interests of the superpowers (Fidler 2004: 50). Removed from the powerful strategic interests of states, international health developed a humanitarian ethos that directly conflicted with the state-based security politics of the Cold War. Fidler (2004b: 110) argues that the preamble to the WHO Constitution best expresses this vision of international health as concerned with "individual rights, human solidarity and universal justice." By the 1990s, forty years of separation and divergent development characterized the relationship between global health and national security.

Against this recent history of a humanitarian international health disconnected from state interests, the debate around the national security implications of HIV/AIDS emerged in the late 1990s. Assisted by concern about emerging infectious diseases and bioterrorism, HIV/AIDS and the field of global health quickly rose to the pinnacle of international affairs and security politics. HIV/AIDS was discussed at the UNSC, by presidents and prime ministers, and declared a "clear and present danger to the world" by U.S. Secretary of State Powell (2001: para. 16). This represents a "revolution" in the political status of global health, "nothing in the prior history of national and international efforts on public health compares to the political status public health has reached today" (Fidler 2004: 45). The reintroduction of global health, specifically HIV/AIDS, into the high politics of

[1] The phrase "international health" refers to cooperation between states on public health issues. "Global health" is used to refer to international health activities involving states and non-state actors including international organizations, non-governmental organizations (NGOs), foundations and individuals. There is no agreed upon definition of global health, but the U.S. Institute of Medicine (1997: 2) defines global health as "health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions." Lee and Collin (2005: 3) use different language and define global health as health issues "where the determinants circumvent, undermine or are oblivious to the territorial boundaries of states and, thus, beyond the capacity of individual countries to address through domestic institutions."

national security, and what this means for the fight against the pandemic, is the subject of this thesis.

The links between HIV/AIDS and national security represent a transformation of the politics of the disease that has had a major impact on the political and financial support to address the pandemic. Despite the importance of this transformation, these linkages have received relatively limited critical analysis from within the global health community. However, authors from the fields of political science and international relations have produced numerous analyses of the relationship between HIV/AIDS and national security. The majority of these summon evidence to outline logical ways the HIV/AIDS pandemic may threaten national security, often focusing on militaries, peacekeepers and the possibility of the disease contributing to state instability or failure. The links expounded in these papers are often accompanied by an appeal to increase political attention and funding for HIV/AIDS because of its potential to impact national security. This formulaic structure has left considerable aspects of the relationship between HIV/AIDS and national security under analyzed. In particular, the global health community has not yet analyzed the lessons of securitization, and impacts of linking HIV/AIDS to national security interests.

Similarly, the lack of a detailed history of this relationship has stifled coherent analysis, and contributed to misunderstandings about the impacts of the linkage of HIV/AIDS and national security. In the global health and national security literature, only one book briefly outlines the events that led to the securitization of HIV/AIDS at the UNSC and in the U.S. (Behrman 2004). Some events before and after these developments have been described in other publications, but to date there has been no comprehensive analysis. Because of this lack of historical research and case studies, cases where HIV/AIDS was linked to national security considerations before 2000 have been largely ignored. This is unfortunate because the links between HIV/AIDS and national security from 1985 to 1995 had major impacts on efforts to fight the pandemic and hold important lessons for today. Furthermore the major acts of securitization at the UNSC and in the U.S., and their impact on efforts to fight the pandemic, are more complex than current analysis suggests.

This thesis thus seeks to contribute to current knowledge by constructing the first history of the HIV/AIDS – national security nexus from the beginning of the pandemic until 2007. This nexus is defined by this thesis as historical cases where HIV/AIDS was securitized (as defined by Buzan et al. 1998,) as well as more inclusively, cases where HIV/AIDS was linked to the activities of institutions of security, such as United Nation's peacekeeping forces and various African militaries. This history introduces important events from the period between 1985-1995 into the debate on HIV/AIDS and national security, explores the political machinations that lead to securitization, and provides a needed historical framework for future research.

Constructing the first history of the HIV/AIDS – national security nexus allows for a fuller accounting of the risks and benefits of securitization than has been possible to date. Elbe (2006a: 125) argues that the question of whether HIV/AIDS should be addressed as a security issue is essential, and that debate on the HIV/AIDS – national security nexus must be expanded beyond empirical questions to address this normative question:

> Given the growing policy resonance of arguments about the security implications of HIV/AIDS, the time has come to reflect more thoroughly on how such a framing of the pandemic could facilitate international efforts to reduce its spread and how this framing might also be counterproductive to these efforts.

Only two authors have specifically sought to examine this normative question of whether HIV/AIDS should be securitized, both from the field of international relations. Peterson (2002) and Elbe (2006a) seek answers to this question by weighing the risks and benefits of securitizing HIV/AIDS. Peterson's conception of the risks and benefits is based on attempts to securitize the environment in the 1980s-1990s, as well as the linkage between disease and security in Europe during the nineteenth century. Elbe's analysis is based on an application of the securitization theory of Buzan et al. (1998). Elbe's analysis begins with the normative dangers and benefits of securitization, and applies these to HIV/AIDS.

This thesis seeks to make a major contribution to existing knowledge by adding a third, namely an historical case study perspective, to the debate initiated by Peterson and Elbe on the risks and benefits of securitizing HIV/AIDS. This thesis, like Elbe (2006a), adopts Buzan et al.'s (1998) securitization theory. However, unlike Elbe (2006a) the basis of risks and benefits of the HIV/AIDS – national security nexus in this thesis are

located in the study of the historical links between HIV/AIDS and national security. Benefits in the fight against HIV/AIDS are measured as anything that increased resources or political attention for HIV/AIDS, and which was then used to fight the epidemic according to basic public health principles. For example, a benefit of securitization could be increased political leadership, which was used to implement successful prevention programs. Risks of the HIV/AIDS – national security nexus are correspondingly anything that compromised efforts to fight the disease, or garnered political attention that distorted or undermined public health efforts. For example, a risk of securitization could be increased political attention that sought to only address HIV/AIDS in countries of strategic interest, and therefore undermined global efforts to fight the disease. This assessment is particularly targeted to address the global health community's interests in the determinants of the political priority of HIV/AIDS, and concerns about utilizing national security justifications for global health action. Based in historical case studies of the nexus, this assessment introduces a novel, third weighing of the hazards and benefits of securitizing HIV/AIDS that presents a related, but different set of hazards and benefits from the ones identified by Elbe (2006a) and Peterson (2002).

Constructing a history of the HIV/AIDS – national security nexus also allows for a fuller examination of the role global health actors have played in the securitization of HIV/AIDS to date. This represents a second critical question to address from a global health perspective, in addition to the broader weighing of the hazards and benefits of securitization. Whether and how global health actors have contributed to the revolution in the political treatment of HIV/AIDS has important implications for the future of global health and for its interactions with the national security community. The answers to this question will also demonstrate where and how global health has successfully influenced political debates on HIV/AIDS, and where and why global health leadership and research has failed to have political influence. Thus, evaluation of the role of global health actors in the securitization of HIV/AIDS is the third contribution to knowledge of this thesis.

The final original contribution of this thesis is the testing of conceptual frameworks that have been put forth so far to explain this nexus and, more broadly, the relationship between global health and national security. This thesis brings together four conceptual frameworks, and tests their explanatory power against explanations of historical events gathered in this research from interviews and documents. The most salient aspects of the

conceptual frameworks are highlighted in the history and may be brought forward for further academic usage. Aspects of the nexus that are not explained by current conceptual frameworks are identified. In this way, this thesis aims to bring greater empirical and conceptual clarity to the HIV/AIDS – national security nexus.

1.2 Purpose and objectives

The purpose of this research is to strengthen empirical and conceptual understanding of the HIV/AIDS – national security nexus by applying historical and global health perspectives, and to offer a novel assessment of the risks and benefits of securitizing the HIV/AIDS pandemic.

To achieve this purpose, the research will undertake the following objectives:

1. Conduct a full literature review, incorporating both public health and international relations literature, for evidence on and conceptualizations of the HIV/AIDS – national security nexus.
2. Create a history of events where HIV/AIDS was linked to national security considerations through document review and in-depth interviews with those involved.
3. Assess the historical hazards and benefits of linking HIV/AIDS to national security considerations for efforts to fight the pandemic.
4. Assess the role and effectiveness of global health actors in influencing events of the nexus and the political status of efforts to fight HIV/AIDS.
5. Test and offer improvements for current conceptual frameworks seeking to explain the HIV/AIDS – national security nexus.
6. Put forth recommendations for the global heath community on engagement with the national security community, and for addressing the linkages between global health and national security.

1.3 Methodology

To construct a history of the HIV/AIDS – national security nexus, this thesis has used documents and semi-structured interviews with key policymakers involved in events that linked HIV/AIDS and national security.

1.3.1 Document review

An extensive review and interpretation of primary and secondary documents relating to the HIV/AIDS – national security nexus was undertaken. Four sources of documents were used in this review. First, national government and UN publications were used including official government publications from Thailand, the UK, and the U.S. In the case of the U.S., Freedom of Information requests have unearthed previously classified CIA studies of HIV/AIDS. The research also makes extensive use of transcripts of UNSC and UN General Assembly meetings on HIV/AIDS which are available online. Second, the research examines numerous NGO and grey literature sources that have commented on the HIV/AIDS – national security nexus. Third, an interdisciplinary search of scholarly papers on the links between national security and HIV/AIDS has been performed using Medline, JSTOR, Bath Information and Data Services, EBSCO and OCLC. Fourth, newspaper and magazine reports on the links between HIV/AIDS and national security have been searched using LexusNexus, Kaisernetwork.org, globalhealth.org, and Google.com. Citations from all of the sources above were then used to locate further publications and resources.

1.3.2 Semi-structured interviews

The research conducted 28 semi-structured interviews, along with numerous less formal exchanges with key informants at conferences, meetings and by email. Interviews were especially critical for unmasking the differences between the public rationales for an event, and the private views of policymakers and those involved. The gap between public rational and private explanations for political events is often large. However the combination of national security and global health, two fields with different objectives and world views, and one field with a penchant for secrecy, seemed to make this gap particularly vast. In much of the history revealed by this thesis, including the dramatic securitization of HIV/AIDS at the UNSC, the public explanations of events were shown

to be deficient through interviews with key policymakers and actors. Interviews were also essential to go beyond a sequence of historical events to uncover the motives and perspectives of those involved. Often in these interviews, a story from one participant's perspective brought aspects of the HIV/AIDS – national security nexus into clearer view than would have otherwise been possible. Some of these stories have been quoted at length in this thesis.

The selection of key informants began with nine preliminary interviews with persons in the U.S. Department of Defense and Department of State, NGOs, and academia in Washington D.C. A snowball technique was employed to identify further contacts in other policy communities. Further interviews were conducted with persons involved in the HIV/AIDS – national security nexus from a wide variety of backgrounds, with a focus on the U.S., Africa, Asia, the UN, and military forces. Access to informants was better than expected. Difficulties were only occasionally encountered reaching the highest levels of government and international organizations. For instance, interviews were requested but not possible to arrange with Richard Holbrook and Peter Piot. While both perspectives would have been informative, an interview with Holbrook's deputy at the UN and an informal discussion with Peter Piot and review of his speeches largely compensated for the lack of formal interviews with the most senior policymakers. Interviews with high level military and intelligence officials were often conducted on a 'not for attribution' basis, which allowed officials to discuss the topic freely without danger of compromise. This allowed important and usually secret military and intelligence community perspectives on HIV/AIDS to be examined. At no point did a lack of access to officials or other persons compromise the construction of this history. A full list of interviews is attached in Appendix A.

The interviews themselves were approximately one hour in length, with follow-up questions asked through email. In person interviews were recorded and transcribed, while detailed notes were taken during phone interviews. An offer to be "off the record" or "not for attribution" was frequently used to obtain more honest perspectives from policymakers, especially when their explanation differed from official accounts or the perspective of their organization. In these cases, the policymaker's perspective is often found in a quote from a confidential source, or is represented by another source that corroborates their perspective. In interviews, there was always a strong attempt to obtain

the most honest recollections and perspectives to limit institutional biases. Those interviewed were generally open and candid, sometimes surprising so, resulting in informative and sometimes fascinating insights into the nexus that would have been unavailable without the use of interviews. Transcription and detailed note taking, and offers to be "not for attribution" or "off the record" greatly improved the quality and accuracy of interview data available.

1.3.3 Data analysis

Documents, semi-structured interviews and numerous informal discussions have been synthesized to create this history. In most cases, documents were used to outline the historical events studied. Interviews were then used to go further into depth about events, revealing perspectives and behind the scenes occurrences that are usually unpublished and unrecorded. Documents were then revisited for signs confirming or calling into question information from interviews. Often interviewees would be contacted by email with follow-up questions to clarify events or statements.

This thesis has endeavored to provide ample confirmation of the events and arguments described within. In some cases such as the role of national security concerns in Thailand's response to HIV/AIDS, documents and interviews are in close agreement. In other cases such as the justifications for the U.S. President's Emergency Plan For AIDS Relief (PEPFAR) initiative, interviews contradict official documents and narratives. Close agreement among multiple interviewees about the rationale behind PEPFAR provided confidence for arguing that the official justifications were incomplete and that key players interpreted events differently. Multiple sources have been used to support the description of all historical events, arguments, and conclusions. Single sources have only been used to convey perspectives or ideas from an individual perspective, or how a policymaker's interpretation of events influenced their actions.

1.4 Thesis outline

Chapter 2 begins by providing a background on HIV/AIDS and conceptions of national security. A review of the global epidemiology and impact of the HIV/AIDS pandemic, followed by an outline of the responses to the disease, begin the chapter. The next

section includes a history and discussion of the concept of national security. This section concludes by adopting Buzan et al.'s (1998) securitization theory for the purposes of understanding national security and analysis of the process of securitization. The third section of the chapter brings these two fields together by outlining four conceptual frameworks for understanding the HIV/AIDS – national security nexus. Each framework highlights a different aspect of the nexus, and is tested and used to draw attention to common themes throughout the following historical chapters.

A review of the literature on the HIV/AIDS – national security nexus comprises Chapter 3. Based upon Feldbaum et al. (2006a), the literature review focuses on how the main links between HIV/AIDS and national security have to date been defined and conceptualized. These main links are the populations of militaries and peacekeepers, the potential impact of HIV/AIDS on state stability, and the impact of the epidemic on the strategically important states of Russia, India, China, Nigeria and Ethiopia. A review of critical approaches to the question of linking HIV/AIDS and global health in general to national security interests follows. The literature review then narrows to focus on the small number of articles that specifically discuss the utility, risks and benefits of securitizing HIV/AIDS. Two of these articles, Peterson (2002) and Elbe (2006a), are directly relevant to the thesis question and are discussed in detail.

Chapters 4, 5, and 6 are the historical chapters describing the HIV/AIDS – national security nexus. Chapter 4 examines the period between 1985 – 1995 and the links between HIV/AIDS and national security in Uganda, Thailand, Cambodia, and within the intelligence agencies of the U.S. and Soviet Union. Chapter 5 delineates the events that led to the securitization of HIV/AIDS at the UNSC and in the U.S., as well as their immediate impacts. Chapter 6 investigates the policy impacts of securitization between 2000 – 2007, as well as the revision of HIV/AIDS prevalence estimates among armed forces.

Each of these chapters ends with a discussion of the conclusions from that time period. Chapter 7 builds on the analysis and conclusions of each chapter, drawing overall conclusions addressing this thesis's purpose and objectives.

1.5 Limitations and biases

Any attempt to create the first history of a subject is likely to have limitations. These limitations are likely to be exaggerated if the history is brings together two very different fields – global health and national security – the latter which has a strong penchant for secrecy and classified information. This section discusses the caveats of this thesis, and the actions taken to limit these problems.

First, the choice to focus on HIV/AIDS, rather than another disease or public health issues more broadly, was necessary to narrow the scope of the thesis, but in turn limits the generalizability of this thesis in important ways. First, HIV/AIDS occupies a middle ground among the links between global health issues and national security. It is neither as accepted a national security threat as biological weapons, nor as rejected as malaria, injuries, or non-communicable diseases. Because of the unique characteristics of the HIV/AIDS pandemic, as well as the politics that surround the disease, the findings of this thesis on the HIV/AIDS – national security nexus may not be easily generalizable to other disease areas or to global health in general. Despite this limitation, the huge impact of the HIV/AIDS pandemic and substantial pubic health resources dedicated to fighting the disease allows lessons from this case-study of HIV/AIDS to be drawn about the broader relationship between global health and national security.

Second, the choice to limit this thesis to examining the risk and benefits of securitization *for the fight against HIV/AIDS*, was necessary to limit the scope of the thesis. However, it is critical to note that this choice excludes consideration of the impact of securitization of HIV/AIDS on broader global health efforts aside from HIV/AIDS. This is an important caveat because a major criticism of the increase in funding and political attention for HIV/AIDS, which this thesis argues is partially due to securitization, is that it has improperly drawn attention and funding away from other global health efforts. This broader question represents a different avenue of research, and thus the question of what the impact of the securitization of HIV/AIDS has been on global health efforts in general still awaits examination[2].

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[2] Mead Over's working paper from the Center for Global Development argues that PEPFAR has actually created an unprecedented global "entitlement" program, whose growth could consume other U.S. global health and development budgets in the coming years. This paper could form the basis of a serious critique

Third, this thesis examines securitization in context of national security, and only briefly discusses human or other levels of security. While human security has been shown to be a useful construct in examining the implications of HIV/AIDS (Elbe 2006b), this thesis focuses on national security primarily because of its relevance to political prioritization and funding. Issued deemed of national security importance can attract extraordinary funding and political attention from states. Human security issues have not traditionally received such attention. For the same reasons, feminist perspectives on security are not a focus of the analysis of this thesis (Tickner 1995). Furthermore, difficulties mustering political attention and funding presented a major challenge of addressing HIV/AIDS for the first twenty years of the HIV/AIDS pandemic, and this thesis provides evidence that linking the disease to national security interests played a pivotal role in generating beneficial government action. Thus a focus on national security was chosen for its strong relevance to political prioritization and funding. In addition, and as described in the first pages of this thesis, the links between infectious diseases and national security are centuries old, but were largely neglected for the duration of the Cold war. This thesis tells some of the fascinating story of the rediscovery of the linkages between public health and national security.

The fourth limitation of this thesis is imposed by the adoption of Buzan et al.'s (1998) securitization theory. This thesis conceives of the links between HIV/AIDS and national security as those cases in which securitization of the pandemic has taken place, and more broadly, where the disease was linked to the activities of institutions of security. While this conception derives directly from securitization theory, it represents a choice by the author which limits the scope of the thesis. Other authors writing on the HIV/AIDS – national security nexus could use a broader definition of national security that would change the focus of a history in important aspects. In particular, the choice to use securitization theory has excluded some links between HIV/AIDS and national security that are usually discussed in the literature on the nexus. The interactions between HIV/AIDS and conflict, for example, are not addressed here because they are not cases of securitization. Neither are military efforts to fight HIV/AIDS addressed unless they are part of the larger securitization of HIV/AIDS by the government. Similarly,

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of the impact of the securitization of HIV/AIDS on broader global health efforts and funding. For more information, see: http://www.cgdev.org/content/publications/detail/15973

determining whether or not HIV/AIDS is a objective security threat to a state is not a question this thesis seeks to address, because Buzan et al. (1998) argue that security is a "self-referential practice," and that it is the process of securitization that must be studied. Nor is the goal of this thesis to attempt to gather new evidence to support the links between HIV/AIDS and national security, although some new evidence is provided. Thus, the choice of securitization theory uses a particular concept of security which, in some ways, narrows the conception of the HIV/AIDS – national security nexus. However, this narrowing has the benefit of forming a more cohesive and concise definition of securitization that then allows the question of the risks and benefits of securitizing HIV/AIDS to be directly addressed (for a discussion of securitization theory see Chapter 2.5).

Furthermore, this thesis has excluded the cases of Botswana, Russia and Fiji from detailed examination because of a lack of evidence concerning the political consequences of the use of term security in reference to HIV/AIDS. While leaders of Botswana, Russia and Fiji have described HIV/AIDS as a threat to their national security, strong evidence is lacking on whether these speech acts had a significant impact on efforts to address the disease that would merit inclusion in this thesis. Because of a lack of research on securitization in these countries, and evidence on the impact of these speech acts, these countries are not examined in detail in this thesis. Further research is needed to determine the impact of these potential securitizations, particularly in Botswana and Russia, (some of which is already underway, see Sjöstedt (2008) and Chabrol (2008)).

The primary bias that affects this thesis is a form of publication bias. In traditional epidemiology, publication bias occurs because studies that report positive results are more likely to be published than those that report no association (Gordis 2000). This bias affects the findings of this thesis in two important ways. First, failed attempts to securitize HIV/AIDS are much less likely to be reported and publicized than successes. By definition, successful securitizations push HIV/AIDS to the highest levels of politics, while unsuccessful attempts do not become government policy and may go unreported. Because of this bias, it is possible that this thesis underreports instances of failed securitization. Underreporting may be greater for developing countries because highly affected states are more likely to view HIV/AIDS as a national security threat, and because developing countries generally publish fewer position papers on foreign policy

and national security. It has been difficult to overcome this aspect of publication bias because of the lack of records on failed attempts at securitization. However, two failed attempts at securitization of HIV/AIDS in the U.S. intelligence community have been uncovered, as well as a failure to address the linkages between peacekeeping operations in Cambodia and the spread of HIV/AIDS.

The second way publication bias has affected this thesis is through the possibly disproportionate focus on well-documented events that link HIV/AIDS and national security. This bias may be particularly acute when examining issues related to national security, intelligence agencies and armed forces because the publication of policy documents by these communities is rare. The exception to this trend is the U.S., whose government, intelligence agencies, and armed forces have together published the U.S. national security strategy, declassified intelligence assessments of HIV/AIDS, and publicly discussed efforts to limit the spread of HIV/AIDS in African militaries. Freedom of Information legislation has also resulted in the availability of previously classified U.S. intelligence assessments. Partially because of the unusual availability of U.S. intelligence, military and national security documents, this thesis has a strong focus on the links between HIV/AIDS and national security as conceived by U.S. agencies and policymakers. The U.S. has taken the lead in addressing the HIV/AIDS – security nexus, and was responsible for bringing the disease to the UNSC, so a strong focus on the U.S. can be justified and is not solely the result of publication bias. However, it is recognized here that there is a greater focus on the U.S. than there would be if other countries were more open with analysis and policy documents from their intelligence agencies and armed forces.

The representativeness, quality and depth of the interviews was critical to both creating a history of the nexus and its analysis. As previously discussed, access to policymakers involved in the nexus was excellent. Policymakers from all countries and international organizations were universally willing to discuss their experiences and insights on the links between HIV/AIDS and national security. Conducting interviews on a "not for attribution" basis facilitated interviews with personnel from the CIA, U.S. military, U.S. State and Executive Agencies who would otherwise be unable to discuss the subject. Phone interviews and email follow-ups were utilized to interview African and Asian policymakers when travel and in-person interviews were not feasible. Only the most

elite policymakers, such as Richard Holbrooke, Peter Piot and Colin Powell, were not available to be interviewed. In these cases, interviews with their deputies, examination of their public speeches and writings, and questions asked during public talks were used to compensate for the absence of in-person interviews. In no case was a substantial lack of access to policymakers encountered. Due to the relatively small number of events that comprise the HIV/AIDS – national security nexus, most of the major policymakers involved were interviewed for this thesis. The combination of excellent access and a small number of necessary interviews greatly benefited the representativeness of the interviews, limiting the bias due to who was able to be interviewed.

Chapter 2: A conceptual framework for understanding the HIV/AIDS – national security nexus

2.1 Introduction

This chapter begins with a review of the two main subjects of this thesis: HIV/AIDS and national security. These reviews are each based in the literature and methods of their own fields. The HIV/AIDS section utilizes the public health literature to summarize the current state of the pandemic, and characteristics of the global response. Next, the section on national security utilizes international relations theories and literature to review the various definitions of security, and discuss the contested broadening of security studies since the early 1980s. Buzan et al.'s (1998) securitization theory is presented at the conclusion of the section on security, and provides a critical tool, utilized by this thesis, for understanding how an issue becomes securitized.

The final section of this chapter is a bridge from this chapter's uni-disciplinary reviews of HIV/AIDS and national security, to the next chapter's interdisciplinary review of the literature on the HIV/AIDS – national security nexus. This section presents four conceptual frameworks which seek to explain the linkages and relationship between global health and national security. Each of these four frameworks illuminates different aspects of this complex nexus, and each framework will be discussed and tested against the historical case studies described in Chapters 4-6.

2.2 The global epidemiology of HIV/AIDS

The Human Immunodeficiency Virus (HIV) causes Acquired Immunodeficiency Syndrome (AIDS), which leads to the failure of the immune system and life-threatening opportunistic infections if untreated. First described in 1981, HIV/AIDS has become a global pandemic affecting virtually every country in the world (CDC 1981, UNAIDS 2006). UNAIDS (2006) estimates that HIV/AIDS has infected 65 million people, 25 million of whom have so far died of the disease. In 2007, new UNAIDS (2007) estimates 33.2 million people are living with HIV/AIDS. 2.5 million are estimated to have become newly infected in 2007, while 2.1 million died of AIDS (UNAIDS 2007). These estimates represent a significant reduction from 2006 estimates. UNAIDS attributes this reduction to improved methodology and available country-level data,

particularly in Angola, India, Kenya, Mozambique, Nigeria and Zimbabwe (UNAIDS 2007). However, some authors have argued that UNAIDS deliberately overstated global estimates and potential for transmission to non-high risk populations to increase political attention and funding for the pandemic (Chin 2007; McNeil 2007).

Sub-Saharan Africa is the most affected region of the globe with 68% of global infections and 22.5 million persons infected (UNAIDS 2007). Seventeen countries in this region have adult prevalence rates above 5%. Botswana (24.1%), Lesotho (23.2%), Mozambique (16.1%), Namibia (19.6%), South Africa (18.8%), Swaziland (33.4%), Zambia (17%), and Zimbabwe (20.1%) have severe epidemics with adult prevalence rates estimated at over 15% (UNAIDS 2006). The epidemic in sub-Saharan Africa appears to be stabilizing at high levels of infection, with deaths from AIDS matching new infections, and declines in prevalence in some countries. Approximately 810,000 people are on antiretroviral (ARV) therapy in the region (UNAIDS 2006).

After Africa, the Caribbean is the second most affected region of the world by percentage of infected persons. An estimated 230,000 persons are estimated to be living with HIV/AIDS in the region, with epidemics driven by heterosexual transmission in the context of poverty and gender inequality (UNAIDS 2007). Rates of HIV/AIDS have stabilized in some areas of Haiti and the Dominican Republic, and ARV therapy in Barbados and Bahamas has reduced deaths from AIDS. Despite these successes, AIDS remains the leading cause of death among adults in the region (UNAIDS 2006). Haiti and Bahamas have the highest adult prevalence rates in the region: 3.8% and 3.3% respectively (UNAIDS 2006). Barbados, Dominican Republic and Jamaica all have rates above 1%, while Trinidad and Tobago has an estimated adult prevalence of HIV/AIDS of 2.6%.

Asia has an estimated 4.9 million people living with HIV/AIDS. 2.5 million of these live in India. India's large population results in a national HIV/AIDS prevalence of 0.36% (UNAIDS 2007). A similar situation exists in China, where 650,000 people are living with HIV/AIDS but only 0.1% of all adults are infected (UNAIDS 2006). Prevalence of HIV/AIDS among the countries of South-East Asia is between 0.1% - 1.5%. Epidemics in Thailand and Cambodia are declining because of successful prevention efforts.

Myanmar (Burma), Vietnam, and Indonesia are experiencing fast growing epidemics. Approximately 180,000 people are on ARV therapy in Asia (UNAIDS 2006).

Eastern Europe and Central Asia have fast growing epidemics accounting for 1.6 million people living with HIV/AIDS (UNAIDS 2007). Russia and the Ukraine account for almost all of the infections in this region. Estimates of total HIV/AIDS infections in Russia and the Ukraine are 940,000 and 4100,000 respectively (UNAIDS 2006). Transmission in this region occurs predominantly through injection drug use or sex with injection drug users. High rates of HIV/AIDS among prison populations, who have little ability to learn about or prevent HIV/AIDS, are also contributing to these epidemics. Access to ARV therapy is low in the region, with only 13% receiving needed treatment (UNAIDS 2006).

The situation in Latin America, home to 1.6 million people living with HIV/AIDS, is mixed. Successful interventions have limited prevalence of HIV/AIDS to under 1% in Argentina, Brazil, Chile, Costa Rica, Mexico, Panama, Uruguay, and Venezuela (UNAIDS 2006). Brazil in particular has been successful in offering widespread access to ARV therapy. 73% of persons in the region who need treatment are receiving ARV therapy, the majority of these in Brazil. However, intense epidemics are occurring in Belize, Guyana and Honduras with adult prevalence rates above 1.5% (UNAIDS 2006). Men who have sex with men are a driver of the epidemic that is under-addressed by governments because of stigma. Heterosexual transmission is also on the rise.

2.1 million people are living with HIV/AIDS in North America, Western and Central Europe (UNAIDS 2007). Deaths from AIDS have been dramatically reduced in these regions because of widespread access to ARV therapy. However prevention of new infections has been less successful with continuing transmission from heterosexual and gay sex, as well as injection drug use. The United States, with 1.2 million people living with HIV/AIDS, faces particular problems reducing the rapid growth of the epidemic among women and racial minorities. In Western and Central Europe, with 720,000 people living with HIV/AIDS, the primary transmission route is through heterosexual sex. The dramatic decrease in deaths from AIDS differentiates these regions from other areas of the globe.

Oceania has an estimated 75,000 infected persons, with Papua New Guinea accounting for over 70% of these infections (UNAIDS 2007). The national prevalence rate in Papua New Guinea is 1.8%, where the epidemic is continuing to grow through heterosexual transmission and insufficient government action (UNAIDS 2006). Australia accounts for 16,000 of the other infections in Oceania (UNAIDS 2006). Australia's epidemic is driven primarily by unsafe sex between men.

With the exception of Sudan, adult prevalence of HIV/AIDS is below 0.1% in North Africa and the Middle East (UNAIDS 2006). Sudan faces a serious epidemic with national adult prevalence estimated at 1.6% (UNAIDS 2006). Epidemics are growing in Algeria, Islamic Republic of Iran, Libyan Arab Jamahiriya and Morocco. The main mode of transmission is unprotected sex, although injection drug use is a major factor in the Islamic Republic of Iran and Libyan Arab Jamahiriya. There is a lack of epidemiological and public knowledge about HIV/AIDS in the region (UNAIDS 2007).

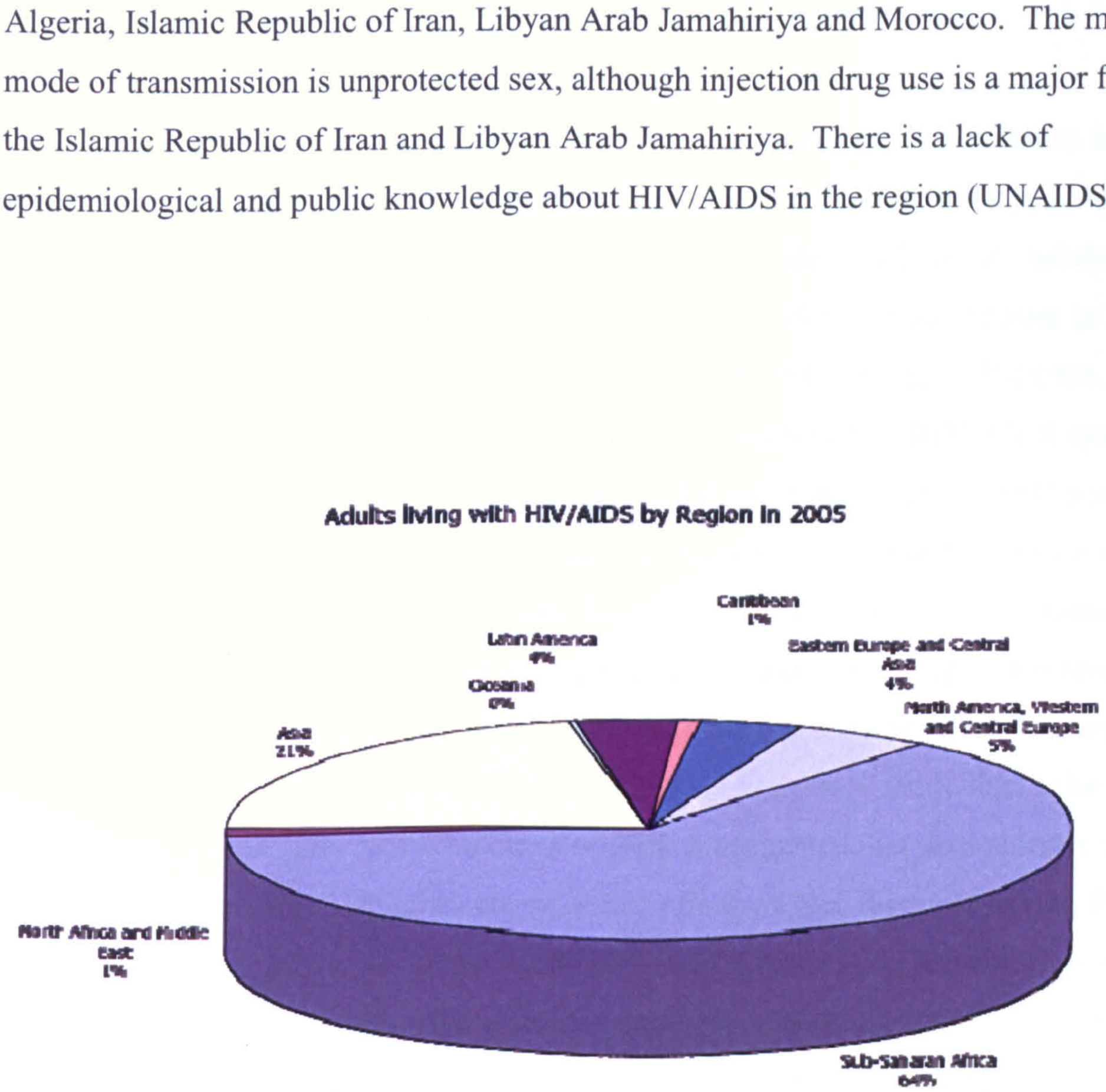

Figure 2.1: Adults living with HIV/AIDS by region in 2005. Adapted from UNAIDS 2006.

2.3 The global response to HIV/AIDS

The global response to the HIV/AIDS pandemic has been insufficient to stop the spread of the disease. Barnett and Whiteside (2002: 5) describe the response of government and international institutions as "glacial," while UNAIDS (2006: 4) states that "the response to the AIDS epidemic to date has been nowhere near adequate." Prins (2004: 931) writes that the response to HIV/AIDS has been so insignificant that a visitor from Mars observing the pandemic "would conclude that humanity took a conscious decision in the early 1980s to allow the pandemic to run without interference..." In only 25 years, HIV has spread from localized "hot spots" of infection to nearly every country on the planet, infecting 65 million people and killing 25 million (UNAIDS 2006: 4).

The causes of this slow response are mulitfactoral. Farmer (1992, 1999, 2003) argues that stigma associated with HIV/AIDS and structural violence against the poor have inhibited responses to the pandemic. Barnett and Whiteside (2002) argue that the long timeframe from HIV infection to the development of AIDS has made it easier to deny the epidemic until it is too late for effective control. Feachem (2003: para. 10) cites examples of people denying that their "culture" is susceptible to a HIV/AIDS epidemic. Eberstadt (2002: 23) writes that the response to HIV/AIDS has been "muted" because the most affected region of Sub-Saharan Africa has minimal importance to global economics and politics and is therefore ignored. The fact that HIV/AIDS is a sexually transmitted disease that was initially discovered among socially stigmatized groups including gays and drug users, added to the stigma associated with the disease and reluctance to public address the epidemic (Valdiserri 2003; Putzel 2003). Economic modeling of the impact of HIV/AIDS in the early 1990s by the World Bank suggested that the epidemic would have benign, or even beneficial macroeconomic effects, which downplayed the threat of HIV/AIDS (Putzel 2003). A failure to comprehend the magnitude and complexity of the HIV/AIDS pandemic also contributed to the slow response (Putzel 2003; Valdiserri 2003). Epstein (2007), and Chin and Bennett (2007) argue that the global response has been held back by not correctly perceiving the critical role concurrent sexual networks play in driving the epidemic. These, and other factors at the global, national, and local levels, have contributed to the inadequate response to HIV/AIDS and the pandemic's continued growth.

Successes in reducing rates of HIV/AIDS at the national level are rare but do exist. Uganda has seen a stabilization of national HIV/AIDS prevalence since the mid-1990s (Okware et al. 2001; Green et al. 2006). However the extent of this success, and its causes, are subject to considerable debate (Parkhurst 2002; Allen 2005; Green et al. 2006). Thailand also successfully reduced prevalence of HIV/AIDS during the 1990s by promoting condom usage during commercial sex, but is facing challenges maintaining this success (UNDP 2004; UNAIDS 2006; Ainsworth et al. 2003). Brazil's response to HIV/AIDS has offered universal access to ARVs, which has helped bring the epidemic under control (Piot and Coll Seck 2001; Galvao 2002; Oliveira-Cruz et al. 2004). Despite these successes, the HIV/AIDS pandemic has continued to grow in most countries.

2.4 What is Security?

Security is a contested concept. Scholars and practitioners of security studies have offered dozens of definitions over the last 60 years, with none achieving the widespread recognition of, for example, the WHO Constitution's definition of health.[4] Disagreement covers all aspects of the term "security" save one: that security entails freedom from threats or danger. The focus of security, or whose security is important, from individuals to nation states to global society to levels in between, is the central question in this ongoing debate. Moreover, the nature of potential threats to security, from foreign militaries to infectious diseases, also remains contested.

Buzan, Wæver, and de Wilde (1998) describe security as the survival of a referent object. They use the concept of "levels of analysis" to site the referent object. Buzan's (1983) earlier work identified three "levels" of security: the individual, state and global, while Buzan et al. (1998: 5) cite five levels of analysis. Levels of analysis are not a theory of security or international relations; the concept provides a heuristic framework for understanding theories of security and whose security is to be protected.

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[4] Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

2.4.1 National Security

The traditional and still dominant approach to security studies focuses on security at the level of the state, i.e. national security. The state is the referent object of national security. National security has traditionally been pursued as the number one priority of governments because, it is argued, without survival of the state, no other priorities or goals of government can be achieved. Referencing the neorealist assumption of an anarchic international system, Waltz (1979: 126) argues, "In anarchy, security is the highest end. Only if survival is assured can states safely seek such other goals as tranquility, profit, and power." Governments seek to protect and promote their national security through their military, economic, domestic, and foreign policies.

However, how states have defined their national security has undergone a contested broadening and narrowing over the last eighty years. For the great powers during the interwar period, diplomacy, international understanding, national self-determination and disarmament were viewed as the most important means to promoting security (Baldwin 1995). Immediately following World War II until 1955, security was not seen as the primary goal of all states, but rather "as one of several values, the relative importance of which varied from one state to another…" (Baldwin 1995: 122). Furthermore, national security was to be pursued using both military and non-military approaches.

After 1955, a significant narrowing of security studies occurred, due to the advent of nuclear weapons and onset of the Cold War. Calling the period between 1955–1965 the "golden age" of security studies, Walt stated that the "central question was straightforward: how could states use weapons of mass destruction as instruments of policy, given the risk of nuclear exchange" (Walt 1991: 214). Smith (1999: 72) recalls the sense of control that such a narrow definition of security offered: "I remember only too well the buzz that being a 'master of the universe' of nuclear matters gave me… It was a world of clear parameters and established facts." Walt (1991: 212) clearly expresses this narrow definition of security studies as "the study of the threat, use, and control of military force."

This vision of national security, focused on the nuclear threat, deeply affected the security community's perspective of what constituted a security threat. Threats were defined as external and military in nature, such as that posed by the Soviet Union to the Western world during the Cold War. Elbe (2006b: 2) argues that during the Cold War, the "greatest threat to the West (and indeed mankind) was… deemed to emanate from the armed forces, especially nuclear capabilities, of other states. Twentieth century security policy evolved in a way that reflected these… historical conditions…" Furthermore, threats to national security were to be addressed by the build up of military power to create a balance of power. These ideas are deeply rooted in realist and neo-realist perspectives of international relations. Tickner (1995: 176) summarizes the realist perspective: "For realists, the meaning of security was subsumed under the rubric of power. Conceptually, it was synonymous with the security of the state against external dangers, which was to be achieved by increasing military capabilities." Ayoob (1995) similarly summarizes the realist perspective:

> as it has been traditionally used in international relations literature, the term security is based upon two major assumptions: one, that most threats to a state's security arise from outside its borders, and, two, that these threats are primarily, if not exclusively, military in nature and usually require a military response if the security of the target state is to be preserved. (Ayoob 1995: 5)

This vision of national security and desire for clarity in the field has persisted into the present day.

2.4.2 Broadening of national security

This narrow conceptualization of national security began to be challenged in the 1980s. Writing about U.S. administrations since the beginning of the Cold War, Ullman (1983: 129) argues that "every administration in Washington has defined American national security in excessively narrow and excessively military terms. Politicians have found it easier to focus the attention of an inattentive public on military dangers, real or imagined, than on nonmilitary ones…" Ullman writes that pursuing national security in only military terms is dangerous for two reasons. First, this perspective causes states to focus only on military threats and ignore possibly harmful non-military threats. Second, he argues that this perspective causes a militarization of international relations that will

increase global insecurity in the long-term. Seeking to redress the narrow focus on external military threats, Ullman offers a new and broader definition of national security. He writes,

> a threat to national security is an action or sequence of events that (1) threatens drastically and over a relatively brief span of time to degrade the quality of life for the inhabitants of a state, or (2) threaten significantly to narrow the range of policy choices available to the government of a state or to private, nongovernmental entities (persons, groups, corporations) within the state. (Ullman 1983: 133)

Mathews (1989: 162) similarly argues that a redefinition of security is required to "include resource, environmental and demographic issues." Addressing transnational threats such as environmental disasters requires the dismissal of the close linkage between national sovereignty and national borders, and new diplomacy to "cope with the world's growing environmental interdependence" (Mathews 1989: 174).

The concept of "common security," first created by the 1982 Independent Commission on Disarmament and Security Issues, known as the Palme Commission, also sought to provide an alternative to traditional conceptions of national security. The Commission was heavily influenced by the threat of nuclear war between the two superpowers. Instead of responding to this threat with the buildup of military power, they conceived of this mutual threat as creating interdependence in the international system. The Commission wrote "our interdependence reflects the crucial technological fact of the contemporary age: *there are no effective defences against missiles armed with nuclear warheads*..." (Independent Commission on Disarmament and Security Issues 1982: 5). In such an environment, "military strength alone cannot provide real security" (Independent Commission on Disarmament and Security Issues 1982: 4). The Commission concluded that states must cooperate to reduce nuclear and other arms, and to isolate and manage conflict in international society when it occurred.

Collective or common security does not differ from national security in that it still focuses on states as the main players in the international system, and the fundamental role of military power in affecting relationships between states. However, collective security departs from national security's belief that the buildup of military power is the only possibility defense in an anarchic international system. The collective security

perspective holds that states can build trust in the international system, and thus create collective security arrangements which maintain stability, prevent conflict, and stop aggression (Baylis 2001).

The collective security perspective defines security threats more broadly than national security. While maintaining that states are the fundamental players in the international system, a collective security perspective suggests that threats can come both from state and non-state sources. The Palme Commission began this broadening of the definition of security to focus on people's well-being. It states, "common security requires that people live in dignity and peace, that they have enough to eat and are able to find work and live in a world without poverty and destitution" (Independent Commission on Disarmament and Security Issues 1982: 172). Collective security challenges the national security perspective by advocating cooperative arrangements between states to manage conflict, and embracing a broader conception of threats to security.

While collective security focused on a different way to achieve security between states, the "third world security school" examined national security from the perspective of the weaker and poorer states of the South (Smith 1999: 81). Ayoob (1995) argues that the traditional definition of security, focused on external military threats, is a Western concept and ill-suited to application in the third world. Specifically, security threats to third world states frequently emanate from inside the state and are often "domestic challenges to the legitimacy of political regimes frequently supported by outside intervention" (Tickner 1995: 179). Ball (1988) argues that economic security is closely tied to national security in the third world because conflicts can arise when elites cling to exploitative social, economic and political systems. Thomas (1987) argues for an expansive definition of threats to national security and that basic human needs should be considered a dimension of national security. A final and important aspect of third world security studies is the observation that the pursuit of security between the great powers has generated insecurity for the third world. Ayoob (1995: 7) observes that superpower competition turned "the Third World into a relatively low-cost, low-stakes arena in which the rivalries of the major powers could be played out without affecting those powers' vital interests or posing the threat of general war in the nuclear age." The third world security school challenged the definition and breadth of traditional national security, while remaining focused on the level of the state.

The end of the Cold War provided further challenges to the traditional and narrow conception of national security. Smith (1999: 75) writes that "neorealism suffered massively because of its inability to cope with the end of the Cold War. Nor does it seem able to account for the patterns of international conflict that have replaced the Cold War." Baldwin (1995: 132) also finds the field of security studies to be

> poorly equipped to deal with the post-cold war world, having emerged from the cold war with a narrow military conception of national security and a tendency to assert its primacy over other public policy goals. Its preoccupation with military statecraft limits its ability to address the many foreign and domestic problems that are not amenable to military solution.

Both collective and third world security challenged the traditional conception of national security. However like national security, both theories remain firmly focused at the level of the state. After the end of the Cold War, a new conception of security was offered which sought to move the referent object of security from the state to the individual. This radical re-conceptualization of security, termed human security, places individuals as the primary referent object.

While the earliest conceptions of human security date from discussions on the establishment of the UNSC in 1945, the United Nations Development Programme's (UNDP) seminal *Human Development Report* in 1994 reintroduced the concept as "freedom from fear, freedom from want" (UNDP 1994: 24). UNDP writes that human security has two main aspects that grow from this initial definition of freedom from fear and want. The report states that human security is "safety from such chronic threats as hunger, disease, and repression. And second, it means protection from sudden and hurtful disruptions in the patterns of daily life – whether in homes, in jobs or in communities" (UNDP 1994: 23).

The focus on the security needs of individuals, over state militaries and their balance of power, represents a radical shift in perspective away from the state-based approaches outlined above. This shift in perspective is intentional. UNDP introduces the concept of human security by stating that "[t]he concept of security has for too long been interpreted narrowly: as security of territory from external aggression, or as protection of national interests in foreign policy or as global security from the threat of nuclear holocaust. It

has been related more to nation-states than to people" (UNDP 1994: 22). Human security is needed because although the "state remains the fundamental purveyor of security… it often fails to fulfill its security obligations – and at times has even become a source of threat to its own people" (Commission on Human Security 2003: 2). By viewing individuals as the referent object of security, human security seeks to protect people, not just borders from external military aggression.

Accompanying this radical reconceptualization of the referent object of security is a broadening of what is considered a threat to security. UNDP (1994) categorizes the types of threats to human security into seven areas: economic, food, health, environmental, personal, community and political. The Canadian government, along with Japan and Norway, has incorporated human security into their security policies and defines the concept at "safety for people from both violent and non-violent threats" (King and Murray 2001/2002: 590). Other authors decline to enumerate a list of threats to human security, but write that human security seeks to protect people and communities from "a broad range of threats" that vary by society and individual (Commission on Human Security 2003: 2). Ingram (2005a: 524) finds the common theme across these diverse efforts to broaden the concept of national security, writing that "it is the sense of urgency and priority that proponents of these concepts wish to mobilize, while de-centering the state."

2.4.3 Backlash against expansive definitions of security

While these attempts to incorporate different levels of security, and a broader range of issues, into the theory and practice of security found adherents, traditional conceptions of security that focus on the state and military threats remain prevalent among policymakers and in many academic circles (McInnes 2004b). A number of authors fought back against both attempts to incorporate new issues such as the environment or HIV/AIDS into the national security discourse, and human security's attempt to reorient the referent object of security towards individuals. The most common argument against the expansion of security studies is that a broader definition of security will be less able to prioritize threats and therefore destroy the very purpose of security studies. Walt (1991: 212) argues that declaring issues such as "pollution, disease, child abuse, or economic recessions" to be threats to security excessively expands the field. "Defining the field in

this way would destroy its intellectual coherence and make it more difficult to devise solutions to any of these important problems" (Walt 1991: 213). Others argue that a broad definition of security will make security studies inseparable from regular foreign policy (Baldwin 1995). The common refrain summarizing this argument is: if everything is a security issue, then nothing is.

Deudney specifically attacks the linkage of environmental degradation to national security.[5] Echoing Walt's argument, Deudney (1990: 266) writes that "Disease, old age, crime and accidents routinely destroy life and property, but we do not think of them as 'national security' threats or even threats to 'security'... If everything that causes a decline in human well-being is labeled a 'security' threat, the term loses any analytical usefulness and becomes a loose synonym of 'bad'." Deudeny also argues that the primary purpose of declaring environmental degradation to be a security threat is to simulate political action. However, he believes this appeal will backfire because the "'whole earth' sensibility at the core of environmental awareness" calls into question the privileging of states and their national security in world politics (Deudeny 1990: 268). Deudeny concludes that the linking of environmental problems to national security is both analytically inaccurate and unlikely to benefit the environmental cause.

Efforts to move the referent object of security from states to individuals have been similarly criticized. Paris (2001: 102) describes the concept of human security as "so vague that it verges on meaninglessness – and consequently offers little practical guidance to academics... or to policymakers who must prioritize among competing policy goals." Paris finds that proponents of human security have a vested interest in keeping the concept broad and ambiguous because this helps unite the coalition of states and organizations seeking to use human security to appropriate political and financial resources traditionally associated with national security. Khong (2001: 233) describes the results of securitizing every individual on the planet as "(total) paralysis of our ability to prioritize" and unlikely to aid the poor and destitute of the world.

2.4.4 The enduring nature of national security

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[5] Deudney's article is used by Peterson (2002) as a template for her examination of the risks and benefits of securitizing HIV/AIDS.

Despite considerable debate about the definition of threats to security and what the legitimate referent object of security is, the powerful and influential nature of the national security perspective remains. Khong (2001: 231) explains that once an issue is securitized "its status in the policy hierarchy changes. It becomes an urgent issue, worthy of special attention, resources, and fast-track or immediate amelioration or resolution, perhaps even by military means." Buzan et al. (1998: 29) write that securitization "means to present an issue as urgent and existential, as so important that it should not be exposed to the normal haggling of politics but should be dealt with decisively by top leaders prior to other issues." Thus despite the conceptual debates, issues that are considered threats to the security of a state will rise to the highest levels of national and international politics.

2.5 How do issues become securitized?

To understand how issues come to be considered security threats, or are securitized, we turn to the work entitled *Security: A New Framework for Analysis* by Buzan et al. (1998). Described by Elbe (2006a: 126) as the "*locus classicus*" for understanding securitization, Buzan et al. (1998) argue that security is not simply about the use of force, but about a particular type of politics. Security politics are an extreme version of politicization where rules may be broken and emergency measures adopted to address an issue. Thus Buzan et al. (1998) define securitization as when an issue is presented as an existential threat to a referent object (usually but not exclusively the state) that legitimizes emergency measures that would have been impossible before securitization.

While traditional approaches to security define security and "then seek to ascertain empirically whether an issue *genuinely* represents a security threat," Buzan et al. argue that objective measures of security do not exist (Elbe 2006a: 127). Security analysis is concerned with future threats and prioritization based on imperfect information which prevents objective measurement of threats to security. Furthermore, different referent objects will have different thresholds for threats, which also prevent objective measurement of what is or is not a security threat. Instead of seeking objective measures of security, Buzan et al. (1998: 25) argue that securitization can be understood as "the intersubjective establishment of an existential threat with a saliency sufficient to have substantial political effects." An issue is a security threat "not necessarily because a real

threat existential threat exists but because the issue is presented as such a threat" (Buzan et al. 1998: 24). The authors define "security" as a move "that takes politics beyond the established rules of the game and frames the issue either as a special kind of politics or as above politics… as a more extreme version of politicization" (Buzan et al.1998: 23).

To explain securitization as the presentation and acceptance of an existential threat to a referent object, Buzan et al. (1998) utilize speech act theory. Speech act theory holds that language can do more than simply convey information, language can perform actions (Elbe 2006a). They cite the examples of betting, making a promise, and naming a ship. These actions are performed by speaking, but "by saying the words, something is done" (Buzan et al. 1998: 26). Securitization is a similar process. In securitization, an issue is presented as an existential threat to a referent object. This is a securitizing move, a linguistic claim that an issue should be addressed with the highest priority and emergency measures. If this securitizing move is accepted and emergency measures are legitimated, then the issue has become securitized. The speech act of presenting an issue as a security threat has generated action.

Buzan et al. (1998) describe three units involved in analysis of securitization: referent objects, functional actors, and securitizing actors. *Referent objects*, as previously discussed, are things that are perceived to be existentially threatened and deserve protection. *Functional actors* are those who influence the dynamics of securitization, but who are neither the referent object nor securitizing actor. *Securitizing actors* are persons or a group of persons who perform the securitizing speech act. Not every actor can successfully argue for securitization. Certain actors, such as political leaders, governments, and pressure groups are more privileged in articulating a securitizing move because their arguments are more likely to be accepted. To what extent those in global health have been functional or securitizing actors in the HIV/AIDS – national security nexus is an important question this thesis will seek to address.

Not all securitizing moves result in securitization. Only when a securitizing move is accepted and emergency actions are legitimated can an issue be considered securitized. Buzan et al. (1998: 31) write that 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?" Elbe (2006a) summarizes the process of securitization as having four constituent components. The process begins with (1) *securitizing actors* who argue that a (2) *referent object* is (3) *existentially threatened* which justifies the use of (4) *emergency measures* to combat the threat.

Because Buzan et al. (1998) find that security threats are not measurable by objective standards, and that securitization is a form of intersubjective politics, the securitization of issues is a political choice. Securitizing actors must chose to present an issue as a security threat, and an audience must choose to accept this argument and legitimize emergency measures. Buzan et al. (1998: 29) caution that the choice of "[n]ational security should not be idealized," and that security should be seen as a failure to address issues through normal political processes. They argue that national security can provide opportunities to silence opposition, exploit threats for domestic purposes, address an issue with less democratic control and oversight. However these negatives must be weighted against the possible advantages of securitization, including "focus, attention and mobilization" (Buzan et al. 1998: 29). The implications of securitization theory for HIV/AIDS are considered in greater detail by Elbe (2006a) and are summarized in Chapter 3.6.2.

This research argues that securitization theory provides a powerful tool for understanding how HIV/AIDS became a national security issue, and offers an outline of the possible risks and benefits that accompany securitization. This thesis will utilize Buzan et al.'s definition of security and securitization theory because, uniquely among security perspectives, it offers a method of analyzing the processes and impacts of securitization.

2.6 Frameworks for understanding the HIV/AIDS – national security nexus

The securitization of HIV/AIDS and other health issues represents a "revolution" in the treatment of global health issues (Fidler 2004: 45). Fidler (2004: 45) argues that "Nothing in the prior history of national and international efforts on public health compares to the political status public health has reached today." A number of authors have examined this "revolution" seeking to understand the new relationship between

national security and global health. In three papers, (Feldbaum& Lee 2004; Feldbaum et al. 2006a, and Feldbaum et al. 2006b) Feldbaum et al. describe differences in values, referent objects and culture between national security and global health. These differences are discussed here under the framework of a communitarian – cosmopolitan dichotomy as described by Brown (1992). Lee and McInnes (2004) examine the influence and independence of global health when interacting with national security, and offer a prescriptive framework for how global health and national security should interrelate. Finally, Fidler (2005a and 2005b) seeks to explain the political rise of public health and what it means for the relationship between the global health and national security fields through two related frameworks.

These four frameworks seek to explain and illuminate different aspects of the HIV/AIDS – national security nexus. Each author has mustered evidence to support their framework, but how well do these frameworks explain or apply to the historical events of the HIV/AIDS – national security nexus? After outlining each conceptual framework in this chapter, this thesis will 'test' the frameworks for their explanatory power in the following historical chapters. The conceptual frameworks will be noted when they explain a particular event or action in the nexus. Aspects of the frameworks that are confirmed by the historical case studies will be noted and used to further illuminate the events. This thesis will also note when the four conceptual frameworks fail to explain an event, thus showing areas for further development of conceptual frameworks seeking to explain the links between global health and national security.

2.6.1 Communitarianism and cosmopolitanism in the HIV/AIDS – national security nexus

The goals and values of national security, which seek to ensure the survival of a single state against threats which have traditionally been conceived as military and external to the state in nature, have been described above. Using Brown's (1992) survey of normative theory, the normative perspective of national security may be described as *communitarianism*, defined as placing the focus of world politics on the political community of the state (Smith 2001). This communitarian position bears resemblance in

practice to the realist theory of international relations.[6] However, Brown's normative perspectives are focused on moral and ethical values. This focus on values, as opposed to theories of international relations, is essential to enable comparisons with the field of global health. This is because the practice of global health is associated with no theory of international relations, but does carry strong values that often conflict with the communitarian position. An example of the communitarian position may be found in Condoleezza Rice's vision for U.S. national security expressed during the 2000 U.S. elections. Rice (2000: 47) opposes replacing the U.S. national interest with "'humanitarian interests' or the interests of 'the international community.'" She argues the pursuit of U.S. national interests should be the primary objective to U.S. policy. Rice (2000: 47) opines that "there is nothing wrong with doing something that benefits all humanity, but that is, in a sense, a second order effect" to the pursuit of national interests. Thus Rice expresses a communitarian position, that the proper focus of politics is the state, in this case, the U.S. and its interests.

Communitarianism is one of the two main normative positions on world politics (Brown 1992). In contrast, *cosmopolitanism*, as defined by Smith (2001: 230) focuses not on states but on "humanity as a whole or on individuals." The vision of global health as seeking "to improve the world's health, including that of the most vulnerable peoples" is a cosmopolitan one (Feldbaum et al. 2006b: 196). This cosmopolitan world view is deeply embedded in the global health community. Addressing a global health audience, Daulaire (2003: 1) writes:

> Most of us in health professions have a simple response to the question of why we engage in global health: because it is right to help those who are sick and in need, and because this is at the heart of our calling. It is an opportunity to give back for all we have been given.

Fidler (2004: 50) traces the history of public health activities and finds that the cosmopolitan perspective of global health developed after public health successes in developed countries led to public health becoming "associated with improving health conditions and services in poor, developing countries." Global health efforts eschewed national security considerations and were "predominantly matters of humanitarianism

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[6] The realist theory of international relations is different from the commonly used term realpolitik, which refers to the "adoption of policies of limited objectives which had a reasonable chance of success" (Evans and Newnham 1998).

that did not directly affect the national interests of richer, more affluent countries" (Fidler 2004: 50). Beyond being separate from national security, Fidler writes that conceptions of global health outlined in the Preamble of the WHO Constitution were actually designed to be in opposition to the framework of national security and communitarianism, (what Fidler terms the "Westphalian" or "power paradigm." Fidler (2004: 64-65) writes:

> The Preamble of the WHO Constitution expresses… a perspective on public health almost completely at odds with the premises and assumptions informing the power paradigm… the WHO Constitution turns its back on thinking about health and infectious disease threats through the Westphalian lenses of state-centrism, competitive national interests, and power. The Preamble instead expresses a vision of health and infectious disease threats in terms of individual rights, human solidarity, and universal justice.

Fidler (2004: 68) finds that the WHO Constitution ushered in a post-World War II era of international health cooperation focused on health in developing countries, "the right to health, universal health solidarism in the international health community, and redistributive justice on a global scale." Furthermore, public health shifted towards disease-specific health strategies, which bypassed notions of national sovereignty and non-intervention that formed the basis of the Westphalian framework and communitarian perspective, to focus on certain health needs of individuals and communities within states. The overall normative basis of global health is cosmopolitan in perspective, focused on health of individuals and communities, rather than the interests of states.[7] Fidler's historical perspective demonstrates the contrast and conflict between global health's cosmopolitan position and the communitarian perspective of national security.

The conclusion that the normative perspectives of global health and national security are different may be considered obvious to some in the global health community. However, this conclusion is not shared by all those involved in the HIV/AIDS – national security nexus. The 2002 U.S. *National Security Strategy* argues that U.S. values and national interests form a "union" that is the basis of U.S. national security (White House 2002: 1). In this statement, the Bush Administration is arguing that U.S. can pursue communitarian interests and cosmopolitan values without sacrificing either. In fact, the basis of the U.S.

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[7] This has not prevented politically savvy global health actors, such as Richard Feachem, Peter Piot, and the U.S. Institute of Medicine from occasionally arguing that global health is in a state's communitarian interests to support. This is however, the exception to the generally humanitarian and cosmopolitan normative basis of global health.

National Security Strategy is the concurrent pursuit of both communitarian interests and cosmopolitan values. As an example, the *Strategy* cites disease, poverty and war in Africa. The *Strategy* argues that these threaten "both a core value of the United States – preserving human dignity – and our strategic priority – combating global terror" (White House 2002: 10). The 2003 UK Foreign and Commonwealth Office *International Priorities* strategy paper also links improvements in global health to improvements in UK national security (Feldbaum et al. 2006b). Feldbaum et al. (2006b: 196) critique this linkage of communitarian interests and cosmopolitan values in U.S. and UK security strategies and conclude:

> the objectives of global health and national security are different. Global health is a humanitarian endeavor that seeks to improve the world's health, including that of the most vulnerable peoples, while national security works to protect the interests of people within a given state. Thus, while the interests and objectives of global health and national security may at times overlap, it is important to recognize that they can also come into direct conflict.

Representing broadly accurate generalizations about the global health and national security communities, the communitarian – cosmopolitan dichotomy provides a useful framework for examining the interaction of these communities in relation to HIV/AIDS. This dichotomy helps illuminate three specific differences between national security and global health. First, national security and global health have different objectives. The objective of national security is the protection and pursuit of a state's national interests. It is a second order consideration whether this pursuit benefits persons in other countries. The objective of global health is to improve the health of all people within and across states, with a special focus on the health of the poorest and most vulnerable populations.

Second, national security and global health have different referent objects. National security is focused on the state, while global health focuses on human communities (Feldbaum and Lee 2004). These human communities may overlap with national boundaries, but more often exist above or below the state level. For example, regional and global communities are addressed in UNAIDS yearly reports on the state of the HIV/AIDS pandemic. Transnational ethnic groups, such as Kurds living in Western Turkey and Northern Iraq, form communities that stretch across states, while subnational groups such as the Navajo Nation within the U.S. or inhabitants of cities form

communities below the state level that are the subject of public health efforts. Only rarely do the referent objects of national security and global health coincide.

The different objectives and referent objects of national security and global health, embodied in the communitarian – cosmopolitan dichotomy, may undermine cooperation in the HIV/AIDS – national security nexus. The different normative perspectives of each field ensures that a complete harmony of interests is unlikely to occur while addressing the HIV/AIDS pandemic. Resolution of differences in favor of national interests may compromise global health activities, while privileging global health over national security may serve to reduce high-level state involvement in fighting HIV/AIDS.

The third consequence of the communitarian – cosmopolitan divide between national security and global health is the resulting difference in the cultures of each field. These cultural differences may begin with the personalities, values, and politics of the people involved in each field. Persons for whom global health's humanitarian efforts resonate will be drawn to global health. Those who find the national security perspective and the pursuit of national interests compelling will migrate into the national security field. Ken Bernard (Interview) explains that people in national security are different from people in global health: "You find people who want to do security things, they just like it. They like thinking about nuclear weapon defense. They're not interested in immunizing children to protect against measles. If they were, they'd go into that." The different normative perspectives of national security and global health may cause culture shock as people from each field reject the normative perspective of the other and therefore the linkages between the fields. These cultural differences may seriously inhibit understanding and cooperation in the HIV/AIDS – national security nexus (see Figure 2.2).

	Global Health	**National Security**
Normative perspective	Cosmopolitan	Communitarian
Objective	Improve health of all people	Ensure survival of one state
Referent Object	Human communities	State
Culture	Humanitarian	Power Politics

Figure 2.2 Different perspectives of global health and national security

2.6.2 Models of engagement for global health and national security

Lee and McInnes (2004) offer a different framework for understanding the relationship between global health and national security. Instead of examining the normative perspectives of each field, Lee and McInnes examine the capacity of the global health community to maintain influence and independence in its interactions with the more powerful national security community. They describe models and examples of how the fields of global health and national security relate to each other. These models demonstrate the different interactions that take place between global health and national security. Lee and McInnes then evaluate the risks and benefits of these models for cooperation between global health and national security and suggest a course of action that maintains global health's independence and influence.

The first model Lee and McInnes (2004: 16) present is that of global health as "supplicant" to the more powerful and influential national security community. As evidence, Lee and McInnes cite Feldbaum and Lee (2004: 26) who argue that a group of global health leaders have sought to increase attention and funding for global health "through appeals to the self-interest of wealthier countries." These "politically-savvy public health leaders such as Kenneth Shine, Richard Feachem, Gro Harlem Brundtland and Peter Piot" describe global health problems such as HIV/AIDS as threats to national security and foreign policy interests to gain increased focus on these health problems at high levels of government (Feldbaum and Lee 2004: 26). Lee and McInnes (2004: 16) describe this relationship as "supplicant," because global health is "a supplicant looking to other policy communities for assistance." Garrett (2000) describes public health as being a supplicant to national security interests in cooperation in addressing the threat of bioterrorism. Garrett (2000a: 550) writes that in their interactions with the defense, intelligence and law enforcement communities, public health "was on board the train, but clearly not in the conductor's seat." From a global health perspective, Lee and McInnes find this relationship unsatisfactory because the resulting policy will be driven by national security and foreign policy interests, not those of global health. They recognize

that some benefits may accrue from this type of relationship, but argue that in a supplicant relationship, the most pressing global health issues are unlikely to be addressed and that policies aimed at alleviating human suffering may be compromised by power politics.

The second model for the relationship between global health and national security is that of the "Trojan horse." In this model global health uses health issues that resonate with traditional national security concerns, such as bioterrorism and infectious disease epidemics, as a "Trojan horse" to gain a "place at the table" with national security (Lee and McInnes 2004: 16). Having secured a place in national security and foreign policy debates, global health can then attempt to influence the agenda to better address global health problems. Lee and McInnes (2004: 16) note that the risk of this model is that, having secured a place at the table, global health may "lack the political muscle" to shape debates in a way that gains genuine health gains. The narrow interests of national security may continue to define the terms of the debate and the global health community's participation.

The third model is that of a "partnership," where the tools and skills of each community are utilized for the greater good. This model would theoretically eliminate the problems of the "supplicant" and "Trojan horse" models because neither policy community's goals would be privileged. Lee and McInnes (2004: 16) cite the WHO's *Health as a Bridge for Peace* initiative, which seeks to use health interventions to improve health in post-conflict situations and bring warring parties together, as an example of this "partnership" model.[8] Lee and McInnes raise questions about the practical implementation of this model including: who brings the communities together and how are disputes between the communities resolved? However, a larger problem with the "partnership" model may be that it is difficult to imagine the national security community ceding any authority over issues it deems of grave national security importance. In cases such as these, the national security community may seek the scientific advice of the global health community, but decision-making on such an issue would likely remain firmly within a state's national security bureaucracy.

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[8] Rushton and McInnes (2006) finds that the "Health as a Bridge for Peace" initiatives failed due to a lack of evidence supporting their efficacy.

The final model is that of global health as an "independent actor" (Lee and McInnes 2004: 17). This model reverses the "supplicant" model to ask what the security community can do for the pursuit of global health. The *Framework Convention on Tobacco Control* is an example of the "independent actor" model. To enact the *Framework Convention,* global health advocates initiated work with the foreign policy community, argued that it would be in their interests to participate, and provided advice on implementation (Lee and McInnes 2004). This model may be attractive to the foreign policy and security communities because of its clarity of purpose and clearly delineated scope of cooperation. Lee and McInnes also note that a benefit of this model is that it does not contest the identities of either field, or challenge them to think in new ways about the relationship between global health and national security. However the disadvantages of maintaining the traditional identities of global health and national security are that legitimate new linkages between the fields are left unaddressed, and that new cooperative approaches that may benefit global health are unrealized.

Of the four models presented, Lee and McInnes (2004) conclude that "supplicant" and "Trojan horse" are unlikely to successfully achieve global health goals. They find that global health acting "as an independent actor" may be the most effective strategy for engagement with the national security and foreign policy communities. Their framework suggests that the maintenance of global health's influence and independence in interactions with the national security community is critical to determining the effectiveness of global health actions.

2.6.3 The high politics of national security and the low politics of health

Fidler (2005a, 2005b) offers a framework of "high and low politics" for understanding the relationship between health and national security. High politics are "issues of crucial importance" to states (Evans and Newnham 1998: 225). These crucial issues are predominately issues of national security, described by Fidler (2005b: 180) as "issues of war and peace, competition for power, the dilemma of national security, and the fight for survival in anarchy" that involve the material interests of states. National security is a high political issue handled with priority at the highest levels of government. In contrast, issues considered "low politics" are not fundamental to states interests and are handled "by the bureaucracy employing standard operating procedures" (Evans and Newnham

1998: 310). Here Evans and Newnham's definition of "low politics" overlaps with Buzan et al. (1998) securitization theory. Low political issues are handled with the routine procedures of government, not the emergency measures of a securitized issue. Issues of low politics often involve cooperation between states on non-essential aspects of economic, environmental, social and health policy. Low politics also include issues that involve state's pursuit of their normative values, such as the protection of human dignity (Fidler 2005a).

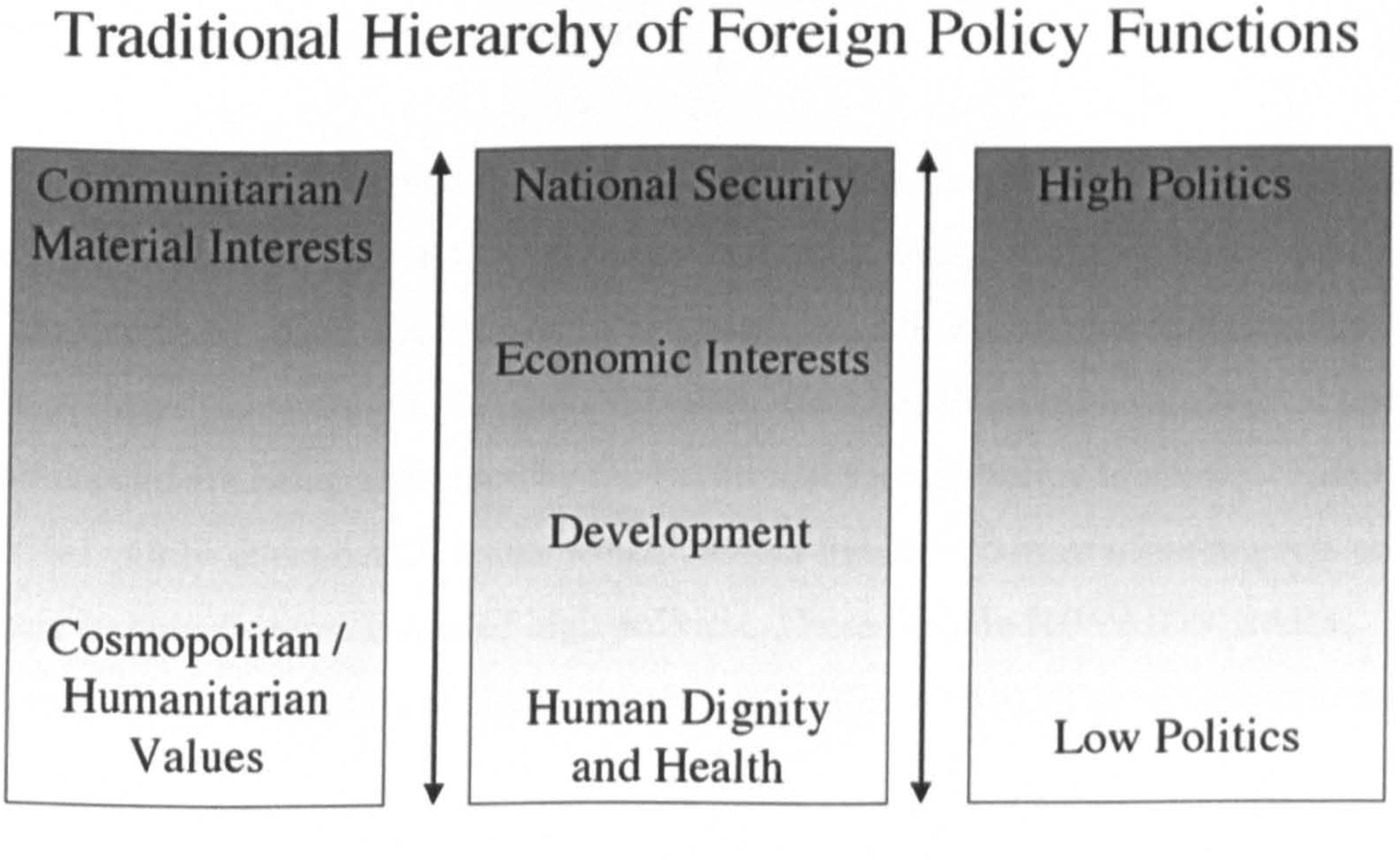
Fidler then uses this framework to describe three models interpreting the meaning of health's rise in political priority. Fidler's analysis is based on an historical review of the political stature of global health issues. Fidler (2005b) acknowledges that health has been an issue for foreign policy and international relations since at least 1851 when the first International Sanitary Conference was held. Despite the sanitary conferences and some international cooperation to address health problems, health remained a low priority for governments. Fidler (2005b: 180) argues that this changed in the mid-1990s, when health experienced a "political revolution" which brought health issues into the realm of high politics. Evidence for this "revolution" includes the rise of bioterrorism, HIV/AIDS, and infectious diseases as threats to national security, findings on the large impact of poor health on macroeconomic development, impacts of epidemics on international trade and commerce, and greater focus on health issues by national and international aid organizations (Fidler 2005b). As discussed in the next section, this "revolution" is described in terms of health's rise from low to high politics, and is interpreted using the three models of "revolution, remediation and regression" (Fidler 2005a).

Global health has traditionally been considered an issue of low politics. Fidler (2005b: 180) observes that even within the world of "low politics," health issues have low priority, leading him to describe health as "really low politics." The status of "really low politics" traditionally accorded to global health activities was due their technical, non-political, and humanitarian nature (Fidler 2005b: 180).

The dichotomy of high and low politics overlaps with the communitarian – cosmopolitan divide. While the communitarian – cosmopolitan framework revealed the different values, referent objects and cultures of the two communities, the high and low politics

dichotomy creates a hierarchy of political issues. Communitarian issues such as national security exist at the top of this hierarchy, while cosmopolitan issues such as global health are at the bottom. This dichotomy also resonates with Lee and McInnes' (2004: 16) concern with the difference in "political muscle" between global health and national security. The low political priority of health issues may result in global health becoming a "supplicant" to the high politics of national security. The following figure, adapted from Fidler (2005a), illustrates the relationship between high and low politics, material interests and normative values, and places national security and health along this continuum. It demonstrates how national security is an issue of high politics, based in a communitarian perspective and focused on the material interests of states. Global health has traditionally been viewed as a low political issue, because of its concern with human dignity, health and cosmopolitan values.

Figure 2.3 Traditional Hierarchy of Foreign Policy Functions



Adapted from Fidler 2005a.

2.6.4 The cause of the transformation: Revolution, remediation or regression?

Having established the high and low politics framework for understanding the traditional relationship between health and national security, Fidler (2005b: 179) seeks to explain the "transformation" that has allowed health to rise in political importance since the mid-1990s. Fidler (2005a) uses three models to explicate the movement of health as an issue of "low politics" into the realm of "high politics." These models are termed: revolution, remediation, and regression.

The *revolution* model posits that a revolution in the relationship between health and foreign policy explains health's rise into high politics. This revolution has been caused by the emergence of a "global health ethic" in which health has become "a pre-eminent *political value* for 21st century humanity" (Fidler 2005a, 2005b: 184). Health is no longer a technical and non-political activity, but has become a political value that influences state behavior. This revolution has "collapsed the traditional dichotomies between low and high politics, and between material interests and normative values" and cosmopolitan and communitarian perspectives (Fidler 2005a: 5). The revolution model argues that normative values are now considered part of the material interests of states'. In other words, health has become an issue of high politics because of the recognition by states of health's tremendous importance.

The second model is termed *remediation*. This model posits the continued survival and relevance of the traditional foreign policy hierarchy, with national security as its most important issue. This directly contradicts the perspective of the revolution model. What has occurred, according to this model, is that select health issues have escaped low politics and are being addressed by the traditional foreign policy hierarchy (Fidler 2005a). Only select health issues which have or threaten to have acute impacts on state interests have become issues of high politics. These include HIV/AIDS, SARS, bioterrorism, and a future influenza pandemic (Fidler 2005b). The remediation model argues that:

> health issues have become more prominent foreign policy issues because health-related threats to the material interests of states and capabilities of states have increased. When diseases threaten, or show the potential to threaten, national security, military capabilities, geopolitical or regional stability... foreign policy makers take notice. (Fidler 2005b: 184)

The remediation model posits that select health issues are now considered high politics only because they threaten the material interests of states. Other health issues remain low political issues because they do not threaten state interests and are therefore of low priority in the traditional foreign policy hierarchy.

The third model is termed *regression*. This model posits that the cause of health's rise on political agendas is due to the worsening of global health problems. A "parade of public health horribles" have demonstrated to policymakers the need to intervene in the practice of global heath (Fidler 2005a: 6). These "horribles" include the HIV/AIDS pandemic, emerging and reemerging diseases, growing burden of non-communicable diseases, bioterrorism and the proliferation of bioweapons, and decaying local and global public health capacity (Fidler 2005a). Far from being a public health success, the treatment of health as an issue of high politics signifies the failure of public health efforts and "regression."

In discussion of the three models, Fidler (2005b: 184) dismisses the revolution model for a lack of evidence supporting the proposition that health has become a "pre-eminent political value." Fidler (2005b) cites the rapid progression of the HIV/AIDS pandemic over the last decade as evidence that states have not behaved as if they placed the highest value on health. It is harder to dismiss the remediation and regression models. These models share the idea that worsening global health problems have contributed to health's emergence as an issue of high politics, however the remediation model concludes that these worsening health issues have become high political issues because they threaten state's material interests. Fidler (2005b: 189) concludes that the remediation model's retention of the traditional foreign policy hierarchy provides a "robust explanation" for the rise of select health issues to the level of high politics.

Despite the remediation model's explanatory power, Fidler (2005b) notes a problem with using the traditional foreign policy hierarchy based on power politics to understand and address health issues. The problem is that public health produces scientific evidence that is valid irrespective of power politics. To successfully address health issues, states must rely on scientific principles to direct their action. As Fidler (2005b: 187) states: "jumping from anarchy to power politics without appreciating epidemiology causes foreign policy on health issues problems." He also cautions that public health experts

underestimate the problem anarchy poses for inter-state cooperation. The new global health and national security nexus contains scientific principles that national security cannot ignore, as well as issues of anarchy and state power that global health cannot deny. Fidler (2005a) concludes that there has been some convergence of state's material interests and moral values that represents a new phase in the relationship between health and foreign policy. This convergence will require changes by both global health and foreign policy to manage power politics, scientific practice, and morality.

Conceptual Model	***Components of the Conceptual Model***			
Communitarian-Cosmopolitan Model	Referent object	Objective	Culture	
Models of Engagement (Lee and McInnes 2004)	Supplicant	Trojan Horse	Partnership	Independent Actor
High – Low Politics Model (Fidler 2005b)	High Politics: Issues of critical importance to states	Low Politics: Non-critical issues		
Cause of the Transformation Model (Fidler 2005a)	Revolution	Remediation	Regression	

Figure 2.4: Summary of conceptual Models for the HIV/AIDS – National Security Nexus and their components

2.7 Conclusion

The four frameworks each describe a different aspect of the HIV/AIDS – national security nexus. The communitarian – cosmopolitan dichotomy illustrates the different objectives, referent objects and cultures of global health and national security.

Supplicant, Trojan horse, partnership and independent actor models for the relationship between global health and national security focus on navigating the large gap in political power between global health and national security for the benefit of global health efforts. The high and low politics dichotomy is also rooted in the differences in political priority, and links these differences to the high politics focus on the material interests of states and the focus on humanitarian values common to low political issues. Finally, the revolution, remediation and regression models seek to understand the transformation of certain health issues into national security threats and what this transformation means for the relationship between global health and national security. These frameworks will be tested in the following historical chapters and used to illustrate the tensions within the HIV/AIDS – national security nexus.

Chapter 3: Literature Review

3.1 Introduction

The UNSC meetings on HIV/AIDS and Resolution 1308 were "watershed" events that brought the idea that a disease could threaten national security into the public policy and academic discourse (Elbe 2006a: 123). Between 2000 – 2006, dozens of academic papers and think-tank reports sought to explore the links between HIV/AIDS and security and offer policy proscriptions for addressing these links. Taking the lead from U.S. leadership on linking HIV/AIDS and security at the UNSC, many of the academic and public policy papers are written by Americans or targeted at U.S. policymakers. This large group of publications both provides evidence and evaluates the relationship between HIV/AIDS and security, and offers policy recommendations for addressing the HIV/AIDS – national security nexus. Here we will first examine how academic and think-tank publications conceptualize the HIV/AIDS – national security nexus. This section will be based on Feldbaum et al.'s (2006a) review of the national security implications of HIV/AIDS, and focus on the most rigorous and influential papers examining the nexus[9]. Next, critical perspectives on the securitization of HIV/AIDS will be examined. Finally, the two papers that specifically address the risks and benefits of securitizing HIV/AIDS, Peterson (2002) and Elbe (2006a), will be discussed in detail and linked to the aims of this thesis.

In their review of the national security implications of HIV/AIDS, Feldbaum et al. (2006a) argue that three main issues form the predominant linkages between HIV/AIDS and national security. The first describes the impact of HIV/AIDS on individuals critical to the maintenance of state and international security: soldiers and peacekeepers. The second suggests that the epidemic in some sub-Saharan African nations may cause state instability and failure. The third focuses on the security effects of the worsening pandemic on the large, strategically important states of Russia, India, China, Nigeria and Ethiopia (see Figure 3.1). This framework will be used to organize the publications that

[9] A number of papers on the nexus that were deemed overly polemical and/or not influential are not discussed in detail in this literature review. For example: Barnett and Prins (2005), Chemical and Biological Arms Control Institute, & Center for Strategic and International Studies (2000), Gow (2002), Kassalow (2001), and Price-Smith (2002a).

examine the links between HIV/AIDS and national security.

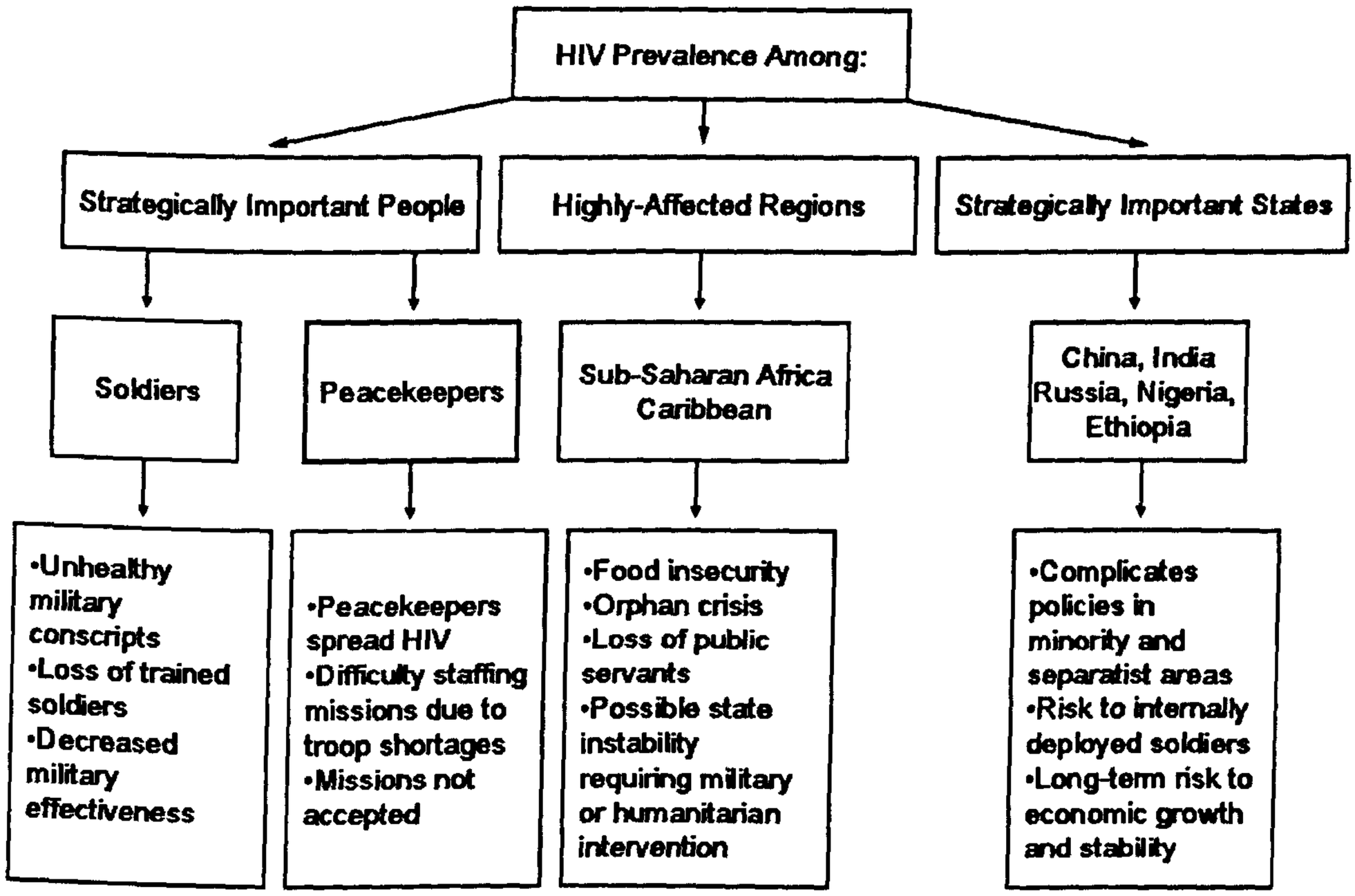


Figure 3.1: Pathways for HIV/AIDS impact on national security, adopted from Feldbaum et al. 2006a: 774.

3.2 Strategically Important Populations: Armed Forces

The impact of HIV/AIDS on armed forces represents the most direct link or "primary connection" between the disease and national security (Singer 2002: 147). This is because armed forces and their operational capabilities are considered a primary element of a state's national security. Anything that affects the capabilities of armed forces, including HIV/AIDS, will rank as a serious threat to national security. There is also a long history of infectious diseases impacting on military operations (McNeill 1976; Curtin 1998). Smallman-Raynor and Cliff (2004: 4) write that "down the ages, war epidemics have decimated the fighting strength of armies, caused the suspension and cancellation of military operations, and brought havoc to the civilian populations of

belligerent and non-belligerent states alike." Because of this direct linkage, and history of diseases effecting military performance, most authors examining the HIV/AIDS – national security nexus consider the impact of HIV/AIDS on militaries as central to their analyses (International Crisis Group 2001; Heinecken 2001a; Heinecken 2001b; Schneider and Moodie 2002; Ostergard 2002; Singer 2002; Elbe 2002; Elbe 2003; Garrett 2005; Feldbaum et al. 2006a; McInnes 2006; Whiteside, De Waal and Gebre-Tensae 2006).

1998-2004 Papers

Before 2005, authors relied almost exclusively on only two publications for data on the prevalence of HIV/AIDS in military populations and reasoning for the assumption that prevalence was higher in military populations than among civilians. The reliance on these two papers, *AIDS in the Military* by UNAIDS (1998) and *The Global Infectious Disease Threat and Its Implications for the United States* by the U.S. National Intelligence Council (2000) (here referred to as National Intelligence Estimate or NIE 99-17), was due to a scarcity of other studies on rates of HIV/AIDS in military populations (both studies are examined in detail in Chapter 5, and the role of data on HIV/AIDS in military populations is examined in Chapter 6). In 2005, the data and reasoning of these two papers began to be questioned and estimates of HIV/AIDS in military populations revised downwards (Garrett 2005; Whiteside, De Waal and Gebre-Tensae 2006; Feldbaum el al. 2006a). If this downward revision is correct, the papers published between 2001-2005 tend to overestimate the prevalence of HIV/AIDS among armed forces, particularly in Sub-Saharan Africa.

The UNAIDS (1998) study contributed two widely cited arguments to the literature on the HIV/AIDS – national security nexus. First, UNAIDS (1998: 3) argued that "in peace time, STD infection rates among armed forces are generally 2 to 5 times higher than in civilian populations; in time of conflict the difference can be 50 times higher or more." This statistic indicated that militaries were a high risk population for HIV infection and already had significantly higher prevalence of HIV/AIDS than civilian populations. The citation of this statistic in the literature on HIV/AIDS and national security is then ubiquitous from 2001-2005, including Elbe (2002, 2003), Heinecken (2001b), International Crisis Group (2001), Schneider and Moodie (2002), and Tripodi and Patel

(2004). The second widely cited argument from *AIDS in the Military* is the explanation for why militaries have greater risk from, and a higher prevalence of, HIV/AIDS infection. UNAIDS (1998) asserts that five factors put military populations at higher risk:

> Lengthy tours of duty away from home result in the need to relieve stress and sexual tension.
> Risk taking ethos of the military may encourage risky sexual behavior.
> Most military personnel are in the 15-24 age group at highest risk for HIV infection.
> Military on peacekeeping missions are often better paid than local populations, giving them the ability to purchase sex.
> Military camps and bases often attract sex workers.

UNAIDS (1998: 3) statistic of "2 to 5 times" higher rates of STDs among military populations and rationale for the military as a high risk group became accepted wisdom, or less charitably, "shibboleths," to authors writing on the HIV/AIDS – national security nexus between 2001-2005 (Whiteside, De Waal and Gebre-Tensae 2006: 201).

Many authors writing between 2001-2005 also relied on NIE 99-17, the U.S. National Intelligence Council (2000) report on infectious diseases and national security. This report supported the assertion made by UNAIDS (1998) that the military was a particularly high risk group for HIV/AIDS and cited UNAIDS's rationale for why militaries were at greater risk than comparable civilian populations. NIE 99-17 added to the data on HIV/AIDS among military populations by asserting that HIV/AIDS prevalence in Sub-Saharan African militaries "ranges from 10 to 60 percent" (National Intelligence Council 2000: 52). Supporting this assertion is a table of the rates of HIV/AIDS among seven Sub-Saharan African countries, with Angola and Democratic Republic of Congo estimated to have military prevalence rates between forty and sixty percent (this table is reproduced and discussed in detail in Chapter 5). This data is based on a classified 1999 study by the Defense Intelligence Agency and Armed Forces Medical Intelligence Center whose sources and methodology remain classified. This did not however prevent the frequent citation of NIE 99-17 to support the proposition that rates of HIV/AIDS among Sub-Saharan African militaries were extremely high.

UNAIDS (1998) and the NIE 99-17 (National Intelligence Council 2000) accounted for almost all of the unclassified information on the prevalence of HIV/AIDS among armed

forces available before 2005. Because of this, the literature on the link between militaries and HIV/AIDS between 2001-2005 builds from the same statistics in these two papers and differs only in their interpretation of the meaning of these high rates of HIV/AIDS among military populations.

The general interpretation of data, suggesting higher rates of HIV/AIDS among military populations, is that the disease will decrease military effectiveness and, in turn, threaten national security. The NIE 99-17 suggests that, although it is difficult to directly connect HIV/AIDS prevalence and battle performance, the large number of officers and key military personnel dying of HIV/AIDS will decrease "combat readiness and capability" (National Intelligence Council 2000: 52). More specifically, the National Intelligence Council (2000) finds that the greatest impact of HIV/AIDS on militaries will be caused by the loss of officers, noncommissioned officers, and enlisted soldiers with specialized training on advanced weapons systems. This is due to the difficulty, cost and time needed to replace these soldiers who perform critical roles in modern militaries. Building from the data presented on HIV/AIDS prevalence in sub-Saharan African militaries, NIE 99-17 argues that this region will face the greatest military challenges from HIV/AIDS. However in the longer term, countries of the former Soviet Union and China may also face military challenges from HIV/AIDS (National Intelligence Council 2000).

Heinecken (2001b: 122) concurs with the analysis of the NIE 99-17, and writes that the loss of military leaders to HIV/AIDS will cause a "hollowing out" of militaries which will reduce morale, discipline, cohesion, and overall military effectiveness. More specifically, Heinecken (2001a) finds that high prevalence of HIV/AIDS among Southern African militaries will impact armed forces in four ways. First, force procurement will be impeded because the HIV/AIDS epidemic will reduce the number of healthy and qualified personnel available for military service. Second, HIV/AIDS will "hollow out" the middle management of militaries causing delays in the training, education and development needed for force preparation. Third, if militaries do not deploy HIV positive troops, they may be unable to deploy full contingents of troops or even troops that have trained together before. On the other hand, deployment of HIV positive troops is problematic because of the adverse conditions faced by deployed soldiers and the need for extensive vaccinations that may be dangerous for those with

compromised immune systems. Fourth, militaries will face difficulties sustaining forces as funding is shifted from military budgets to address HIV/AIDS and militaries care for increasing numbers of HIV/AIDS affected soldiers and their families. These factors cause Heinecken (2001a: Concluding Remarks para. 1) to describe HIV/AIDS as "a pending national disaster – a strategic priority."

Elbe (2002: 163) and Ostergard (2002) similarly conclude that HIV/AIDS will reduce "operational efficiency among Africa's armed forces." In addition to the factors raised by Heinecken (2001a), Elbe (2002) argues that the epidemic is creating new political and legal challenges for civil-military relations as militaries attempt to manage the issue of HIV positive soldiers. Elbe (2002: 170) also finds that the presence of the disease will raise the social costs of armed conflict in Africa by significantly increasing the total number of "eventual war-related casualties."

Other analysts argue that the impact of high HIV/AIDS prevalence among militaries will have even greater strategic implications. The International Crisis Group (2001: 20) writes that "weakened national militaries are per se a risk for increasing instability inside a nation, and with its neighbours." Large numbers of military deaths from AIDS may lead to criminal behavior by militaries and less participation in peacemaking efforts (International Crisis Group 2001). Furthermore, the International Crisis Group (2001: 21) warns that the tactical advantages stemming for a neighbor's military suffering from HIV/AIDS "may trigger wars." Governments that fail to successfully address HIV/AIDS may also be vulnerable to *coups d'etats*. Echoing these concerns, Singer (2002: 149) warns that AIDS-weakened militaries may lead to "domestic instability and may even invite foreign attack."

Elbe (2003) presents a more complex and convincing view of the strategic implications of HIV/AIDS. He begins by recognizing that there is no evidence that the impact of HIV/AIDS on armed forces has inspired or foreclosed an outbreak of armed conflict. Elbe (2003) then identifies six factors that will determine how severe the impact of HIV/AIDS on armed forces will become. These factors are:

HIV/AIDS prevalence
Number of soldiers with AIDS
Type of armed force

Levels of specialization and technical proficiency
Size of the armed forces compared to the civilian population
Level of resources and leadership available to address HIV/AIDS

These factors illustrate the complexity of anticipating the impact of HIV/AIDS on armed forces. The impact of HIV/AIDS will vary depending the on the characteristics of the specific military under study (Elbe 2003).

Elbe (2003) specifically addresses the assertion by the International Crisis Group (2001) and Singer (2002) that high HIV/AIDS prevalence in militaries may indicate weakness and trigger attacks. Elbe (2003) notes that this would only occur if there is already existing animosity between two nations, and those nations faced starkly different prevalence rates of HIV/AIDS. Elbe (2003) notes that this scenario is unlikely to exist and generate wars. Further downplaying the strategic impact of HIV/AIDS, Elbe writes that in wealthy and stable regions the military impact of the epidemic may be negligible. He cites the example of Botswana, which has one of the world's highest prevalences of HIV/AIDS, and has not been engaged in significant armed conflict since the epidemic began. Also discussed is the possibility that high rates of HIV/AIDS in a military may constrain offensive military plans, resulting in a strategic benefit of decreased warfare. Elbe (2003) concludes that HIV/AIDS is unlikely to spark new wars or "hollow out" militaries, but will pose significant challenges for armed forces. Evaluating the impact of HIV/AIDS on militaries will remain a complex task dependent on assessing a number of factors that vary considerably from military to military.

2005-2006 Papers

The four papers published between 2005-2006 that discuss the impact of HIV/AIDS on armed forces contend that the estimates of HIV/AIDS prevalence in armed forces cited by UNAIDS (1998) and National Intelligence Council (2000) are overestimates (Garrett 2005; Feldbaum et al. 2006a; McInnes 2006; Whiteside, De Waal and Gebre-Tensae 2006). McInnes (2006: 320) cautions that previous estimates of HIV/AIDS among military populations need "to be treated carefully" and are "no longer so clear cut." Garrett (2005: 25) writes that these earlier estimates "appear to be off target", while Whiteside, De Waal and Gebre-Tensae (2006) call the idea, that militaries have higher prevalence of HIV/AIDS than civilian populations, a shibboleth. Garrett (2005) and

Feldbaum et al. (2006a: 775) argue that "HIV prevalence among armed forces is equal to or slightly greater than civilian rates from the same country." Whiteside, De Waal and Gebre-Tensae (2006) provide the more nuanced view that young soldiers are likely to have lower prevalence of HIV/AIDS than civilian populations, while older soldiers may have higher prevalence.

Despite agreement between these papers, that previous studies overestimated the prevalence of HIV/AIDS among armed forces, available data on the subject remains extremely limited. Garrett (2005) bases her conclusions on government and military statements, as well as other unnamed sources. Feldbaum et al. (2006a) reach a similar conclusion through interviews with military officials in Sub-Saharan Africa and the United States. McInnes (2006) cites comments by De Waal, while Whiteside, De Waal and Gebre-Tensae (2006: 203) write that their conclusions are based on "some limited data from the military, extrapolations from other data, and epidemiological logic." States continue to view rates of HIV/AIDS in their militaries as national security secrets, resulting in a scarcity of rigorous published studies on this subject.

Despite reduced estimates of HIV/AIDS prevalence among armed forces for data currently available, Garrett (2005) argues that the disease will continue to claim large numbers of military personnel, and may threaten the ability of militaries to maintain law and order. By 2005, availability of ARV therapy was greatly expanded due to the availability of cheaper generics and important recognition that treatment is essential for prevention activities. Garrett (2005) observes that the provision of ARV therapy may extend the lives of critical military personnel and therefore reduce the impact of the disease. However, she argues that provision of ARV drugs to only the upper echelons of a military could "undermine rank and file morale, and could even lead to rebellion" (Garrett 2005: 29). Furthermore, ARV therapy may only briefly postpone the impact of HIV/AIDS on militaries if drug resistant strains of the virus emerge.

Feldbaum et al. (2006a) also find that the reduced estimates of military prevalence of HIV/AIDS are still sufficient to have an impact on affected militaries. This is because highly trained soldiers are "difficult and expensive to replace, and their absence interrupts the training of younger recruits" (Feldbaum et al. 2006a: 775). Both Garrett (2005) and Feldbaum et al. (2006a) cite unpublished work by Murray Feshbach that

suggests that the Russian HIV/AIDS epidemic is exacerbating an existing shortage of healthy recruits for the Russian military. The large populations of China and India provide insulation from these shortages. However, both countries are increasingly monitoring the growth of the epidemic among their armed forces. Feldbaum et al. (2006a) argue that the extent to which a military relies on conscription will alter the impact of HIV/AIDS because HIV positive conscripts may complete their service before developing AIDS.

McInnes (2006) argues that evidence on rates of HIV/AIDS on military populations was drawn from limited experiences in the mid-1990s and is no longer accurate. The limited nature of the data from the 1990s, and the rising rates of HIV/AIDS among general populations, particularly in Sub-Saharan Africa, account for some of this discrepancy. In some states, such as Thailand, militaries have implemented successful prevention campaigns (McInnes 2006). Other states, such as South Africa, do not recruit or renew contracts for HIV positive military personnel (McInnes 2006). McInnes notes that both of these prevention policies can sharply reduce prevalence of HIV/AIDS in militaries and therefore the impact of the disease. McInnes (2006) further notes that militaries are well-prepared for the loss of personnel due to conflict, and that this preparation will serve to limit the impact of HIV/AIDS on affected militaries.

Whiteside, De Waal and Gebre-Tensae (2006: 217) present a sustained critique of the pre-2005 "accepted wisdom" concerning the impact of HIV/AIDS on militaries and national security. Differentiating between new recruits and older military personnel, Whiteside, De Waal and Gebre-Tensae (2006) argue that prevalence of HIV/AIDS among new military recruits is likely lower than that of comparable civilian populations. This is for two reasons. First, new recruits are in a demographic group of men between 17-22 years of age who have lower prevalence of HIV/AIDS than women of the same age. Thus military recruits who are predominantly male will have lower rate of HIV/AIDS than a comparable civilian population which includes women. Second, militaries in Africa screen recruits for HIV/AIDS and reject those that are HIV positive. Whiteside, De Waal and Gebre-Tensae (2006) note that this screening may not be publicly acknowledged, or even constitutionally legal, but does occur. The combination of demographics and military screening of recruits suggest that new military recruits

have lower prevalence of HIV/AIDS than previously assumed (Whiteside, De Waal and Gebre-Tensae 2006).

Whiteside, De Waal and Gebre-Tensae (2006) question the rationale expressed in UNAIDS (1998) for why military populations are at special risk of STDs and HIV/AIDS. They provide counter-examples to this rationale, arguing that "some military units are immobile for long periods of time, some... are located in their home communities, some are disciplined into conservative behaviour, and many are poorly and irregularly paid" (Whiteside, De Waal and Gebre-Tensae 2006: 205). Despite questioning this rationale, Whiteside, De Waal and Gebre-Tensae (2006) find that, in the absence of an efficacious prevention program, prevalence of HIV/AIDS among longer serving military personnel are likely to be higher than comparable civilian populations.

Whiteside, De Waal and Gebre-Tensae (2006) also seriously question the assumption that HIV/AIDS will undermine military effectiveness. They argue that some African military leaders were aware of the threat the disease posed at early stages of the pandemic, and took steps to limit the impact on their military. For example, the military in Senegal led the successful national response to HIV/AIDS. In Ethiopia, the military recognized the threat of HIV/AIDS and implemented prevention programs in advance of the national government. The South African military created HIV/AIDS prevention and treatment programs "in contradiction to government policies that did not prioritize AIDS at all" (Whiteside, De Waal and Gebre-Tensae 2006: 209). The response of these militaries has greatly reduced the likelihood that HIV/AIDS will threaten their effectiveness. Even in militaries that do not implement successful HIV/AIDS prevention programs, Whiteside, De Waal and Gebre-Tensae (2006) argue that the impact of the disease may be overestimated. Militaries have "built in" features that will allow them to minimize the impact of HIV/AIDS (Whiteside, De Waal and Gebre-Tensae 2006: 211). These include redundancy of expertise to guard against loss of personnel due to conflict, and the ability to proactively manage their strategic personnel needs. Furthermore, the authoritarian nature of militaries has prevented challenges to military hierarchy related to the provision of ARV therapy, even in cases when favoritism and bias has influenced the provision of treatment (Whiteside, De Waal and Gebre-Tensae 2006).

In summary, the impact of HIV/AIDS on the strategically important population of the armed forces represents the most direct link between the disease and traditional national security concerns. Authors writing about the impact of HIV/AIDS on militaries before 2005 relied exclusively on the data and arguments in two publications: UNAIDS (1998) and National Intelligence Council (2000). These authors concluded that militaries are at high risk for HIV/AIDS, have prevalences of HIV/AIDS that are greater than civilian populations, and that the disease would have severe impacts on affected militaries. Authors writing after 2005 have questioned earlier estimates of HIV/AIDS in armed forces, and argued that the impact of the disease on militaries is dependent on a number of country-specific factors including the response of the military. Despite the downward revision of estimates, authors since 2005 still maintain that HIV/AIDS pose challenges to the functioning of armed forces, although of a less severe degree than previously assumed. Data on the prevalence and impact of HIV/AIDS on militaries remains scarce and is often classified as national security secrets. This continues to limit researchers' ability to accurately assess the true impact of HIV/AIDS on armed forces.

3.3 Peacekeepers

UN and regional peacekeepers are perceived as a second strategically important population that link HIV/AIDS to national security considerations. Concerns about the impact of HIV/AIDS on peacekeepers and peacekeeping operations stem from two sources. First, reports exist of peacekeepers spreading HIV/AIDS on missions in Cambodia (Beyrer 1998; UNAIDS 1998; Tripodi and Patel 2002; Bazergan and Easterbrook 2003), Sierra Leone and Liberia (International Crisis Group 2001; Singer 2002; Bazergan and Easterbrook 2003). These concerns have increased since allegations of sexual abuse perpetrated by UN peacekeepers in the Democratic Republic of the Congo (Holt and Hughes 2005). Peacekeepers allegedly spreading the disease was the stated reason for the UNSC addressing the issue of HIV/AIDS in 2000, (although other motivating factors will be discussed in Chapter 5.) Second, data on the prevalence of HIV/AIDS presented in UNAIDS (1998) and the National Intelligence Council (2000) led to concerns that peacekeeping operations could be undermined by the disease.

Articles published on the HIV/AIDS – national security nexus often note the potential impact of the disease on peacekeeping operations. The NIE 99-17 argues that high rates

of HIV/AIDS among military populations will make peacekeepers vectors for spreading HIV/AIDS, and will limit the effectiveness of international and regional peacekeeping operations (National Intelligence Estimate 2000). The International Crisis Group (2001: 21) describes the impact of HIV/AIDS on peacekeepers as an "international security issue," and warns that the higher prevalence of the disease among militaries may prevent affected countries from contributing peacekeeping troops, therefore undermining peacekeeping operations. Singer (2002: 152) asserts that peacekeeping troops are "among the primary mechanisms of spreading the disease at a mass level to new areas." However, there is little evidence to support this conclusion. Similar to previous studies, Singer (2002) and Tripodi and Patel (2002) conclude that high prevalence of HIV/AIDS among militaries will make states less able and willing to contribute to peacekeeping operations. Garrett (2005: 33) describes the link between HIV/AIDS and peacekeeping as a "threat to global security" which will further spread the disease, and undermine the credibility and capacity of the UN to aid conflict-affected countries. These studies share a common basis in data on HIV/AIDS among armed forces, whose limitations are discussed above, and anecdotal reports of peacekeepers spreading HIV/AIDS from Cambodia, Sierra Leone and Liberia.

Elbe (2003) and Feldbaum et al. (2006a) provide a more robust framework for understanding how HIV/AIDS may undermine peacekeeping operations, although prevalence data on HIV/AIDS among peacekeeping troops remains limited. Elbe (2003) and Feldbaum et al. (2006a) argue that HIV/AIDS may undermine peacekeeping operations in four ways. First, limited evidence from Cambodia, Sierra Leone, Liberia and other peacekeeping operations indicates that some peacekeepers have spread HIV/AIDS while deployed. The allegations of sexual abuse by peacekeepers in the Democratic Republic of the Congo have reinforced these claims (Holt and Hughes 2005). While these acts likely have limited impact on regional epidemics, they do significantly undermine trust in UN peacekeeping missions [10] (Feldbaum et al. 2006a).

Second, as rates of HIV/AIDS increase in militaries, countries may be unable to spare troops for peacekeeping missions. This fear is closely related to early data on rates of HIV/AIDS among militaries, particularly in the peacekeeper donating countries of South

[10] The spread of HIV/AIDS in Cambodia after the UN peacekeeping operation UNTAC may be an exception.

Africa and Nigeria. Elbe (2003: 42) notes that the South African National Defense Force (SANDF) has "grave concerns" about its ability to supply enough troops to UN and regional peacekeeping missions. Feldbaum et al. (2006a) argue that African peacekeeping missions, such as in Sudan, could be imperiled if South Africa and Nigeria become unable to supply peacekeeping troops due to HIV/AIDS. This concern will extend beyond Africa if HIV/AIDS prevalence rises in the major troop contributing nations of South Asia, including India, Bangladesh, Pakistan, and Nepal, although this is increasingly unlikely (Chin and Bennett 2007).

Third, if peacekeeping troops return home from missions infected with HIV/AIDS, countries may become less willing to contribute troops to peacekeeping missions. While a country refusing to contribute troops because of fears of HIV/AIDS infection remains only a speculative possibility, there is strong evidence that peacekeepers have become infected while on missions. For example, peacekeeping troops from Uruguay, U.S., India, and Indonesia returned home from the UNTAC mission in Cambodia infected with HIV/AIDS (Soeprapto et al. 1995; Beyrer 1998). The Indonesian military's experience in the UNTAC mission is particularly illustrative of the threat HIV/AIDS poses to peacekeepers. Indonesian forces suffered eleven ultimately fatal HIV/AIDS infections, far exceeding the two nondisease-related deaths suffered by Indonesian peacekeepers (Soeprapto et al. 1995). In this case, HIV/AIDS posed the greatest threat to Indonesian peacekeepers serving in Cambodia. A further challenge to the commitment of peacekeeping troops is that the length of the tour of duty has been correlated with increasing prevalence of HIV/AIDS. Evidence from the ECOMOG regional peacekeeping mission found that HIV/AIDS prevalence among Nigerian peacekeeping troops increased from 7% to 10% to 15% over the three years of deployment [11] (Adefolalu 1999). If peacekeepers continue to face high risks of HIV/AIDS infection while deployed, countries may begin to limit their commitments to peacekeeping operations (Elbe 2003; Feldbaum et al. 2006a).

Fourth, HIV/AIDS may impact on a country's willingness to host peacekeeping missions because they have been associated with the spread of HIV/AIDS. In 2001, Eritrea

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[11] ECOMOG is a regional peacekeeping mission, distinct from UN missions. Regional missions generally have longer tours of duty than UN missions, which results in longer time away from home for peacekeepers and, in this case, increasing prevalence of HIV/AIDS. (Roxanne Bazergan, personal communication).

demanded that the UN ensure that no HIV positive peacekeepers be deployed in the UNMEE (UN Integrated Regional Information Network 2001). Similar requests have been voiced by Sudan (Agence France-Presse 2004), Sierra Leone and during the Balkans conflict (Elbe 2003). While these requests have been unsuccessful, they demonstrate concerns by conflict-affected countries with the risk of peacekeeping troops spreading HIV/AIDS while deployed. (These objections to hosting HIV positive peacekeepers also have a significant political dimension, see Chapter 6 for more information.) Similar to HIV/AIDS data in military populations, data on HIV/AIDS among peacekeepers and during peacekeeping operations is scare and is subject to politicization.

3.4 Impact of HIV/AIDS on state stability in highly-affected states

The impact of HIV/AIDS on state stability is both the least understood, and most potent potential impact of the pandemic on national security. The fact that not a single state has ever collapsed or experienced political instability due to HIV/AIDS has not prevented this argument from being used extensively in literature on the HIV/AIDS – national security nexus. The political potency of the concept of failed states, particularly post-9/11, has ensured that this linkage has received widespread coverage.

Concerns about the potentially destabilizing impacts of HIV/AIDS were first expressed in the National Intelligence Council (2000) estimate on infectious diseases. The estimate argued that infectious diseases, particularly HIV/AIDS would "add to political instability and slow democratic development in Sub-Saharan Africa, parts of Asia, and the former Soviet Union, while also increasing political tensions in and among some developed countries" (National Intelligence Council 2000: 50). In an influential report, the International Crisis Group (2001: 1) also argued that the overall impacts of the pandemic would undermine state stability in the following way:

> AIDS can be so pervasive that it destroys the very fibre of what constitutes a nation: individuals, families, communities; economic and political institutions; military and police forces...the impact of AIDS is profound enough to challenge fundamentally the security and stability of a growing number of states around the globe.

In similar analyses, Singer (2002) and Piot (2005) also cite the negative impact of HIV/AIDS on numerous sectors that will endanger the continued functioning of governments:

> AIDS causes dangerous weaknesses in the pillars of an otherwise stable state: its military; governing institutions and economy. The disease is accordingly no longer just a symptom but a fundamental catalyst of state crisis. (Singer 2002: 149-150)

> How can governments function, public services operate, agriculture and industry thrive, and law enforcement and militaries maintain security, when they are being stripped of able-bodied and skilled women and men? (Piot 2005a: 3)

The main argument sustained in these, and other analyses including Price-Smith (2002) and Price-Smith and Daly (2004), Ostergard (2002), and Kassalow (2001), is that by decreasing life expectancy and economic growth, and diminishing the functional capacity of numerous government sectors, HIV/AIDS may destabilize states, particularly those most affected in Sub-Saharan Africa.

A number of more sophisticated analyses also examine the potential impacts of HIV/AIDS on state and political stability, but conclude with less alarmist findings. Elbe (2003: 60) finds that HIV/AIDS may increase competition for resources and "exacerbate a variety of economic, political and social tensions" that contribute to processes traditionally associated with state failure. However Elbe (2003) cautions that there is strong variability in the ability of states to respond to these forces, and that the impact of the pandemic on political stability will change depending on the state. Analyses by de Waal (2003a, 2003b, 2006) outline the impacts of HIV/AIDS on African governance and economic development but ultimately conclude that the pandemic is a "manageable catastrophe" (de Waal 2006a: 1). Youde (2007) argues that HIV/AIDS will have an insidious but indirect impact on democratic stability in Africa by undermining the administration of elections through onerous voter registration requirements that disenfranchise those sick with AIDS and their caregivers, while allowing governments to manipulate election results by keeping those killed by AIDS on voter rolls. Whiteside, de Waal, and Gebre-Tensae (2006: 216) dismiss many of the arguments linking HIV/AIDS to state failure as shibboleths and conclude that the "case for AIDS contributing to national insecurity is best stated in its minimal form: there is no element in the HIV/AIDS epidemic that contributes positively to good governance..."

Literature suggesting that HIV/AIDS may destabilize Sub-Saharan African states has also focused on AIDS orphans as a potentially destabilizing threat. The National Intelligence Council (2000: 50) estimate describes AIDS orphans as a "lost orphaned generation… with little hope of educational or employment opportunities" who will be vulnerable to radicalization or exploitation by political groups. Both Singer (2002) and the International Crisis Group (2001) note the risk that AIDS orphans will be targeted for recruitment as child soldiers, furthering warfare and destabilization in Sub-Saharan Africa. On the subject of AIDS orphans, this literature from the study of international relations and national security departs considerably from the public health literature. A number of public health analyses of AIDS orphans have found that AIDS orphans are disadvantaged in their education opportunities, access to health services, and psychological distress, but are largely being cared for by extended families and not turning to crime (Monasch and Boerma 2004; Andrews, Skinner, and Zuma 2006; Culver, Gardner, and Operario 2007).

3.5 Impact of HIV/AIDS in second wave states of Russia, India, China, Nigeria and Ethiopia

The final main linkage between HIV/AIDS and national security discussed in the literature does not focus on highly affected states, but on strategically important states in the early stages of their HIV/AIDS epidemics. This analysis has largely emerged in response to U.S. national security concerns about potential political, economic or military instability in countries of particular strategic interest to the U.S. and global security. The main states discussed in this category are Russia, India and China, with Nigeria and Ethiopia included in some analyses. Russia, India and China are particular foci of this analysis because they represent three of the seven declared nuclear states, are economically and militarily powerful, play major roles in global security, and in the case of India and China account for over one-third of the world's people. Driven by national security interests and forecasting on the course of the pandemic, this "second wave" literature has been politically potent despite being based on limited data.

The U.S. National Intelligence Council (2002), in a follow-up to their 2000 estimate, published the first report in this area titled: "The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China." They justify their focus on these countries by explaining that they are strategically important, among the world's most populous, in the early to middle stages of HIV/AIDS epidemics, and have yet to give efforts to fight the pandemic the "sustained high priority that has been key to stemming the tide of the disease in other countries" (National Intelligence Council 2002: 1). Using forecasting of the course of the epidemic, and judging the ability of these governments to respond effectively, the NIC (2002: 22) writes that Nigeria and Ethiopia will be the "hardest hit" among these countries by HIV/AIDS. In Russia, the NIC estimates that HIV/AIDS will exacerbate already severe health problems, hurt economic growth and may further worsen shortages of military personnel. The NIC concludes that India and China's larger populations will lessen the political and economic impacts of the epidemic, and that HIV/AIDS will not pose a "fundamental threat through 2010 to their status as major regional players..." (National Intelligence Council 2002: 25). While the NIC's "Next Wave" report does not suggest that these strategically important states will collapse, it does argue that the number of people with HIV in these populous countries will be greater than the number of infected persons in Sub-Saharan Africa, and that the disease will have "significant economic, social, political, and military implications" (National Intelligence Council 2002: 5).

More alarmist is Eberstadt's (2002) article in the prestigious journal *Foreign Affairs* on the "Future of AIDS" in Russia, India and China. Eberstadt's (2002: 35) forecasting (which also contributed to the 2002 National Intelligence Council report) predicts that even mild epidemics in these three countries will "match or exceed that of the entire worldwide HIV crisis up to now." Indeed, Eberstadt (2002: 24) argues that in terms of total numbers, the center of the epidemic "will shift from Africa to Eurasia in the coming generation." Similar to the National Intelligence Council's "Next Wave" report, Eberstadt focuses on these countries because of their strategic and economic importance, population size, and lack of serious efforts to address the disease. Eberstadt acknowledges the difficulties and complexities of forecasting the future of the epidemic and, in fact, his estimates are viewed as of 2008 as vast overestimates of the situation (Chin and Bennett 2007). However Eberstadt's (2002: 22) main conclusion is stated

strikingly: "the coming Eurasian pandemic threats to derail the economic prospects of billions and alter the global military balance."

Eberstadt also provides a clear realist statement of why the world's powerful states, as of 2002, had paid little attention to fighting the devastating epidemic in Africa. This statement implies that a major rationale for linking HIV/AIDS to national security interests is to ensure greater political support for action to fight the pandemic.

> Africa's AIDS catastrophe is a humanitarian disaster of world historic proportions, yet the economic and political reverberations from this crisis have been remarkably muted outside the continent itself. The explanation for this awful dissonance lies in the region's marginal status in global economics and politics…The states of the region are thus not well positioned to influence events much beyond their own borders under any circumstances, good or ill -- and the cruel consequence is that the world pays them little attention. (Eberstadt 2002:23)

Publications warning of a "Next Wave" of HIV/AIDS in strategically important states have been used to pressure these states into action on HIV/AIDS, by linking the disease to their strategic interests, as well as to argue for increased donor funding to tackle the pandemic (Feldbaum et al. 2006a).

Ingram (2007) observes that Nigeria has become a particular focus of this debate within the U.S. government and U.S.-based think-tanks. He argues that Nigeria is a location where U.S. geopolitical interests in stability and energy resources are overlapping with biopolitical interests in preventing and treating HIV/AIDS through PEPFAR. This has created a situation where "the US is directly implicated in… the current and future human rights and gender and sexual relations of Nigerian citizens as well as the country's governance as a strategic state in energy security and counter-terrorism" (Ingram 2007: 528). Ingram argues that the implications of this complex constellation of interests focused on Nigeria are yet to be determined, but that such mixed motives are reminiscent of the colonial era.

Feldbaum el al. (2006a) observe that the linkages between HIV/AIDS and national security look different from the perspective of these next wave countries. From the perspective of Russia, India and China, HIV/AIDS raises internal security challenges to these states. Feldbaum el al. (2006a) agree that India and China's large populations will

likely largely shield these states from major political, social or economic impacts from the pandemic. However, they argue that the disease in these states is driven

> in significant part by injection drug users along heroin trafficking routes, and their interactions in turn with sex workers and the general population. High HIV infection rates among injection drug users and their sexual partners in Xinjiang and Yunnan in China, and Manipur in India, overlap areas of ethnic minorities, political insurgency, and separatist sentiment. Xinjiang and Manipur have large numbers of Chinese and Indian security forces, respectively, who are at elevated risk of HIV infection through commercial sex with local populations (Feldbaum et al.: 776-777).

Feldbaum et al. (2006a) conclude that areas where HIV/AIDS overlaps with heroin trafficking routes, minority populations and insurgency will pose additional significant challenges to limiting the spread of the disease in these strategically important states.

Sjöstedt (2008) further examines this second wave argument from the Russian perspective, arguing that the securitization of HIV/AIDS was an international norm that Russia was slow to accept. Tracing Russian government statements on HIV/AIDS from 2000-2006, Sjöstedt argues that acceptance of the "HIV/AIDS as a security threat" norm was resisted because of Russian perceptions of itself as an international power that gave, not received, international aid and advice. Sjöstedt (2008: 22) argues that while the evidence "does not clearly indicate that AIDS is seen as a security threat," the securitization norm likely played a role in increasing the politicization of the disease in Russia.

3.6 Critical Perspectives on HIV/AIDS and National Security

Both Elbe (2005) and Ingram (2005a, 2005b, 2007) critically engage with the links between HIV/AIDS and security beyond the epidemic's impact on strategically important populations and states, and highly-affected regions. Elbe (2005: 404) argues that framing HIV/AIDS as a threat to security is not just important politically, but is important because "it turns international security into a site for the global dissemination of a biopolitical economy of power." Building from the work of Michel Foucault, Elbe (2005: 405) argues that linking HIV/AIDS to security turns the biological characteristics of populations into high political issues, sanctions the statistical surveillance and monitoring of high risk populations, and has involved a large number of political actors

in "optimizing the health of populations." Recognizing that such biopolitical strategies have "historically been Janus-faced," Elbe (2005: 408) warns that securitization brings attention to an issue, but does not specify the response. Terrible violations of human rights could theoretically be justified if HIV/AIDS was viewed solely within a security framework, including denial of treatment, quarantine, legal persecution. To avoid these dangers, Elbe suggests presenting the security dimensions of HIV/AIDS as only one aspect of the epidemic, using a human security framework, and insisting that policy responses to the disease do not violate human rights.

Ingram (2005a, 2005b) analyzes the securitization of HIV/AIDS by mapping the discourses surrounding globalization, development and security. Ingram (2005b) notes the increasing use of security rationales for health and development initiatives in the U.S., and contrasts this with the rejection of such security rationales for health and development policy in the United Kingdom. He argues that dangers of using health to serve national security interests are that such actions will undermine the credibility of health professionals, threaten open governance systems that are need to response to global health challenges, and remove the human rights grounding that should drive most health and development initiatives (Ingram 2005a).

3.7 Securitization of HIV/AIDS: Elbe and Peterson

The explosion of literature since 2000 on the HIV/AIDS – national security nexus has predominantly focused on the potential and empirical links between the disease and national security. Most of these publications argue that HIV/AIDS does threaten national security, and that the response to the disease should be upgraded to reflect this threat. Only two published papers known at the time of writing have critically engaged with the normative question of whether the disease should be securitized and, if so, what are the potential risks and benefits. The first, Peterson (2002), draws on the experience of the environmental sector to argue that the securitization of HIV/AIDS will not benefit the fight against the pandemic. In the second paper, Elbe (2006a) utilizes Buzan et al.'s (1998) securitization theory to elicit the risks and benefits of securitizing HIV/AIDS. Elbe does not conclude that HIV/AIDS should or should not be treated as a security issue, but seeks to raise awareness of the issues and recommend actions for limiting the negative effects of portraying the disease as a threat to national security. These two

papers are reviewed here in depth as the basis of core debates about the securitization of HIV/AIDS that this thesis seeks to contribute to. The conclusions of these two papers will be contrasted with the findings and conclusions of this thesis.

3.7.1 Susan Peterson: Epidemic Disease and National Security

Peterson (2002: 44) begins by noting that, despite widespread and high-level attention to the threat of infectious diseases to security during 2000–2002, "systematic analysis of the link between [infectious diseases] and national security remains largely unfulfilled." Peterson's (2002: 47) article aims to address this gap by examining the severity of infectious diseases globally, the differences between human and national security in their relation to diseases, the causal links between epidemic disease and national security, and finally asks the question, "why it matters whether we view AIDS and other [infectious diseases] as security threats or primarily as health and development challenges." It is this final question which bears directly on the analytical focus of this thesis in terms of the broader impacts of securitizing HIV/AIDS.

Peterson's first section introduces the readers in the security community to the scope and impact of infectious diseases globally. She notes that, despite progress against infectious diseases in developed countries, infectious diseases remain a "significant and growing threat" (Peterson 2002: 47). She makes this point clearly to her security audience by comparing the number of deaths from infectious disease to those from warfare. Peterson cites a WHO study that estimates that, between 1945 and 1993, HIV/AIDS, TB and malaria killed 150 million people, while 23 million died in wars.

However, threats to security are not only measured by absolute numbers of people killed. Peterson explores the different conceptions of security and their relationship to disease. She writes that how security is defined will determine the scope of the relationship between disease and security. After outlining the history of the concept of human security, Peterson argues that the relationship between disease and the concept of human security is a simple one. Infectious diseases are serious threats to human security "because of the enormous loss of life they cause" (Peterson 2002: 50). Peterson (2002) cites former U.S. presidential candidate Al Gore's address to the first UNSC meeting on HIV/AIDS in 2000, where he argues that the heart of the human security agenda is

protecting lives, and that HIV/AIDS will kill more people than all the wars of the twentieth century.

While attempts to link disease to human security are a means of gathering attention and resources to address infectious diseases, Peterson (2002: 51) suggests there are three "flaws" to such arguments based on previous attempts to link the environmental issues to security interests, particularly Deudney (1990). The first flaw is that linking disease and human security begs the question of whether all serious health problems are threats to security. This is a common criticism of human security, which is also emphasized by Paris (2001), Khong (2001) and others. Peterson argues that the concept of human security does not provide guidance on how to prioritize threats and therefore destroys the utility of the concept of security. Fein (2000) states the classic formulation of this criticism: "If everything is a national security problem, then nothing is." The second flaw is that the link between disease and human security is likely to be of limited utility and impact within the security policy community. Peterson (2002: 51) writes that policy elites concerned with security remain "cool to the idea of human security" and will pay little attention to this linkage unless diseases can be demonstrated to impact on traditional national security concerns (i.e. core military and economic capacities). Third, Peterson argues that it is not clear that anything is gained by linking human security and disease that is not already achieved by the more traditional linkages between public health, and the development, human rights and humanitarian agendas.

In addition to these three flaws, Peterson argues that appealing to human security may have unwanted effects. Appealing to the security community implies that human health is less important than security and that efforts to improve health can only be justified by measuring health's impact on security. These statements are clearly contrary to the intentions of those seeking greater action on infectious diseases by arguing that they represent a serious threat to human security. Peterson also argues that linking health and security may imply that a military response to global health issues is required, when global health may be better served by other approaches. Because of these flaws and unwanted effects, Peterson focuses the rest of her article on the relationship between disease and national security.

After dismissing attempts to link disease and human security, Peterson begins a critical examination of the causal relationships between disease and national security. Perhaps seeking greater credibility with security policy-makers, Peterson selects a traditional and conservative definition of national security as her basis for this examination. Peterson (2002: 52) defines national security as "the preservation of the state – its territorial integrity, political institutions, and national sovereignty – from physical threats." This definition is based on Walt (1991) and Paris's (2001) description of "national security" and "redefined security." Thus Peterson's (2002: 54) criterion for when a health issue becomes a security threat is when that issue threatens "the territory, institutions, or sovereignty of the state." Her analysis concludes that epidemic diseases can contribute to the outbreak of violent conflict, or influence the outcome of conflicts. These effects will be most pronounced in sub-Saharan Africa, while only posing long-term and indirect threats to the U.S. (Peterson 2002).

Peterson makes four arguments against linking diseases including HIV/AIDS to national security. Her first is based on the conclusion of the previous section, which stated that infectious diseases represent only a distant threat to the security of the U.S. and other developed countries. While epidemic diseases will have large impacts in sub-Saharan Africa, "a humanitarian and even a security threat to southern Africa does not necessarily threaten other states' security unless southern Africa is of vital interest to them" (Peterson 2002: 79). Peterson observes that the U.S. has not used such arguments in justifying its involvement in Somalia and Rwanda in the 1990s. Due to this weak link between disease and the national security of developed nations, Peterson concludes that arguments that link disease to security will likely be unsuccessful in generating greater responses to HIV/AIDS in developing countries.

Peterson is alone among analysts of the HIV/AIDS – national security nexus in offering her second argument. Here Peterson (2002: 80) argues that "it is not clear… that anything is gained by adopting the rhetoric of national security to address [infectious diseases]." Numerous authors, including Elbe (2006), Singer (2002), Feldbaum et al. (2006a), have argued that linking HIV/AIDS to national security agendas may result in "greater political commitment and funding" (Feldbaum et al. 2006a: 777). These benefits are often assumed to have at least as much importance as the actual implications of the disease on national security. Peterson, however, focuses on the relative strengths

of the arguments linking HIV/AIDS and security, compared to those linking HIV/AIDS and other areas. She argues that, while HIV/AIDS is a staggering threat to a multitude of areas of human activity, the security of states is not one of these. Peterson (2002: 79-80) writes: "From a national security perspective... AIDS poses a far smaller threat to most states than it does from almost any other viewpoint, including health, human rights, economic and political development, and social and economic justice." With this argument, Peterson dismisses any benefits to the linking HIV/AIDS and other infectious diseases to national security. This precise question of whether the securitization of HIV/AIDS holds any benefits will be revisited throughout this thesis.

After concluding that linking HIV/AIDS to national security offers no benefit, Peterson further undermines the case for linking the disease and national security by presenting two dangers of this approach. Both of these dangers are unintended consequences of seeking to address HIV/AIDS and other infectious diseases by appealing to the national security interests of states. First, Peterson presents the danger that securitization will relieve developed states of a moral obligation to respond to health crises in developing countries. Developed countries will be relieved of their moral obligation because, as proponents of linking disease and national security imply by their arguments, "only national security concerns can justify significant expenditures on disease control" (Peterson 2002: 80). Peterson supports this argument by comparing the high-level international health cooperation achieved to address disease during the nineteenth century, when epidemics in Europe endangered trade between states, with the loss of interest in the health of developing countries by developed countries during the twentieth century because they were believed protected by new pharmaceuticals and public health interventions. Peterson (2002: 80) concludes from this example that appeals to narrow national interests were not successful in creating "a sustained commitment to international health cooperation" and are "no more likely to promote the sustained commitment that will be necessary to fight AIDS in Africa and elsewhere."

However, here Peterson recognizes that there may be benefits to health when states see improving health as in their strategic interests, in direct contradiction of her second conclusion. Despite this inconsistency, Peterson raises a serious question, which will be examined by the historical case studies in this thesis, about whether developed countries have been relieved of their moral responsibility to respond to health crises in the

developing world because of the argument that HIV/AIDS poses a threat to the national security of developed countries.

Peterson argues that the second danger of linking disease to national security agendas is that this linkage may undermine trust in national disease control and biological weapons non-proliferation programs. While no evidence is provided to support this assertion, the argument is that, if disease control efforts become associated with the selfish national security interests of states, they will become increasingly distrusted and arouse suspicion in other states. This lack of trust and suspicion will then further undermine global health. An example of this type of situation may be the argued undermining of humanitarian aid in Afghanistan due to the U.S. military's conduct of both military and humanitarian operations concurrently (Ford 2001). Peterson (2002: 80) suggests "it may be more fruitful to view disease and health issues as concerns for U.S. foreign policy deserving of multilateral responses, rather than as narrow security threats requiring bilateral policy responses that may provoke suspicion." This fear that linking disease control programs to national interests will undermine trust in public health is valid and will be investigated in this thesis.

In addition to Peterson's argument about undermining trust, she also voices a commonly held assumption about securitization; specifically that securitization necessitates a particular type of policy response involving the traditional national security apparatus including military and police forces, and characterized by bilateral or unilateral approaches. Similarly, Csete (2007: 720) fears the "other side of the coin" of securitization is "the unfettered pursuit of a public security agenda, including counterterrorism measures, on the lives of people who are most affected by, or vulnerable to, HIV/AIDS." This question of whether securitization of HIV/AIDS necessitates a security-driven response to the pandemic, or whether global health approaches can result from securitization, is another question this thesis will seek to answer through historical case studies.

In short, Peterson's analysis finds no benefits to, and a number of risks arising from linking HIV/AIDS and other diseases to national security interests. These risks are that developed states will be relieved of their moral obligation to respond to health crises in developing countries, and that this linkage will generate distrust and undermine disease

control efforts. Because of these risks, Peterson (2002: 81) concludes that HIV/AIDS is an unprecedented health tragedy that calls for "humanitarian assistance, not for the garrisoning of states behind national boundaries and national security rhetoric." For these reasons, Peterson (2002: 81) states that for those seeking to rally support "for anti-AIDS efforts Africa, portraying the disease as a security issue may be exactly the wrong strategy to employ." Despite underestimating the benefits of the HIV/AIDS – national security nexus, Peterson's critique of this linkage generating distrust and reduced moral commitment to health crises in developing countries represent areas warranting further investigation in this thesis.

3.7.2 Stefan Elbe: Should HIV/AIDS be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security

In the literature to date, Elbe (2006a) grapples most directly with the normative question of whether HIV/AIDS should be securitized. While Elbe (2006a) recognizes the need for research into the empirical links between HIV/AIDS and security (and has published on these empirical links in Elbe (2002) and (2003)), he argues that this debate must be widened to encompass the normative questions of what are the benefits and drawbacks of addressing the disease through the framework of national security.

To conduct this examination, Elbe uses the securitization theory of Buzan et al. (1998). After summarizing their framework and theory of securitization, Elbe (2006a: 126) concludes that securitization "is precisely what has happened to the issue of HIV/AIDS in recent years." Elbe writes that the debate around HIV/AIDS meets Buzan et al.'s four criteria for the securitization of an issue: securitizing actors, a referent object, an existential threat, and calls for emergency measures.

Buzan et al. (1998: 1) caution against securitizing issues, arguing that there are "intellectual and political dangers in simply tacking the word security onto an ever wider range of issues". They warn that "security should be seen as a negative, as a failure to deal with issues as normal politics" (Buzan et al. 1998: 29). Elbe builds on this perspective to examine the two major dangers arising from securitization as applied to HIV/AIDS. The first danger is that securitization "processes usually lead to a greater

level of state mobilization, enabling the state to encroach on an increasing proportion of social life where it might not be desirable" (Elbe 2006a: 127). More specifically, Elbe summarizes Buzan et al.'s first concern in two parts. First, securitization can remove an issue from ordinary democratic debate into the higher echelons of power where transparency and democratic scrutiny can be more limited. Second, securitization and the term "security" may be used by governments to justify emergency measures which override the rule of law and civil liberties, and silence opposition to the state.

Applying these concerns to the case of HIV/AIDS, Elbe (2006a: 128) finds that framing the disease "as a security issue pushes responses to the disease away from civil society toward the much less transparent working of military and intelligence organizations, which also possess the power to override human rights and civil liberties." Elbe cites the U.S. CIA's increasing involvement in examining the national security implications of HIV/AIDS as evidence for this argument. Furthermore, there are numerous historical examples of states infringing on the civil rights of those with HIV/AIDS and other diseases (e.g. SARS). Elbe cites examples of Haitians in the U.S. being denied housing and employment during the early years of the HIV/AIDS epidemic, and the UK government considering compulsory HIV screening for prospective immigrants in 2003. Elbe (2006a: 128) finds that this evidence

> undoubtedly justify the first normative concern... that the involvement of the state in the management of wider social issues can also have detrimental effects in terms of placing the management of such an issue behind closed doors, and by paving the way for civil liberties to be overridden if this is deemed necessary by the state.

However within this statement is the assumption that states are only involved in wider social issues, such as HIV/AIDS, when such issues have become securitized. In fact, states already have significant power to override civil liberties to address public health problems and infectious disease epidemics separate from their implications for national security. The ability of public health authorities to override individual rights is codified in U.S. constitutional law beginning with the 1905 case of Jacobson v. Commonwealth of Massachusetts, which established the power of the state to act against the individual for the benefit of the public's health (Joseph 2003). (For further discussion of public health and individual rights, see Feldbaum and Lee (2004)) Elbe's examples have little to do with securitization, but instead are examples of the use and misuse of public health

powers. Elbe's concern that the CIA has increased its study of HIV/AIDS does not necessarily lead to the conclusion that the CIA is leading U.S. responses to the epidemic. Elbe's argument cannot be discarded however, because it is possible that the securitization of HIV/AIDS may potentially increase the use and misuse of these public health powers to the detriment of people living with HIV/AIDS. As in the above discussion of Peterson (2002), the fear here is whether securitization will result in security community-led responses to the pandemic.

The second danger Elbe (2006a: 127) cites from his examination of securitization theory is that "the language of security attaches to issues a particular 'threat-defense' logic that may not always be appropriate or beneficial for addressing these issues." This threat-defense logic holds three dangers. First, Elbe argues that viewing HIV/AIDS as a security threat could remove efforts to fight the disease from a humanitarian and development framework, and place them in a state-centric framework focused on national security. Elbe warns that if securitization of HIV/AIDS is accepted, efforts to fight the disease may be limited to those instances where the disease is seen to threaten narrow national security interests. This concern echoes Peterson's (2002) argument that viewing HIV/AIDS as a national security threat will relieve countries of their moral and humanitarian commitment to address the disease.

A second and related danger of securitizing HIV/AIDS is that the "threat-defense" logic will shift funding priorities from addressing the epidemic among civilian populations to a focus on the "core institutions of the state, including the armed forces" (Elbe 2006a: 129). Elbe argues that low-income countries with scarce resources may prioritize treatment for armed forces and elites over civilian populations, or even divert ARVs from civilian to military treatment programs because of the portrayal of HIV/AIDS as a threat to national security. Elbe writes that, while no examples of the latter have been officially documented, many states have prioritized access to ARVs by elites and their armed forces. He argues that this has resulted in a situation where soldiers in Africa often have better access to health care and ARVs than civilians in the same country. Elbe therefore argues that the securitization of HIV/AIDS may help those who already have the greater chance of receiving ARVs, rather than providing treatment for HIV/AIDS based on need. This danger exists at the global level as well, where donor funding could be focused on countries of strategic importance over those in greatest

need. As Ingram (2005a: 539) rightly observes: "the landscape of political insecurity is not fully congruent with the landscape of need."

The third danger of the "threat-defense" logic is that it will undermine efforts to normalize societal attitudes towards people living with HIV/AIDS. Stigmatization of people living with HIV/AIDS and the perception of HIV/AIDS as a disease of outsiders has inhibited attempts to prevent the spread of the disease since the beginning of the pandemic (Valdiserri 2003; Putzel 2003). Elbe (2006a: 130) fears that presenting the disease as a "destructive and debilitating threat" will undermine the advances made in destigmatizing the disease and acceptance of those living with HIV/AIDS. However, this argument confuses the virus of HIV/AIDS, and people living with HIV/AIDS, as the source of the security threat, as Elbe acknowledges later in his article. The argument that people living with HIV/AIDS are a threat to national security is both inaccurate and objectionable. But this argument is rarely made, and is not to be found in any of the published works on the HIV/AIDS – national security nexus. It is the securitization of the HIV/AIDS virus, not people with HIV/AIDS, which is at issue in publications on the nexus. While securitization may provide some nefarious governments with a justification for violating the rights of people living with HIV/AIDS, this would be more directly linked to the government's character and not to the securitization of the disease. Thus, this danger of securitizing HIV/AIDS may be overstated.

Unlike Peterson (2002), Elbe (2006a) finds that the securitization of HIV/AIDS could bring benefits to the fight against the disease and for persons living with HIV/AIDS. Citing Buzan et al. (1998: 29), who argue that the dangers of securitization must be weighed against "the possible advantages of focus, attention and mobilization," Elbe seeks to explore the benefits of securitizing HIV/AIDS.

"Excessive state mobilization" forms the basis of Elbe's (2006a: 130) first set of risks in securitizing HIV/AIDS. At the same time, however, the mobilization of states to fight HIV/AIDS also represents a potent advantage to securitizing the epidemic. As Elbe (2006a: 131) observes, in "countries most seriously affected by the AIDS pandemic, it is not excessive state mobilization that poses the main problem, but, on the contrary, the utter absence of a meaningful state response to the disease." Because the global response to HIV/AIDS has been characterized by insufficient mobilization to stem the pandemic,

the increased mobilization of states could represent a particularly strong benefit of securitizing HIV/AIDS. Elbe writes that the securitization of HIV/AIDS at the UNSC worked toward this goal of increasing state action in fighting HIV/AIDS. In other words, the intent of beneficial securitization would be to shift the issue of HIV/AIDS from a non-politicized issue that generates little state action, to a politicized issue that states seek to address at a high level.

Elbe finds that removing HIV/AIDS from general debate, and into the higher echelons of power, previously cited as a danger of securitization, also offers potential benefits for mobilizing efforts to fight the disease. Securitizing the disease has broken the silence surrounding HIV/AIDS in these policy circles, resulting in meetings at the UNSC and the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases. In both these cases, securitization pushed politicians and state leaders to discuss the disease and move it higher on their agendas. Elbe also argues that securitization has shifted the response to HIV/AIDS, from often under-resourced ministries of health, to those with greater political and financial clout. This shift may benefit those with HIV/AIDS if this clout is used to expand treatment and prevention programs.

While Elbe cites Buzan et al.'s warning that securitization can allow the overrule of the rule of law, Elbe also finds that the ability of states to overrule patent protections outlined in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) is a potential advantage of securitization. Securitization may aid highly affected states seeking a "security exception" from the TRIPS agreement allowing them to import ARVs at lower costs than would be available if the provisions of TRIPS were honored (Elbe 2006a: 133). Even if the security exception to TRIPS is not used, the potential for this exception is an important bargaining tool in negotiations between countries and pharmaceutical companies over the price of AIDS medications. Elbe observes that this benefit of securitization has a unique economic benefit to highly affected states, beyond increased resources and attention, which was only achievable by arguing that HIV/AIDS represents a threat to national security.

The "threat-defense" logic that securitization brings to HIV/AIDS may also have benefits in fighting the disease. Both Elbe (2006a) and Peterson (2002) cite the state-centric and

self-interested nature of security as a potential drawback to linking HIV/AIDS to national security. Elbe (2006a) however also argues that previous appeals to altruism and humanitarianism have so far failed to generate sufficient political will and resources to successfully fight HIV/AIDS. In this situation, "the appeal to the naked self-interest of states is the only strategy left in light of the pressing daily humanitarian implications of the pandemic" (Elbe 2006a: 134). Appealing to the self-interest of states may help justify significantly expanding funding for HIV/AIDS by donor governments. Elbe cites the US$15 billion PEPFAR program as an example of the financial benefits that can accrue from securitization. Linking HIV/AIDS to national security may also benefit highly affected countries by provoking governments in Africa to prioritize the disease in political agendas and budgets. Elbe writes that the highlighting of the impact of HIV/AIDS on armed forces has been a critical part of the strong political leadership on HIV/AIDS in Uganda, Ethiopia and Malawi. In these cases, a security framework has succeeded in generating state action on HIV/AIDS where humanitarian and altruistic frameworks failed.

The "threat-defense" logic of security may also be beneficial to fighting HIV/AIDS by increasing the involvement of armed forces in fighting the disease. Elbe cites the increasing funding for the U.S. Department of Defense HIV/AIDS Prevention Program, which assists countries to prevent and treat HIV/AIDS in their armed forces, as an example of a benefit from securitization. This program also supports the dependents of soldiers with treatment and prevention, reaching both military and civilian populations. Elbe notes that here, securitization has generated new resources from military budgets to fight the disease. Furthermore it is argued that militaries represent an important group in the fight against HIV/AIDS, because they may be at elevated risk for the disease, have sexual relations with civilian populations, and are more easily targeted by prevention and treatment programs. Thus securitization may benefit the fight against HIV/AIDS by increasing military involvement. Elbe notes however that privileged access to ARVs for military personnel would likely be opposed.

Elbe concludes that securitization theory does not seek to answer the question of whether HIV/AIDS should be securitized, but to cultivate a deeper understanding of the risks and benefits of securitization. On this basis, Elbe suggests three recommendations for minimizing the dangers of securitization. First, those seeking to link HIV/AIDS to

national security should present the security impacts of the disease as only one dimension of the disease. They should note that HIV/AIDS is also an issue of health, development, gender, and other areas. This will help insure that the security dimensions of the disease complement, rather than replace, the humanitarian and altruistic frameworks that have traditionally governed responses to the disease. Second, Elbe suggests describing HIV/AIDS as a security *issue*, rather than a dangerous security *threat*. He argues that this will preserve the political benefits of the term security, while reducing excessive fear of HIV/AIDS or increasing stigmatization of people living with HIV/AIDS. Third, those framing HIV/AIDS as a security issue should be clear that the virus, and not people living with the disease, is the source of the security problem.

Effect of securitization	***Negative impact on HIV/AIDS (Risks)***	***Positive impact on HIV/AIDS (Benefits)***
Greater state mobilization	• Reduced democratic scrutiny and transparency • Justifies emergency measures that may override civil liberties	• Greater state mobilization on HIV/AIDS is needed • Aids security exception argument under TRIPs
Threat-defense logic	• Moves HIV/AIDS from humanitarian and development framework to state-centric framework of national security • May shift funding priorities from civilians to elites and armed forces • May restigmatize people living with HIV/AIDS	• Humanitarian justifications unsuccessful in raising sufficient political and financial support • Armed forces must be further involved in fighting HIV/AIDS • May avoid stigmatization by saying the virus is the security threat

Figure 3.2: Summary of Elbe (2006a)

3.8 Conclusion

Most authors writing about the HIV/AIDS – national security nexus have provided descriptions of the linkages between the disease and security, while appealing for greater action to fight HIV/AIDS. Other authors have commented on the strategy of appealing to national security interests, or using the UNSC, to address HIV/AIDS. Most relevant to the aims of this thesis are Peterson's (2002) and Elbe's (2006a) efforts to grapple with the question of whether HIV/AIDS should be securitized, and the risks and benefits that arise from securitization of the pandemic. With the goal of adding a third perspective to the work of Peterson and Elbe, the next three chapters create a history of cases in the HIV/AIDS – national security nexus, concurrently evaluating conceptual frameworks and the conclusions of both authors. Chapters 4, 5 and 6 trace the ways in which consideration of HIV/AIDS as a national security issue has impacted the fight against HIV/AIDS since the mid 1980s. This history begins with events in Uganda, Thailand, Cambodia and the U.S. that linked HIV/AIDS and national security between 1985-1995, but which occurred before securitizations in the U.S. and at the UNSC, and widespread debate about the national security implications of HIV/AIDS. Chapter 5 sets out the events that cumulated in the securitization of HIV/AIDS by the U.S. government and the UNSC. Chapter 6 examines the consequences of securitization on policies and efforts to fight HIV/AIDS. The final chapter will then build on the evidence presented to draw the conclusions of this thesis, and address the questions raised by the conceptual framework chapter and the literature review.

Chapter 4: The early history of the HIV/AIDS – national security nexus: 1985-1995

This chapter traces the HIV/AIDS–national security nexus from 1985–1995. This timeframe roughly overlaps with the explosive spread of HIV during the first decade of the pandemic, and is well before HIV/AIDS was widely discussed as a security threat after the UNSC meetings in 2000 and concurrent U.S. intelligence reports on the pandemic. Because this time period predates the official securitization of the pandemic, to date linkages between HIV/AIDS and national security during this period have rarely been incorporated into analysis. This chapter aims to remedy this deficit, and demonstrate the relevance and lessons of this early period in understanding more fully the HIV/AIDS – national security nexus.

This lack of analysis is not because linking the disease to national security was uncommon or unimportant during this earlier period. In fact, the pandemic was linked to the national security interests of two early success stories in fighting HIV/AIDS, Uganda and Thailand. This thesis argues that there is strong evidence that consideration of the national security implications of HIV/AIDS was a critical component of these countries' mobilization and successes in limiting the spread of the disease.

Also during this time, the U.S. and Soviet intelligence agencies considered the emerging pandemic through the lens of superpower competition. The Soviet Committee for State Security's (KGB) efforts created an enduring conspiracy theory suggesting the U.S. developed the disease as a biological weapon. The CIA's declassified studies of HIV illuminate a Cold War perspective on the disease, as well as strong biases within the U.S. intelligence community against incorporating infectious diseases into national security calculations. Both cases illustrate risks of the nexus, and difficulties in bridging the fields of global health and national security.

The final case described in this chapter focuses on the role peacekeepers played in igniting Cambodia's HIV/AIDS epidemic. These events illuminate, not only the role of security forces in spreading the disease, but the UN's lack of interest in addressing this problem and, more broadly, the barriers to securitization of HIV even when the disease represented a serious threat to the lives of peacekeepers. The UN's inaction in Cambodia

is particularly important to understand, because it was the issue of peacekeepers spreading the disease that would later vault HIV/AIDS into the considerations of the UNSC in 2000.

Thus the period 1985-1995 is critical to understanding the HIV/AIDS – national security nexus, and a full history of the nexus remains incomplete without these four cases. As discussed in this chapter, many of the current tensions within the nexus, as well as its potential benefits and hazards, are revealed through this early history.

4.1 Early recognition in Uganda

A historical examination of the linkages between HIV/AIDS and national security must begin with a widely circulated story about the first known time the disease was perceived to be a threat to national security. This occurred in an exchange between Ugandan President Yoweri Museveni and Cuban President Fidel Castro in 1986 about the HIV/AIDS prevalence of Ugandan troops. This exchange seemed to spur Museveni's government into greater action on HIV/AIDS, which would later result in a degree of success in reducing national prevalence of the disease. This exchange is difficult to characterize because the perception of HIV/AIDS as a threat to national security is said to have occurred, not in policy documents or government statements, but in the mind of President Museveni. Despite the unusual nature of this linkage, evidence does exist, including from Museveni himself, that this exchange contributed to motivating Uganda's early, and eventually successful response to HIV/AIDS. Therefore, the first time HIV/AIDS was perceived as a threat to national security, it helped spur successful government action to fight the disease.

By 1986, when Museveni became President of Uganda, the country was facing one of the earliest and worst epidemics of HIV/AIDS in Africa. Before taking power, he had learned that HIV/AIDS could be transmitted through heterosexual sex and warned his commanders that "they could be killed by promiscuous sexual relations" (Putzel 2003: 20). After taking power, Museveni continued to address HIV/AIDS by sending his Minister of Health to announce to the World Health Assembly that Uganda faced an epidemic of HIV/AIDS (Putzel 2003). Publicly discussing the disease was unusual

among African leaders at the time. Putzel (2003) credits Museveni's openness about HIV/AIDS to the fact that the country had little foreign investment or tourism to lose, and that the international community had offered funding to help Uganda fight the disease.

The critical event occurred in 1986 when President Museveni sent sixty of his generals to Cuba for further military training. Cuba's military, which had fought in Angola in the mid 1970s, had experience with its soldiers being infected with HIV/AIDS. As a result, Cuba tested the Ugandan soldiers for HIV/AIDS. Of the 60 soldiers, 18 tested positive for HIV, a prevalence rate of 30%. At a conference of non-aligned states in Zimbabwe in 1986, Castro reported these results to Museveni, saying "Brother, you have a problem" (Garrett 2000: para. 21; Allen 2002; Betty King Interview).

After this exchange, Museveni became personally involved in the response to HIV/AIDS and treated the disease as an issue of the highest political priority. Within a month of this exchange, Uganda's National AIDS Control Program was established (Tumushabe 2005). President Museveni became highly engaged in the response to HIV/AIDS, personally arguing to Ugandans that "fighting AIDS was a 'patriotic duty' requiring openness, communication and strong leadership" (Green et al. 2006: 338). Using military metaphors to describe Uganda's efforts against HIV/AIDS, Museveni securitized the epidemic and encouraged Ugandans to "fight HIV like we fought Amin" (Justin Parkhurst Interview). Museveni's "charismatic directness in addressing the threat placed HIV/AIDS on the development agenda and encouraged constant and candid national media coverage of all aspects of the epidemic" (Green et al. 2006: 338). This early and high level involvement by President Museveni is cited as the beginning Ugandan government's active response to HIV/AIDS (Putzel 2004; Elbe 2006; Green et al. 2006).

It appears from the above that Uganda's expanded efforts to fight HIV/AIDS in 1986 were triggered by Museveni's exchange with Castro. Museveni himself stated that his early actions on HIV/AIDS grew from his exchange with Castro about HIV/AIDS prevalence among the Ugandan military (Tumushabe 2005; Elbe 2006). Putzel (2003: 20) also cites this exchange as the beginning of Museveni's taking "a personal interest and a direct role in stepping up government efforts to fight the epidemic." Putzel (2003)

notes the ubiquitous presence of this exchange in policymaker's explanations of Museveni's early response to HIV/AIDS.

Authors have offered two rationales for why his exchange with Castro caused Museveni to act on HIV/AIDS. The first is that Museveni knew many of the soldiers who had been diagnosed as HIV positive. David Kihumuro Apuuli, head of the Ugandan AIDS Commission said that Museveni was upset "because these were comrades who had fought with him in the bush" (Garrett 2000: para. 21). A second rationale for beginning Uganda's major national efforts to control HIV/AIDS was the perception that HIV/AIDS posed national security challenges for the Ugandan state. Tumushabe (2005: 8) writes that "it would not be far fetched to conclude that the potential threat AIDS posed to the army, which was President Museveni's primary power base, led to the pragmatic steps such as creation of the AIDS Control Program... and the openness of Government towards HIV/AIDS." Princeton Lyman (Interview), former U.S. Ambassador to South Africa and Nigeria, says Castro's warning about high rates of HIV/AIDS in the top tier of his military "did alarm Museveni and was one of the reasons that he was so outspoken, so aggressive" on HIV/AIDS. These perspectives suggest that Museveni acted out of security concerns for his nation's military and his own powerbase. Because of this, Tumushabe (2005: 9) calls the exchange between Museveni and Castro the moment "the strategic and political importance of HIV/AIDS was... born."

The national security implications of HIV/AIDS for Uganda cannot be credited alone for Uganda's widely described and debated success in lowering national prevalence of the disease. A wide variety of factors unrelated to national security must be considered as contributing to Uganda's success (Green et al. 2006), including questioning the degree of Uganda's achievement (Parkhurst 2002; Allen 2006). However, this thesis argues that the threat HIV/AIDS posed to the Ugandan military and Museveni's powerbase caused the President to begin government efforts to fight the disease. In this Ugandan example, it was the strategic implications of HIV/AIDS which led to the disease's political prioritization.

The Ugandan experience suggests that perceiving HIV/AIDS as a threat to national security can elevate the disease into high politics, and generate increased governmental (and in this case beneficial) action to fight the disease among civilian and military

populations. The high – low politics model is clearly relevant here, neatly illustrating the movement of the disease from a largely unknown entity into the highest levels of Ugandan politics. These events also support the application of Fidler's (2005a) remediation model to describe the factors causing the transformation of the disease into an issue of high politics. Museveni addressed HIV/AIDS not because health was a politically transcendent value (the revolution model) or because public health efforts had failed (the regression model), but because the disease threatened to impact on the concerns of the traditional foreign policy sphere.

The Ugandan experience clearly contradicts Peterson's (2002) finding that there are no benefits to linking HIV/AIDS to national security. Clear beneficial action did result by Museveni's linking of HIV/AIDS to national security concerns. This event does confirm her finding that there is a threat to Africa from infectious diseases, but there is no evidence from this example to support her further conclusion that the nexus will generate distrust in global health efforts. This may be because the link between HIV/AIDS and national security generated political will, but actions to address the disease were broadly focused on both military and civilian populations. In other words, securitization only requires that emergency measures be enacted, not specifically military or police measures. The Ugandan case demonstrates that public health responses to HIV/AIDS can result from securitization. Similarly, there is no evidence that the linkage of HIV/AIDS to Ugandan national security generated the negative impacts of securitization outlined by Elbe. Conversely, greater state mobilization and the strong involvement of the armed forces were major benefits of securitizing HIV/AIDS at this early stage in Uganda's epidemic.

It should be noted that other African governments have responded differently to similar data about HIV/AIDS prevalence in their militaries. Both the Ethiopian and South African militaries discovered a high prevalence of HIV/AIDS among their armed forces, viewed the disease as a threat, and worked to prevent and treat HIV/AIDS among their armed forces (Whiteside, De Waal, and Gebre-Tensae 2006). However in Ethiopia, these military-based efforts occurred well before comparable efforts to address HIV/AIDS in civilian populations. In South Africa, military efforts to fight the disease developed "in contradiction to government policies that did not prioritize AIDS at all" (Whiteside, De Waal, and Gebre-Tensae 2006: 209). In both cases, the national security

implications of HIV/AIDS generated only military-focused responses to the disease and did not impact broader civilian policies. Thus in neither case was the disease securitized. In Zimbabwe, the presence of HIV/AIDS in the military since the 1980s generated almost no action by President Mugabe or the Zimbabwean government. Only in 2004, when China expelled Zimbabwean National Army officers for being HIV positive, did Zimbabwe begin to address HIV/AIDS among its armed forces (Garrett 2005). These states serve as counter-examples to the Ugandan experience, demonstrating that a multitude of factors are involved in determining a national response to HIV/AIDS, even when the disease is perceived as a threat to the military.

These counter examples demonstrate that perceiving HIV/AIDS as a threat to national security is not a sufficient condition to elicit a strong governmental response to the disease. However these events in Uganda do demonstrate the powerful potential benefit of linking HIV/AIDS to national security where responsible leadership and other enabling political factors are present.

4.2 Intelligence Services and HIV/AIDS: Cases of CIA and KGB Involvement

In 1987 and 1991, the U.S. intelligence community produced the first known intelligence community studies on the impact of HIV/AIDS in sub-Saharan Africa and globally. The first CIA study was completed only six years after the first published report of the existence of HIV/AIDS, demonstrating an early interest in the disease that is unanticipated by the conceptual frameworks reviewed in Chapter 3 (CDC 1981). The two studies describe devastating humanitarian, economic and military impacts of HIV/AIDS in sub-Saharan Africa, but these are not cosmopolitan or humanitarian analyses, but are clearly based in the communitarian perspective of national security. Despite predicting enormous devastation from HIV/AIDS, both studies conclude that the pandemic has limited implications for U.S. national security interests. The response to the 1991 Estimate reveals strong biases within the U.S. intelligence community against considering HIV/AIDS as a threat to national security. The response also revealed the low political status of HIV/AIDS at that time, and an assumption that the security implications of HIV/AIDS would be benign in highly affected states. These studies are an essential part of the early history of the nexus, illuminating the security community's

initial perspective on HIV/AIDS and a stark communitarian – cosmopolitan divide between the global health and national security communities as a major hazard of the nexus.

The CIA was not the only intelligence agency thinking about HIV/AIDS during this early period. Around 1986, the Soviet KGB (U.S.S.R. Committee for State Security) launched a disinformation campaign to seemingly take advantage of confusion about the origins of HIV/AIDS and its disproportionate impact on Africa. This disinformation campaign alleged that the disease was actually a product of U.S. research into biological weapons. The campaign was widely disseminated and, as argued by this thesis, likely impeded public health efforts to fight HIV/AIDS through the present day. The KGB's efforts represent a uniquely egregious case of using the disease in pursuit of a country's national security objectives, and illustrate another risk from the nexus that is unanticipated by existing conceptual frameworks.

4.2.1 The 1987 U.S. National Security Estimate: Sub-Saharan Africa, Implications of the AIDS Pandemic

On June 1, 1987, the CIA issued National Security Estimate 70/1-87 on the implications of HIV/AIDS in Sub-Saharan Africa. Made public in 2001 under the Freedom of Information Act, this is the earliest known evaluation of HIV/AIDS by any state intelligence agency. Written with the goal of informing U.S. national security policy, this document exhibits a communitarian perspective on the HIV/AIDS epidemic in Sub-Saharan Africa. Despite forecasting "devastating" humanitarian, economic and military consequences for Africa, the Estimate concludes that the epidemic's strategic impact on the U.S. will be limited (National Intelligence Council 1987: 4). This communitarian rationale for studying HIV/AIDS will prove to be a constant feature of U.S. intelligence reports on the pandemic.

The Estimate was initiated because by 1987, the National Intelligence Council believed that HIV/AIDS was a "deadly epidemic… spreading out of control in Sub-Saharan Africa" (National Intelligence Council 1987: 1). The goal of the Estimate was to examine "the serious implications of the AIDS pandemic for African, Soviet Bloc, Western, and U.S. interests" (National Intelligence Council 1987: 1). It paints a

devastating picture of the spread of HIV in Sub-Saharan Africa, which has largely been confirmed by actual events. The estimate states that: "the long-range impact of AIDS will be devastating. Heavily infected countries will suffer irreplaceable population losses in those groups most essential to their future development: midlevel economic and political managers, agrarian and urban workers, and military personnel" (National Intelligence Council 1987: 4-5). In addition to the huge human cost of the disease, the estimate states that AIDS will adversely affect the mining industry and agricultural production in Sub-Saharan Africa.

This Estimate argues that HIV also has important security implications for affected African countries. These include the loss of highly trained and experienced officers, low morale, and a decreasing pool of young men available for military service due to HIV/AIDS. Tension within and between states could also be caused by the epidemic. The Estimate worries that travel restrictions, border closings and quarantines could inflame political tensions and engender military responses. However, the potential implications of HIV/AIDS for African security are not the focus of the Estimate.

The central intent of the analysis is to understand how HIV/AIDS could impact upon U.S. strategic interests and standing in the Cold War. The impacts of the pandemic on both the Soviet bloc and U.S. are described in terms of the potential impact on the military, development aid programmes, and public image. For the Soviet bloc, the estimate suggests that the HIV pandemic "could raise the cost for Havana and Moscow, and could eventually weaken their resolve to maintain current levels of troops and advisers in Africa... Military and civilian personnel will face rigorous testing upon return from Africa" (National Intelligence Council 1987: 5). As to impacts on the U.S., the Estimate argues that AIDS in Africa will pose problems for relationships with affected African states. These problems will stem from increasing African demands for assistance and aid to stop HIV/AIDS. The Estimate argues: "the United States and Western countries appear to offer only the future hope for a vaccine or cure, while currently denying the massive assistance that would be needed to care for the victims and raise health services to developed-world standards" (National Intelligence Council 1987: 15). The Estimate argues, from its focus on U.S. interests, that poor relations with African states may impact on basing agreements, aircraft landings and military port calls for the U.S. military.

This 1987 Estimate represents the first analysis of HIV/AIDS from a national security perspective. The Estimate clearly demonstrates the communitarian perspective of national security focused on national interests, particularly the difference in referent objects between the global health and national security communities. The Estimate concludes that HIV/AIDS will have enormous humanitarian, economic and military impacts on Sub-Saharan Africa, but that these impacts will be of little importance to U.S. national security. This analysis is based on the referent object of national security being the state, and is not primarily concerned with humanitarian suffering or strategic impacts of HIV/AIDS outside of the U.S. and Soviet Union. In contrast, a global health and cosmopolitan approach to HIV/AIDS would focus on the most affected human communities and their humanitarian needs as the referent object, regardless of their location in a nation state.

While the communitarian – cosmopolitan dichotomy has clear relevance here, the CIA study of HIV/AIDS challenges the starting perspective of the models of engagement identified by Lee and McInnes (2004). In this case it was not the global health community acting as a supplicant to the national security community, but the national security community independently seeking out HIV/AIDS as a subject of intelligence. This foreshadows the increasing U.S. intelligence community focus through the 1990s on transnational threats. This change in focus was largely due to the end of the Cold War and collapse of the Soviet Union, which removed the key subject of U.S. intelligence efforts, and led to policymakers and analysts attempting to anticipate possible new threats to U.S. national security. Thus the change in the geopolitical landscape after the end of the Cold War pushed the national security community to study new types of potential threats including infectious diseases such as HIV/AIDS. This, and further U.S. intelligence studies of HIV/AIDS and infectious diseases, suggests that the models of engagement fail to fully account for an independently initiated national security community interest in global health issues.

The Estimate does support Elbe's contention that the threat-defense logic of security will push HIV/AIDS into the state-centric framework of national security. However this study's lack of impact on policymaking makes it difficult to assess in light of Peterson and Elbe's conclusions on the risks and benefits of securitization.

Nothing about the response to this Estimate is known, although the response was likely similar to the dismissal and "indifference" that characterized the response to a similar 1991 Estimate on HIV/AIDS discussed next (Gellman 2000a: para. 5). Despite the disease's potential to cause devastation in Sub-Saharan Africa, the U.S. intelligence community concluded that HIV/AIDS posed only limited challenges to U.S. interests. This conclusion did not call for further urgent investigation. It would be four years before the U.S. intelligence community revisited the issue of HIV/AIDS.

4.2.2 1991 Intelligence Memorandum "The Global AIDS Disaster"

In 1991, the CIA produced another classified study on HIV/AIDS entitled *The Global AIDS Disaster*. This study is not available publicly and a Freedom of Information request by the author has not yielded access to the study at the time of writing. Because of this, this research must rely on Barton Gellman's (2000a) report of the study in the *Washington Post*. Gellman briefly describes the content of the study and describes in detail the response to the study by the U.S. intelligence community. This response suggests strong bias within the U.S. intelligence community against considering HIV/AIDS as a subject of national security analysis, and again demonstrates the strongly communitarian perspective of the U.S. national security community in 1991.

The Global AIDS Disaster, also known as *Interagency Intelligence Memorandum 91-10005*, broadened the CIA's inquiry into HIV/AIDS from its impact on sub-Saharan Africa, as described in the 1987 study, to the entire globe. The 1991 memorandum also extended its projections to the year 2000, predicting 45 million total infections, decreases in life expectancy by 15 years, and 10%-30% infection rates in sub-Saharan Africa. Gellman (2000a: para. 3) writes that, at the time these numbers "beggared comparison. There were not that many combatants killed in World War I, World War II, Korea and Vietnam combined." Despite these sobering projections, which proved slight underestimates of actual figures in 2000, the report appears to have had little effect on awareness of the pandemic or policymaking within the U.S. national security community. Gellman (2000a: para. 5) reports that the document

> landed near the top of the pile of incoming intelligence at the White House and Cabinet agencies... The authors prepared for the flurry of briefings that accompanies release of a major intelligence product. Save for then-Surgeon General C. Everett Koop and a Pentagon medical unit, no one asked.

The principle author of the report, Kenneth Brown, describes the reaction to the Memorandum as "indifference"(Gellman 2000a: para. 5).

It is argued here that at least three factors contributed to the indifferent response to *The Global AIDS Disaster*. First, the idea that a disease would have major global and national security consequences, on par with two World Wars, was new and unfamiliar to the intelligence community. Fritz Ermarth, then Chairman of the National Intelligence Council, stated, "You've got to have a critical mass of people that are primed to see a problem like this in strategic terms... Just to put the words under their noses... doesn't get their attention. It's kind of remote, it's distant, it's not obvious what you do about it anyway. And here you're talking 1991, and that critical mass didn't exist" (Gellman 2000a: para. 23). The CIA was reluctant to even study HIV/AIDS, partially because of lingering fears of association with the KBG disinformation campaign (discussed in the next section,) but also because many in the intelligence community did not think that a disease should be considered a threat to national security. The authors "could not obtain CIA approval for use of personnel and computer modeling resources" while "internal critics declared global AIDS an unfit subject of intelligence" (Gellman 2000a: para. 16). The U.S. intelligence community, in short, was highly reluctant to broaden their scope of inquiry beyond traditional national security threats to examine the issue of HIV/AIDS, even when the disease was forecast to cause deaths on such a major scale.

Second, the scope of the disaster outlined in the Memorandum demanded massive government expenditure to address, expenditure so large that it was easier to deny the problem than to act upon it. William Foege (former director of the Centers for Disease Control and Prevention (CDC)) says, with regard to the first reaction to the disease's estimates, that it would take US$3 billion per year to fund global prevention programs: "That's impossible. We could never spend those kinds of resources" (Gellman 2000a: para. 9). Because HIV/AIDS was an issue of low political priority, it was inconceivable that the disease would receive funding commensurate with that of a "high politics" issue. The relatively low political status accorded HIV/AIDS is confirmed by comparing the US$3 billion considered "inconceivable" to fight the disease with the 1991 U.S.

Department of Defense budget of approximately $280 billion (U.S. Department of Defense 1997).

The third factor that inhibited action, in the wake of the publication of *The Global AIDS Disaster,* was the perception that the security implications of HIV/AIDS would be benign, and might ultimately even be beneficial for highly-affected states. The authors of the Memorandum describe frequent conversations with colleagues on the National Intelligence Council who were skeptical that the HIV/AIDS pandemic would have any negative effects on national security. One argued that the epidemic "will be good, because Africa is overpopulated anyway" (Gellman 2000a: para. 15). Others thought that officers dying of AIDS in allied militaries "boosts morale, because there's more room for advancement" (Gellman 2000a: para. 15). Some intelligence analysts thought that the loss of young soldiers within African militaries to AIDS would not present problems because of the large numbers of unemployed men that could serve as replacements. They argued: "If you have one 18-year-old with a Kalashnikov [rifle] and he dies, you find another 18-year-old" (Gellman 2000a: para. 16).

A callousness to the predicted extreme suffering and death that would be caused by HIV/AIDS permeates these statements, and strongly illustrates the security community's communitarian values that place state interests above humanitarian concerns. The strength of the objection to considering HIV/AIDS a subject of national security analysis suggests a deep resistance within the U.S. intelligence community to thinking seriously about a non-traditional threat to security.

Overall these two early CIA studies on HIV/AIDS, considered for the first time by the public health field by this thesis, provide the starting point for examining the historical background to U.S. intelligence and national security community perceptions of the pandemic. In the late 1980s and early 1990s, these perceptions were a major barrier to securitization of the pandemic, and exemplify the communitarian – cosmopolitan divide within the HIV/AIDS – national security nexus. As discussed in Chapter 5, within a decade these perceptions would undergo a transformation.

4.2.3 The KGB Disinformation Campaign

While the CIA was studying the national security implications of HIV/AIDS for the U.S., the Soviet KGB was actively pursuing a global disinformation campaign centered on the pandemic. The Soviet campaign, implemented by the KGB, originated and spread the rumour that HIV/AIDS had been purposely developed as a biological weapon by the Pentagon at its medical research laboratories in Fort Detrick, Maryland[12]. This nefarious and largely successful disinformation campaign by the USSR used the emerging pandemic in pursuit of Soviet propaganda and national security objectives in the cold war. In addition to spreading disinformation, this thesis argues that the campaign may have had lasting negative impact on HIV prevention efforts, particularly among African Americans. The disinformation campaign also provides a novel example of one danger of linking HIV/AIDS to national security interests.

The first instance of the disinformation campaign is thought to have taken place in 1983 in the Indian newspaper *Patriot*. Widely considered a "vehicle for Soviet disinformation," *Patriot* is purported to have published a letter to the editor from an anonymous but "well-known American scientist and anthropologist" (United States Department of State 1987: 2). The letter, whose actual existence is in dispute, is purported to have claimed that HIV/AIDS was the "result of the Pentagon's experiments to develop new and dangerous biological weapons" which had been analyzed at the CDC and Fort Detrick (United States Department of State 1987: 2).

Two years later in October 1985, the disinformation campaign was fully launched with the publication of "Panic in the West or What is Hidden Behind the Sensation About AIDS" in *Literaturnaya Gazeta*, an elite Soviet weekly (United States Department of State 1987: 3). This article quoted extensively from the *Patriot* letter, describing the newspaper as a "well-respected Indian newspaper" while omitting the fact that the source of the story was an anonymous letter to the editor (United States Department of State 1987: 3). From this article, the disinformation campaign grew, with further stories appearing in 13 countries in 1985, and 49 countries by 1986 (United States Department

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12 A convincing body of genetic sequencing research has dated and placed the emergence of the HIV virus to between 1902-1921 in southeastern Cameroon (Gilbert et al. 2007). The earliest sample of the HIV virus on record is from 1959, from a Bantu male living in Leopoldville, Belgian Congo (now Kinshasa, Democratic Republic of Congo,) considerably before the KGB disinformation campaign suggested the virus was produced by the Pentagon (Zhu et al. 1998). Other scientific findings on the origins of HIV/AIDS are Chitnis et al. (2000), Korber et al. (2000), Marx et al. (2001), and Moore (2004).

of State 1987). From January through July 1987 alone, the United States Department of State (1987) counted 91 appearances of the campaign across the globe.

The centerpiece of the disinformation campaign was the publication of a "pseudoscientific study" by East German scientists Jakob and Lilli Segal, and Ronald Dehmlow titled "AIDS – Its Nature and Origin" (United States Department of State 1987: 4) The study claimed that HIV/AIDS could not have originated in Africa, but was actually manufactured by American biological weapons scientists at Fort Detrick (National Intelligence Council 1987). HIV/AIDS was, the Segal's and Dehmlow claimed, the engineered result of purposely recombining two other retroviruses, VISNA and HTLV-I. In a later book, Jakob Segal summarized this argument:

> The first occurrence of AIDS corresponds to the opening of a high security laboratory in the Pentagon-owned biological research center at Fort Detrick, taking into account the incubation period. It is documented that the Pentagon was awarded the task and the means by the U.S. Congress to genetically manufacture a virus similar to the characteristics of AIDS. It also fits that AIDS occurred for the first time in New York, not very distant from Fort Detrick. We may thus rightly claim: AIDS resulted from a first attempt to manufacture new biological weapons through genetic engineering.[13] (Segal 1990: 218)

The Segal's study was released to coincide with the 1986 Non-Aligned Movement Summit where Cuban President Fidel Castro told Museveni that his military forces had a 30% prevalence of HIV/AIDS (National Intelligence Council 1987). Described by the CIA as the "most enduring contribution" to the disinformation campaign, this study was "made available to a large Third World audience in Harare", and "appeared in dozens of countries worldwide and been serialized for weeks in Tanzanian, Ghanaian, and other African newspapers…" (National Intelligence Council 1987: 17). The campaign was disseminated through multiple channels, often citing previous disinformation publications as authoritative sources. The KGB also used English language Moscow Radio broadcasts in 1986-1987 into Southern Africa to spread the HIV/AIDS disinformation. For example, on 11 November 1986, the Moscow World Service (1986: para. 2) broadcast: "scientists in a number of countries working independently have come to the conclusions that the deadly AIDS virus is man-made. One of them, the French professor Jakob Segal, is certain that the virus was produced in secret laboratories maintained by the Pentagon at Fort Detrick in Maryland." The 1987 Estimate also

[13] Thank you to Alexander Schratz for translating this passage from the original German.

describes a number of "letters to the editor" which appeared in newspapers in Kenya, Senegal, and Uganda, reporting that HIV had been created at Fort Detrick, and that a Ghanaian newspaper reported early in 1987 that the "United States intended to use Africans as guinea pigs to test AIDS vaccines" (National Intelligence Council 1987: 14). The following cartoon, which appeared in Pravda, illustrates another iteration of the disinformation campaign.

Pravda, daily paper of the CPSU Central Committee, October 31, 1986

Caption above cartoon states: "The AIDS virus, a terrible disease for which up to now no known cure has been found, was, in the opinion of some Western researchers, created in the laboratories of the Pentagon." The words on the flag emanating from the beaker state: Virus "AIDS." Caption below the cartoon reads: "Pentagon (AIDS) specialists."

Figure 4.1: Source: United States Department of State 1987: 1.

A spokesman for the U.S. Pentagon described the campaign and U.S. frustrations in countering it in the *New York Times*: "The technique used has been to plant the story in friendly newspapers outside the Soviet Union and then to quote those newspapers as

authoritative in the Soviet news organs... It's obviously a systematic campaign... What's really troublesome is that this stuff tends to be believed in Third World countries" (Associated Press 1987: para. 8). Andrew and Mitrokhin (1999: 244-245) describe the campaign as "probably the most successful anti-American active measure of the Gorbachev era" and observe that:

> the AIDS fabrication not merely swept through the Third World, but took in some of the Western media as well. In October of 1986 the conservative British [tabloid] *Sunday Express* made it its main front-page story. During the first six months of 1987 alone, the story received major news coverage in over forty Third World countries.

The AIDS disinformation campaign made it to the U.S. as well. On one of the three major evening news shows, news presenter Dan Rather reported "that a Soviet publication had charged that an American military laboratory had developed the virus that caused the AIDS epidemic" (Accuracy in Media 2005: para. 1).

After vigorous American protests, the disinformation campaign was discontinued in August 1987. In 1992 then Russian Intelligence Chief Yevgeni Primakov admitted to the Russian newspaper *Izvestiya* that the information had been "fabricated in KGB offices" (United States State Department 2005: para. 6). Confirming the KGB office origins of the campaign is the appearance of the campaign in the notes of Vasili Mitrokhin, a defector who worked in the KGB's foreign intelligence archives and hid notes of classified files under the floor of his dacha (Andrew and Mitrokhin 1999).

This disinformation campaign illustrates a clear risk of linking of HIV/AIDS and national security: the nefarious use of the disease to pursue national security aims. The communitarian objective of the KGB was to pursue Soviet strategic interests by implicating the U.S. military in the recent appearance and spread of HIV/AIDS. There are strong indications that this campaign worked and had multiple impacts on both the intended target of the U.S., as well as unintended impacts on public health efforts to fight the disease.

The Estimate worries that the KGB campaign could impact the U.S. by contributing to an "African backlash" against the country, as well as accusations of racism (National Intelligence Council 1987: 17). The campaign is described as "exploiting black African

sensitivities to racism and so-called Western imperialism, Moscow has taken full advantage of regional fears, ignorance, and some careless Western statements in its efforts to provoke anti-U.S. sentiment" (National Intelligence Council 1987: 17). The campaign was also felt directly by the CIA. Some at the CIA, including Director William Webster in 1991, worried that studying the disease would create "propaganda liabilities" because the KGB campaign had associated the U.S. with the disease (Gellman 2000a: para. 18). The liability that studying HIV/AIDS at the CIA might create was that "somebody would try to imply that we're only monitoring our own dastardly deeds" (Gellman 2000a: para. 18).

Despite the correction issued and the revealing of the original source of the disinformation reports, the analysis undertaken in this thesis suggests that this campaign has had long-lasting and unintended consequences that continue to hinder public health activities related to HIV/AIDS today. Specifically, the current views of African Americans on the origins of HIV/AIDS suggest that the KGB campaign has had a lasting impact on public perceptions and, in turn, efforts to fight the pandemic. For example, a 2005 study among African American men revealed worrying percentages that agreed with the following statements that were part of the KGB disinformation campaign:

> HIV is a man-made virus. 48.3%
> AIDS was produced in a government laboratory. 30.5%
> AIDS is a form of genocide against blacks. 20.7%
> HIV was created and spread by the CIA. 16.1% (Bogard and Thorburn 2005)

These results have been replicated by Klonoff (1999), Bogard and Thorburn (2006), and Ross, Essien and Torres (2006). Reinforcing the current and widespread nature of these conspiracy beliefs was the announcement by 2004 Noble Peace Prize recipient Wangari Muta Maathai that HIV/AIDS was created as a biological weapon by the West to kill black people: "In fact it (the HIV virus) is created by a scientist for biological warfare" (ABC News 2004: para. 6).[14]

It is not known, and will likely impossible to accurately ascertain, whether these beliefs among African Americans in the U.S. and expressed by Maathai actually originated from the release of KGB disinformation in Africa. No studies to date have sought to address

[14] Maathai has since played down these comments.

this question. However, the close similarity between these conspiracy beliefs and the earlier KGB disinformation campaign suggests that there is likely to be a linkage. This is supported by the fact that there was widespread global coverage of the disinformation campaign by the mass media. Thus it would seem conceivable, perhaps even likely, that some of the widely held conspiracy theories about the origins of HIV/AIDS originate with the KGB campaign.

The linkage between the KGB campaign and currently held conspiracy theories about HIV/AIDS is important, from a public health perspective, because belief in such theories have had a negative impact on public health practice. Bogart and Thorburn (2005: 217) find that "endorsement of conspiracy beliefs was associated with more negative attitudes toward using condoms and less consistent condom use..." In other words, belief in these conspiracy theories about the origins of HIV/AIDS puts people at greater risk of becoming infected with the disease. If the KBG disinformation campaign contributed to the HIV/AIDS conspiracy beliefs held by African Americans, the use of HIV/AIDS to pursue Soviet national security interests will have created a lasting barrier to fighting the pandemic.

Interestingly, neither Bogard and Thorburn nor other researchers draw a link between HIV/AIDS conspiracy theories and the KGB disinformation campaign. Bogard and Thorburn (2005: 213) hypothesize that conspiracy theories "stem from historical and current racial discrimination in the U.S. health care system, the most well-publicized example of which is the Tuskegee syphilis study." Thomas and Quinn (1991) attribute the source of the conspiracy theories to the social context of inequality facing African Americans and the Tuskegee study. A *Lancet* editorial (2005) states that African Americans have many reasons to mistrust the U.S. government including slavery, Jim Crow, the Tuskegee study, health care disparities, and discrimination. In Africa, Niehaus and Jonsson (2005: 182) argue that HIV/AIDS conspiracy beliefs among South African men are actually articulations of their "adverse experiences of deindustrialization" in the global labor market, although they report that some South African men reportedly linked the work of Dr. Wouter Basson and South African biological weapons research to HIV/AIDS and the U.S. military. These varied hypotheses offer explanations for a person's susceptibility to believing conspiracy theories, and the persistence of these theories among certain groups over time. However, these hypotheses fail to account for

the similarity between the specific content of the conspiracy theories put forth (i.e. that HIV/AIDS was developed by U.S. intelligence services as a biological weapon) and the KGB disinformation campaign.

In relation to this thesis, the failure of previous analyses to attribute the KGB campaign as the source of HIV/AIDS conspiracy theories suggests a disconnect between those examining global health and national security literature. While not conclusive, this disconnect may be due to differences in culture between those working in global health and national security, suggesting a communitarian – cosmopolitan divide. Interestingly, none of the conceptual frameworks anticipates the nefarious and offensive use of HIV/AIDS to pursue national security objectives. Peterson does suggest that linking HIV/AIDS and national security may generate distrust, but does not anticipate that this would be an intended impact of state efforts.

In summary, the KGB disinformation campaign represents a uniquely nefarious case of HIV/AIDS being used to pursue a country's national security aims. While lying outside the scope of conceptual frameworks, and Peterson and Elbe's studies of the securitization of HIV/AIDS, this campaign may have had a lasting impact on efforts to fight the disease. Furthermore, the absence of discussion of the KGB campaign in the global health literature on HIV/AIDS conspiracy theories suggests a gap between the public health and national security literatures. This campaign should be an instructive example of the potential negative health consequences when public health is used in pursuit of national security efforts.

4.2.4 Discussion

Between 1987 and 1991, two CIA studies evaluated the scale of the HIV/AIDS pandemic, accurately predicted the evolution of the epidemic, and argued that the disease would devastate Sub-Saharan Africa while causing death on the scale of the World Wars globally. While the Estimates predicted massive humanitarian consequences of the HIV/AIDS pandemic, the implications for U.S. national security were deemed to be limited. Both Estimates illustrate the communitarian perspective embedded within the national security analysis. The negative response to the 1991 Estimate revealed a bias among the U.S. national security community against studying health issues, the low

political status of HIV/AIDS, and the perception that the deaths caused by HIV/AIDS would have benign, or even beneficial, implications for national security. The intelligence community response to the 1991 Estimate demonstrates the communitarian perspective of national security analysis and clearly shows that the objective of their analysis is to pursue the interests of the state.

The 1987 and 1991 U.S. intelligence assessments of HIV/AIDS were "securitizing moves" (Buzan et al. 1998: 29). In these studies, a securitizing actor (the analysts) argued that HIV/AIDS posed an existential threat to "generations of Africans" which demanded emergency measures ($3 billion in funding) (National Intelligence Council 1987: 3). Largely because the referent objects of this securitizing move were individuals in Africa and African countries, and not the United States of America, this securitizing move was rejected by the U.S. intelligence community. The strong bias against studying a low political issue like HIV/AIDS also contributed to the rejection of this attempt to securitize the disease.

These years also demonstrated the use of HIV/AIDS for the purposes of propaganda and political manipulation by the KGB. The KGB disinformation campaign exploited the recent emergence and stigma surrounding HIV/AIDS to fight a propaganda war against the U.S. in Africa and globally[15]. This nefarious campaign demonstrates that the pursuit of national interests can compromise public health information. This campaign may also have inadvertently created lasting barriers to HIV/AIDS prevention activities by creating or spreading a conspiracy theory on the origins of HIV/AIDS that has been linked to decreased use of condoms by at-risk populations.

The national security community's independent interest and action on HIV/AIDS is not accounted for by Lee and McInnes' (2004) models of engagement. This is an important omission because, in the1980s, the intelligence agencies of both superpowers studied HIV/AIDS, and in the case of the Soviet Union, incorporated the disease into so-called "active measures" against the U.S. (Andrew and Mitrokhin 1999: 245). The communitarian – cosmopolitan model is better able to describe the security community's engagement with HIV/AIDS, while the security community's focus on the impacts of the

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[15] In a related example, Garrett (2005: 35) recounts how Libya accused and imprisoned five Bulgarian nurses and a Palestinian doctor for "deliberately infecting 426 children with HIV." Moammar Quaddafi argued that the nurses were acting on orders from the CIA and Israeli intelligence.

disease on state interests confirms Fidler's remediation model. Because the NIC Estimates represent a failed attempt to securitize HIV/AIDS, the negative impacts of securitization outlined by Peterson and Elbe did not occur. None of the conceptual frameworks specifically anticipates the nefarious engagement of national security actors using HIV/AIDS in pursuit of state interests. Peterson (2002) does caution that the linking of the disease to national security will generate distrust. However, it is Elbe's (2006a) list of negative impacts of securitization, including reduced transparency, overriding of civil liberties, and addressing of HIV/AIDS through a state-centric framework, that best accounts for the KGB disinformation campaign.

4.3 The role of national security concerns in Thailand's HIV success

While Uganda represented the securitization of HIV/AIDS from the perspective of a political leader, and the CIA studies of HIV/AIDS framed the disease from within a U.S. national security perspective, the Thai response to HIV/AIDS securitized the epidemic as a national security threat to the entire nation. Viewing HIV/AIDS as a security threat allowed the mobilization of the highest levels of the Thai government, including the Ministry of Defense, in response to the pandemic. This thesis argues that this securitization transformed the disease into an issue of high politics in Thailand and was critical to beginning the country's successful efforts to lower national prevalence of HIV/AIDS. This example provides the clearest case to date of how securitization of the pandemic can bring important benefits to the fight against the disease.

In 1989, the first round of national epidemiological surveillance in Thailand found rates of HIV among female commercial sex workers (CSW) in Chiang Mai of 44% (Ainsworth et al. 2003). While previous waves of HIV in Thailand, among gay men and IDUs, had generated limited public response, this epidemiological finding "startled the nation" (UNDP 2004: 9). Also in 1989, the Royal Thai Army (RTA) began biannual testing of the approximately 60,000 21-year old males conscripted into military service each year. These young conscripts were a nationally representative sample of sexually-active young Thai men. The testing found that 0.5% were infected, a relatively high rate for a young age group with only a few years of sexual activity (UNDP 2004). By 1993, 4% of conscripts nationally tested HIV positive, with the rate in Northern Thailand

closer to 14% (Ainsworth et al. 2003). These findings demonstrated to the government and public that HIV was no longer confined to certain margins of society and stigmatized populations where the disease had existed since the 1980s. In fact through CSWs, their male clients, and the client's wives and families, HIV had the potential to affect the majority of people in Thailand. As Beyrer (1998: 23) writes, the potential sexual network affected "*was* Thailand."

The RTA responded forcefully by prohibiting soldiers from visiting brothels and punishing soldiers for becoming infected with sexually transmitted diseases (STDs) (Beyrer 1998). However, these policies failed to reduce the spread of HIV, and rates among conscripts continued to rise. The punitive nature of these policies were mirrored in the civilian sphere by a unsuccessful AIDS bill that would have required mandatory testing of people in high-risk groups (UNDP 2004).

In 1991, a failed military coup brought in a new Thai government lead by Khun Anand Panyarachun. Under this government, the response to HIV/AIDS flourished. Khun Anand promoted Khun Mechai Viravaidya, a family planning activist, to run the government's response to HIV/AIDS. Khun Mechai convinced the Prime Minister to chair the National Committee on AIDS Prevention and Control himself. Making the Prime Minister directly responsible for Thailand's response to the epidemic transformed the disease into a high politics issue and was a critical step in creating the country's successful, multisector response. UNDP (2004: 13) observes that "Positioning the programme in the Office of the Prime Minister was more than a symbolic demonstration that AIDS was a government priority. It gave the response political clout. It sent a signal to all government sectors that everyone had to contribute to the response." The participation of the Thai Ministry of Defense (MOD) in the AIDS Committee also demonstrated the disease's new status as an issue of high politics. The MOD participation also provided "a good opportunity for the military sector to take part in the development of national HIV/AIDS policy, as well as providing advice on appropriate HIV/AIDS approaches in the military..." (UNAIDS 2004: 16).

In 1991, the first studies of HIV/AIDS risk in Thailand began to be published (Weniger 1991, Beyrer 1998). These studies found that unprotected commercial sex was the driving force behind the rapid growth of the Thai epidemic. Equipped with broad

political support, the government created a national program to promote safer sex called "The 100% Condom Campaign." The Campaign's aim was to have 100% condom usage in commercial sex establishments throughout the country. The campaign was composed of three parts. First, the Ministry of Health distributed 60 million condoms annually to sex workers and soldiers, and in health centers, workplaces and hotels (UNDP 2004). Second, sanctions and police action were threatened against commercial sex establishments where condoms were not being used. Although it appears that police action was rarely taken, the threat of closure was used to ensure compliance with the 100% Condom Campaign (Ainsworth et al. 2003). Finally, a major radio and television campaign "bluntly advised men to use condoms with prostitutes" (Hanenberg et al. 1994: 243). This was a particularly Thai approach, in that prostitution was illegal, but tacitly accepted and practically addressed by the police and government.

The military's participation on the National Committee on AIDS Prevention and Control was matched by programs on the ground. The MOD "promoted condom use and provided AIDS education to new conscripts," who numbered approximately 60,000 per year of high risk young men (UNDP 2004: 17, Saengdidtha and Rangsin 2005). The RTA provided counseling and treatment for HIV-positive soldiers who were not infected through drug use beginning in 1991. The military also developed a wide array of research partnerships that "strengthened the knowledge base for interventions, gave focus to public health measures, and, importantly, measured their effectiveness" (Beyrer 1998: 33). These research partnerships between the RTA and international public health institutions made the Thai HIV/AIDS epidemic one of the most extensively studied and best understood epidemics in the world.

It was these research collaborations that first indicated that "The 100% Condom Campaign" was working. In 1993, interviews with military conscripts showed that fewer men were visiting commercial sex workers, and those that did were more often using condoms, although rates of HIV consistently increased in each new cohort of conscripts (Beyrer 1998). Then among the second intake of conscripts in 1993, the prevalence of HIV declined for the first time (UNDP 2004). The first intake of 1994 and subsequent cohorts of conscripts confirmed that Thailand had begun to reduce the incidence of HIV infection. These events marked the beginnings of the Thai government's successful efforts to limit the spread of HIV/AIDS. This reduction in national HIV prevalence is a

rare achievement globally. While Thailand still faces challenges in maintaining and extending the successes of the early 1990s, Thailand's response to the epidemic is estimated to have saved eight million lives by 2004 (UNDP 2004).

Published reviews of Thailand's success in reducing the incidence of HIV infection are unanimous in recognizing the important role of national security concerns in generating political support and momentum for action against the epidemic. UNDP (2004: 13) writes that in 1991, "Fighting AIDS was placed on par with safeguarding the nation." UNAIDS (2004: 33) concludes: "Seeing HIV/AIDS as a threat to national security was the key to Thailand's success in fighting the epidemic. It ensured decision-makers' prompt decision-making and instilled a commitment to fight HIV/AIDS."

The specific national security concerns raised by the fast growing epidemic were outlined by the RTA, and focused on the risk of decreasing military effectiveness, increased financial burdens due to prevention and care efforts, and the psychological impact of the disease on soldiers and their families. The impacts as described by the RTA were:

> The military preparedness of the RTA has suffered as a result of HIV/AIDS, which has caused illness and death among RTA personnel. The RTA is now faced with the challenge of needing to recruit HIV-negative personnel while avoiding human rights violations.
>
> There is a psychological effect, due to the anxiety and discrimination associated with HIV, both from inside the RTA and from the families of army personnel in their own communities.
>
> There are additional burdens for the medical and social services in the RTA, including the cost of campaigns to prevent new infections, counselling services for groups at risk and for those infected, care for people living with HIV/AIDS, and social support measures for them and their families.
>
> Field medical services personnel are at risk of contamination from HIV-positive patient's blood and body fluids, and must screen all blood for field use.
>
> Screening for deployment for overseas missions, such as the UN peacekeeping force, is more complicated and time-consuming for groups at risk of contracting HIV. (UNAIDS 2004: 11-12)

These direct impacts of HIV/AIDS on the Thai military and the disease's broader implications for Thai society came to be viewed as a threat to Thai national security.

Within the military, HIV/AIDS was treated as a military threat to the country, akin to an invading army. Chris Beyrer (Interview) says that "the message from the top was that HIV prevention was a patriotic duty for soldiers, and that protecting your buddies by making sure they had condoms was the same thing as protecting them from enemy bullets. These kinds of military metaphors were used all the time and did appear to be motivating." The perception of HIV/AIDS as a threat to national security drove the RTA's active response to the disease and the MOD's participation on the National AIDS Committee.

However, the high incidence of HIV among conscripts was not the only concern for the military and policymakers. Ram Rangsin was an army physician working in a Chiang Mai military camp during 1990-1993 and is currently Assistant Professor at the Department of Military and Community Medicine, in Phramongkutklao College of Medicine in Bangkok. Rangsin suggests that it was not just high infection rates among military conscripts that caused alarm. More broadly, it was viewed as a threat to an entire generation of Thai men of whom military conscripts were representative. Rangsin states:

> There were a lot of concerns during that time since the epidemic was so large and spread quickly. The Royal Thai Army at that time might view the HIV prevalence information among military conscripts a proxy indicator for young Thai men rather than its own threat because of the long incubation period of the disease and the conscripts usually stay in the military service only for 2 years. (Ram Rangsin Interview)

Beyrer agrees with Rangsin. Beyrer argues that "the military data in North played a major role in getting the Government to respond to HIV prevention. This was to some extent due to national security concerns, and to some extent due to use of conscripts as a good proxy for young men in the Kingdom in general" (Beyrer Interview). Because military conscripts represented young Thai men, high rates of HIV in conscripts was viewed as both a threat to the Thai military and as a broader threat to Thai society as a whole.

Rangsin also notes that only the conscripts were tested for HIV/AIDS. He states that the "RTA did not have the HIV information on the other active military officials during that time" (Rangsin Interview). Beyrer (Interview) elaborates on this point. He says,

It is important to note that the actual military (career, officers corps, etc, everyone who would not fit into conscripts) did not participate in the HIV screening, and did not ever agree to testing or to outside prevention programs. I can't say what happened behind closed doors, but I do know that over time, many of the officers we worked with wanted the JHU [Johns Hopkins University] collaboration to test them, since they heard the messages about risks (sex worker visits, mostly) and knew they had risks.

Beyrer's elaboration suggests another explanation for the Thai military viewing HIV/AIDS as a serious national security threat - officers and high-ranking military officials felt themselves threatened by the disease. This possibility adds a personal dimension to the strong and active response of Thai military officials, and may therefore bear some similarity to the rationale for Museveni's action against HIV/AIDS in Uganda.

The threat HIV/AIDS posed to Thailand was even broader than the disease's impact on the military and young men. HIV/AIDS also represented a threat to Thailand's national security through its potential economic impact. When Rangsin (Interview) raised the issue of economic loss due to HIV/AIDS, he was asked "Was the economic loss that could be due to AIDS viewed as a security threat?" He replied: "Yes, it was, I think. This might be one of the main reasons that the government allocated a lot of fiscal budget to fight against HIV especially from sexually transmission." Khun Mechai, the famous family planning activist who ran the Thai government HIV/AIDS efforts, also viewed HIV/AIDS as a threat to Thai national security because of its potential economic and demographic impact. He writes:

> We did a study to determine probable scenarios from 1990 to 2000 if nothing was done about HIV in Thailand. The projections indicated that we would have almost four million HIV-infected people by the year 2000. We would lose about 25 years of productive work from each person, and 20 percent of our GDP annually. That would be far greater than any economic downturn that Thailand has ever experienced or anticipated. This became very, very important. The people who ran our country were not convinced that a 'health issue' could be a major threat to national security. But when you talked about money, then they began to realize how many people we would lose and how many we would need to retrain. (UNDP 2004: 16)

This thesis argues that the perceived threat that HIV/AIDS posed to Thailand's military, general population, and economic development caused the country's leadership to securitize the epidemic and respond to the disease as a threat to national security. The

successful campaign carried out as a consequence of securitization is believed to have saved an estimated eight million lives, and is viewed as a rare success story in the global HIV/AIDS pandemic (UNDP 2004).

At least four factors are unique to this case of securitization and Thailand's resulting success in reducing the national prevalence of HIV/AIDS. First, Thailand embraced a broad understanding of national security that included human, demographic and economic well-being, in addition to traditional military and security considerations. This broad view of national security enabled HIV/AIDS to be quickly accepted as a high politics issue once evidence of its potential impacts was mustered. As later chapters will demonstrate, conceptions of national security that embraced HIV/AIDS were rare before 2000. Second, the Thai military has a broad mission that goes beyond national security to include development and aid to the Thai people. UNAIDS (2004: 4) writes: "Aside from its traditional defense duties, the RTA has always been actively involved in the development of the country and in providing aid to the Thai people." This broad remit may have helped the military enact major efforts to fight a disease that was not a traditional military threat to security. Third, Beyrer (1998: 17) argues that a practical mentality, an ability "to adapt, and to make amazingly rapid social changes" is part of Thai culture. The 100% Condom Campaign was implemented between the government and commercial sex establishments, despite prostitution being illegal. This pragmatic outlook seems to have aided Thailand to overcome the stigma associated with HIV/AIDS and enact effective measures to fight the disease. Finally, and perhaps most importantly, is that the epidemic in Thailand had a discernable "hub" of transmission that could be addressed: commercial sex workers. This situation differs from sub-Saharan Africa where the main source of transmission is concurrent heterosexual relationships. Targeting the hub of transmission allowed Thailand to strategically focus its efforts on

> curbing HIV transmission among those people most likely to acquire and transmit the virus… Sex work did not account for all HIV infections, but it was, at the time, the hub of Thailand's epidemic – and the intensified response zeroed in on it. The response therefore could be marshaled against a compact target: reducing the spread of HIV through commercial sex… (UNDP 2004: 30)

In summary, while a number of factors contributed to Thailand's successful reduction of national prevalence of HIV/AIDS, treating the epidemic as a threat to Thailand's security was a critical step in generating early political support and leadership on HIV/AIDS

prevention and control. The potential military and economic impact of the epidemic, as well as epidemiological data on military conscripts, helped HIV/AIDS rise to the top of the political agenda in the 1990s more rapidly than in other countries. As an issue of high politics, the response to HIV/AIDS mobilized non-health ministries including the MOD and the Prime Minister's office. National security considerations also drove the military to make unique contributions to Thailand's multi-sectoral response through surveillance and education of military conscripts. Thailand's relatively successful fight against HIV/AIDS began with the securitization of the epidemic, but then subsequently succeeded through implementation of a pragmatic and widespread public health campaign.

Thailand's securitization of HIV/AIDS strongly supports Fidler's remediation model. The reason HIV/AIDS rose to the level of high politics in Thailand was that the disease threatened aspects of Thailand's broad conception of national security. There is no evidence from this case to support either the revolution or regression models. Thailand's strong response to HIV/AIDS is also an example of Lee and McInnes' (2004) partnership model. The partnership between public health actors and Thailand's national security apparatus, and indeed between many elements of the Thai government, was facilitated by Thailand's broad concept of national security, the progressive government of Khun Anand Panyarachun, and the clear threat HIV/AIDS posed to the Kingdom's economic and military interests.

The Thailand experience also supports Elbe's outline of the positive benefits of securitization. By securitizing the epidemic, greater state mobilization was achieved but was not accompanied with large-scale decreases in civil liberties or democratic scrutiny. Neither did securitization's threat-defense logic remove the disease from a humanitarian framework, shift funding towards elites or the military, or further stigmatize people living the disease. In fact, soldiers and police were both targets of prevention efforts and helpful in ensuring the cooperation of commercial sex establishments with the 100% Condom Campaign.

The threat-defense logic of securitization benefited Thailand's efforts to fight the disease by demonstrating the multiple impacts of the epidemic across sectors which increased political support for addressing the disease, and by justifying military participation in

anti-HIV efforts. This is a critical lesson about the HIV/AIDS – national security nexus that to date is not widely understood. Many authors, Peterson included, assume that securitization will automatically result in a securitized or militarized response to the disease, which they critique. However, as the Thai case demonstrates, securitization involves invoking emergency measures to address a threat, but does not specify which type of measures must be adopted. Securitization theory is essentially agnostic on the substance of the response to a threat, as long as the response involves "emergency measures." Therefore, it should not be assumed that a strong public health driven response to HIV/AIDS is necessarily incompatible with securitization. In fact, a strong public health driven response is exactly what resulted from Thailand's securitization of HIV/AIDS.

4.4 Peacekeepers spreading HIV/AIDS in Cambodia

The experience of peacekeepers spreading HIV/AIDS in Cambodia extends the early linkages drawn between HIV/AIDS and national security beyond threats to national military forces, as discussed in Uganda and Thailand as well as U.S. intelligence studies, to peacekeeping troops and operations. There is evidence from Cambodia that peacekeepers, while deployed to assist in stabilizing the country and organizing democratic elections, spread HIV/AIDS. While the spread of HIV/AIDS by peacekeepers in Cambodia generated little political response at the time, the issue would later be central to addressing the disease in the UNSC in 2000. The indifferent response to evidence of peacekeepers spreading HIV/AIDS, by both public health and international security communities, is an important case where the disease was not securitized despite evidence that HIV/AIDS seriously threatened peacekeeping troops and would have major public health consequences in Cambodia. Without a securitizing actor to argue for securitizing the epidemic in Cambodia, the United Nations Department of Peacekeeping Operations (DPKO) was left to implement half-hearted efforts designed more to limit bad publicity than to prevent the spread of HIV/AIDS. These events are important to examine for two reasons. First, the issue of peacekeepers spreading HIV/AIDS would later be used as an essential rationale for the UNSC meetings on HIV/AIDS discussed in Chapter 5. Understanding why this issue catapulted HIV/AIDS into the UNSC in 2000, but failed to generate any substantive action in 1992 when

peacekeepers seemed to play a critical role in igniting the Cambodian epidemic, is critical. Second, this case demonstrates the risks to both civilians and peacekeepers of failing to act on tangible linkages between HIV/AIDS and national security.

In 1992, the United Nations Transitional Authority in Cambodia (UNTAC) was established to supervise the end of armed conflict and organize national elections for the next year. The 1993 elections were successful, with 90% of voters participating. However, there is evidence that UNTAC contributed to the beginning of the HIV/AIDS epidemic in Cambodia. UNTAC was composed of approximately 20,000 military and police personnel from 45 different countries. Beyrer (1998: 64) describes the interaction between the peacekeepers and Cambodians:

> The great majority [of peacekeepers] were young men, often of limited education. They walked into a country long closed to the outside world, starved for cash, and full of people eager to take their dollars... The infusion of cash from these forces into local economies after years of poverty and isolation was undoubtedly too great an attraction for many women (and brothel owners, managers, and traffickers) to resist.

Anecdotal evidence suggests that the presence of peacekeeping forces "dramatically increased the demand for sex services" and that sex workers doubled the number of customers seen each night during the UNTAC mission (Beyrer 1998: 64). Peacekeepers also took leave in neighboring Thailand, where prevalence of HIV/AIDS among sex workers was high (see previous section), and brought back HIV to Cambodia (Ledgerwood 1994). Evidence from returning peacekeepers provides corroborating evidence that the UNTAC mission helped spread HIV in Cambodia. Forty-five percent of Dutch marines and sailors participating in UNTAC reported "having sexual contact with sex workers or other members of the local population during a five-month tour" (UNAIDS 1998: 2). Returning soldiers from the U.S. and Uruguay were infected with subtype E of HIV, suggesting they became infected during their tour in Cambodia or in a neighboring country where subtype E is prevalent (Artenstein 1995; Beyrer 1998). Fifteen percent of Indian soldiers participating in UNTAC returned home HIV positive (Beyrer 1998). Eleven of the 3627 Indonesian soldiers participating in UNTAC became HIV positive during their deployment (Soeprapto 1995). These eleven "ultimately fatal" infections "far exceeded" the two non-disease-related deaths among Indonesian peacekeepers (Soeprapto 1995: 1305). Across the entire UNTAC mission, 21

peacekeeping personnel were killed in hostile action in Cambodia, while 47 were officially diagnosed as HIV positive, with the true number "probably as high as 150" people (Ledgerwood 1994: 7). Thus peacekeeping deaths from AIDS far exceeded combat deaths during the UNTAC mission, and the disease posed the most serious threat to the lives of deployed peacekeeping forces.

The presence of UNTAC coincided with the explosive spread of HIV in Cambodia (UNAIDS 2004). The relationship between UNTAC and the HIV epidemic in Cambodia remains only an association (as opposed to a causal relationship), as no research has successfully quantified the epidemiological impact of the UNTAC forces. Further research is unlikely to clarify this situation because HIV/AIDS surveillance data was not collected before the arrival of the UNTAC mission. Cambodia's first sentinel surveillance survey was conducted in 1995, after the end of the UNTAC mission (Bazergan 2004). Despite this evidentiary uncertainty, the prevalence of HIV in peacekeepers returning from the UNTAC mission indicates that peacekeepers did transmit and become infected with the disease while deployed. It is reasonable to conclude that the presence of UNTAC troops made some contribution to the growth of the HIV epidemic in Cambodia in the early 1990s. Officials in Cambodia routinely blame UNTAC for the spread of HIV and prostitution (Beyrer 1998). Asked what would be the legacy of the UNTAC mission which held the first free and fair elections in Cambodia's history, Prime Minister Hun Sen answered: "AIDS" (Richburg 1998: para. 11).

Despite Cambodia's objections to these events, peacekeepers returning from the mission infected with HIV/AIDS, and descriptions of the peacekeepers spreading HIV in newspapers and public health journals, these events had almost no impact on policies for future peacekeeping operations. The UN was concerned with the impact of these accusations on the reputation of peacekeepers, but addressing HIV/AIDS was "beyond the remit and comfort zone" of the UN DPKO (Roxanne Bazergan Interview). Ledgerwood (1994: 7) writes that a DPKO community relations office did distribute condoms and information on sexually transmitted diseases, but that these efforts were "clearly too little too late." The message from the UN Secretary General's Special Representative in charge of the mission was "boys will be boys " (Ledgerwood 1994: 7). The only other UN response to peacekeepers spreading HIV/AIDS in Cambodia was to

callously minimize the potential for bad publicity by instructing UNTAC personnel "not to park UN vehicles in front of brothels" (Ledgerwood 1994: 8). This instruction strongly suggests that the DPKO's concern with their political reputation was greater than their concern about spreading HIV/AIDS. With no securitizing actor to bring attention to these issues, the likely spreading of HIV/AIDS by the UNTAC mission generated little substantive response.

Similarly, these events did not cause greater examination of the links between HIV/AIDS and security in either the public health or national security literature.[16] Although it cannot be known with certainty, the indifferent response to evidence of peacekeepers spreading HIV/AIDS by both public health and international security communities may indicate discomfort in addressing areas where public health and national security issues overlap.

Arguably, the greatest political effect of UNTAC's potential role in the beginnings of the HIV epidemic in Cambodia were to make Richard Holbrooke, then a private U.S. citizen visiting Cambodia, aware of the link between peacekeepers and HIV/AIDS. His later efforts as a securitizing actor would be pivotal to recognizing the links between HIV/AIDS and national security. Eight years after UNTAC's mission at the second UNSC meeting on HIV/AIDS and peacekeeping, Holbrooke was U.S. Ambassador to the United Nations and described his first encounter with the issue.

> On a personal note, I first encountered this issue in 1992 when as a private citizen I visited Cambodia and visited the United Nations Transitional Authority in Cambodia (UNTAC) in Phnonm Penh and talked... [with] the United Nations team. I was deeply impressed by their efforts, but I was disturbed by the fact that the United Nations forces were already spreading AIDS. I was so disturbed, in fact, that on 27 July 1992, as a private citizen, I wrote a letter... raising this issue. (United Nations Security Council 2000b: 6)

Holbrooke later described the contents of the letter in greater detail, saying "I don't understand this, you're trying to keep peace in Cambodia and your forces spend each night spreading AIDS in the streets" (Ambassador Richard Holbrooke 2000a: para. 2).

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[16] Beyrer (1998) is the exception for the public health community.

It is important to note that the Cambodian experience is not a unique case of peacekeepers being implicated in the spread of HIV/AIDS. While reports are scarcer than that available from Cambodia, peacekeepers may have also spread HIV/AIDS while deployed in Sierra Leone (Astill 2001). Suggestive evidence for this comes from the U.S. General Accounting Office (2001) which found that 32% of peacekeepers deployed in Sierra Leone came from countries where national prevalence of HIV/AIDS is greater than 5%. Richard Holbrook (2000b) suggested that UN peacekeepers may have spread HIV/AIDS while deployed in East Timor, and the allegations of sexual abuse by peacekeepers in the Democratic Republic of Congo raises the possibility of HIV transmission (Holt and Hughes 2005). The response to these events will be discussed in more depth in Chapter 5.

In summary, peacekeepers deployed in the UNTAC mission spread and became infected with HIV/AIDS. The UNTAC mission coincided with an explosive growth of the HIV/AIDS epidemic in Cambodia, and evidence suggests that peacekeepers contributed to the worsening of the Cambodian epidemic. Although reports of these events were widespread, they generated little response from the UN, which generally ignored or sought to minimize the issue during the mission. Nor was there significant study of these events in the public health or international relations literature. This is surprising because the spread of HIV/AIDS by peacekeeping forces would later generate outrage and be the central reason for bringing the disease to the attention of the UNSC in 2000. However no such securitizing actor existed during the UNTAC mission to call attention to this issue, despite evidence that HIV/AIDS posed a deadlier threat to peacekeepers than any other cause, and evidence of a growing Cambodian epidemic of HIV/AIDS. Neither DPKO nor the Cambodian government, which was weak and in a transitional phase, argued to securitize the issue of peacekeepers spreading HIV/AIDS. Because of the lack of a securitizing actor, this issue received little public attention.

The case of the UNTAC mission being implicated in the beginnings of the Cambodian HIV/AIDS epidemic also suggests that there are dangers in not addressing the links between national security and HIV/AIDS. A failure of the security community to understand the impact of deploying peacekeepers in Cambodia, within the context of a growing regional HIV/AIDS epidemic, likely led to the rapid growth of Cambodia's epidemic. This undercut the UNTAC's mission to aid the Cambodian people and their

eventual success in holding elections. Furthermore, failure to understand the risk HIV/AIDS posed to the UNTAC personnel made the disease the greatest threat to the lives of the peacekeepers during the mission. Although implied by Elbe's (2006a) work, nowhere in the literature on the nexus is there an examination of the negative impacts that occur when tangible links between the disease and national security are left unaddressed. The UNTAC mission suggests that the absence of a securitizing actor to address tangible links between the disease and national security can harm efforts to fight HIV/AIDS.

4.5 Conclusions

The above analysis describes how, between 1985–1995, well before widespread debate about the national security implications of HIV/AIDS in the scholarly literature, the disease was already being strongly linked to national security considerations in at least four countries. The cases of Thailand and Uganda demonstrate potential benefits from securitizing HIV/AIDS. In Thailand, and to a lesser extent in Uganda, perception of the disease as a threat to national security pushed the response to HIV/AIDS up the political agenda, involved heads of state and mobilized critical levels of resources. Securitization transformed HIV/AIDS, from a low politics to high politics issue in these countries, and the public health response to the disease in both countries benefited from this prioritization.

Concerns about the spread of HIV/AIDS in the militaries of Thailand and Uganda were a major reason for securitizing the disease, and the militaries in both countries were heavily involved in the response to HIV/AIDS. However viewing the disease as a threat to national security in Thailand and Uganda did not result in the garrisoning of states behind national borders as Peterson (2002) feared, or the movement of the response to HIV/AIDS away from civil society and toward the "less transparent workings of military and intelligence organizations" (Elbe 2006a: 128). In fact, the Thai police and armed forces made valuable contributions to the Thai public health efforts that successfully responded to the epidemic. This research finds that the securitization of HIV/AIDS in Thailand and Uganda led to strong government responses being mobilized, based on

public health principles, to limit the spread of the disease among both civilian and military populations.

Similarly, no evidence was found that the securitization of HIV/AIDS resulted in increased stigmatization of those living with the disease. In fact, the open discussion of the disease by heads of state appears to have contributed to a de-stigmatizing of the disease which "encouraged political actors to break the silence surrounding HIV/AIDS" (Elbe 2006a: 132). In Thailand and Uganda, securitization of HIV/AIDS contributed to the development of strong public health programs that achieved successes in reducing national prevalence of HIV/AIDS. In these two countries, securitization of HIV/AIDS demonstrated powerful benefits for the fight against HIV/AIDS and no significant negative impacts.

The CIA studies of HIV/AIDS in 1987 and 1991 represent failed attempts to securitize HIV/AIDS in the U.S. While these studies accurately predicted the devastating impact of the epidemic in sub-Saharan Africa, the security implications of HIV/AIDS for the U.S. were deemed to be limited. Further undermining these securitization moves was the view by some, within the U.S. intelligence community, that the epidemic would have benign or even beneficial impacts on the national security of affected states. That the referent objects of these threats to national security were African people and states, and not the interests of the U.S., led to rejection of these attempts to securitize HIV/AIDS. A strong resistance against considering HIV/AIDS as a national security issue also contributed to the failure of these securitizing moves. The failure of these early U.S. intelligence reports to generate increased action on HIV/AIDS confirms Peterson's (2002: 46) view that appealing to the national interests of the U.S. will "likely fail, because the true security implications of IDs for the United States remain limited and indirect."

The KGB disinformation campaign represents the use of HIV/AIDS in pursuit of Soviet national security objectives. This situation is not specifically anticipated by any of the conceptual frameworks. Nor is this campaign understood to be a cause of HIV/AIDS conspiracy theories which undermine prevention efforts today, although this thesis argues that this is a strong possibility. The disinformation campaign provides an

example of the negative impacts of nefariously linking HIV/AIDS to national security objectives.

The case of deployed UNTAC peacekeepers spreading and becoming infected with HIV/AIDS demonstrates two links between the disease and peacekeeping operations. First, peacekeepers do seem to have contributed to the rapid growth of HIV/AIDS in a country they were assigned to help. Second, HIV/AIDS emerged as the greatest threat to the lives of peacekeepers deployed in Cambodia. Despite these links, the issue of peacekeepers and HIV/AIDS generated little response from the security or public health communities and remained unsecuritized. DPKO and staff in Cambodia seemed unable and unwilling to address the issue. Similarly, there were no challenges to DPKO from public health leaders concerned about peacekeepers' impact on HIV/AIDS epidemics. The absence of a securitizing actor to recognize and address these links between HIV/AIDS and national security undermined the success of the UNTAC mission, was a likely accelerator of the HIV/AIDS epidemic in Cambodia, and put peacekeepers at greater risk of HIV infection.

This research finds that the role of global health actors throughout these cases is largely limited to the production of epidemiological data on HIV/AIDS. This data played a key role in generating responses to HIV/AIDS in Thailand and Uganda, and was the basis of the U.S. intelligence assessments of the pandemic. However the production of data was the extent of public health action in these cases. Global health leaders did not advocate for viewing the disease as a threat to national security or play major political roles. They were functional actors in the background of these events, supplying critical epidemiological information into the policymaking process. This situation bears the closest resemblance to the independent actor model described by Lee and McInnes (2004). There is no evidence of global health being a "supplicant" to national security interests during this period. In fact, it was the U.S. and Soviet intelligence communities that sought to address the issue of HIV/AIDS, a reversal of the supplicant model that is not provided for by the models of engagement.

The U.S. intelligence studies and UNTAC mission experience reveal major differences in perspective between public health and national security, and difficulty bridging areas where the two fields overlap. The greatest difference between the benefits of

securitization found in Thailand and Uganda, and the indifferent response to the UNTAC experience and the U.S. intelligence studies, seems to be the direct nature of the security threat to Thailand and Uganda. The perception of a clear national security threat to the state resulted in beneficial action against HIV/AIDS in Thailand and Uganda. However, a threat to foreign persons or states, or UN peacekeepers, was insufficient to cause increased action by others in fighting HIV/AIDS. The importance of the securitizing actor is also clearly demonstrated by the Cambodian UNTAC mission case, where such an actor was missing. This finding supports the utility of the communitarian – cosmopolitan model, particularly its focus on the different referent objects of the national security and global health fields, which provides a salient explanation for these cases where the disease was not securitized.

Overall, the cases of Thailand and Uganda demonstrate clear benefits in fighting HIV/AIDS when a country views the disease as a threat to its own national security. However U.S. intelligence studies of HIV/AIDS epidemics in Africa and globally, and the spread of the disease by deployed peacekeepers, were not cases of securitization due to the referent object and absence of securitizing actor respectively. In both cases, greater action against HIV/AIDS would likely have saved lives, but was not forthcoming. Finally, the KGB disinformation campaign provides a stark example of the risks of linking HIV/AIDS to a national security agenda.

The years between 1985 and 1995, before HIV/AIDS was widely discussed as a national security issue, demonstrate much of the complexity of the current day HIV/AIDS – national security nexus. This chapter has endeavored to reintroduce this early history of the nexus into the current debate on the risks and benefits of securitization. Chapter 5 will move from the diverse national histories described above into the story of how and why HIV/AIDS was securitized at the global level by the UNSC and U.S. The tensions in the nexus will remain relevant, as will the critical role played by individuals in shaping events. However the events will take place on a global stage, with its greater complexity and array of competing political interests.

Chapter 5: The Global Securitization of HIV/AIDS

While Chapter 4 presents four countries where HIV/AIDS was linked to national security concerns, this chapter seeks to present the history of events in the U.S. and at the UNSC which securitized HIV/AIDS on the global stage during 1999-2000. As Elbe (2006a: 126) observes, securitization

> is precisely what has happened to the issue of HIV/AIDS in recent years, where arguments have shifted from humanitarian and public health ones to officials in international organizations, governments, and non-governmental organizations (securitizing actors) increasingly arguing that beyond these humanitarian considerations, the survival of communities, states, and militaries (referent objects) is now being undermined (existentially threatened), unless drastic measures (emergency measures) are undertaken by national and international actors to better address the global pandemic.

This chapter will examine these arguments, and the history of the global securitization of HIV/AIDS. The chapter begins by examining the intellectual antecedents to securitization, which include the U.S. Institute of Medicine's conceptualization of emerging infectious diseases, and UNAIDS efforts to produce improved epidemiological estimates of the pandemic globally and among armed forces. The chapter then proceeds to examine in detail the events that led to the publication of a U.S. national intelligence estimate on infectious diseases and the UNSC meetings on HIV/AIDS, which together securitized HIV/AIDS on the world stage.

As important as the processes of securitization are the broader lessons on the nexus that emerge from a history of this time period. This chapter provides a critical contribution to this thesis because, while it is clear that HIV/AIDS was securitized, the events of securitization were complex. Securitization took place at a time when the HIV/AIDS pandemic was exploding in sub-Saharan Africa and Eurasia, and global health actors may assume that epidemiological findings drove HIV/AIDS into the highest levels of international politics. However this thesis finds that political interests having little to do with global health, and the actions of key policymakers often played fundamental but under recognized roles in enabling securitization to proceed. Without these political interests and their interaction with key individuals, it is doubtful that securitization of HIV/AIDS would have occurred.

The role global health actors played in the events of securitization, which this thesis argues contributed to a major transformation in the political treatment of the disease, is also examined in this chapter. Major differences in culture and perspective between the global health and national security communities, which shape events in this history, are also apparent. Examining the complexity of the events of securitization, particularly the role of ulterior political interests, key individuals, and the communitarian – cosmopolitan divide provides important insights into the HIV/AIDS – national security nexus, and serves to enhance understanding of the implications of the securitization of HIV/AIDS.

5.1 The Introduction of Emerging Diseases into U.S. National Security

Emerging diseases such as HIV/AIDS did not always have high political priority. The development of effective vaccines for most childhood illnesses, and widespread use of antibiotics for bacterial infections led the U.S. Surgeon General to declare in 1967 that "the war against infectious diseases has been won" (Fauci 2004: 1887). However, during the last forty years, new diseases have emerged alongside the resurgence of known diseases, some increasingly resistant to antimicrobials and drug treatment. At least thirty new diseases have been identified since 1973, a rate of almost one per year. Among them are HIV/AIDS, hepatitis C, Ebola, Hantavirus, SARS and Nipah virus. Previously known diseases such as cholera, yellow fever and dengue have re-emerged dramatically, and some like tuberculosis, have re-emerged in multi-drug resistant forms. Disease vectors have also become resistant to insecticides and increased their geographic range, bringing malaria, African sleeping sickness, West Nile virus, Rift Valley fever, yellow fever and dengue into new territories and even hitherto unaffected continents. Collectively, these diseases have been termed "emerging diseases" (Henig 1994: *x*, King 2004).

The concept of emerging viruses (and later emerging diseases) was coined at a conference on emerging viral agents in 1989 by virologist Stephen Morse (Henig 1994). The conference spurred significant interest in the concept of emerging diseases, resulting in a major study by the U.S. Institute of Medicine (IOM) on the causes and possible responses to emerging diseases. Published in 1992, the IOM report was entitled *Emerging Infections: Microbial Threats to Health in the United States*. The preface to the report describes the decision to limit the study to "emerging microbial threats to U.S.

public health" as a way of narrowing a broad topic (Institute of Medicine 1992: *vi*). However, King (2002: 767-768) accurately describes the IOM report as the "centerpiece of a major public health campaign" to link infectious diseases with U.S. economic and security interests, and define an "*emerging diseases worldview.*"

The first sentence of the IOM (1992: *v*) report clearly frames the threat of infectious diseases in what was becoming an increasingly popular notion of post Cold War interdependence: "[I]n the context of infectious diseases, there is nowhere in the world from which we are remote and no one from whom we are disconnected." Viewed from the perspective of U.S. national security in 1992, this represented a dramatic departure from Cold War conceptualizations of national security. The collapse of the Soviet Union had removed the perceived preponderant security threat to the U.S., and by its absence had created space for such new security threats to be considered. Furthermore, the processes of globalization had undermined the traditional protection afforded by geography, borders and military strength that had defined the pursuit of national security in the twentieth century. The combination of these factors, the collapse of the Soviet Union and the processes of globalization, would enable the IOM's framing of emerging infectious diseases to become a powerful argument for securitization.

In 1995, this concept of a new kind of threat to the U.S., against which Americans believed they had limited defense, was also embraced by popular and somewhat alarmist culture. Published that year, *The Coming Plague: Newly Emerging Disease in a World Out of Balance* by medical journalist Laurie Garrett, and *The Hot Zone: A Terrifying True Story* by Richard Preston describe the emergence of Marburg, HIV/AIDS and other diseases, and an Ebola outbreak among monkeys in Virginia respectively. The same year, the film "Outbreak", starring Dustin Hoffman as a military scientist, depicted an outbreak of a deadly African virus in the U.S. Accentuating growing fears of acute epidemic diseases was an actual outbreak of Ebola in Kikwit, Zaire (now Democratic Republic of the Congo) that killed 81% of the 315 people infected.

Partially in response to this Ebola outbreak, and partly due to high levels of public attention to the threat of emerging diseases, U.S. President Clinton issued a Presidential Review Directive (PRD) in 1995 directing the U.S. National Security Council (NIC) to

study American vulnerability to bioterrorism.[17] R.P. Eddy ran the PRD in 1995 and describes the process as follows:

> I ran this interagency process with the CIA, OED and all the other agencies to try and get them to help us understand what the President, basically what the threat was. So the PRD is first, it lets us just see what we are doing and what assets we have and what your options are. And the PDD, Presidential Decision Directive, is the President then saying, 'Well based on what we've done, here's what we're gonna do.'(R.P. Eddy Interview)

Eddy confirms that the origins of the PRD lay with the Kikwit outbreak and increasing public concern about emerging diseases. The PRD

> was basically initiated because of the Ebola outbreak in Kikwit, Zaire, but also a feeling, there was a movie called "Outbreak" with Dustin Hoffman – and a book called "The Hot Zone" – so there was this, sort of, awareness that potentially microbes could be a potential security issue" (Eddy Interview).

During the PRD, Eddy had a prescient conversation about the national security implications of HIV/AIDS. Eddy remembers a State Department staff member saying:

> 'You're talking about Ebola, you're talking about anthrax, a little bit in terms of smallpox and other diseases and the risk to national security. Have you considered HIV/AIDS?' And I almost laughed! AIDS and national security, it's ridiculous and I immediately shut him up and moved on… (Eddy Interview)

Eddy says his skepticism about the potential for HIV/AIDS to have an impact on national security was widespread at the time and "continues today" (Eddy Interview).

Despite Eddy's skepticism, his PRD became a Presidential Decision Directive (PDD) released on 12 June 1996. The PDD mentions Ebola, drug-resistant tuberculosis and HIV/AIDS as posing "one of the most significant health and security challenges facing the global community" (White House 1996). Despite describing a threat to the "global community," the PDD focuses on the national security interests of the U.S.:

> Addressing this challenge requires a global strategy as most cities in the United States are within a 36 hour commercial flight of any area of the world -- less time

[17] A PRD was the Clinton Administration's mechanism to direct reviews and studies by U.S. government agencies. A Presidential Decision Directive (PDD) was the Clinton Administration's mechanism to declare Presidential decisions on national security matters.

> than the incubation period of many infectious diseases. Furthermore, the United States is vulnerable to a release of biological agents by rogue nations or terrorists, which could result in the spread of infectious diseases. (White House 1996: para. 1)

While the PDD focused on all emerging diseases, especially exotic and gruesome killers like Ebola, this is the first time that HIV/AIDS was officially described as a threat to U.S. national security. The idea that diseases "over there" could come "over here" clearly references the IOM's conceptualization of emerging diseases and changed the national security calculus from the early U.S. intelligence reports on the HIV/AIDS epidemic where few risks to U.S. national security were found. The IOM's approach is that of the supplicant model, described by Lee and McInnes (2004), whereby the public health community appealed to the state-based interests of national security in order to increase attention and funding to address infectious diseases. In this case, their efforts successfully introduced infectious diseases into U.S. national security analysis as a recognized threat. It is important to also consider that, concurrently, the collapse of the Soviet Union and recognition of the processes of globalization, had created a policy space for new threats to national security to be addressed. While this was not a case of securitization, because no emergency measures resulted from the PDD, these events provided an initial framework for understanding how diseases could be considered a threat to national security. While the securitization of HIV/AIDS did not follow this model exactly, the concept of emerging diseases successfully introduced public health issues into national security analysis, and provided a foundation for the later securitization of HIV/AIDS.

5.2 The role of global health actors: Providing the evidence base on the HIV/AIDS pandemic

The role of global health actors in securitizing HIV/AIDS can be understood by examining the actions and motivations of the main international agency charged with fighting HIV/AIDS. Between 1987 and 1995, WHO's Global Programme on AIDS (GPA) was the lead institution in the UN's response to HIV/AIDS. As the international response grew, the GPA faced difficulties coordinating other UN organizations, as well as donor governments which also channeled resources bilaterally (Collinson and Lee 1996). The leadership style of then WHO Director-General Hiroshi Nakajima, and

differences in opinion over the relative emphasis to place on biomedical or human rights-based approaches to the disease, led to the departure of the inspiring GPA head Jonathan Mann in 1990. This alienated leading donor governments, already disenamoured with WHO, during Nakajima's tenure. Merson (2006: 2415), who assumed the head of GPA between 1990-1995, writes that the organization

> was unable to muster the necessary political will in donor and affected countries, and its effectiveness was compromised by rivalries with other United Nations (U.N.) organizations, concern about the senior leadership of the WHO, and an increasing preference of wealthy governments for bilateral aid programs.

These pressures led to WHO resolution WHA46.37 in 1993 which called for "a study of the feasibility of setting up a new AIDS programme" (Collinson and Lee 1996: 4). Two years later, on 1 January 1996, UNAIDS was launched. The difficulties at GPA, and the years spent establishing UNAIDS, had hampered the UN's ability to organize an effective global response to HIV/AIDS. As one GPA staff member commented on the transition from GPA to UNAIDS, "We have lost two years in this changeover. Two years that we could have used to fight the disease" (Collinson and Lee 1996: 5).

The formation of UNAIDS improved the UN's interagency ability to contribute to the fight against HIV/AIDS. Among the early actions of the new head of UNAIDS, Peter Piot, was investing in the epidemiological resources to track and investigate the epidemic (Behrman 2004). Poku (2004: 100) writes that, with the formation of UNAIDS, came significant progress on "the reliability of information regarding the nature, intensity and direction of the virus not only across the globe, but also within individual countries." This investment in epidemiology resulted in a vast improvement in estimates of HIV/AIDS incidence and prevalence.

Steven Morrison (Interview), Executive Director of the Center for Strategic and International Studies HIV/AIDS Task Force, singles out the formation of UNAIDS, and its provision of rigorous data on HIV/AIDS, as a turning point that brought the epidemic greater political attention. Morrison (2001: 201) writes that UNAIDS data "brought across starkly the enormity and complexity of the HIV/AIDS crisis" which "ultimately prompted the administration and congress to move beyond business as usual." Princeton Lyman (Interview), who served as U.S. Ambassador to South Africa and Nigeria, also notes the importance of "a reliable set of single statistics" by UNAIDS in drawing more

political attention to the disease. UNAIDS statistics were influential because they were viewed as rigorous and conveyed the enormity of the pandemic. While this was not the first time global estimates of the pandemic had been issued, it was the first time rigorous estimates were widely viewed and accepted among U.S. policymakers. UNAIDS estimates of the global HIV/AIDS situation, revised yearly since 1998, were a major contribution to high-level political awareness of HIV/AIDS, and therefore the transformation of the disease into a high politics and national security issue.

Also published by UNAIDS in 1998 was *AIDS in the military*. This report was later widely cited by authors writing about the national security implications of HIV/AIDS, with two of its main arguments becoming "accepted wisdoms" to those examining HIV/AIDS in military populations (Whiteside, De Waal, Gebre-Tensae 2006: 201). The first of these arguments is that military populations are at higher risk of sexually transmitted diseases, including HIV/AIDS. UNAIDS (1998: 3) writes that "In peace time, STD infection rates among armed forces are generally 2 to 5 times higher than in civilian populations; in time of conflict the difference can be 50 times higher or more." This statistic was based on "conventional wisdom" drawn from the U.S. military experience during World War II, and the wars in Korea and Vietnam, as well as on estimates of HIV/AIDS in the Zimbabwean and other armies from a 1995 Civil-Military Alliance (CMA) survey (Stewart Kingma Interview).

The second widely-cited argument were the five explanations offered by UNAIDS (1998) for these high rates of STDs in military populations. First, lengthy military service away from home causes emotional stress and encourages commercial sex. Second, the risk-taking ethos of armed forces may inure soldiers to risky sexual practices. Third, armed forces are comprised of the 15-24 year olds who are the demographic group at highest risk for HIV infection. Fourth, soldiers and peacekeepers stationed abroad are often wealthier than local populations, which give them the financial ability to purchase sex. Finally, military and peacekeeping camps often attract sex workers, facilitating commercial sex and risky sexual practices. The report continues to argue that HIV/AIDS may affect military preparedness and presents challenges in preventing transmission between military and civilian populations.

While this report concerns the affects of HIV/AIDS on militaries, it did not explicitly attempt to securitize the epidemic. Stuart Kingma (Interview), medical advisor to GPA, UNAIDS and the CMA, and author of the *AIDS in the military* report, recalls that the potential political benefits of addressing the national security implications of HIV/AIDS were "noted at the time, but were not a driving factor." Public health concern about the spread of HIV/AIDS among military populations was the main rational for two reasons. First, as noted in *AIDS in the military*, UNAIDS believed that rates of STDs were two to five times higher in military populations, which put them at significant risk of infection with HIV/AIDS. Second, UNAIDS noted that militaries were poorly integrated with civilian HIV/AIDS prevention programs. Militaries maintained separate hospital systems and were generally felt to be able to maintain the health of their personnel without recourse to international aid. Furthermore, militaries were not viewed as "legitimate recipients of international aid" (Kingma Interview). The combination of these factors made the armed forces a high risk and underserved population that UNAIDS sought to address. Kingma (Interview) emphasized that UNAIDS focus on militaries was not driven by an attempt to securitize the epidemic. He supported this view by recounting how UNAIDS rapidly broadened their campaign from militaries to include all uniformed services including customs officials, police forces, and other groups not related to national security (Kingma Interview).

By 1999 however, Piot was arguing that "There are African countries where it is said that more than 50 percent of all the military are H.I.V. infected, and that is a problem of national security" (Altman 1999: para. 28). Ingram (2007) and Behrman (2004: 175-176) similarly recount how Piot and the UNAIDS staff sought to put the disease onto a high political agenda, and increasingly used a "political strategy" to link the epidemic to "economic and security considerations." Piot (2005: para. 86) argued in 2005 that putting "AIDS on the political agenda" was his primary objective upon taking charge of UNAIDS in 1996, and that redefining the disease as a security issue was part of this objective. Thus, by 1999, the reluctance of UNAIDS to using securitizing language seemed to have been overcome, and Piot was making securitizing arguments.

While the production by UNAIDS of rigorous global, country and military estimates of rates of HIV/AIDS in 1998 contributed to recognition of the disease as a threat to national security, these events did not represent an attempt to securitize the epidemic. In

1998, UNAIDS was largely motivated by a desire to produce comprehensive epidemiological data on the epidemic and a specific concern that military populations were at high risk of HIV/AIDS and underrepresented in civilian health programs. UNAIDS specifically chose not to link the disease to communitarian and national security interests at this time, but instead chose to continue to pursue the organization's cosmopolitan objectives. The *AIDS in the Military* report was a cosmopolitan examination of the spread of HIV/AIDS among the armed forces because it focused on this population as a vulnerable and underserved group in relation to HIV/AIDS. However by 1999, Piot began linking HIV/AIDS to national security agendas using the data they had gathered, with the intent to move HIV/AIDS onto higher-level political agendas. UNAIDS data on the global epidemic and among armed forces played a key role in informing and framing much of the later debate on how HIV/AIDS may have an impact on traditional national security considerations. Piot's securitizing arguments, while not directly accepted by a public or national security audience, provided further basis for the successful securitizations in the U.S. and at the UNSC.

5.3 Injecting health issues into U.S. national security

With this groundwork laid by the IOM's conceptualization of emerging diseases, and UNAIDS epidemiological evidence that the pandemic was exploding globally and among armed forces, a public health doctor with foreign policy experience sought to securitize HIV/AIDS within the U.S. government. His efforts would be pivotal in creating a major U.S. national intelligence estimate on infectious diseases that focused on HIV/AIDS and had a strong impact on U.S. policy towards the pandemic.

Ken Bernard is a physician with public health training who had overseen the U.S. Peace Corps program in Africa and engaged with the WHO from the U.S. Mission in Geneva. In 1998, Bernard approached his boss and the head of the U.S. Department of Health and Human Services (HHS) Donna Shalala. He wanted Shalala to lobby then U.S. National Security Advisor Sandy Berger to create a new position on the U.S. National Security Council (NSC) for Bernard.[18] Bernard was to have the unprecedented title of "Senior

[18] The National Security Council is the U.S. president's primary forum for debating national security and foreign policy issues. National security advisors and cabinet officials are the usual attendees. For more information, see: http://www.whitehouse.gov/nsc/.

Advisor for International Health" at the NSC, the first position at the NSC to be dedicated to health issues (Behrman 2004: 228).

Bernard had recognized the potential links between health and national security while working to keep Peace Corps volunteers healthy. He recalls that

> there's more applicability to these issues than just the health of volunteers. You know, it's like, wait a minute, how does health fit into the overall context of development? And how does development fit into the overall context of security? And then you start looking at militaries that are continually being dragged down because their soldiers have malaria all the time. So I would say, the first time I really started thinking about [health and national security] was probably in the mid 80s, in dealing with the peace core volunteers. (Bernard Interview)

Bernard thought that health issues, especially bioterrorism and some infectious diseases including HIV/AIDS, had to be considered as national security issues. The unchecked spread of disease had political consequences that were not being recognized by U.S. policymakers. Bernard wanted to get the NSC to begin to examine the national security implications of infectious diseases and bioterrorism. Bernard thought that:

> the line between health and security seemed to be arbitrary and it seemed to be based, primarily, on what the security people and the health people wanted their jobs to be. So, security people like by and large, bi-national confrontational politics, the East versus the West, the Germans versus the French, the French versus the English, the United States versus the Japanese, the United States versus Russia, Poland versus Germany, you know, it's like this is real national security, that's what they do – not soft under-belly stuff. Soft fuzzy stuff like, social stuff, health stuff, that's not real national security. Well, the health people, of course, public health people especially, have no interest or had no interest in any hard security issues. It was, we have babies dying here and you're telling me that you're trying … you're arguing over whether it's a legal or an illegal landmine. What absurdity is this? These people are crazy, you know, and what happened was, the two communities were not only running in parallel and not talking to each other, but actually at odds with each other and I think it was really, kind of, inappropriate. (Bernard Interview)

Beginning at the NSC in 1998, Bernard encountered great resistance to the concept of linking health and national security. Bernard describes the experience of starting the health and national security office:

> Nobody was here, I didn't have anything to do for six months. No one could figure out why I was here. They'd come up the hallway and say, I understand

> you're a doctor and you're working for Sandy Berger [the U.S. national security advisor], are you like, you know, going on trips and taking care of the health issues that come up, you know when people get sick… Speaking of which, you know, I've been running and my knees have been hurting, do you mind taking a look at it? And there was just no sense in the public, in the national security community that health had a seat. (Bernard Interview)

Bernard found that his background as a physician and in public health actually hindered his interactions with other policymakers in the White House and NSC. After being asked to examine a colleague's knee and being treated as Sandy Berger's personal physician on trips, Bernard decided to hide his health background. Bernard "actually had his secretary take the "MD" off of his White House business card, finding that he was taken more seriously as a traditional policy maker than as "a health guy" (Behrman 2004: 229). Bernard's descriptions of his experiences as a public health doctor in the U.S. national security community are humorous illustrations of the communitarian –cosmopolitan divide, specifically the differences in culture between the global heath and national security communities. This theme will be revisited throughout this chapter as HIV/AIDS is increasingly discussed within the U.S. national security community.

Despite resistance to the idea of health issues having any effect on national security, Bernard kept pushing for a seat at the national security table for public health issues. He had dual goals. First, he wanted to get the national security policy community engaging with the real risks of infectious diseases. Second, he sought to get the U.S. government to bring its huge resources to addressing major global health problems. Behrman (2004: 229) writes, "Bernard knew that if an issue was deemed of national security import, it attracted funds with a velocity that no other area of the U.S. government can match. He made it his mission to inject health, particularly global AIDS, into the national security agenda." In short, Bernard was actively seeking to securitize HIV/AIDS to gain greater attention to the disease, an example of the supplicant model (Lee and McInnes 2004).

One opportunity Bernard found to push this perspective was on the PDD that President Clinton had ordered in 1996. The PDD was languishing at the NSC. Bernard found the director of the project, David Gordon, National Intelligence Officer for Economics and Global Issues, and urged him to complete the paper. Gordon remembers that Bernard "made an appointment to see me and ginned me up to get me going on this paper with a writ from Sandy Berger. He pushed hard to get this going" (Behrman 2002: 45).

Bernard's efforts to link infectious diseases with national security within the U.S. government and to push the NSC to produce a report were effective. The NSC produced a classified version, the *National Intelligence Estimate 99-17*, in 1999. It was entitled, "The Global Infectious Disease Threat and Its Implications for the United States." Unlike previous CIA and NSC studies of HIV/AIDS, this report had major effects on the political profile of infectious disease and HIV/AIDS in particular.

5.4 U.S. National Intelligence Estimate 99-17

Released in an unclassified version in January 2000, National Intelligence Estimate 99-17 (hereafter NIC 99-17) published by the National Intelligence Council (NIC) was the most in depth examination of global health issues by the American national security community to date. Similar to previous NIC reports on HIV/AIDS, NIC 99-17 is concerned with the economic, social and political implications of infectious disease. While recognizing the humanitarian impacts of infectious diseases, the report attempts to explicate the effects of infectious disease on the material interests of the U.S. In other words, the main referent object of Estimate, like most U.S. national security reports, is the United States. The title of NIC 99-17, "The Global Infectious Disease Threat and Its Implications for the United States," accurately reflects this communitarian national security perspective on infectious diseases.

The main conclusion of NIC 99-17 was that emerging and re-emerging infectious diseases will "complicate U.S. and global security over the next 20 years" (National Intelligence Council 2000: 5). The statement that U.S. security will be affected by infectious diseases was unprecedented in 1999. As discussed below, this designation was dismissed by critics in 2000 and beyond. However, this conclusion was hardly a call to arms to defeat infectious diseases. The report describes infectious diseases as having "implications" for the U.S., not explicitly as a national security threat to the U.S. NIC 99-17 also uses the term "global security," which broadens the mandate of the report to include most serious economic, social or political impacts of disease across the globe. (This reflects the Clinton administration's ambiguity about whose security the HIV/AIDS epidemic threatens.) By stating that the epidemic threatens both U.S. and global security, NIC 99-17 purposely leaves this critical issue ambiguous. Finally, the

report suggests that these complications of U.S. and global security will occur "over the next 20 years," an extremely long timeframe for national security analysis (National Intelligence Council 2000: 5). These factors all served to downplay the conclusions of NIC 99-17.

NIC 99-17 applies national security scenario planning to outline three possible futures of infectious diseases over the next 20 years. The most likely scenario for the future of infectious diseases is described as "deterioration, then limited improvement" (National Intelligence Council 2000: 9). In this scenario, HIV/AIDS worsens from 2000-2010, but "decreases fitfully after that, owing to better prevention and control efforts, new drugs and vaccines, and socioeconomic improvements" (National Intelligence Council 2000: 9). NIE 99-17 predicts that infectious diseases will continue to thrive in developing countries due to poverty and poor health care capacity, especially in the least developed countries. This future of steady progress could be imperiled by the appearance of a new and deadly infectious disease, a massive increase in rates of HIV/AIDS, or a bioterrorist attack using a highly contagious agent. Interestingly, the NIC 99-17 does not consider the effects of different U.S. actions and how they would impact these scenarios. The final impression is of a world of infectious diseases largely beyond U.S. control and likely to slowly improve without specific interventions.

Although NIC 99-17 is focused on infectious diseases generally, the section on economic, social and political impacts of disease is centered on the HIV/AIDS epidemic. The report describes HIV/AIDS as having major macro and microeconomic effects, reducing GDP growth in highly affected countries, hurting corporate profitability especially in the mining industry, and hurting small farmers. The economic impact of HIV also extends to governments as the disease makes increasing claims on national health systems. The report echoes a common public health complaint that the massive public spending on HIV/AIDS "threatens to crowd out other types of health care and social spending" (National Intelligence Council 2000: 49). Even with highly affected countries spending large portions of their health care budgets on HIV/AIDS, most at the time would be unable to afford ARV's for more than a small percentage of their HIV positive populations.

The section on the social impact of infectious diseases is also dominated by the HIV/AIDS epidemic. NIC 99-17 warns that the reductions in life expectancy and the demographic effects of the epidemic will increase political instability and give rise to a generation of poor, angry and radicalized AIDS orphans with implications for the stability of other states and by extension, U.S. national security.

At least some of the hardest-hit countries, initially in Sub-Saharan Africa and later in other regions, will face a demographic catastrophe as HIV/AIDS and associated diseases reduce human life expectancy dramatically and kill up to a quarter of their populations over the period of this Estimate. This will further impoverish the poor and often the middle class and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization (National Intelligence Council 2000).

NIC 99-17 returns to the issue of AIDS orphans by linking the breakdown of families due to disease, to social and economic dislocations, which then have follow-on political consequences. The report states that approximately 35 million children will have lost one or both parents to AIDS in 2000, and that number will rise to 42 million orphans by 2010. The authors argue that these orphans in the highly affected countries will constitute a

> 'lost orphaned generation' by 2010 with little hope of educational or employment opportunities, these countries will be at risk of further economic decay, increased crime, and political instability as such young people become radicalized or are exploited by various political groups for their own ends; the pervasive child soldier phenomenon may be one example. (National Intelligence Council 2000: 50)

The report suggests that further social and political instability is likely to result from HIV infection among political and military leaders. These infections may intensify struggles for power and undermine transitions to democracy. The NIC concludes that "the infectious disease burden will add to political instability and slow democratic development in Sub-Saharan Africa, parts of Asia, and the former Soviet Union, while also increasing political tensions in and among some developed countries" (National Intelligence Council 2000: 50). These potential social impacts of HIV/AIDS are part of

the NIC's argument outlining the relevance of the pandemic to U.S. national security interests, and to securitize the disease.

In the next section of the report, "Destabilizing Political and Security Impact," NIC 99-17 offers estimates of HIV prevalence among selected militaries in Sub-Saharan Africa (National Intelligence Council 2000: 50). Based on a 1999 unpublished report by the U.S. Armed Forces Medical Intelligence Center, which is part of the Defense Intelligence Agency, the report provides estimates of HIV infection in seven African militaries as follows:

Country	Estimated HIV Prevalence (percent)
Angola	40 to 60
Congo (Brazzaville)	10 to 20
Cote d'Ivoire	10 to 20
Democratic Republic of the Congo	40 to 60
Eritrea	10
Nigeria	10 to 20
Tanzania	15 to 30

Figure 5.1: Estimated HIV Prevalence in seven African Militaries. Source: National Intelligence Council (2000: 53)

The original report by the Armed Forces Medical Intelligence Center is classified, so the origins and methodology behind these estimates is unknown.

These rates among African militaries are significantly higher than those among the same country's civilian population. NIC 99-17 echoes the UNAIDS 1998 report and attributes this to soldier's "risky lifestyles and deployment away from home" (National Intelligence Council 2000: 52). While African militaries are clearly at risk, the report also discusses the poor health status of the armed forces in Russia. The impact of HIV on armed forces will be greatest among "hard-to-replace officers, noncommissioned officers, and enlisted soldiers with specialized skills and among militaries with advanced weapons and weapons platforms of all kinds" (National Intelligence Council 2000: 52).

Despite these large effects, the authors think it is difficult to directly connect HIV prevalence and war fighting performance. They conclude that despite the lack of a direct connection, HIV will likely decrease combat readiness and capability among highly affected militaries. The linkage between HIV/AIDS and armed forces, originally outlined by the UNAIDS *AIDS in the Military* report, is the second part of the NIC's argument for the relevance of HIV/AIDS to U.S. national security interests.

As the most in-depth analysis of public health issues by the U.S. national security community, NIE 99-17 would play a critical role in the securitization of HIV/AIDS in the U.S. While the report itself did not clearly argue that the pandemic posed an existential threat to the U.S., it persuasively outlined an argument suggesting that the pandemic would have serious implications for U.S. national security. Furthermore the authors of the Estimate, the U.S. NIC, were a highly credible securitizing actor at the center of the U.S. national security community. HIV/AIDS was not securitized fully by the publication of NIC 99-17, but both the arguments for securitization and a credible securitizing actor were in place.

NIE 99-17 diverges starkly from traditional public health analyses in two ways. First, the de-classified estimate contains few references for the evidence it discusses. Most of the report consists of unsourced statements, such as "There were 19.5 million new malaria infections estimated in the Asia and Pacific region in 1998, many of them drug resistant, and 100,000 deaths due to malaria", that would require a reference if published in a scholarly journal (National Intelligence Council 2000: 28). While the seven charts and tables in the report do reference sources including the WHO, World Bank, and the Institute of Medicine, two of these reference unpublished and classified studies by the Defense Intelligence Agency and Armed Forces Medical Intelligence Center. Arguably the most important and original information is contained in "Table 6" which lists "HIV Prevalence in Selected Militaries in Sub-Saharan Africa" (National Intelligence Council 2000: 53). However, NIE 99-17 contains no methodology section or access to the original classified studies. Unlike data presented in public health or medical journals, there is no way to assess the design of the study or the sources of data, and therefore the accuracy of this information presented. While this information is clearly classified for reasons of national security, the classification of public health information and secrecy

about sources and study methodology represents a major departure from the scientific use of public health information.

Second, the conclusions in the report are primarily based on logically extrapolating from epidemiological data to reach conclusions relevant to the national security community. This is because there is very little data that directly addresses the issues the report examines: what are the political effects of diseases and how might diseases impact militaries, peacekeepers and state stability. For example, the conclusion that "the severe social and economic impact of infectious diseases is likely to intensify the struggle for political power to control scarce state resources," is not directly based on historical events but on a 1996 study by the State Failure Task Force (National Intelligence Council 2000: 10). This study found that infant mortality, much of which is caused by infectious diseases, was linked to political instability. This association is due to infant mortality being a good single measure for overall quality of life, which is also associated with political instability (Esty et al. 1999). Despite the State Failure Task Force's writing in 1999 that "*we are certain that there is NO direct causal connection between infant deaths and ensuing political crises,"* NIC 99-17 cites this study in support of the threat infectious diseases pose to state stability (Esty et al. 1999: 51). An Intelligence Officer involved in the preparation of the report admits that "there is no smoking gun but the logic is there" (Confidential Intelligence Interview). This logically extrapolating from the data is not scientifically rigorous, even if the subject matter is the spread of disease. This lack of scientific rigor is sometimes necessary in the national security field because data may not exist to answer questions that require immediate action. However, this lack of a scientific approach is significantly different from that of the public health field and raises questions about the use of public health data to assess national security issues.

Despite the methodological shortfalls of the report, in the words of one U.S. Intelligence Officer, NIE 99-17 "opened the debate" on HIV/AIDS as a national security issue (Confidential Intelligence Interview). Similarly, David Gordon, the director of the team that produced the report, believes that the report "did have a big impact..." (Behrman 2002: 42). Strong arguments for securitization of HIV/AIDS from a credible securitizing actor were now in place.

5.5 The Impact of NIE 99-17

Why, after years of rapid growth of the pandemic and numerous NIC reports on the disease, did NIE 99-17 create an opening in the U.S. government to address HIV/AIDS? Gellman (2000a: Black and White para. 2) writes that the NIE 99-17 resulted in "a sudden urgency in the Clinton administration to act. No important new scientific feature of the epidemic had been discovered in a decade. What mobilized the government, after seven years of modest effort, has been difficult for its policymakers to identify." Steven Morrison (Interview), believes that the emergence of UNAIDS and its improved estimates of the global epidemic helped move the policy debate on HIV/AIDS forward. Gellman himself provides some of the political context in an earlier article. He writes that African American leaders have "adopted the cause of AIDS in Africa" and are pressuring the U.S. to change trade policies that keep the price of ARVs out of reach of most in the developing world (Gellman 2000b: para. 7). AIDS activists also repeatedly "blindsided" Vice President Al Gore's presidential campaign by disrupting his campaign events and chanting "Gore is killing Africans, AIDS drugs now!" (Gellman 2000b and Richwine 1999: para. 10). These events seemed to have "accelerated the White House's response" (Gellman 2000b: para. 8). The convergence of these political factors with the emergence credible and shockingly large UNAIDS estimates of the global epidemic, as well as the previous framing of emerging diseases as threats to U.S. security by the IOM, seems to have opened policy space for the NIC's arguments on the relevance of HIV/AIDS to U.S. national security.

In addition, a worry about legacy towards the end of the Clinton Administration also seems to have contributed to the sudden priority given to HIV/AIDS. The epidemic had been growing throughout the Clinton years, essentially in full view, but U.S. financial assistance for the pandemic had remained at low and only slowly growing levels (Kates and Summers 2004).

> Pervading the recent U.S. effort is a strong sense among participants of time misspent. The virulence of the pandemic was accurately foreseen, and 'the United States didn't exactly cover itself with glory,' said one close advisor to Clinton. 'We saw it coming, and we didn't act as quickly as we could have,' said Helene D. Gayle, a physician who directs AIDS prevention at the CDC. 'I'm not sure what that says about how seriously we took it, how seriously we took lives in Africa.' (Gellman 2000b: para. 25)

Gordon notes, "What [NIE 99-17] really did, was give a tool, for those in the administration…to run with it" (Behrman 2002: 42). Ken Bernard, who pushed for the creation of the report itself, now had the implicit backing of the NIC to address the national security implications of HIV/AIDS and other diseases. He approached Leon Fuerth, Vice President Al Gore's national security advisor and expected U.S. National Security Advisor if Gore won the Presidency. Leon Fuerth (Interview) first heard of the links between HIV/AIDS and security thorough the classified version of NIE 99-17. He had developed a theory of "Forward Engagement" to address and ameliorate long-term threats to security that fit well with the NIE 99-17's vision of infectious diseases, HIV/AIDS in particular, causing political, social and economic instability (Fuerth Interview). Fuerth embraced the idea that HIV/AIDS should be addressed as a national security threat. Fuerth and Bernard agreed that a national plan on HIV/AIDS was needed.

> They needed a strategy that outlined the objectives, the costs, and the tasks… Armed with that strategy, they could take it to the deputies (a collection of the deputy secretaries and directors of key U.S. departments and agencies), and then to the principals (secretaries and directors). With their recommendation and the president's approval, it would become U.S. national security policy. The funds and structural reform, they suspected, would follow. (Behrman 2004: 230)

Fuerth made Bernard co-chair of a new interagency working group on HIV/AIDS, along with Sandy Thurman, director of the White House Office of National AIDS Policy and "AIDS czar." Despite high hopes, according to Behrman (2004), turf battles and personal differences between Bernard and Thurman undermined this process. Cultural differences between global health and national security also contributed to the group's failure. In the first and critical deputies meeting, Thurman presented a "threat assessment" on HIV/AIDS to members of the NIC in the White House Situation Room. Her presentation revealed the cultural divide between global health and national security policy communities, as well as different referent objects of the different communities (represented in this thesis as the communitarian – cosmopolitan divide.) At the meeting:

> Thurman did not speak the same language as her "security" colleagues. She spoke of humanitarian suffering, orphans, mother-to-child transmission. The security crowd leaned back, eyebrows bent cynically. They were skeptical of "nontraditional" issues to begin with, and Thurman's briefing seemed more a "public service think piece" than a threat assessment…deputies meetings are

> supposed to be conclusive, and for the most part it was "amateur hour," and provided ammunition to validate the skeptics' doubts. (Behrman 2004: 237-238)

Both cultural differences, and Thurman's discussion focusing on human suffering as opposed to U.S. strategic interests, precluded a successful meeting. Gellman (2000b: 9) echoes Behrman's description of the vastly different experiences and perspectives between the global health and national security communities with this anecdote: "So unfamiliar are public health agencies with the apparatus of national defense that one early task force meeting was delayed when Co-chairwoman Sandra Thurman, whose Office of National AIDS Policy is across the street from the White House, could not find the Situation Room." Turf battles detailed by Behrman (2004) and the communitarian – cosmopolitan divide impaired cooperation and doomed the working group's efforts to directly engage the U.S. national security community in the fight against HIV/AIDS.

In April of 2000, Barton Gellman published his article in the *Washington Post* that brought the issue of whether HIV/AIDS was a threat to U.S. security into public view. The article was based on NIE 99-17 and the work of Bernard and Thurman's working group (Gellman 2000b). It was titled "AIDS is declared threat to security: White House fears epidemic could destabilize world" (Gellman 2000b). The article declared that the Clinton Administration believed that HIV/AIDS was a threat to U.S. national security, even though NIE 99-17 had specifically avoided this formulation. The article began:

> Convinced that the global spread of AIDS is reaching catastrophic dimensions, the Clinton administration has formally designated the disease for the first time as a threat to U.S. national security that could topple foreign governments, touch off ethnic wars and undo decades of work in building free-market democracies abroad. (Gellman 2000b: para. 1)

Gellman's article provoked widespread public debate on HIV/AIDS and security that lasted through the 2000 presidential elections, and into the beginning of the Bush administration. While the article described the White House as declaring HIV/AIDS to be a threat to security, there is no official process for declaring a threat to national security or list of such threats, and no such action had taken place. Susan Rice, former Assistant Secretary of State for Africa explains "There's no formal process. It's not like there's a process for designating somebody a state sponsor of terrorism...There's no such list of threats" (Behrman 2002: 5). Joe Lockhart, President Clinton's Press Secretary, was questioned on this issue two days after the article appeared.

Q: Joe, when did the NSC come to the decision that the global AIDS crisis is a threat to national security?

MR. LOCKHART: The NSC has been working on this particular issue for now almost two years. I think two years ago they set up an office and put on some staff to deal with health issues, because they do, ultimately, go to our national security.

I mean, if you look at Africa, where AIDS is now the largest killer of any diseases that exist, you have very staggering numbers... you've got projections in some places where 50 percent of the military will contract HIV-AIDS in the not too distant future.

Those can be very destabilizing numbers. And they have an impact on us. We have an interest in Africa, as far as our own national security, and we need to look at this problem -- as the NSC has done, very much so this year, but going back over the last couple of years -- as a national security issue...

Q: Joe, what transpired on this issue over the weekend? I mean, was there some announcement or something that NSC did --

MR. LOCKHART: No, I think the *Washington Post* decided to run a story on it. There was nothing -- I mean, there was no formal designation of this...

Q: Joe, on Josh's question, are you saying that the NSC members did not vote, this is a threat to national security, something like that? Did not --

MR. LOCKHART: That's correct. No, there's no formal designation. We've been working on this. We put staff on as far back as two years ago, on the NSC, to deal with health issues, and AIDS in particular. (White House Daily Briefing, 2000: para. 26)

As described above, NIE 99-17 does not unequivocally state that HIV/AIDS represents a direct national security threat to the U.S. David Gordon, the director of the NIE 99-17 project, deliberately avoided stating that the disease posed a direct risk to U.S. national security. He explains his rationale:

> We didn't sort of say, here's the line where health issues become security issues... We didn't want to set up a line for what crosses over, because we never would have gotten that consensus with the Intelligence Community... The explicit judgment was of a much lower hurdle. It's that infectious diseases taken generally pose challenges to the United States on health and national security issues. We didn't try to disaggregate that and say this is, that isn't. (Behrman 2002: 41-42)

Despite NIE 99-17 carefully avoiding designating HIV/AIDS as a direct threat to U.S. national security, Gellman's article had the effect of forcing the Clinton administration to

back the article's claim that "AIDS is [a] declared threat to security." The unpalatable alternative was to downplay the importance of HIV/AIDS at a time when the administration was trying to emphasize its attention to the issue. Ken Bernard welcomed the increased attention to the security implications of HIV/AIDS generated by Gellman's article:

> Barton Gellman's thing [that HIV/AIDS is a national security issue], which nobody [in government had] ever announced...it was very cleverly done. He did a good job and actually did us all a big favor...there was no point in time when the U.S. declared AIDS a national security issue. It was never declared a national security issue because until you got up to senior policy makers, people like Princeton Lyman, or Holbrooke, or for that matter, the Vice President's National Security Advisor Fuerth, nobody would ever take it seriously. (Bernard Interview)

Gellman's article had pushed the arguments within NIE 99-17 into the realm of public debate. In the public discourse, a less nuanced view of the security implications of HIV/AIDS than that presented in NIE 99-17, prevailed. It became U.S. government policy that HIV/AIDS threatened national security, and thus the pandemic was securitized within the U.S. The emergency measures that resulted from securitization will be discussed in Chapter 6. A critical finding from these events is that HIV/AIDS was only fully securitized in response to Gellman's *Washington Post* article, and the accompanying political pressure to emphasize the importance of the pandemic.

The Clinton Administrations new position on HIV/AIDS drew criticism as well. Republican Senator Trent Lott thought the Clinton administration was pandering to gay rights groups by calling HIV/AIDS a national security threat. Lott was asked if he thought HIV/AIDS was a national security threat. He responded:

> I saw that in the *Washington Post* this morning....I didn't see it in other papers, and the answer is no, I don't. I guess this is just the President trying to make an appeal to, you know, certain groups. But no, I don't view that as a national security threat. Not to our national security interests, no." (Lott 2000: para. 6)

An article by Bruce Fein (2000) in the conservative *Washington Times* also derided the link between HIV/AIDS and security. He wrote that, in espousing this link to national security, the Clinton administration

neglected to note, however, that chronic convulsions, tyranny, corruption, civil insurrections, tribal, ethnic, and religious enmities, war and human-rights violations have been the soundtracks of Africa since decolonization commenced in 1957 decades before AIDS appeared on the dismal scene.

At present, Sierra Leone, Nigeria, Sudan, Ivory Coast, Eritrea, Ethiopia, Rwanda, Burundi, the Congo, Uganda, and Angola are all plagued by acute internal or external conflicts, none of which features AIDS as even a supporting actor…

If everything is a national security problem, then nothing is. A sensible political discourse about national security priorities and funding is arrested. When genuine dangers appear, the public may yawn, as if hearing the boy who shouted "wolf" too often. (Fein 2000: para. 4)

Conservative columnist William F. Buckley Jr. argued that linking HIV/AIDS and national security was "rhetorical opportunism" that impaired analytical scrutiny of real security threats (Buckley 2000: para. 5). Similarly, David Sanger (2000: para. 4), a *New York Times* White House correspondent, asked:

> Just when does a big problem turn into a national security threat?… It is hard to tell. As the Clinton presidency winds down, the definition of national security threats has gotten ever fuzzier. Even some senior members of the administration worry privately that the White House regularly overplays its hand and should reserve the national security argument for events tightly linked to the prospect of the United States becoming involved in conflict. "There's a significant risk of crying wolf," one of the president's top security advisers concedes. "This isn't Sputnik," he added, in another allusion to the Eisenhower years, when appeals for education funds could be based on fears that the Russians were well ahead in the race to build the first I.C.B.M.'s.
>
> Clearly there is a strong moral argument for helping the destitute ravaged by AIDS, in Africa or elsewhere. And no doubt the disease could lead to political instability. But so can poverty, and the 1.3 billion people who live on less than a dollar a day trigger meetings at the World Bank these days, not in the Situation Room.
>
> Advisers to Mr. Bush, eager to portray the current occupants of the White House as long on butter and short on guns, carry the argument one step further: by making the list of security threats too long, they argue, the Clinton administration risks taking its eye off more imminent threats. Or as Paul Wolfowitz, dean of the school of Advanced International Studies at Johns Hopkins University and one of those advisers, wrote recently, AIDS in Africa and the environment are serious problems, but calling them national security threats carries 'the implication that conventional security is no longer something we need to worry much about.'

Ken Bernard believes that the critical responses to Gellman's *Washington Post* piece share a lack of understanding of the new post-Cold War security threats, including

diseases, which the U.S. now faces. After Gellman's article, "several people came out saying, poppycock…There was this big pushback. It was more pushback than was reasonable. It was like, me thinks thou protests too much. Why is it that this bothers you so much? And it's because they're much more comfortable with traditional security" (Bernard Interview).

While there was resistance to this securitization of HIV/AIDS, emergency measures were adopted in the wake of the Estimate and its coverage in the press. U.S. funding for global AIDS was increased to US$450 million for 2001, a three-fold increase since 1999 (Behrman 2004). In addition, the Clinton Administration appointed the first U.S. special envoy for HIV/AIDS. These measures had limited impact because they were implemented very close to end of its term in office, but they demonstrate the successful securitization of HIV/AIDS that resulted from the publication of NIE 99-17 and the resulting public discussion of the nexus.

5.5.1 Discussion

The creation, publication and declassification of NIE 99-17 was a major event in the HIV/AIDS – national security nexus. More than any other single document, NIE 99-17 both defined the links between HIV/AIDS and U.S. national security and brought those linkages to the attention of top-tier policymakers in the U.S. and abroad. Based in the communitarian perspective of national security, the Estimate presented data and outlined the ways in which infectious diseases could threaten U.S. and global security. However the publication of the Estimate alone did not serve to securitize the pandemic in the U.S. In fact, the Estimate scrupulously avoided the argument that HIV/AIDS was a direct national security threat to the U.S. because the authors felt the U.S. intelligence community would not agree upon such a statement. It was only when Gellman's (2000b) article appeared in *Washington Post,* provocatively entitled "AIDS is declared threat to security: White House fears epidemic could destabilize world," that the Clinton Administration publicly embraced the argument that the pandemic was a threat to U.S. national security. While the creation of NIE 99-17 and increasing attention to the global pandemic would have ensured an increase in political attention to HIV/AIDS, it seems to have been a newspaper article that led the U.S. government to adopt the position that the pandemic was a threat to national security and securitize HIV/AIDS.

This case of securitization was informed by data produced by global health actors, primarily UNAIDS estimates of the global pandemic and on prevalence among armed forces, and Piot and the IOM's arguments on the threat emerging diseases, and HIV/AIDS in particular, posed to the U.S. interests. However, traditional public health actors played little role in the production of NIE 99-17 or the subsequent political debate that followed. In the end, despite policy space opened by the collapse of the Soviet Union and accelerating globalization, UNAIDS evidence, UNAIDS, IOM and NIC arguments that HIV/AIDS threatened U.S. national security interests, and the efforts of people within the U.S. intelligence community to raise the profile of the pandemic, it was a strongly titled newspaper article that finally succeeded in creating the political pressure necessary to securitize HIV/AIDS in the U.S. Gellman's article forced the Clinton Administration to choose between backing the designation of HIV/AIDS as a threat to U.S. national security, or downplaying the importance of the pandemic at a time when the Administration was trying to emphasize its action against the disease for political reasons. This thesis argues that the securitization of HIV/AIDS in the U.S. was an intensely political process, in which the Clinton Administration and other actors involved in the securitizing move were influenced by these ulterior political motivations and considerations.

Bernard played the pivotal role in gaining momentum for the Estimate and inserting the national security implications of HIV/AIDS into the policy process. Bernard has a public health background, but it was his strategic understanding of the culture and operations of U.S. national security enabled him, (in contrast with Sandra Thurman,) to successfully introduce HIV/AIDS onto the U.S. national intelligence agenda. One of Bernard's self-described main goals was to link infectious diseases with U.S. national security to attract greater funding and political attention to global health. This is a clear example of the supplicant model, where public health frames issues as threats to national security seeking to benefit from the political power and resources of the security community. In this case, the supplicant model was successful in linking HIV/AIDS to national security interests and generating increased political attention. However the hazards of the supplicant model for public health were also clearly apparent. In framing HIV/AIDS as a national security threat, the supplicant model resulted in an Estimate focused on U.S. strategic interests rather than efforts to alleviate the human suffering

caused by HIV/AIDS. Elbe (2006b) clearly outlined this shift from a humanitarian to national security framework as one of the risks of securitization.

It should also be noted that there was independent security community interest in addressing infectious diseases and HIV/AIDS. While there was also resistance from within the security community to studying public health issues, the security community acted with independent interest in infectious diseases in a way that is not fully accounted for by the models of engagement. Finally, Fidler's remediation model is highly relevant here in describing the factors behind health's rise into high politics. The political attention and funding that resulted from the NIE 99-17 were largely due to the potential impact of infectious diseases on U.S. strategic interests. It was, as the title of the Estimate suggests, *The Global Infectious Disease Threat and Its Implications for the United States* that drove HIV/AIDS on the U.S. national security agenda and high political status.

5.6 The United Nations Security Council, HIV/AIDS and Resolution 1308

Occurring concurrently in 1999 was planning for the first UNSC meeting HIV/AIDS. The UNSC had never met to discuss HIV/AIDS before, in fact, the Security Council had never met to discuss any health issue in the over 4,000 meetings held since its founding. The UNSC's meetings on HIV/AIDS, and resulting Resolution 1308, would securitize the pandemic at the central institution of international security and contribute to the rising political attention to HIV/AIDS. Looking back upon the meeting and resultant resolution from 2005, Executive Director of UNAIDS Peter Piot said:

> When we look at the history of the fight against AIDS, there is no doubt that resolution 1308 (2000) is a milestone in the response to the epidemic. By underscoring the fact that the spread of HIV/AIDS, if unchecked, may pose a risk to stability and security, the Security Council, through resolution 1308 has transformed how the world views AIDS. (United Nations Security Council 2005: 5)

Yet this case of securitization and resulting transformation of the treatment of HIV/AIDS, as in the U.S. securitization of HIV/AIDS, was the result of an intensely political process which was strongly influenced by factors outside of the

field of global health. Far from being a clear recognition of the importance of HIV/AIDS to international security, as Piot suggests above, the securitization of HIV/AIDS at the UNSC was resisted from the beginning.

5.6.1 Planning and Reasons for the UNSC meetings on HIV/AIDS

The idea to hold a UNSC meeting on HIV/AIDS was Richard Holbrooke's, then U.S. Ambassador to the UN. Holbrooke is known as an ambitious diplomat who was appointed as Ambassador to the UN after negotiating the Dayton Peace Agreements that ended the war in Bosnia and Herzegovina.[19] In December 1999, Holbrooke was touring southern Africa with Russ Feingold, Chairman of the U.S. Senate Foreign Relations Committee's Subcommittee on Africa. Feingold describes Holbrooke as "one of the leading diplomats of the twentieth century, and he had never been to southern Africa" (Sternberg 2002). Holbrooke scheduled visits related to HIV/AIDS in each of the ten countries he visited. These he described as "horror shows" which had a strong effect on him (Behrman 2004). At one visit to an AIDS orphanage in Lusaka, Zambia, Holbrooke saw

> several hundred children, clothed in rags, gather at a former bus depot for a needed meal and free schooling. The American visitors were charmed by the children, their singing and dancing — and horrified to learn that at the end of the day they would be turned out into the streets to sleep and forage for dinner, sometimes trading sex for warmth or food. (Sternberg 2002: para. 17)

On the flight home after this visit, Holbrooke telephoned UN Secretary General Kofi Annan. The U.S. was scheduled to have the rotating presidency of the first UNSC meeting of the new millennium. As the U.S. ambassador, Holbrooke could influence the agenda. Feingold describes the conversation: "It was at this point… that he just started doing what Dick Holbrooke does. I watched him call up the Secretary-General and tell him we have to have a Security Council meeting on AIDS. The Secretary General said, 'We can't do that. AIDS isn't a security issue'" (Sternberg 2002: 18). Annan's response reflected how novel this conceptualization of HIV/AIDS was in 1999, even to persons

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[19] One confidential interviewee told the following joke to illustrate Holbrooke's ambition: "What was the most dangerous place in Bosnia during the War? Between Richard Holbrooke and the CNN camera."

knowledgeable about the pandemic. Nevertheless, Holbrooke wanted to hold a "Month on Africa" with a special focus on HIV/AIDS.

This analysis argues that Holbrooke had at least four reasons for this. First, arising from his personal experiences, Holbrooke seemed to be genuinely concerned about the HIV/AIDS pandemic and wanted to initiate more action to fight the disease.

Second and similar to Bernard, Holbrooke felt that strategically calling the pandemic a threat to security would greatly increase the political profile of HIV/AIDS. Addressing the disease at the UNSC was an obvious choice for Holbrooke, because it was the most important and visible venue he had access to. But getting the UNSC to address HIV/AIDS was also important because he felt it could transform the treatment of the epidemic by policymakers from a low-level health issue, to an issue of international security addressed at the highest levels of government. Eddy, Holbrook's deputy at the UN, recalls why Holbrooke wanted the UNSC to address HIV/AIDS: "He believed that if you don't do it in the Security Council, it won't get done – it's the only [UN] body that gets things done" (Eddy Interview). To Behrman (2002: 71-72), Eddy recalls Holbrooke saying: "If we get AIDS in the Security Council that will begin to break down the stigma, that will begin to get more money to the issue, that will bring more leadership to the issue, and that will lead to a solution....We have to get it into the Security Council for it to matter." In short, Holbrooke thought he could transform the way the world addressed HIV/AIDS by getting the UNSC to securitize the pandemic.

Holbrooke's third and critical reason for holding a "Month on Africa" was the longstanding issue of unpaid American assessed contributions to the UN. The U.S. owed the UN almost a billion dollars, and the primary mission of the U.S. delegation to the UN was to reduce these dues (Eddy Interview 2004; Nossel 2001). Nossel (2001: 96), who also served on Holbrook's staff at the UN, summarized this challenge as convincing "188 other countries to fork over more [money] so that – during the longest period of prosperity in its history – the world's richest country could pay less." U.S. contributions to the UN were a longstanding thorn in the side of U.S.-UN relations and were, in Holbrooke's own words, his "number one issue" (Wallis 2001). To achieve this reform, Holbrooke needed votes and political capital. By holding a "Month on Africa" at the

UNSC, Holbrooke hoped to gain the gratitude of African states, which he could then ask for their votes to reduce U.S. dues to the UN. Eddy (Interview) recalls:

> Part of [Holbrooke's] motivation to do all the HIV work and counseling, I'm convinced that's because Africa has a lot of influence and votes in the UN and our number one objective was not HIV. Our number one objective internally was to get U.S. assessments reduced. We felt we were paying too much and in order to pay less, we needed a lot of countries to vote.

The UNSC's "Month on Africa" and meetings on HIV/AIDS were part of a much larger and ultimately successful foreign policy gambit by the U.S. to win votes to reduce U.S. dues to the UN.

Holbrooke's final reason for focusing the UNSC on the HIV/AIDS epidemic appears to have been for personal political gain. The background to Holbrooke's calculations was that Gore was in a tight race for the U.S. presidency, and had been heckled by AIDS activists during his campaign. As previously discussed, Gore's announcement of his presidential campaign was marred by AIDS protestors shouting "Gore is killing Africans, AIDS drugs now!" (Richwine 1999: para. 10) As before, these protests had pushed Gore and the Clinton Administration to further action on HIV/AIDS in an attempt to defuse the issue.

Holbrooke was a rising Democratic diplomat, and on the shortlist to become Secretary of State in the event of a Gore win. Weeks before the UNSC session on HIV/AIDS, Holbrooke called Leon Fuerth (Gore's national security advisor) and asked if Gore would chair the UNSC session on HIV/AIDS. Holbrooke recalls that "Leon got it immediately and made it happen" (Behrman 2004: 163). Behrman (2004: 163-164) describes Holbrooke's political calculus in staging the meeting on HIV/AIDS at the UNSC and inviting Gore: "In one masterful stroke, Holbrooke managed to confer prestige on his event, and also alleviate a debilitating political liability for the VP, thereby tightening his already very strong relationship with Gore, and cementing his standing as the front-runner to become Gore's secretary of state." In short, Holbrooke sought to provide a unique platform for Gore to cement his national security qualifications and address HIV/AIDS in hopes that this would improve his and Gore's political fortunes.

Interestingly, one consideration that did not seem to feature in Holbrooke's deliberations was strong evidence that HIV/AIDS could impact national and international security. As Annan's response to Holbrooke's call from Zambia in 1999 showed, HIV/AIDS was not yet considered a security issue. As described above, at this time, the classified NIE 99-17 report discussed the national and international security implications of infectious disease, but did not describe the HIV/AIDS epidemic explicitly as a threat to U.S. national security. Nonetheless, Holbrooke felt that his argument that HIV/AIDS could threaten national and international security was strong enough and he was famously "impervious to setbacks" (Sternberg 2002: 24).

Holbroooke assigned Eddy, who had run the PRD in 1995, to be the lead for his plan to address HIV/AIDS at the UNSC. Eddy recalls Holbrooke arguing that HIV/AIDS "is a massive destabilizing force to nations… and it is a massive threat to peace and security, period. No nuances necessary" (Eddy Interview). But like Holbrooke, Eddy ran into resistance from the start. His first phone call was to Bill Wood, U.S. Principal Deputy Assistant Secretary of State for International Organization Affairs and UN expert. Wood was clear: "He said, RP [Eddy], you know, very pedantically, the charter of the UN Security Council says a 'threat to peace and security,' and that's not HIV, end of story. This just doesn't happen" (Eddy Interview). Wood was referencing Article 34 of the UN Charter, which outlines the responsibility of the UNSC:

> The Security Council may investigate any dispute, or any situation which might lead to international friction or give rise to a dispute, in order to determine whether the continuance of the dispute or situation is likely to endanger the maintenance of international peace and security. (United Nations 1945: Article 34)

Anything that was not a threat to the "maintenance of international peace and security" was outside the purview of the UNSC. It seemed like a literal reading of the UN Charter would prevent the UNSC from addressing HIV/AIDS. However, Holbrooke seemed to embrace Buzan et al.'s (1998) view of security as an intersubjective understanding of what constitutes an existential threat, and is therefore subject to change though the process of securitization. In other words, HIV/AIDS could become an accepted threat to security if a credible security organization like the UNSC says it is. Eddy remembers his and Holbrooke's argument at the time:

> It's like, this is a security issue because we say it is. It's not like he needs some sort of academic, stereotypical foreign policy officer to tell you, 'Well, technically it's not a threat to peace and security and here's why and because of that technicality…' If the Security Council says it is, it is. If the Council votes that the emergence of super large slurpees[20] is a threat to peace and security, then it is." (Eddy Interview)

To try to gather more support for addressing HIV/AIDS at the UNSC, Eddy invited all interested countries and military attachés at the UN to a discussion of the issue. He hoped this would "be a great way for me to create a bunch of momentum that will allow me to get more progress in the [Security] Council" (Eddy Interview). However Eddy underestimated the stigma associated with HIV/AIDS, and the difference between discussing HIV/AIDS in private and an open UN meeting. Eddy tells the story:

> So we walked into one of the huge conference rooms at the UN and every seat is full and it's like, what's going on here? So, there's 183 countries in the UN at that point, there's 15 that are on the Council and they're still there. Everyone's got one or two people in this room and I'm like, oh boy…I gave my statement on here's what we're trying to do and here's what's going on. There are a number of African Military Attachés who I had been working with, particularly the one from Nigeria, who was a General, he was a real alpha male African General, who would look you in the eye, squeeze your hand, quite a presence. And he would tell me, 'look, this is a big deal.' And the different Attachés would say 'RP, this is a big deal, you've got to fix this, this is not just a peacekeeping issue, but it's just the issue that HIV really matters and my military's getting ripped up, the country's getting ripped up…' there's no two ways about it, they were supportive of the issue. But once we got in the room, they weren't. They couldn't appear to be… The basic punch line from these guys was, 'who do you think you are? You've just said in your statement, you're saying to the Council, that our nations are under some sort of siege or are unstable because of this virus, you know, that's the worst kind of hegemony, it the worst kind of paternalism,' - all this crap. They have these buzzwords in the UN that are sort of a 'get out of jail free' card. Anytime you can blame someone for paternalism, you win. Anyone you can blame for not paying their bills, you win. So you can imagine the U.S. gets it on both sides. And that's what they were basically saying – this is a paternalistic point of view; we're doing very well, thank you very much. Our country's not falling into a shitter, we do not have a lack of military control. And, of course, they had to say that. You're the Nigerian Military Attaché, you can't sit in a room in front of every nation, you can when you're having a beer with RP, but you can't in front of 183 other countries, so it was really brutal. (Eddy Interview)

When asked about why the African military attachés would not discuss the issue of HIV/AIDS and national security, Eddy replies:

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[20] Super large slurpees are a North American partially frozen beverage that come in a variety of fruit and soda flavors. The UK equivalent is a Slush Puppie.

> It was just face. Well, at the end of the day, they did it because they wanted to cable back to Kinshasa or whatever country capital it was and say, 'look this is what happened, I stood up and said we're doing fine.' And the alternative would be to cable back and say, 'yeah, this guy from the United States got up there and said that there's a large number of sub-Saharan African countries that are in grave danger and I didn't do anything or agree with them' – they can't do that. And this is back when a lot of the thinking was still, kind of, perverted around the idea about like, tourism dollars are going to go down if people understand HIV/AIDS is a big issue here, or, you know, it was a lot of denial, a lot of wrong thinking. (Eddy Interview)

Chastened by his failure, Eddy "went back and I talked to Holbrooke, and I said, 'We just got pummeled' and he said, 'well… so what, it's not up to them'" (Eddy Interview). By this, Holbrooke meant that only the permanent members of the UNSC, and not all the member states of the UN, decide what topics to address. Yet the U.S. still faced opposition from three of the five permanent members of the UNSC: France, China and Russia (Schoofs 2000). Only the UK tepidly supported U.S. efforts to address HIV/AIDS at the Security Council from the beginning (Eddy Interview).

To overcome this resistance, the U.S. had to water down its proposed resolution on HIV/AIDS and draw a clearer link between the pandemic and the responsibilities of the UNSC. Eddy (Interview) recalls:

> Initially I said, I'm pushing for…straight up and down, AIDS matters. The resolution says it matters and you do all these things about it and it is a threat to peace and security – and it was like, no way – not going to happen. And then I went back and said, 'Okay, what do we do?' The next argument was, okay: it's a threat to the peace and security of Africa and here's why. All these facts, the militaries, and then the Africans said no.
>
> Interviewer: Sounds like they were extremely reluctant.
>
> Yeah, oh absolutely…somewhere I have my edits on the resolution which are fascinating because it starts like: HIV is a clear and present security danger to the future of the world and we will have to deal with it and every nation has to do the following things and, you know, absolutely true. And at the end of it we're like, you know: noted that some people sometimes think, when they're not really paying attention, that HIV might be an issue. The language just got so watered down.

The U.S. delegation was having serious difficulty obtaining agreement on addressing HIV/AIDS at the UNSC. However, the U.S. delegation finally found the issue that

linked the HIV/AIDS epidemic to the responsibility to the UNSC: peacekeeping forces. As previously discussed, studies had linked UN peacekeepers to the rapid growth of the HIV/AIDS epidemic in Cambodia and in Sierra Leone. Because UN peacekeeping missions are authorized by the UNSC, the behavior of peacekeepers on UN missions and their role in spreading disease could be viewed as a responsibility of the UNSC. This linked the pandemic to the UNSC's responsibility for the "maintenance of international peace and security," and gave Holbrooke and the U.S. delegation the necessary rationale for addressing HIV/AIDS at the UNSC.

Holbrooke repeated this link between HIV and peacekeeping constantly in the lead up to the UNSC meetings and during 2000. He told the UNSC, "We must avoid the supreme irony which would occur if, in the course of trying to prevent conflicts, United Nations peacekeepers spread a disease even more deadly than the conflicts themselves" (United Nations Security Council 2000b: 6). This wording placed HIV/AIDS solidly within the purview of the UNSC and greatly aided in gaining the support of the five permanent members of the UNSC, although Russia still opposed the session on HIV/AIDS and would refuse to speak. Holbrooke described this as "an act of classic Russian heavy-handedness… they opposed it, would go along with it because everyone else wanted it, but – and this had us all in the aisles laughing – they would refuse to speak. To which I was tempted to say, 'Do you promise?'" (Schoofs 2000: para. 9). In short, this link between HIV/AIDS and peacekeepers, which would be a focal point of the UNSC Resolution 1308, was a political convenience used to gain acceptance for HIV/AIDS to be addressed by the UNSC.

5.6.2 The 4087th Meeting of the UNSC, 10 January 2000

On 10 January 2000, the first UNSC meeting of the new millennium convened to discuss the HIV/AIDS epidemic. In addition to being the first time a health issue had ever been addressed at the UNSC, the meeting also held a number of other 'firsts' for the people who addressed the UNSC. Peter Piot, Mark Malloch Brown, James Wolfensohn and David Satcher, the heads of UNAIDS, UNDP, the World Bank, and the U.S. Surgeon General respectively, all made presentations to the UNSC. It was the first time anyone from UNAIDS, UNDP, the World Bank or the U.S. Surgeon General had ever addressed the UNSC. Public health and development organizations, even those that are part of the

UN system such as UNAIDS and UNDP, had never been invited to the UNSC because public health and development were generally deemed to be irrelevant to the high politics of security. James Wolfensohn explored this gap between the development and security communities in his comments, challenging the UNSC to recognize the work of international development as also contributing to international peace and security. Wolfensohn stated:

> I believe it is the first time that a President of the World Bank has ever attended a meeting of this body… I do not know a lot about the workings of the Security Council. I have images of you ladies and gentlemen meeting at midnight, having very important meetings, using high diplomacy and power politics to solve very important and pressing issues that face us: issues of conflict, issues of chemical weapons, issues of nuclear challenges and issues of security. The funny thing is that in Washington we think that what we do every day in terms of addressing the questions of development are actions which lead to the very same issue of security and peace (United Nations Security Council 2000a: 8).

The UNSC meeting on HIV/AIDS was breaking new ground, not only by considering development and public health pathways to security, but by discussing a highly stigmatized sexually transmitted disease openly and at the highest levels of international relations. Holbrooke recalled that British Ambassador to the UN Sir Jeremy Greenstock passed him a note during the first session on HIV/AIDS that said: "I daresay this is the first time the word 'condoms' has been used in the Security Council" (Holbrooke 2000a). Because of the subject matter and persons invited, the meeting of the UNSC to discuss HIV/AIDS was an unprecedented linkage of global health and international security.

Two main themes emerged from the discussion at this meeting. First, advocates of human security used the meeting to call for broadening the purview of the UNSC beyond national and international security. In his opening address, Gore argued that by addressing HIV/AIDS, the UNSC was beginning to recognize the need to embrace a broader definition of security to include non-traditional security threats and human security issues. Gore states that HIV/AIDS "sets a precedent for Security Council concern and action on a broader security agenda…We must understand that the old conception of global security – with its focus almost exclusively on armies, ideologies and geopolitics – has to be enlarged" (United Nations Security Council 2000a: 2). Peter Piot seconds this notion of broadening the UNSC's purview beyond state security by arguing that HIV/AIDS in Africa had become "an issue of human security in all senses

of the word" (United Nations Security Council 2000a: 11). Mr. Chowdhury, Ambassador to the UN from Bangladesh, concluded his remarks by saying "We look forward to discussing other non-military threats to peace and security, including such overriding global priorities as poverty, environmental degradation, drugs, organized crime and so on. The world has changed, and the time has come to extend the concept of security as well" (United Nations Security Council 2000a: 17). Michel Duval, Ambassador to the UN from Canada, a major proponent of the concept of human security, reminded the UNSC that "Canada has consistently argued that the Council must broaden its definition of security to include non-traditional threats, especially those which affect human security" (United Nations Security Council 2000a: 4). These arguments illustrate how proponents sought to use the discussion of HIV/AIDS as a "Trojan Horse" to introduce human security issues into the work of the UNSC. However, it is important to recall that the vast human security implications of the epidemic were originally insufficient to allow debate on HIV/AIDS at the UNSC. Only when the epidemic was linked specifically to peacekeepers, and thus directly to the formal responsibilities of the UNSC, was the session approved by the permanent members of the UNSC.

The second theme to the discussions at the UNSC meeting opposed UNSC involvement in human security issues, and argued for a limited UNSC role in addressing the pandemic. UN Secretary-General Kofi Annan argued for a narrowly defined role in addressing HIV/AIDS through the UNSC's traditional role in preventing and resolving conflicts. He states that the UNSC's role "must be to prevent conflict from contributing to the spread of AIDS and from impeding the efforts that other partners are making to control it" (United Nations Security Council 2000a: 5). Dr. Amathila, Namibian Ambassador to the United Nations, echoes Annan's argument but pushes further against UNSC involvement with HIV/AIDS. She argues that:

> While the issue of HIV/AIDS is not under the purview of the Security Council, the primary responsibility of the Security Council in the maintenance of international peace and security will contribute in a major way to minimizing the impact of HIV/AIDS in Africa. By effectively addressing conflict situations in Africa, the Security Council will no doubt assist African Governments in devoting more resources to tackling social and economic problems. (United Nations Security Council 2000a: 13-14)

Ambassadors from Canada, Ukraine and Jamaica also make this same point, arguing that the UNSC will aid the fight against HIV/AIDS through its existing role in preventing and resolving conflict in Africa and other regions. The discomfort with addressing HIV/AIDS at the UNSC expressed in these comments has a likely source in the politics of the UN, where traditionally humanitarian issues such as HIV/AIDS are addressed by the Economic and Social Council or the General Assembly. States that are not permanent members of the UNSC may wish to maintain their ability to address humanitarian issues at either of these venues, which are more representative and provide greater leverage for smaller states in the policymaking process.

5.6.3 UNSC Resolution 1308

On 17 July 2000, the UNSC reconvened to discuss and vote on its first resolution on HIV/AIDS. Resolution 1308 recognizes that the HIV/AIDS epidemic "if unchecked, may pose a risk to stability and security..." (United Nations Security Council 2000c: 2). Despite this stated concern with the broad security implications of the pandemic, Resolution 1308 narrowly applies only to UN peacekeeping missions. This major limitation reflects the difficulties of the U.S. delegation in gaining approval to address HIV/AIDS at the UNSC. In the language of the UNSC, the Resolution "*Expresses concern* at the potential damaging impact of HIV/AIDS on the health of international peacekeeping personnel..." (United Nations Security Council 2000c: 2). The Resolution then encourages all UN member states to work with UNAIDS to develop strategies for HIV/AIDS "education, prevention, voluntary and confidential testing and counseling, and treatment" of peacekeeping personnel (United Nations Security Council 2000c: 2). Finally, the Resolution requests pre-deployment and ongoing HIV/AIDS training for peacekeeping personnel. Bazergan (2004: 1) writes that the "diluted and formulaic wording [of Resolution 1308] hints at unease among many member states regarding the extent to which they are willing to engage with the issue of HIV/AIDS and peacekeeping."

Arguments against substantial UNSC involvement also emerge from the 17 July 2000 meeting on HIV/AIDS and peacekeeping operations. Comments by Ambassadors Greenstock and Holbrooke reveal a behind–the-scenes critique of UNSC involvement with the issue of HIV/AIDS. The critique seems to follow two lines of thought. In the

first, the UNSC is seen to have usurped the power and responsibility of the UN General Assembly (UNGA) and the UN Economic and Social Council (ECOSOC) by appropriating the issue of HIV/AIDS. Ambassador Greenstock condemns with light praise the U.S. efforts to bring HIV/AIDS to the Security Council, and argues that the disease is really the responsibility of the UNGA and ECOSOC:

> We welcome the initiatives that have been taken in the Security Council this year and pay tribute to the leadership of the United States... But the Council does not have the main responsibility in tackling the HIV/AIDS pandemic. All of our delegations must work together in the General Assembly and in the Economic and Social Council to take concrete steps that will make a difference. (United Nations Security Council 2000b: 10)

Bazergan (Interview) supports the conclusion that the UNSC meetings on HIV/AIDS raised tensions among the UNSC, ECOSOC and the UNGA. She says that the "remit of 1308 was tight to stay within the Security Council's mandate." This was to prevent the UNSC from "stepping on the toes of the General Assembly" (Bazergan Interview).

In the second critique, the UNSC is seen to inappropriately infringe on national sovereignty by addressing the issue of HIV/AIDS and the disease among troops in countries donating peacekeepers. By 2000, the UN no longer honored the concept of national sovereignty to the extent that "what went on within states was no concern of any outsider" (Taylor 2001: 335). However, the balance between maintaining international order by respecting national sovereignty and upholding universal human rights by addressing issues within states was still important to the UNSC's operation, with respect of national sovereignty the rule and interventions on behalf of individuals and human rights the exception (Taylor 2001). Sovereignty and non-intervention in the internal affairs of countries were still "cardinal rules" of the international system and critical to the operation of the UN system (Wheeler 2000: 11). By addressing HIV/AIDS among peacekeeping forces, the UNSC seemed to be challenging these rules. Holbrooke seeks to answer both the ECOSOC/GA and sovereignty critiques in his opening statement at the July 17, 2000 meeting:

> I want to say at the outset to my friends who are concerned about the issue of sovereignty and about what the Security Council should and should not do, that this draft resolution in no way infringes on the sovereignty or authority of countries... In no way do we undercut the work of our equally important Economic and Social Council; rather we reinforce it... To be sure, the Security

> Council and the United Nations cannot require Member States to force involuntary testing of their troops. This would violate the United Nations respect for national sovereignty, but we recommend... and urge that all countries increase their testing, especially of those troops that will be send overseas. (United Nations Security Council 2000b: 5)

Holbrooke's statement acknowledges the two arguments against addressing HIV/AIDS at the UNSC, and seeks to reassure member states before the vote on Resolution 1308.

A separate critical issue that arose at the 17 July 2000 meeting was the beginning of a critical examination of how HIV/AIDS may impact on national security and state stability. During the 10 January 2000 meeting, Al Gore outlined how the epidemic may threaten international peace and security. He stated:

> By overwhelming the continent's health services, by creating millions of orphans and by decimating health workers and teachers, AIDS is causing social and economic crises, which in turn threaten political stability. It also threatens good governance through high death rates among the elites, both public and private. In already unstable societies, this cocktail of disasters is a sure recipe for more conflict and conflict in turn provides fertile ground for further infections. (United Nations Security Council 2000a: 5)

At the 17 July 2000 meeting, Mr. Yusuf Juwayeyi, Malawi's Ambassador to the UN, questions this linkage between HIV/AIDS, political instability and conflict though examples of highly-affected countries. Mr. Juwayeyiargues that "the most severely affected countries – Malawi, Botswana, Zimbabwe and South Africa – have been stable countries. There has not been any conflict in these countries for the past decade or two – and, for some of these countries, since their independence" (United Nations Security Council 2000b: 23). These comments mark the beginning of resistance to the linkage of HIV/AIDS and security based on the absence of evidence on this specific causal connection.

5.6.4 Discussion

Given the strong barriers to addressing HIV/AIDS at the UNSC, the occurrence of these meetings is all the more remarkable. This thesis finds that barriers to securitization at the UNSC were strong and took at least four forms. First, the inertia of precedent could have prevented the UNSC and its members from departing from tradition and addressing

a health issue for the first time. Second, internal turf wars among UN bodies led to opposition to addressing the disease in the UNSC, instead of the other organizations that address health-related issues. Third, political opposition to calling HIV/AIDS a national security threat, both in African countries and globally, due to the possible intrusion on national sovereignty that Resolution 1308 posed, proved a major hurdle to holding the UNSC meetings on HIV/AIDS. Finally, there was slim evidence at that time that HIV/AIDS actually posed an explicit threat to national security and political stability. Holbrooke and the U.S. delegation overcame these barriers by focusing on the link between HIV/AIDS and peacekeepers, even though they would later admit that this link was "overblown" because of the very small number of peacekeepers who had been infected with HIV/AIDS while on missions (Eddy Interview).

This thesis also finds that the motivations of Holbrooke and the U.S. delegation to the UN for seeking to securitize HIV/AIDS were multifaceted and not entirely related to fighting the pandemic. Holbrooke's "number one issue" was reducing U.S. dues to the UN, and his focus on HIV/AIDS was partially a means to win African votes for this cause (Wallis 2001: para. 8). In addition to Holbrooke's personal commitment to fighting the pandemic, his political ambitions to become Al Gore's Secretary of State were also factors in his efforts to securitize the pandemic. Despite serious resistance to addressing HIV/AIDS at the UNSC, the U.S. delegation's mixed motivations for securitizing the pandemic, and being forced to rely on an "overblown" linkage to obtain agreement on addressing the pandemic at the UNSC, the U.S. delegation successfully securitized HIV/AIDS at the most important forum of international security.

5.7 Conclusions

This chapter has found that the NIC 99-17 report and subsequent debate, and the UNSC meetings on HIV/AIDS, successfully securitized HIV/AIDS in the U.S. and at the global level. However in both the U.S. intelligence community and the UNSC, securitization was far from clear cut. High-level political interests, unrelated to global health or HIV/AIDS, played a significant role in crafting both events. Specifically, the UNSC meetings on HIV/AIDS were championed by Holbrooke for a number of additional reasons unrelated to fighting the disease, including reducing U.S. assessed contributions to the UN and his own political ambitions. Furthermore, the UNSC meetings on

HIV/AIDS were marked by major disagreements about whether the UNSC should address the disease, whether HIV/AIDS was a threat to national or human security, and what action if any the UNSC should take to address HIV/AIDS. Similarly, NIC 99-17 did not actually argue that HIV/AIDS was a direct national security threat to the U.S. HIV/AIDS was only discussed as a threat to U.S. security after the publication of a *Washington Post* article in 2000 which put pressure on the Clinton administration to embrace its designation as a security threat. In both cases, securitization of HIV/AIDS was greatly aided by fortuitous political situations and political agendas unrelated to global health.

It is argued that two individuals, Ken Bernard and Richard Holbrooke, played critical roles in securitizing HIV/AIDS in the U.S. and at the UNSC. Without Bernard's ability to successfully frame infectious diseases as threats to U.S. national security, it is doubtful that NIE 99-17 would have been produced. Without Holbrooke's idea to address HIV/AIDS at the UNSC, and how doing so could aid other policy objectives, the UNSC meetings on HIV/AIDS would not have occurred. The UNSC meetings on HIV/AIDS were entirely the product of Holbrooke and his staff's efforts. Thus the securitization of HIV/AIDS and resulting political "revolution" was also highly dependent on the actions of these two key individuals (Fidler 2004: 45).

The critical importance of the broader political context and events, and personal advocacy by such individuals, only one of whom has direct public health experience, to the securitization of HIV/AIDS raises questions about the public health community's capacity to influence the security policy agenda. Global health actors played only a limited role in the actual events of securitizing the pandemic, or in motivating specific action by the U.S. intelligence community or at the UNSC. This analysis finds that the global health community had little direct influence over securitization, and thus the resulting transformation of the political status of the pandemic.

In the 1990s, institutional actors from within the global health community, notably the IOM and UNAIDS, played an important role in creating a conceptual framework and evidence base that linked HIV/AIDS to national security interests. In particular, the IOM promoted the view that globalization was creating a highly interconnected world where national borders would no longer protect the U.S. from deadly infectious diseases

previously confined to the developing world, and Piot of UNAIDS began to make securitizing arguments in 1999. This use of the supplicant model successfully laid the groundwork for the later securitization of HIV/AIDS by other actors. Both Bernard and Holbrooke also successfully used the supplicant model to gain attention to the disease by linking it to national security interests.

UNAIDS also contributed to perceptions of HIV/AIDS as a threat to national militaries and UN peacekeepers with its 1998 *AIDS in the Military* report. While UNAIDS did not argue for the securitization of HIV/AIDS at this time, the global epidemiological data and information on HIV/AIDS among armed forces that UNAIDS produced provided a useful evidence base for proponents of securitization. As will be seen in the next chapter, this evidence base would come under greater scrutiny and come to be revised. Before Piot's securitizing moves in 1999, the provision of seemingly reliable statistics about both the pandemic and epidemics among armed forces contributed to arguments for securitization. The independent actor model best describes UNAIDS involvement in securitization before 1999, and thus this model served to indirectly contribute to the securitization of HIV/AIDS.

The common theme through the securitizations of HIV/AIDS in the U.S. and at the UNSC is the relevance of political interests unrelated to HIV/AIDS in shaping events. In both cases, groundwork for securitization was in place, but securitization itself only occurred when outside political interests were aligned with addressing HIV/AIDS as a high political issue. Perhaps the lesson these events hold for global health practitioners is the need, not only to understand national security interests and culture, but the way high-level political interests must also be aligned to succeed in high politics.

In the next chapter, we turn to the emergency measures that resulted from securitization, and examine the diverse consequences of the events described in this chapter.

Chapter 6: The consequences of securitization

As described in Chapter 5, the securitization of HIV/AIDS in the U.S. and at the UNSC around 2000 led to an unprecedented elevation of the political status of HIV/AIDS. Accompanying this new political status was significant new funding to fight the global pandemic. This funding was given in amounts commensurate with the high political status of HIV/AIDS and vastly exceeded previous funding levels. The elevation of political attention and funding for HIV/AIDS is the clearest sign that emergency measures resulted from securitization.

This chapter seeks to trace the consequences of the securitization of HIV/AIDS in both the U.S. and at the UNSC. The first section will examine the rise in funding newly available to fight the pandemic in the wake of securitization. However, while this rise in funding for HIV/AIDS was clear, the direct results of securitization at the UNSC and in the U.S. were less so. The next two sections will examine the results of these securitizations. In the first, the compromises which led to the UNSC meetings on HIV/AIDS would continue to limit the effectiveness of the UN's Department of Peacekeeping Operations (DPKO) actions to address the linkages between peacekeepers and HIV/AIDS. In the second, the Clinton Administration's embrace of HIV/AIDS as a threat to national security would be dismissed by the incoming Bush Administration, only to be embraced a year later after Secretary of State Colin Powell's advocacy for addressing the disease as a national security threat. HIV/AIDS would remain a high political issue in the new Bush Administration, but for a surprising set of political factors in which the national security implications of the disease did not figure prominently. Thus while the rise in political attention and funding in the aftermath of securitization benefited the fight against HIV/AIDS, the direct impacts of securitization at the UN and in the U.S. would prove to be significantly more complex.

As well as providing a hitherto untold history of these events, a number of additional issues are addressed in this chapter including funding for HIV/AIDS, the nature of military HIV/AIDS programs, and the use of scientific data in the nexus. Because of the inclusion of these thematic issues, the structure of this chapter departs from a linear history in its attempt to trace the varied impacts of securitization. The first section shows that funding for HIV/AIDS increased significantly after 2000, with an important impetus for this increase being attributable to securitization. The next two sections continue the

history of events described in Chapter 5 by tracing the implementation of UNSC Resolution 1308, and the evolving U.S. response to HIV/AIDS. This is followed by a brief section addressing the limited degree to which the HIV/AIDS – national security nexus has been accepted outside of the U.S. and UN, and the important American role in promoting this nexus. The chapter concludes with a discussion of the major revision to estimates of HIV prevalence among African armed forces, and what this revision means for the role of scientific data in the HIV/AIDS – national security nexus.

6.1 Impact on the Political Priority and Funding of HIV/AIDS

The UNSC meetings on HIV/AIDS, and declassification of NIE 99-17, marked a turning point in the international framing of, and response to, the disease. It is clear from public statements reviewed, and interviews with policymakers carried out by this research, that these events had a major impact on the political profile of the disease. On 19 January 2001, at the third UNSC meeting on HIV/AIDS, Peter Piot noted specifically that the previous UNSC meetings had a major impact on the political profile of the pandemic:

> The global resolve to tackle AIDS has increased markedly in the six months since the Council's meeting held on 17 July. Many countries have revamped their AIDS plans, have made them more central to decision-making across government and have sought new resources and ways to direct them to the local community level. Many heads of State or Government at the Millennium Summit highlighted AIDS. Initiatives placing HIV in the mainstream of development took place at the G-8 meeting in Okinawa, in the European Commission and among many bilateral donors. Regional efforts have intensified as well, notably, in the Caribbean under the auspices of the Caribbean Community, with the commitment of the Association of South-East Asian Nations to a summit on HIV in South-East Asia and with a summit of the Organization of African Unity coming up... in Nigeria. (United Nations Security Council 2001a: 7)

Elbe (2006b: 121) describes these meetings as "the major international turning point in terms of conceptualizing HIV/AIDS as a security issue" and a "watershed" event. Behrman (2004: 164) writes that the UNSC meetings "helped gain the issue wider press play and prominence with legislators and policy makers" in the U.S. The UNSC meetings on HIV/AIDS, along with the declassification of NIE 99-17 and accompanying public debate, caused an explosion of academic, think tank and press interest in HIV/AIDS and the links between the pandemic and national security. With very few

exceptions, these examinations of the HIV/AIDS – national security nexus were all published after 2000 in the wake of securitization.

One strong indicator of the increased political priority of HIV/AIDS after securitization is the resulting increase in funding provided to fight the pandemic. This funding was provided for "global" or "international" HIV/AIDS, indicating that the funding was not for domestic prevention and treatment, but to fight the pandemic outside the borders of the state providing the funding. Kates and Lief (2006: 2) suggest that "funding from the G7 and other major donors for HIV/AIDS represents the bulk of such international assistance efforts overall, and therefore serves as an important gauge of the response to the epidemic." UNAIDS (2003) analysis of global financing for HIV/AIDS, presented in Figure 9, reveals two significant observations. First, total international funding for HIV/AIDS was extremely low before 1999. Annual funding amounted to between US$300-400 million between 1996 and 1999, and was equal to or lower than this amount prior to 1996 (UNAIDS 2003). Second, funding increased dramatically from 2000, and has continued to grow since this date. This increase is consistent across bilateral funding sources, World Bank loans, UN organizations and donations from charitable foundations.

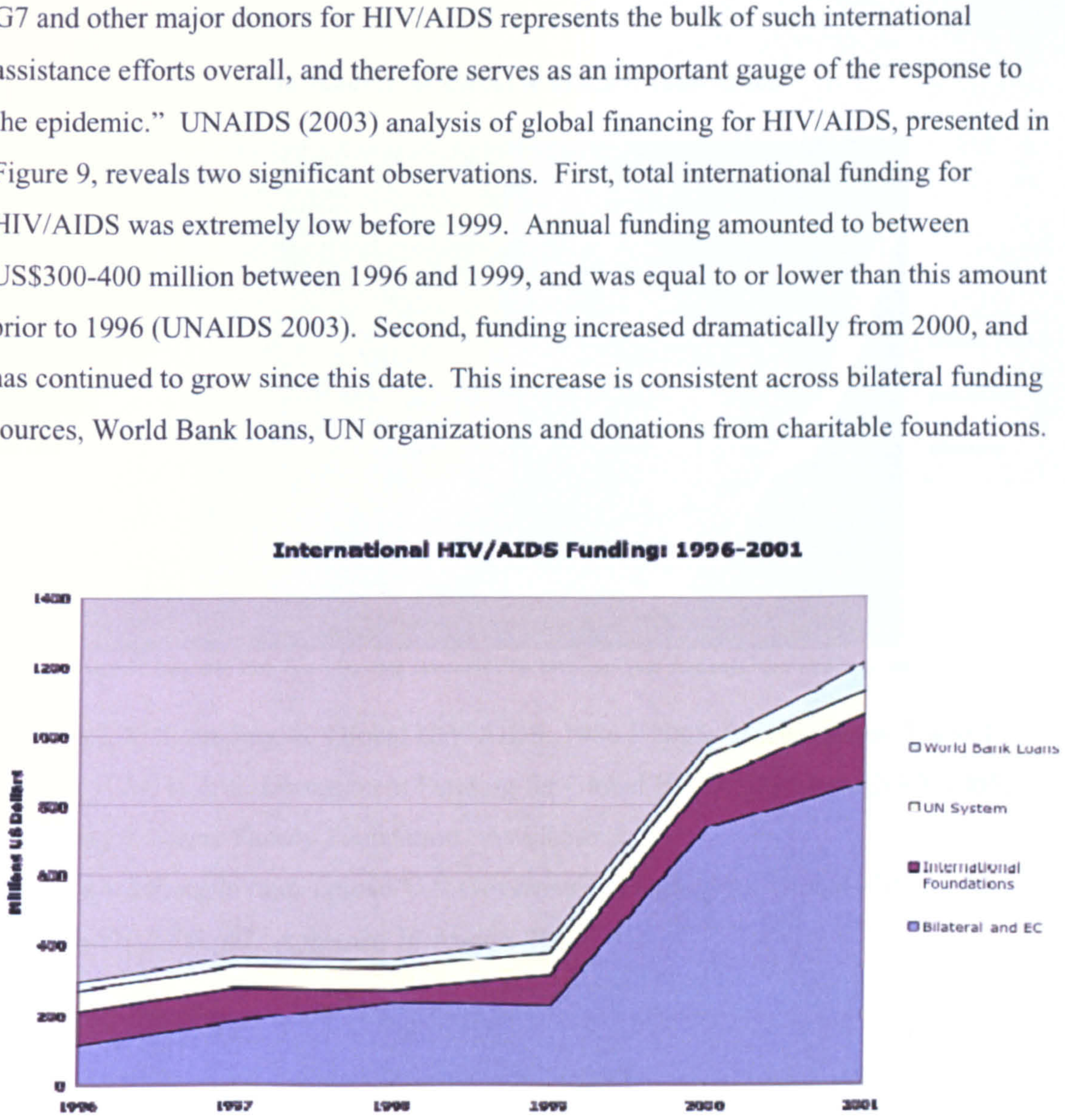

Figure 6.1: International HIV/AIDS funding: 1996 – 2001. Source: Joint United Nations Programme on HIV/AIDS (2003). Report on the State of HIV/AIDS Financing. Geneva, UNAIDS: 18.

Looking at the US and UK specifically, two states which supported securitization at the UNSC, funding for HIV/AIDS underwent a similarly rapid increase beginning in 2000 (Figures 10 and 11). Bilateral U.S. funding for HIV/AIDS, for research and to the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, increased from approximately US$300 million in 1999, to over US$1 billion in 2002, reaching US $2.5 billion in 2005. Bilateral aid for HIV/AIDS given by DFID shows a similar, although smaller increase in funding beginning in the year 2000.

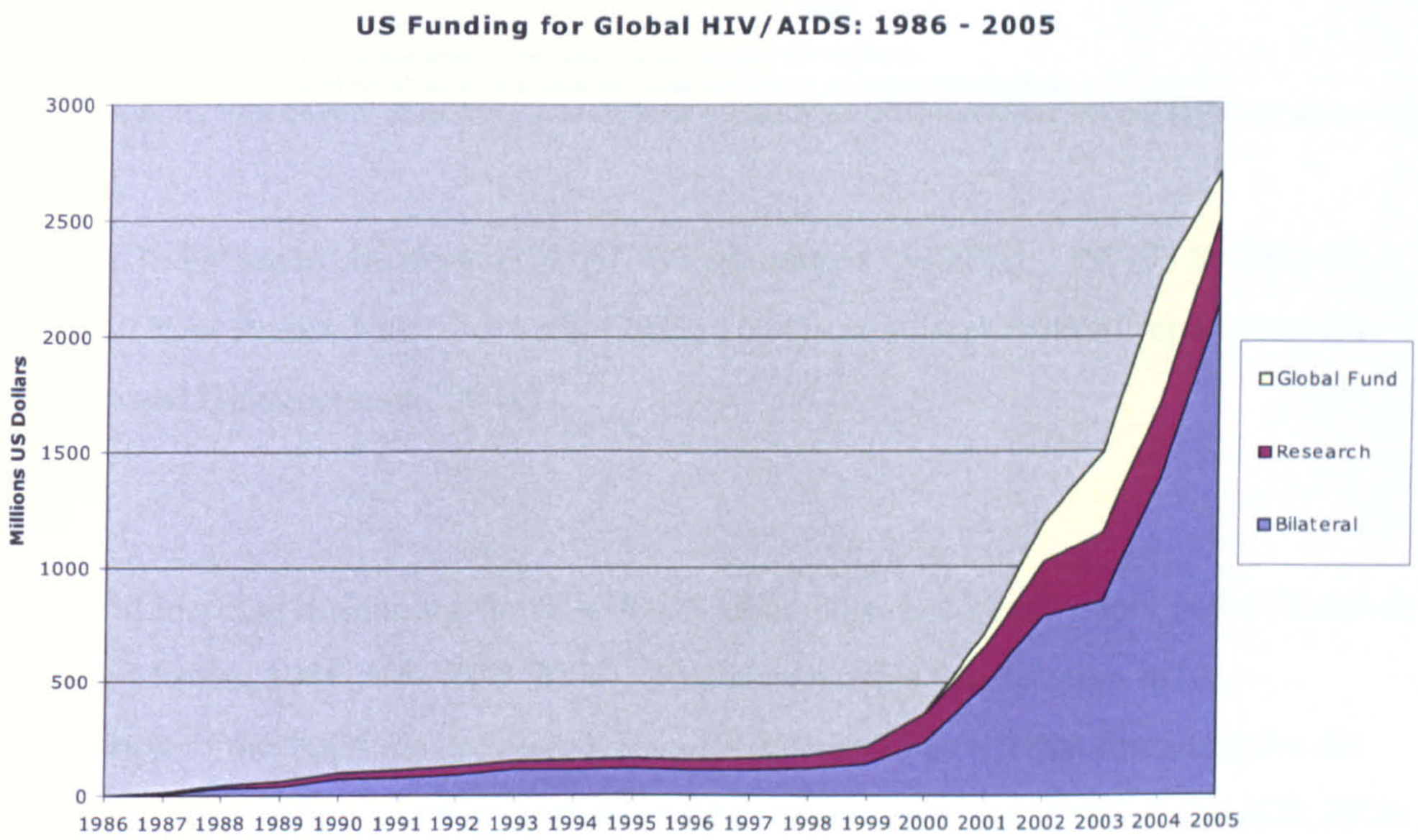

Figure 6.2: U.S. funding for Global HIV/AIDS: 1986 – 2005. Source: Kates, J. and T. Summers (2004). U.S. Government Funding for Global HIV/AIDS Through FY 2005, The Henry J. Kaiser Family Foundation. Available at: http://www.kff.org/hivaids/upload/U-S-Government-Funding-for-Global-HIV-AIDS-Through-FY-2005.pdf. Accessed 18 August 2006.

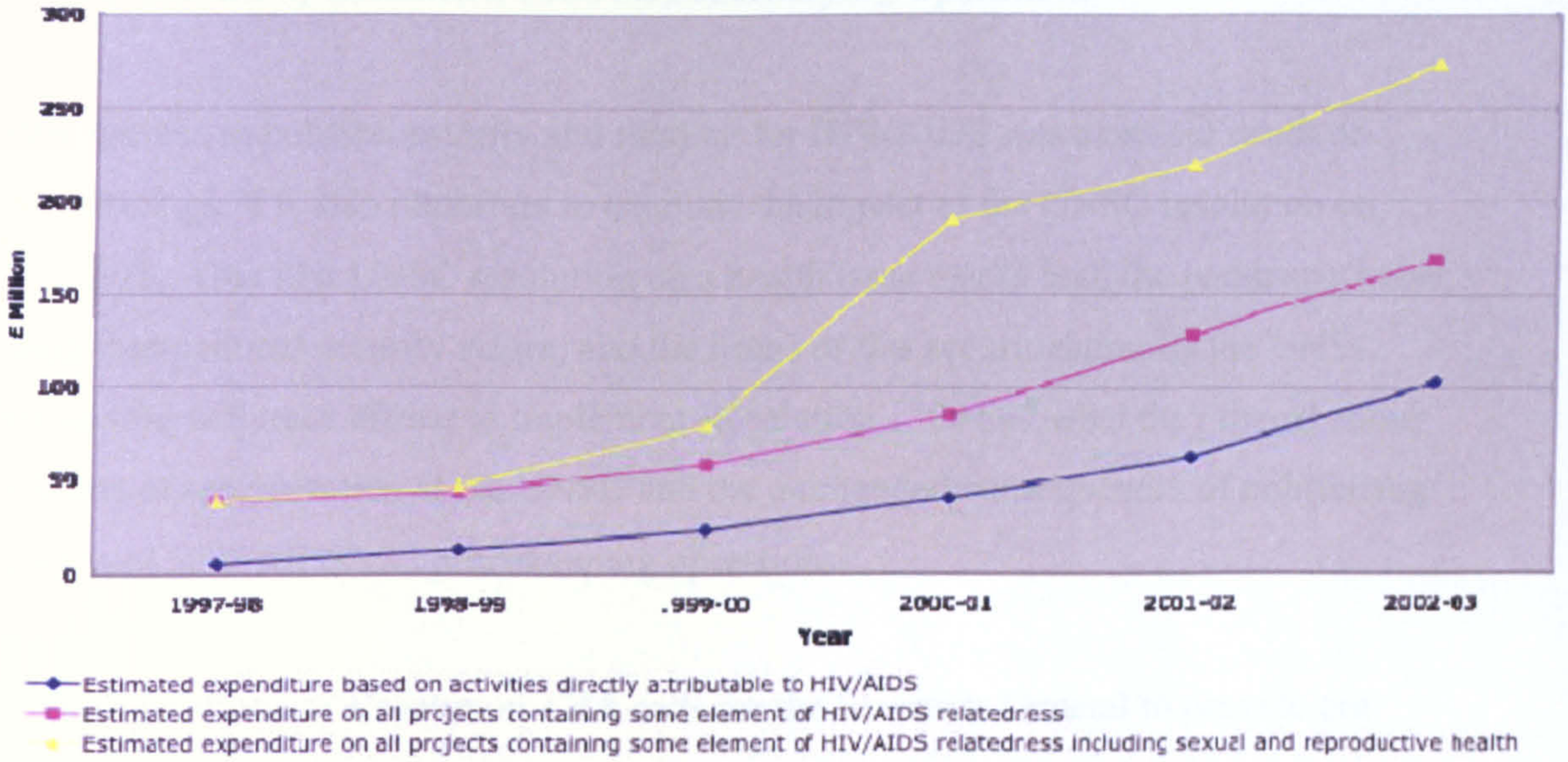

Figure 6.3: Estimated bilateral HIV/AIDS expenditure by DFID, 1997-98 to 2002-03. Source: (Great Britain National Audit Office 2004) and (Great Britain Department for International Development 2004a)

This rapid increase in funding for HIV/AIDS since 2000 has been widely noted (Kates et al. 2006; Merson 2006; UNAIDS 2006). Piot summarizes the situation in his introduction to the *2006 Report on the global AIDS epidemic*: "Total financing for the response in developing countries rose fivefold between 2001 and 2005" (UNAIDS 2006: Foreward).

While the causes of this dramatic growth in funding for HIV/AIDS are multi-factorial, the securitization of HIV/AIDS must be considered one of the significant causes. This is supported by Merson (2006: 2416) who cites four developments that transformed the global response to HIV/AIDS, one of which is the concern that AIDS could threaten "global security." Piot similarly concludes that the "global resolve to tackle AIDS has increased markedly in the six months since the [Security] Council's" meetings on HIV/AIDS (United Nations Security Council 2001a: 7). This significant increase in funding to fight the HIV/AIDS pandemic is the clearest consequence of securitization.

6.2 The Impact of Resolution 1308 on Peacekeeping Operations

While the rise in political priority and funding for HIV/AIDS was a critical result of these meetings, it is also important to examine the impact of the UNSC resolution on HIV/AIDS. This first UNSC resolution on a health issue marks both the pandemic's rise among international security issues, and the limits of this securitization by the UNSC. This section will trace efforts to implement Resolution 1308 and what they reveal about the limits of securitization at the UNSC and the unintended consequences of politicizing the issue of HIV/AIDS and peacekeeping operations.

The main provision of Resolution 1308 calls for the Secretary General to provide pre-deployment and continuing HIV/AIDS training for all UN peacekeepers. The responsibility for enacting this recommendation fell to the UN Department of Peacekeeping Operations (DPKO) and UNAIDS. These new responsibilities fell on the DPKO at a difficult time in its history. The rapid growth of large and complex UN peacekeeping missions in the 1990s had stretched the capabilities of the DPKO to manage missions. In 1999, two scathing reports were issued on UN peacekeeping failures in Srebrenica and Rwanda. As a result, the Panel on UN Peacekeeping Operations produced a report in 2000 intended to guide major reform of peacekeeping missions (known as the Brahimi Report) (Durch 2001).

Six months after Resolution 1308 was passed, the DPKO seems to have taken little action to address HIV/AIDS. Bazergan (Interview), the DPKO HIV/AIDS advisor, believes that the DPKO did not know how to address the issue of HIV/AIDS because it was "out of their remit and comfort zone." This indicates that little had changed in DPKO's perception of HIV/AIDS since the UNTAC mission in Cambodia in the early 1990s. When the UNSC asked for a briefing from the DPKO on its implementation of the resolution, a meeting closed to the press and public was held. Holbrooke's comments following the meeting reveal that the reason for the closed meeting was the lack of progress the DPKO had made in addressing HIV/AIDS among peacekeeping forces. Holbrooke emerged from the meeting and told the press:

> We recognize that DPKO is overburdened and understaffed so what I'm about to say should not be regarded as a personal criticism of any individual in DPKO but I must tell you what I said in the closed meeting, that we find DPKO's

> implementation of this resolution inadequate and insufficient given the gravity of the problem. Now they're trying, they're trying very hard. But they don't have a separate unit set up yet. UNAIDS wasn't even here today, the coordination between DPKO and UNAIDS and this meeting was either non-existent or insufficient. (Holbrooke 2000b: para. 7)

Holbrooke's public scolding worked. On 19 January 2001, the UNSC held an open meeting on the DPKO's implementation of Resolution 1308. After Holbrooke's comments, a defensive Under-Secretary General for Peacekeeping Operations Guéhenno told the UNSC that:

> The Department of Peacekeeping Operations and UNAIDS this very morning signed a memorandum of understanding that… reaffirms our will to increase HIV/AIDS awareness programmes in peacekeeping missions within the overall strategic framework and technical support provided by UNAIDS. (United Nations Security Council 2001a: 5)

The memorandum contained only the barest outline of how DPKO and UNADS would work together, leaving the financial arrangements between the organizations to be settled at a later date (UNAIDS 2001). While the memorandum seems to have been quickly drawn up to counter accusations that DPKO had done little to implement Resolution 1308, Bazergan (Interview) states that it did serve to push the DPKO into action. To complement the DPKO's efforts, UNAIDS had established an office on AIDS, Security, and Humanitarian Response (UNAIDS SHR) in July 2000 to "coordinate UN efforts to address AIDS in national uniformed services and peacekeeping operations" (UNAIDS 2005: 14). It was this office that worked with DPKO to develop a response to Resolution 1308 and programs to prevent HIV/AIDS among peacekeepers.[21]

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[21] Since 2000, UNAIDS SHR and DPKO have worked together to create six interventions designed to reduce the impact of HIV/AIDS on peacekeeping missions. First, as of 2005, major peacekeeping missions have full time HIV/AIDS advisors, while smaller missions have HIV/AIDS focal points (UNAIDS 2005). Second, UNAIDS and DPKO have attempted to strengthen pre-deployment HIV/AIDS training for troops. This has involved developing a training module and encouraging national HIV/AIDS activities to focus on militaries and preparation for peacekeeping deployment. Third, HIV/AIDS advisors on missions provide in-mission training, consisting of an HIV awareness card available in twelve languages and peer education programs (UNAIDS 2005). Fourth, UNAIDS and DPKO ensure the availability of condoms to peacekeepers, while emphasizing that condoms are "not a license for sexual abuse" (UNAIDS 2005: 22). Fifth, voluntary HIV/AIDS counseling and testing is available during missions. As of 2006, DPKO follow the rights-based approach of UNAIDS to testing, however this policy is under review. Finally, HIV/AIDS advisors on missions seek to develop outreach projects to local communities around mission areas using peacekeepers as "agents of change" to educate and prevent HIV/AIDS (UNAIDS 2005: 24). These activities are supported by a small monitoring and evaluation component to assess the impact of these interventions and study the relationship between HIV/AIDS and peacekeeping (Bazergan 2006).

Despite Guéhenno's presentation, Holbrooke still felt not enough was being done to implement Resolution 1308. Holbrooke stated: "Quite frankly, despite what we have heard today, I am still not satisfied" (United Nations Security Council 2001a: 12). While Holbrooke said the signing of a cooperative framework between DPKO and UNAIDS was an important start, the HIV/AIDS educational material DPKO presented was poorly written and five years out of date. Adding to his frustration was that the DPKO was still understaffed and a separate unit for HIV/AIDS not yet created within the DPKO. Dramatizing the issue, Holbrooke told the UNSC: "We spend billions of dollars on peacekeeping at the United Nations. We spend millions to protect our peacekeepers from terrorist attacks and from hostile forces. But I do not think we are spending even $500,000 yet to protect them from HIV/AIDS" (United Nations Security Council 2001a: 12). The difficulties in establishing DPKO action on HIV/AIDS demonstrates an inability or lack of will to take action against the disease that is similar to DPKO actions during the Cambodia UNTAC mission. Only with a very public scolding by Holbrooke was DPKO pushed into action.

Even after UNAIDS and the DPKO began to work cooperatively, they faced a number of serious challenges in seeking to reduce the risk of HIV/AIDS transmission among peacekeepers and the populations they serve. The first of these challenges involves DPKO's inability to even test peacekeepers for HIV/AIDS. Because of the UN's policy of non-discrimination against people with HIV/AIDS and respect for national sovereignty, the UN cannot require the peacekeeping personnel that are donated by member states to be tested for HIV/AIDS at any stage of their deployment (UNAIDS 2005). DPKO can only discourage, but not require, countries from contributing HIV positive troops for peacekeeping operations (United States General Accounting Office 2001). Because of these limitations, Resolution 1308 does not require, but only recommends "education, prevention, voluntary and confidential testing and counseling, and treatment" of peacekeeping personnel (United Nations Security Council 2000c: 2). This is a major limitation of Resolution 1308 which severely undercuts the UN's ability to take effective action to prevent HIV transmission during peacekeeping operations.

A second challenge to DPKO's implementation of Resolution 1308 was the weakness of the evidentiary base, and the DPKO's inability to collect new evidence, on the prevalence of HIV/AIDS among peacekeepers or the public in post-conflict areas. In his

presentation to the UNSC, Guéhenno pointed out that there is "generally a lack of reliable and complete data on HIV/AIDS in the places in which peacekeepers deploy" (United Nations Security Council 2001a: 3). Even if HIV/AIDS epidemiological data were being collected in a country before a peacekeeping deployment, the data collection would likely be crippled by the outbreak of conflict. Bazergan (2004) cites the UN peacekeeping mission in Cambodia as an example of the difficulties of obtaining data on HIV/AIDS during peacekeeping missions.

> HIV surveillance is problematic and rarely a priority in conflict and post-conflict areas and the resulting lack of baseline data in conflict-affected countries make it difficult to determine the impact of a peacekeeping mission. Cambodia, for instance, did not complete its first round of HIV sentinel surveillance until 1995, after the UN mission in the country had already come to an end – so it is impossible to compare the status of the epidemic before and after the mission. Moreover, the breakdown of health services, the mass movement of internally displaced people and refugees and the increased vulnerability of women and children to sexual abuse and exploitation, means that conflict itself, irrespective of a peacekeeping element, may aggravate the course of the epidemic. (Bazergan 2004: 6)

Thus there remained a lack of reliable baseline data on HIV/AIDS to accurately measure the epidemiological impact of peacekeeping missions, as well as limited opportunities to measure the impact of future missions.

Similarly, DPKO has little ability to collect data on the health of its own peacekeepers. The conduct of a required pre-deployment medical exam for peacekeepers is conducted by the troop contributing country, not the UN (Bazergan 2004). While this exam is intended to exclude those with active signs of AIDS, countries do not have to report the results to the DPKO, and there is no enforcement mechanism to ensure the proper conduct of the test or even that those with AIDS are excluded. UN peacekeepers have died of AIDS during the mission in Liberia and the former Yugoslavia, clearly indicating that some countries are not preventing HIV positive persons from serving on peacekeeping missions (Bazergan Interview; Kingma Interview). Other countries do not test their troops for HIV/AIDS. Of the many countries that do test peacekeeping troops, none share these results with the UN (UNAIDS 2005). Guéhenno describes the situation simply: "National governments do not, as a matter of practice, inform the United Nations that one or more of their personnel have contracted HIV/AIDS while on mission" (United Nations Security Council 2001a: 3). This is another example of the

UN's limited ability to effectively act to limit the links between HIV/AIDS and peacekeepers.

UNAIDS and the DPKO also face logistical challenges in educating and training peacekeepers about HIV/AIDS. Bazergan (Interview) describes peacekeepers as a "permanently mobile population." Peacekeepers are deployed for four months to one year, and "contingents deploy and rotate at different times. As a result, a new peer education programme is required at each rotation" (Bazergan 2004: 8). These frequent troop rotations pose a "major hurdle" to providing even a minimum level of HIV/AIDS training to all peacekeepers (Bazergan 2004: 8). UNAIDS and the DPKO also faced religious and cultural objections to the provision of condoms and HIV/AIDS training. There is one report of "a contingent commander reportedly burning a consignment of condoms" (Bazergan 2004: 9). Dr Halle, the former head of the DPKO medical unit, said: "I do not expect a Muslim imam to promote the use of condoms. Nor do I expect a Catholic padre to do that" (Fleshman 2001: 18). The cultural diversity of missions also causes difficulties with language translation and cultural sensitivity in presenting education programs. "There may be over 30 different military and police contributors in any one peacekeeping operation – in Liberia, for example, 60 countries currently contribute uniformed personnel" (Bazergan 2004: 8). Rapid troop rotations, cultural objections to HIV/AIDS education and prevention, and cultural diversity in missions are all major challenges to implementing Resolution 1308.

In addition to the above challenges to addressing the issue of peacekeepers and HIV/AIDS that result from the relationship between the UN and sovereign states, the securitization of the pandemic has created a highly politicized environment replete with "accusations, manipulation, and real concerns" about peacekeepers and HIV/AIDS (Bazergan Interview). Bazergan (2004: 11) writes that:

> the problem with regard to peacekeeping is that the issue get mired in accusations and counter-accusations about who is spreading HIV. Instead of considering HIV/AIDS as a global problem that needs a multi-sectoral response, some troop-contributing countries perceive the DPKO programmes to be an attack on the integrity and reputation of their armed forces.

In other instances, certain parties within countries have politicized the issue of peacekeepers and HIV/AIDS in order to limit or shape UN involvement in a crisis

according to their interests. In 2001, Eritrea wrote to the UNSC requesting that troops deployed on the UN Mission in Ethiopia and Eritrea (UNMEE) be tested for HIV and then HIV-positive troops excluded. Eritrea justified its request by arguing that excluding HIV-positive peacekeepers was not a "'discriminatory practice' targeted at the UN Mission in Ethiopia and Eritrea (UNMEE), but was 'standard national practice that has been in effect since 1993'" (UN Integrated Regional Information Network 2001: para. 1). Eritrea was conducting routine HIV testing of its army "based on the recognition that the army was one of the most sexually active segments of the population" and was "engaged in a very rigorous national campaign to prevent the spread of AIDS" (UN Integrated Regional Information Network 2001: para. 2). The presence of HIV-positive peacekeepers would undermine these efforts Eritrea argued. The UNSC denied Eritrea's request, which played a role in the negotiations for the UNMEE (Bazergan 2004). While Eritrea may have had legitimate concerns about the spread of HIV/AIDS, their request to exclude HIV positive peacekeepers was also a stalling tactic. This is because, as previously discussed, DPKO had no ability to keep HIV positive peacekeepers from participating in missions.

Sudan also announced a similar "AIDS-free policy" for African Union troops monitoring the Darfur region (Agence France-Presse 2004: para. 1). Aahmed Bilal Osman, Sudan's minister of health, explained that the measure was aimed at "safeguarding the health of the people of Darfur" (Agence France-Presse 2004: para. 1). Bazergan (Interview), however, feels that these concerns are a cover for political opposition to UNSC action on Sudan. Other examples of seeking to test and exclude HIV-positive peacekeepers have occurred during the Balkans conflict and in Sierra Leone (Elbe 2003). Bazergan (Interview) explains that the issue of HIV/AIDS and peacekeepers is "both a genuine concern and a political tactic" for governments. While peacekeepers spreading HIV/AIDS is a real issue, it is also being used "as a tool to create leverage for political interests" (Bazergan Interview). The lack of reliable data on rates of HIV/AIDS among peacekeepers and the epidemiological impact of peacekeeping missions have created a vacuum that is filled with political motives. Bazergan (Interview) concludes that "there is no good data, so the issue gets played out in the media" and used to support a country's political interests.

Those familiar with the machinations behind the UNSC meetings on HIV/AIDS and Resolution 1308, as described in Chapter 5, will not be surprised that the issue of peacekeepers and HIV/AIDS is highly political. As described, ulterior political goals in part drove Holbrooke to bring the issue of HIV/AIDS to the UNSC. For him, peacekeepers spreading HIV/AIDS was a way to link the disease to the mandate of the UNSC, but was not the primary issue of concern. In many ways, this situation has continued through UNAIDS and the DPKO's work. While data on peacekeepers and HIV/AIDS is limited, transmission of HIV/AIDS by peacekeepers is likely to have a greater impact on the credibility and trust in UN peacekeeping missions than on regional HIV/AIDS epidemics (Feldbaum et al. 2006a). The DPKO's HIV/AIDS programs are as much about managing the credibility of its missions as preventing HIV transmission.

While the difficulties of implementing Resolution 1308 are substantial, the UNSC has built upon its mandate to address HIV/AIDS during peacekeeping operations in subsequent resolutions. Language encouraging efforts to "sensitize peacekeeping personnel in the prevention and control of HIV/AIDS and other communicable diseases in all its peacekeeping operations" is present in UNSC resolutions on Côte d'Ivoire, Burundi, Haiti and Sudan (UNSC 2004: 1; UNAIDS 2005). Resolution 1318 on conflict in Africa, and Resolution 1325 on women and children in conflict, encourage the incorporation of HIV/AIDS education into peacekeeping missions. Dr. Halle argues that the "DPKO's HIV/AIDS initiative is guided as much by Security Council Resolution 1325 emphasizing the rights of women and children in conflict as it is by Resolution 1308 on HIV and conflict" (Fleshman 2001: 18). In 2005, the UNSC issued a Presidential Statement reaffirming its commitment to Resolution 1308. Thus, while the link between peacekeepers and HIV/AIDS may have greater political than epidemiological impact, the UNSC's efforts to address HIV/AIDS continue.

In summary, the securitization of HIV/AIDS at the UNSC demonstrates both benefits and hazards in the fight against HIV/AIDS. By addressing the disease at the UNSC, Holbrooke generated high level political attention on the pandemic and placed HIV/AIDS on the agenda of the preeminent organization concerned with international security. However, to table the issue at the UNSC, the U.S. delegation to the UN was forced to frame HIV/AIDS in relatively narrow terms that resonated with a strict interpretation of the mandate of the UNSC. This limited the scope of Resolution 1308 to

the issue of HIV/AIDS and peacekeeping operations. Given the UN's limitations on what it can require of member states and their armed forces, from a global health perspective, this narrower framing focused UNSC action on an issue peripheral to the global pandemic, and the UN's ability to address even this peripheral issue of HIV/AIDS among peacekeepers has been restricted. The UN's lack of authority to test peacekeeping troops, to gather data on HIV/AIDS during peacekeeping operations, or even to exclude HIV positive troops from UN missions indicates that the implementation of Resolution 1308 has been weak. The lack of data on peacekeepers and HIV/AIDS, and the use of the disease as a political tool to influence the deployment of peacekeeping operations, further politicizes the issue and impairs constructive action to implement the vision of Resolution 1308.

6.3 National security and HIV/AIDS during the George W. Bush Administration

A similarly complex situation resulted from the securitization of HIV/AIDS in the U.S. As in the case of the UNSC, the gains in political profile and funding for HIV/AIDS were the clearest results of securitization in the U.S. Securitization however played less of a role in guiding U.S. action on HIV/AIDS during the George W. Bush administration than could have been anticipated. Instead, the Bush administration embraced HIV/AIDS for a surprising set of political factors and foreign policy considerations. This section will trace the debate on securitization within the U.S. and its influence on the origins of a massive new U.S. aid initiative to address the pandemic.

When the administration of George W. Bush took office on 20 January 2001, there were few reasons to think that the Administration would devote any attention to the HIV/AIDS pandemic or sustain policy attention to its links with national security. In an interview in 2000 as a presidential candidate, Bush discounted the strategic importance of the continent most affected by HIV/AIDS: "While Africa may be important, it doesn't fit into the national strategic interests, as far as I can see them" (Behrman 2004: 246). In an article in *Foreign Affairs*, future national security advisor and Secretary of State under the Bush Administration, Condoleezza Rice argued that a Republican administration would refocus the U.S. on pursuing its own national interests (a communitarian position,) rather than humanitarian interests or the interests of the international community. Rice

(2000: 47) wrote: "To be sure, there is nothing wrong with doing something that benefits all humanity, but that is, in a sense, a second-order effect." Such statements indicated that the Bush administration would either not address HIV/AIDS as a high priority issue, or would only address the pandemic because of its impact on U.S. national security interests.

A further indication that the Bush administration was unlikely to give concerted attention on HIV/AIDS, or its links to national security, was the abolishment of Ken Bernard's international health position at the NSC on the day the Bush administration took office. Policymakers have offered two interpretations of the abolishment of Bernard's position. In the first, the cutting of the position was seen as part of an overall redefinition and focusing of the NSC that often occurs with each change of administration (Confidential U.S. Government Interview). This view holds that the new administration did not undervalue global health, "just that it was better managed by HHS" and other agencies (Behrman 2004: 247). The second view, expounded by Steven Morrison, holds that the Bush administration explicitly rejected the links between health and national security and eliminated Bernard's position for that reason. Morrison (2005: 8) argues:

> When the Bush Administration came in, they initially rejected this notion [of HIV/AIDS as a threat to national security]. They saw it as poor wooly-minded thinking by the Clinton Administration and there were some tough criticism of this assertion. Where is the evidentiary base? Where have you seen states fail? Where do you see the actual outcomes? What is there beyond antidotal evidence? What are these assertions based on and more over if it is truly a security threat, then why isn't our government or other governments mobilizing with matching responses that are Security Initiatives?

Morrison (2005) identifies Vice President Cheney and National Security Advisor Rice as the source of this skepticism. His perspective is supported by the wave of "ABC" (anything but Clinton) thinking that became an "underpinning credo" of the new administration (Behrman 2004: 247).

In contrast, the new Secretary of State Colin Powell pushed hard against this skepticism and argued in interviews and a statement to the UN General Assembly Special Session on HIV/AIDS (UNGASS) meeting that HIV/AIDS did indeed pose a national security threat. Powell spoke to the UNGASS five months after the Bush administration took

office, and put forth a forceful endorsement of the links between HIV/AIDS and national security:

> AIDS is not just a humanitarian or health issue. It not only kills. It also destroys communities. It decimates countries. It destabilizes regions. It can consume continents. No war on the face of the earth is more destructive than the AIDS pandemic. I was a soldier. But I know of no enemy in war more insidious or vicious than AIDS. An enemy that poses a clear and present danger to the world. The war against AIDS has no front lines. We must wage it on every front. (Powell 2001: para. 15)

Powell is not on record describing how he came to these beliefs. Laurie Garrett (Interview) speculates that because Powell is Jamaican in origin, where prevalence of HIV/AIDS is over 1%, he may have known people affected by the disease.

Powell was supported in his views by CIA Director George Tenet. Tenet had been CIA Director since 1997 and therefore oversaw the production of the seminal NIC 99-17 report. CIA directors are not often replaced when a new administration is elected, so Tenet represented a perspective from the intelligence community that was less affected by the Bush administration's new approach. In a U.S. Senate Committee on Intelligence hearing discussing worldwide threats, Tenet stated on 7 February 2001:

> AIDS in Africa basically takes generations out of play. And then you have refugee flows. And then you have economic disasters. And then you have civil wars that require exfiltration and some kind of involvement whether you choose to or not. And while we all believe we're immune from this, we're not. At some point somebody has to be responsible for it. (Schneider and Moodie 2002: 1)

Morrison (2005) also notes that support for considering HIV/AIDS a threat to national security was found in the U.S. Congress, from the influential International Crisis Group which published the 2001 report *HIV/AIDS as a Security Issue*, and from Nicholas Eberstadt, an influential conservative scholar at the American Enterprise Institute who would later publish *The Future of AIDS* in the widely-read publication *Foreign Affairs*.

In the face of this pressure, Cheney seemed to relent. Interviewed by Tim Russert on the television programme *Meet the Press* in 2001, Cheney argued that HIV/AIDS was in fact of great concern to the Bush administration. Cheney (2001: para. 2) said: "The president agrees wholeheartedly this is a terrible tragedy for mankind, and the numbers are, as you

suggest, when you think about the literally millions and millions of people whose lives are now at risk, because of the AIDS virus, we clearly have an obligation to help for humanitarian reasons, and we will." Morrison (Interview) says Russert then "cornered" Cheney into admitting that HIV/AIDS was a threat to U.S. national security in this exchange:

> MR. RUSSERT: Colin Powell says this is national security issue for the United States. Do you agree?
>
> CHENEY: I think he's right. Yeah. (Cheney 2001: para. 5)

Russert's question had forced Cheney into a choice, between dismissing the links between HIV/AIDS and national security and therefore the popular Secretary of State Powell's strong views on the subject, or agreeing that the pandemic was a threat to U.S. national security. Cheney's endorsement of Powell's views on the nexus was a product of this calculation. As in the Clinton Administration, political pressure played a key role in the Bush Administration's adoption of national security language to describe the HIV/AIDS pandemic.

6.3.1 The "Next Wave of HIV/AIDS": Nigeria, Ethiopia, Russia, India, and China

In 2002, two major reports from the U.S. intelligence community directly embraced the linkage between HIV/AIDS and national security. The first, entitled *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China*, is a U.S. Intelligence Community Assessment and update of the seminal NIE 99-17 discussed in Chapter 5. While the *Next Wave* assessment builds upon the work of NIE 99-17, it focuses specifically on five countries that are of major strategic importance to the U.S. and "are major regional or global players" (National Intelligence Council 2002: 7). Even more than the NIE 99-17, the communitarian perspective of this assessment is clear from its focus on countries of strong strategic interest to the U.S. The *Next Wave* writes that these countries have also been selected because they are:

- Among the world's most populous countries, together representing over 40 percent of the world population.
- In the early-to-mid-stages of an HIV/AIDS epidemic.

- Led by governments that have not yet given the issue the sustained high priority that has been key to stemming the tide of the disease in other countries. (National Intelligence Council 2002: 1)

The assessment argues that these countries will constitute a "second wave" of the HIV/AIDS pandemic beyond the "first wave" in sub-Saharan Africa. The assessment estimates that by 2010, Nigeria, Ethiopia, Russia, India and China will together have 50–75 million HIV positive persons, while sub-Saharan Africa will have 30–35 million infected. In other words, by 2010 these five countries "collectively will have the largest number of HIV/AIDS cases on earth," and will surpass sub-Saharan Africa as the epicenter of the pandemic (National Intelligence Council 2002: 7).

The assessment asserts that all five countries will have difficulties controlling their HIV epidemics in the short to medium term. Citing the success models of Uganda, Thailand and Brazil, the assessment argues that none of the five countries has so far shown the political leadership necessary to replicate these successes. The assessment concludes that HIV/AIDS will have "significant economic, social, political, and military implications in Nigeria, Ethiopia, Russia, India, and China," although the prevalence of the disease will remain below rates in sub-Saharan Africa (National Intelligence Council 2002: 22). Nigeria and Ethiopia will be the "hardest hit" countries, where HIV/AIDS will kill government and business elites, slow economic growth, and complicate the staffing of the military officer corps (National Intelligence Council 2002: 22). The assessment argues that "the further deteriorating of already weak government institutions by the escalating HIV/AIDS crisis could leave Nigeria and Ethiopia seriously weakened states and is likely to reduce their ability to continue to play a regional leadership role" (National Intelligence Council 2002: 23). In Russia, the HIV/AIDS epidemic will exacerbate the health and demographic crisis while slowing economic growth. While the assessment estimates that India and China together will have the largest number of people with HIV/AIDS by 2010, it concludes that the low prevalence rates in these countries will lessen the social, political, economic and military impact of the epidemic[22].

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[22] More specifically, the assessment notes that the Nigerian military is concerned about the loss of key personnel to AIDS, and has mandated HIV/AIDS training for soldiers. The Ethiopian government "does not appear focused on AIDS," and has focused instead on the conflict with Eritrea (National Intelligence Council 2002: 19). The Russian government has been similarly inactive and "faces so many other serious problems that HIV/AIDS is unlikely to receive high-level attention for an extended period until the economic and security costs of neglect become more tangible" (National Intelligence Council 2002: 19).

> We believe that the HIV/AIDS epidemic, by itself, will not pose a fundamental threat through 2010 to the rise of China and India as major regional players. Given the relatively low current prevalence rates and the relatively long period from infection to death, the two countries can manage the impact of the disease through the end of the decade. (National Intelligence Council 2002: 25)

Like previous U.S. intelligence assessments of HIV/AIDS, the *Next Wave* report is located within a communitarian perspective. The report focuses on Nigeria, Ethiopia, Russia, India and China because they are strategically important to U.S. national security interests, as opposed to the health burden posed by HIV/AIDS per se. The assessment also specifically focuses on the military, economic and political impacts of the pandemic. The Next Wave assessment, in particular, raises Elbe's concern that securitization can shift funding and attention from countries in greatest need, in terms of health burden from HIV/AIDS, to countries of strategic interest, in this case to the U.S. While the *Next Wave* report does not suggest shifting HIV/AIDS funding, it framing of the problem in terms of U.S. national security interests gives priority attention to strategically important states over, for example, the highly-affected region of Sub-Saharan Africa. If all U.S. funding for HIV/AIDS were to follow a security-driven logic, funding for HIV/AIDS in Sub-Saharan Africa would be reduced with devastating public health consequences. However, a security-driven approach to American funding for HIV/AIDS has not been embraced, as the discussion of the PEPFAR initiative (Section 6.3.3) will demonstrate.

6.3.2 2002 U.S. National Security Strategy

The second report from the U.S. intelligence community under the Bush Administration to address the links between HIV/AIDS and national security is *The National Security Strategy of the United States of America* (hereafter the Strategy). In a major reorientation of U.S. national security strategy, the Strategy focuses on global terrorism

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The Indian government created the National AIDS Control Organization and has taken other steps to raise HIV/AIDS awareness. However, conflict with Pakistan and religious tensions are higher priority issues for the Indian government. The Chinese government has become more open in acknowledging its rising levels of HIV/AIDS. The assessment suggests this development is due to "senior leaders... concerned about the potential economic, social, and political ramifications of the spreading disease" (National Intelligence Council 2002: 20). Despite the increased political attention to HIV/AIDS in China, domestic funding for HIV/AIDS is low, other issues have higher priority, and local governments may stifle implementation of education and prevention programs. The assessment also notes that weak health infrastructure and the high cost of ARVs will inhibit efforts to combat HIV/AIDS in each country.

and states believed to harbor terrorists. This is a clear response to the events of 11 September 2001 (9/11), when al-Qaeda attacked the U.S. from a safe harbor within the "failed state" of Afghanistan. Declaring an end to the twentieth century's wars over ideas and expansionist states, the Strategy declares: "America is now threatened less by conquering states than we are by failing ones" (White House 2002: 1).

Health issues play an unusually prominent role in the Strategy, which is better known for announcing the Bush administration's policy of preemption against terrorist threats. The Strategy also introduces a new framing of the relevance of infectious diseases to U.S. interests that incorporates, but differs significantly, from the IOM's earlier arguments (White House 2002). Public health issues are discussed in six of the nine chapters of the Strategy, and in the introductory letter by President Bush. HIV/AIDS specifically garners six mentions in the Strategy and one in the introductory letter. In comparison, the previous U.S. statement of national security policy, President Clinton's 1998 *A National Security Strategy for a New Century*, discusses public health only as a secondary issue to bioterrorism and environmental degradation, while mentioning HIV/AIDS only once (White House 1998). Health received no attention in national security strategies before Clinton's 1998 strategy, although President Carter did emphasize the "human right to health" in his foreign policy (Fidler 2004a: 15). The higher profile of HIV/AIDS, and public health issues as a whole, in this key statement of U.S. security policy under the Bush administration signaled the increasing importance given to infectious diseases by the U.S. security policy community since securitization.

The Strategy states that it is based on a distinctive union of American values and national interests, and its references to global health and HIV/AIDS follow this dichotomy. Importantly, this framing of the problem can be seen as an attempt to link the communitarian interests of U.S. national security with cosmopolitan values. In the first of three major sections that discuss global health issues, the White House (2002: 10) describes disease, war and poverty in Africa as threatening "both a core value of the United States – preserving human dignity – and our strategic priority – combating global terror." Here the Strategy embraces the links between disease and state failure, describing them as both unjust and dangerous to U.S. interests. In this way, the authors are arguing that American strategic interests overlap, or are even the same as those of global health. In other words the Strategy argues that by investing in global health, the

U.S. can help Africans suffering from disease, as well as better ensure the creation and maintenance of peaceful and stable African states that will improve U.S. national security. This represents a new framing of the relevance of global health issues to U.S. national security, which incorporated both strategic interests and humanitarian concerns.

The second discussion of global health issues comes in the section on economic growth, free markets and free trade. This section begins by stating "A strong world economy enhances our national security by advancing prosperity and freedom in the rest of the world" (White House 2002: 17). Investments in health are justified as policies that generate "higher productivity and sustained economic growth," and therefore improve U.S. national security (White House 2002: 17). Again, American strategic interests are argued to overlap with actions that improve health.

The final discussion of global health issues occurs in the section on expanding development though opening societies and democratization. The section begins by arguing that extensive global inequalities are "neither just nor stable" (White House 2002: 21). The goal of securing public health, through fighting HIV/AIDS, malaria and tuberculosis is presented as a major component of ensuring development, economic growth and reducing global inequalities (White House 2002).

Permeating throughout the Strategy's discussions of HIV/AIDS and other public health issues is the idea that improving global health and fighting HIV/AIDS is consistent with U.S. strategic interests. Thus the Strategy argues that the pursuit of U.S. communitarian interests will concurrently, and without conflict, also support cosmopolitan values such as improvements in global health. This argument, and the higher priority given to health issues in the Strategy, essentially espouses the "revolution" model put forth by Fidler (2005a: 5), whereby traditional divisions between material interests and normative values collapsed, leading to health being addressed, at least partially, for its own inherent value.

However, this conclusion cannot be fully embraced, as the U.S. National Security Strategy is not a precise representation of U.S. policy for two reasons. First, unlike U.S. intelligence assessments, the National Security Strategy is intended to be a widely available public statement of administration policy. Therefore, the extent to which the linkage of U.S. strategic interests to cosmopolitan values in the Strategy is for the benefit

of U.S. public image at home and abroad must be seriously considered. The linking of communitarian interests and cosmopolitan values in the Strategy may be a public relations effort to improve opinions on U.S. foreign and security policy. Second, the Strategy is a declaratory document that does not serve as a guide to U.S. policy or funding, has no legally-binding power over U.S. government actions. Legislation concerning HIV/AIDS and other global health issues is crafted by the U.S. Congress, while other policies towards global health issues are made by departments within government, not the National Security Strategy. Therefore the authors of the Strategy were not bound by legislative requirements but were free to use rhetorical argument to best support the new national security strategy. Both these factors consequently undermine the strength of the conclusions that can be drawn from the Strategy. However, the unprecedented profile given to public health issues in the Strategy does suggest that certain public health issues including HIV/AIDS have become part of the high level political agenda. The Strategy also introduces a new framing of HIV/AIDS and global health issues, which recognizes both their strategic and humanitarian relevance to U.S. national security and foreign policy objectives.

6.3.3 President's Emergency Plan for AIDS Relief (PEPFAR)

With the publication of the National Intelligence Estimate on the next wave of the HIV/AIDS pandemic in countries critical to U.S. strategic interests, and the higher priority given to HIV/AIDS and public health issues in the U.S. National Security Strategy of 2002, it appeared that HIV/AIDS had now become accepted within the security policy community as a threat to U.S. national security. Just four months after the publication of these documents, President Bush announced a massive increase in U.S. spending on HIV/AIDS in developing countries under the US $15 billion five-year PEPFAR initiative. In contrast, U.S. funding for global HIV/AIDS at the height of the Clinton Presidency was US$360 million per year (Kates and Summers 2004). The next day a *New York Time*s headline concluded: "Bush proposal on AIDS funds shows concern about security" (Stolberg 2003: headline). Journalist Sheryl Gay Stolberg (2003: para. 1) wrote that Bush was recognizing "that by creating political and economic instability abroad, AIDS is also a national security threat that could breed the next

generation of terrorists." Implied in this article is the idea that only relevance to national security could justify such expenditures.

While the linking of HIV/AIDS with the U.S. national security strategy and the announcement of PEPFAR funding would seem to coincide, interviews carried out for this research with U.S. policymakers, including persons working within the PEPFAR program, indicate that concern about the national security implications of HIV/AIDS did not drive the creation or operation of PEPFAR. Bush announced PEPFAR during his 2003 State of the Union speech. In the speech, Bush (2003: section on HIV/AIDS) gives his public rationale for the initiative as a humanitarian effort to save millions of lives by providing ARV therapy to those suffering from HIV/AIDS in Africa:

> Today, on the continent of Africa, nearly 30 million people have the AIDS virus -- including 3 million children under the age 15. There are whole countries in Africa where more than one-third of the adult population carries the infection. More than 4 million require immediate drug treatment. Yet across that continent, only 50,000 AIDS victims -- only 50,000 -- are receiving the medicine they need.
>
> Because the AIDS diagnosis is considered a death sentence, many do not seek treatment. Almost all who do are turned away. A doctor in rural South Africa describes his frustration. He says, 'We have no medicines. Many hospitals tell people, you've got AIDS, we can't help you. Go home and die.' In an age of miraculous medicines, no person should have to hear those words.
>
> AIDS can be prevented. Anti-retroviral drugs can extend life for many years. And the cost of those drugs has dropped from $12,000 a year to under $300 a year -- which places a tremendous possibility within our grasp. Ladies and gentlemen, seldom has history offered a greater opportunity to do so much for so many.

Bush (2003: section on HIV/AIDS) described PEPFAR as "a work of mercy," and did not mention any of the national security implications of HIV/AIDS. The public rationale given for the initiative is that treatment with ARVs is achievable, affordable, and the morally right thing to do. Instead of adopting the IOM's arguments, or the Strategy's formulation of global health issues having both strategic and humanitarian implications, Bush presented PEPFAR as a purely humanitarian endeavour.

Nazanin Samari-Kermani (Interview), a White House Fellow at the State Department who helped design PEPFAR, says that the national security implications of HIV/AIDS are "hardly mentioned at all... Proof that providing AIDS drugs could work was the reason for launching PEPFAR." Behrman (2004) traced the secret meetings of the high-

level group charged by Bush to develop PEPFAR before it was announced in his speech. The mission of this secret group was to "reset the bar with respect to U.S. policy on the issue George W. Bush was steadily coming to think of as the defining humanitarian catastrophe of our time" and recalibrate the level of U.S. investment to fight HIV/AIDS (Berhman 2004: 291). The group's primary questions were: was treatment for HIV/AIDS affordable, was providing ARV therapy in Africa on a large-scale viable, and could doing so have a measurable impact on HIV/AIDS? When, "after months of deliberations the group determined that drugs were now affordable and treatment was viable," the PEPFAR initiative was launched (Behrman 2004: 294). After the clear issue of humanitarian need, the viability of providing widespread access to ARVs in Sub-Saharan Africa was a key rationale for PEPFAR.

The humanitarian nature of PEPFAR can also be seen in the choice of the fifteen focus countries named: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia. Of these, only Ethiopia and Nigeria are "next wave" countries singled out previously by the U.S. intelligence community. One unnamed U.S. State Department official (Interview), who works on international health, confirmed that the U.S. chose countries with high rates of HIV/AIDS and where enough health infrastructure existed to achieve results in increasing AIDS treatment and prevention. These findings suggest that PEPFAR was not designed or motivated by the perceived linkages between HIV/AIDS and U.S. national security interests.

The adoption of a humanitarian rationale for PEPFAR suggests that a reinterpretation of the 2002 National Security Strategy's focus on HIV/AIDS is required. In 2002, the unprecedented focus on global health issues within the Strategy seemed to suggest the successful integration of the pandemic into U.S. national security considerations. Instead it was the second part of the Strategy's framing of global health issues, the focus on their humanitarian impact that would motivate action on HIV/AIDS. Seen in light of the announcement of PEPFAR, the Strategy may have been the Bush Administration's move away from securitization, and towards humanitarian rationales for addressing the HIV/AIDS pandemic.

Of course even as a humanitarian endeavour, the PEPFAR initiative was not free from politics. In addition to the publicly stated humanitarian rationale for PEPFAR, there is widespread agreement behind the scenes that the desire to improve the U.S. global image in the run-up to the 2003 Iraq war was a major factor in the launch of PEPFAR. Morrison (Interview) called PEPFAR the "soft twin of Iraq" and argued that the administration hoped PEPFAR would demonstrate that Bush was interested in more than going to war with Iraq. Laurie Garrett (Interview) describes PEPFAR as "a foreign policy gamble to soften the attack in Iraq." RP Eddy (Interview) described PEPFAR as "a good piece of chess gamesmanship – meaning, nice to meet you, we're the United States and we're going to invade Iraq... We're going to invade Afghanistan... but we're also going to do this massive AIDS program." The *New York Times* wrote: "As Mr. Bush prepares for possible war with Iraq, his new commitment to global AIDS suggests an emerging geopolitical reality: if the United States is going to present itself as having a moral imperative to stop terrorism, it must also take up the cause of morality in a manner that does not involve dropping bombs" (Stolberg and Stevenson 2003: para. 7). Behrman (2004: 306-307) describes the Bush administration's desire to present both the hard and soft sides to U.S. power in the political imagery orchestrated during the State of the Union speech:

> [T]he president's guest of honor, sitting to the first lady's right, Dr. Peter Mugyenyi, the physician from Uganda who had consulted with the [PEPFAR] team and played a central role in their efforts. The first lady was flanked on her other side by a uniformed military servicewoman. It was the desired snapshot: to one side the stick and on the other the carrot, American might and beneficence, both on display.

Thus while PEPFAR was not directly driven by the national security implications of HIV/AIDS, the timing of its announcement, and perhaps its origins, were associated with broader foreign policy and national security objectives of the Bush Administration after 9/11.

A final and major motivating factor in the creation of PEPFAR was the support and encouragement of Christian conservatives. Support among evangelical Christians for the U.S. to address the global pandemic had been building since conservative Senator Jesse Helms told a conference, run by the religious charity Samaritan's Purse, that he was ashamed that he had not done more concerning the HIV/AIDS pandemic (Helms 2002).

In a letter to the *Washington Post*, Helms (2002) emphasized that mother to child transmission of HIV/AIDS could be prevented, which "publicized the fact that in Africa the disease was usually transmitted heterosexually, reaching audiences who had previously disregarded its spread among homosexuals or considered it a God-sent punishment" (Burkhalter 2004: 10). Burkhalter (2004: 8, 14) writes that the Bush administration was "prodded by its conservative evangelical base" to address HIV/AIDS and that "the entry of religious conservatives into the struggle has helped galvanize U.S. AIDS policy and given the issue a welcome hearing in Congress and the White House." Christian conservatives were pushing for the U.S. to become more involved in efforts to fight the pandemic for humanitarian reasons, and were not seemingly motivated by securitization and national security arguments about HIV/AIDS.

The combination of these factors - humanitarian need, proof that scaling up AIDS treatment was achievable, the war in Iraq, and conservative religious support - all appear to have contributed to the creation of PEPFAR. Despite the appearance that perceived national security implications of HIV/AIDS played a key role in the formation of the initiative, the evidence challenges this assumption. Instead, the national security implications of HIV/AIDS drove the issue to the highest levels of the U.S. government and provided new political support for addressing the pandemic. However, once there, HIV/AIDS was treated primarily as a humanitarian issue with foreign policy benefits for the U.S. by the Bush Administration. PEPFAR, the U.S.'s massive scaling up of HIV/AIDS funding and flagship program to fight the disease was a humanitarian initiative and foreign policy gambit to soften the image of the U.S. before the Iraq invasion, but was not driven by the national security implications of the pandemic.

The complex political undercurrents that defined HIV/AIDS as a political issue in the U.S. since 2000 also illustrate the unpredictable nature of high politics. As a low politics issue during the early Clinton Administration, humanitarian arguments proved insufficient to muster significant political action to address the pandemic. However once HIV/AIDS became a high politics issue through securitization, as described in Chapter 5, humanitarian arguments gained footing within a broader foreign policy rationale. Conservative evangelical groups were critical to putting forth this humanitarian rationale for addressing the pandemic. This represents an arresting reversal of the traditional foreign policy hierarchy, where a cosmopolitan perspective that supports humanitarian

action is more politically motivating than a communitarian perspective linked to material interests. This situation would seem to support Fidler's (2005b: 184) revolution model, where support of global health is embraced as a "pre-eminent political value." However, it is unlikely that HIV/AIDS would have been addressed at a high political level at all if not for securitization. Only once HIV/AIDS was a political priority did the Bush Administration address the disease through a cosmopolitan perspective. Even then, the announcement of PEPFAR was clearly used to support ulterior U.S. national security objectives in relation to the Iraq War. Therefore, Fidler's (2006b) remediation model may still accurately describe the relationship between HIV/AIDS and political priority during the Bush Administration.

6.3.4 U.S. Department of Defense HIV/AIDS Prevention Program (DHAPP)

While the PEPFAR initiative was not overtly concerned with U.S. national security, the U.S. Department of Defense (DoD) was quietly building a small program that fully embraced the links between HIV/AIDS and U.S. national security. The *Department of Defense HIV/AIDS Prevention Program (*DHAPP) is a unique military-to-military HIV/AIDS prevention, treatment, and training program. DHAPP is designed to reduce the spread of HIV/AIDS in foreign militaries in pursuit of the national security objectives of preventing state failure, terrorism, and supporting African peacekeeping operations. The DHAPP initiative is important to examine as the main U.S. initiative that directly resulted from, and was motivated by, the securitization of the pandemic.

Beginning in March 2001 with the militaries of nine African countries, DHAPP rapidly expanded to provide assistance for HIV/AIDS prevention among troops in 71 countries by 2005 (Department of Defense HIV/AIDS Prevention Program 2005a, 2005b). Lim (2004: 14) describes the range of HIV/AIDS prevention services DHAPP provides: "The AIDS prevention program provides funding for surveys on knowledge, attitudes, and practices among foreign troops, as well as educational and training materials." DHAPP works to expand access to voluntary testing and counseling facilities, reduce stigma associated with HIV/AIDS among the armed forces, and provide force-wide testing to willing militaries (Lim 2004). Funding is available for expanding health care infrastructure, from construction of new facilities to the purchasing of laboratory equipment including "HIV diagnostic kits, CD4 cell counters, and other sophisticated

medical devices" (Lim 2004: 14). DHAPP also provides training in the U.S. for foreign military physicians, and sponsors regional workshops on HIV/AIDS for military personnel.

In contrast with PEPFAR, the rationale behind DHAPP is closely linked to addressing the national security implications of HIV/AIDS. According to a key informant interviewed by this research, the U.S. military is most concerned that AIDS will cause militaries to lose "highly specialized professional soldiers," and that the loss of these will have a strong effect on their militaries (Military Interview). The interviewee explained that the strength of a military depends on its non-commissioned officers (NCOs) who have eight to fifteen years of experience. Serving this period in the military is essential to ensuring experienced management of the armed forces. However, this length of time is also sufficient for symptoms of AIDS to develop if a NCO is HIV-positive. The concern of the U.S. military is that the loss of NCOs to AIDS will cause the "professional ethos of the military to wither" (Military Interview). If lost, the military loses valuable leadership, the ability to train new NCOs, and established knowledge to effectively operate independently. The interviewee likened the loss of NCOs to AIDS to "barnacles on the hull of a ship" (Military Interview). The interviewee also explained that, in high prevalence areas, the impact goes beyond the prevalence of HIV-positive soldiers. In these areas, uninfected solders, or those who are HIV-positive but do not have AIDS, become responsible for the care of family members who have HIV/AIDS. In the case of South Africa and Zimbabwe, where military infection rates are above 20%, this can reduce the military's effective strength by 50% claims the interviewee.

While the U.S. military views HIV/AIDS prevention within militaries to be important, it is observed that militaries are often overlooked in civilian prevention programs. One key informant noted that "if the U.S. military is not involved, then militaries get overlooked or forgotten" in civilian HIV/AIDS programs (Military Interview). The interviewee stated that "we often assume that the military has its own health system, but military funding is for tanks and bullets, there is no money for health promotion or education." It was also pointed out that working with foreign militaries is often more productive than similar work with foreign governments. "Militaries are often the most functional arm of a government… they are an entity you can work with and get things done" (Military Interview). DHAPP personnel believe that the program therefore plays a unique role in

the global fight against HIV/AIDS by providing support to the uniformed services. Executive Director of the DHAPP Schaffer (2006: video) states:

> Military populations are often excluded from the HIV/AIDS prevention programs in the civilian communities. In addition, military populations believe that civilian programs do not understand their situation and don't apply to them. The DoD HIV/AIDS Prevention Program fills this gap.

Beyond the direct impact of HIV/AIDS on militaries, the DHAPP is motivated by the potential indirect effects of HIV/AIDS on state stability, terrorism, and peacekeeping operations. Colonel Edward Huycke, the command surgeon for the U.S. European Command (EUCOM)[23] states that, at the "U.S. European Command, we see this HIV and AIDS pandemic through a national security lens and through a global war on terror lens…we view the HIV/AIDS as one of the serious threats within the area of responsibility" (CSIS Task Force on HIV/AIDS 2005: 22). Kathy Ward of the International Crisis Group says that "DOD sees a particular security interest in pursuing HIV/AIDS prevention activities with foreign militaries because the spread of HIV is a major destabilizing factor in developing societies, leaving them vulnerable to unrest or infiltration by terrorist elements" (Fisher-Thompson 2005: para. 11).

According to a confidential key informant (Military Interview,) the U.S. is particularly concerned about the effects of the pandemic on state stability. The threat of "failed states is the central reason this program exists" (Military Interview). The interviewee stated that, with HIV/AIDS causing decreasing life expectancy, falling GDP, loss of life, loss of jobs, increasing crime, "you have to wonder if this all will cause state collapse." DHAPP is "making a modest investment early, and the payoff is in avoiding future crises" and state instability (Military Interview).

This concern over state instability focuses on both preventing humanitarian crises that may result in demands for U.S. action, and fears that terrorists can use a failed state as a base for operations. Colonel Huycke places DHAPP's efforts to fight HIV/AIDS within the context of the "War on Terror":

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[23] EUCOM is one of is one of five geographic combatant commands within the U.S. Department of Defense, responsible for all U.S. military activity within its area of responsibility. EUCOM's area of responsibility includes all of Europe, the former Soviet Union, and Africa except for Egypt, Sudan, Djibouti, Somalia, Eritrea and Ethiopia. See: http://www.eucom.mil/english/index.asp and http://en.wikipedia.org/wiki/United_States_European_Command for more information.

The concern of the EUCOM is that with the societal stresses associated with the loss of the leaders, or the loss of the stabilizing influence that the number of places in Africa that are hit hard by the HIV/AIDS epidemic will become places where terrorist move and flourish. Because that is a concern we view the efforts at prevention of HIV/AIDS and treatment where appropriate as helpful on the war on terror. The EUCOM is not fighting the war on terror perhaps the way that the United States Central Command [who oversees operations in Iraq and Afghanistan] is but we view this a long-term, very important contribution to the war on terror. (CSIS Task Force on HIV/AIDS 2005: 37)

DHAPP also argues that it supports U.S. strategic interests by helping to maintain full staffing levels and operation of UN and regional peacekeeping operations with non-U.S. troops by limiting rates of HIV/AIDS in troop contributing countries. Lim (2004: 13) writes that the effect of HIV/AIDS on peacekeeping operations and regional stability are also primary reasons for helping foreign militaries address HIV/AIDS:

> Military forces with significant HIV rates cannot engage as effectively in peace-keeping efforts, and may not be able to maintain their own nation's security, which in turn may lead to regional instability and increased conflict. Thus, U.S. national security interests are served by promoting the health and well being of foreign uniformed military personnel.

The key informant within the military (Military Interview) explains the political reasons behind DHAPP's efforts to support peacekeeping operations:

> [T]he U.S. has an allergy to using U.S. troops for peacekeeping… The UN depends on the 3rd world to supply peacekeeping troops. If there are not enough healthy soldiers from these states, either we need other nations to contribute peacekeeping troops or it won't get done. It is in our (U.S.) national interest to leverage the assets of other nations for peacekeeping.

Colonel Huycke also focuses on peacekeeping in explaining the U.S. strategic concern with high infection rates among African militaries:

> If a military, African military is infected, seriously infected by HIV/AIDS, what does that mean to us? And our concern is that with the weakened military there is an increased potential for conflicts, conflicts in which U.S. interest might be threatened and which we might have to be involved. An impact on peacekeeping operations, you know, we very much are interested in having Africans take care of Africans when it comes to peacekeeping operations on the African Continent. And the impact of deployability on the militaries is very, very important. (CSIS Task Force on HIV/AIDS 2005: 22)

Kathy Ward of the International Crisis Group also notes that DHAPP's efforts are intended to limit the U.S. military's involvement in African crises, saying that the DoD interest in HIV/AIDS "comes at a time when the United States hopes to increasingly use African and other regional forces to provide significant contingents for operations to reduce pressure on overextended U.S. forces" deployed in Afghanistan, Iraq and in the war on terror (Fisher-Thompson 2005: 12).

The confidential military interviewee argues that in addition to concerns about state stability, terrorism, and peacekeeping, the DHAPP provides a diplomatic service for the U.S. In much of the world, "the U.S. military is the best funded and most visible [U.S.] presence" (Military Interview). DHAPP shows that the U.S. is "willing to engage on a broad variety of things including HIV, not just terrorism or loose nukes" (Military Interview). The interviewee explains that there is hope that this broader engagement, outside of the so-called War on Terror, allows the U.S. to more effectively engage countries and build stable relationships. The interviewee explains that DHAPP "is an investment in both you and us. The fewer problems you have, the fewer problems for us. In the long-term, this is win-win" (Military Interview).

According to the confidential Military Interview, the long experience in the U.S. of treating HIV-positive soldiers contributed to gaining expertise in HIV/AIDS prevention and treatment that the DHAPP now shares. The U.S. began force-wide screening for HIV/AIDS in 1986. With hundreds of soldiers infected, HIV/AIDS was a "big, looming concern" of the U.S. military (Military Interview). The interviewee explains that after a painful process of developing policies for treatment of HIV/AIDS, the U.S. military now has a good system for caring for HIV-positive soldiers, as well as effective prevention education and testing policies (Military Interview). Dr. Richard Schaffer, director of DHAPP, says that foreign militaries recognize U.S. experience preventing and treating HIV/AIDS among its military forces. He states:

> They recognize that 20 years ago we were very much in the same position they are in, where we were just starting to set up our policies, just starting to figure out how to deal with our own infected members. So many of them feel we are in a different situation than they are, but they do recognize that we have a history that is similar, possibly, to theirs currently. (Basu 2005: Military to Military HIV Prevention, para. 14)

This U.S. military experience was the genesis of the DHAPP, while concerns about state failure, terrorism, and peacekeeping, as well as the foreign policy benefits of engaging foreign militaries on HIV/AIDS, drove later implementation of the program.

Given PEPFAR's humanitarian orientation, it is only the much smaller DHAPP that has been the American HIV/AIDS program which seeks to directly address the links between the disease and U.S. national security. This program, framed within a communitarian perspective on national security interests of the U.S. military, seeks to prevent and treat HIV/AIDS among underserved (in terms of HIV/AIDS programs) and high-risk military populations. This research finds that the primary goals of this initiative are to stabilize foreign militaries, prevent state weakness due to HIV/AIDS, ensure the health of militaries that donate forces to peacekeeping operations thereby limiting the need for U.S. military contributions, and support ulterior U.S. diplomatic goals. This is a unique example of the U.S. pursuing global health activities because they directly support national security objectives.

It is argued in this research that this is a further example of Fidler's (2005b: 184) remediation model, confirming that when "diseases threaten… national security, military capabilities, geopolitical or regional stability… foreign policy makers take notice." Furthermore, DHAPP's efforts to directly address the national security implications of HIV/AIDS for the U.S. may have allowed the Bush Administration greater latitude to adopt a humanitarian rationale for PEPFAR.

6.4 The HIV/AIDS – national security nexus outside of the U.S. and UN

The HIV/AIDS – national security nexus has remained limited outside of the U.S. and UN. No other countries to date have publicly embraced the links between the disease and national security at the state level, and implemented programs to directly address the national security implications of the pandemic since its securitization in 2000. There has been talk, but little action to suggest that emergency measures have been adopted because of securitizing moves. This brief section will describe how both wealthy donor countries outside of the U.S., and states affected by HIV/AIDS, have declined to

securitize the pandemic. Examining some the reasons why states have not sought to securitize the pandemic also further illuminates commonalities between the cases of securitization in the U.S. and at the UN. Despite a lack of securitization at the national level, African and U.S. militaries maintain a strong interest in addressing HIV/AIDS, suggesting that aspects of the HIV/AIDS – national security nexus will remain relevant despite a lack of securitization outside the U.S. and UN.

6.4.1 Western donor countries and high prevalence states

In contrast with the U.S., to date other major donor countries including the UK, Canada, Australia, and Japan, have rarely framed HIV/AIDS as a threat to their national security, or implemented programs to address the national security implications of the disease. In his review of foreign policy in the U.S., UK, Canada and Australia, McInnes (2004: 39) finds that the "link between health and development is stronger than that between health and foreign policy." Furthermore, he finds that health issues remain a low priority in the foreign policies of the UK, Australia and Canada. Health issues are not even mentioned in the section on global security threats in Australia's 2003 White Paper on foreign and trade policy, while Romanow (2002) finds that "the broader area of health promotion is very much an afterthought in Canada's foreign policy" (McInnes 2004: 34-35). A review of Japan's response to HIV/AIDS contains no mention of the national security implications of HIV/AIDS, and HIV/AIDS is actually a lower priority for Japanese foreign aid than tuberculosis, polio, and parasitic diseases (Japan Center for International Exchange 2004).

Although the UK was broadly supportive of U.S. efforts to address HIV/AIDS within the UNSC, as described in Chapter 5, and has given high priority to the disease in the provision of development aid through DFID, the UK has not chosen to securitize HIV/AIDS. In a review of UK policy towards HIV/AIDS, Feldbaum (2005b: 2) finds that "the UK foreign policy community has neglected to address HIV/AIDS" while the links between health and national security "are weak to non-existent." While aspects of the HIV/AIDS – national security nexus "are mentioned in publications on HIV/AIDS…the UK has taken little action to use foreign policy to fight HIV/AIDS or to address the security implications of the epidemic" (Feldbaum 2005b: 13). Furthermore an advisor to DFID, the lead agency in the UK overseas response to HIV/AIDS, has

called the links between HIV/AIDS and state instability "a bit unrealistic" (Ingham 2004: para. 1). In short, other donor countries have maintained aid programs for HIV/AIDS, but have not securitized the disease nor sought to address the national security implications of HIV/AIDS in their aid programs.

Some states highly affected by HIV/AIDS have occasionally described HIV/AIDS in the language of national security[24]. In a well-publicized example, President of Botswana Festus Mogae described HIV/AIDS in terms of the survival of Botswana: "We are threatened with extinction. People are dying in chillingly high numbers. It is a crisis of the first magnitude" (Rollnick 2002: 4). Russian Deputy Prime Minister Alexander Zhukov has described HIV/AIDS as "an issue of strategic, social and economic security of the country" (World Bank 2005). One hundred and forty two HIV infections out of a total population of 8,020 caused the Minister of Health for Fiji Solomoni Naivalu (2004) to describe HIV/AIDS as a threat to Fijian national security. Outside observers have also considered HIV/AIDS to be a direct threat to highly affected African states (Ostergard 2002; Price-Smith 2002). However, while these descriptions frame the disease as a national security issue and are securitizing moves, the respective governments have not securitized the disease by enacting emergency measures to address the disease. Although Botswana has implemented a strong public health response to HIV/AIDS in an attempt to ameliorate the impact of the disease, there is no evidence that using the language of national security was critical to this response[25]. Similarly, the Russian response to HIV/AIDS has been sluggish, "mired in moralism and xenophobia," and not characterized by the priority of a national security threat (Alcorn 2006: headline). Thus even in states where HIV/AIDS has been described as posing a direct threat to national security, the disease has not been securitized.

Explanations for why HIV/AIDS has either remained a low politics issue outside of the US and UN, or been addressed as high politics but not within the context of securitization, are numerous and varied. A major barrier to securitization may be the

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[24] Excepting the examples of Uganda and Thailand discussed in Chapter 4.

[25] Fanny Chabrol (2008) suggests that Botswana may be considered a case of another country which has securitized HIV/AIDS. She argues that the emergency measures enacted in Botswana, in the wake of Mogae's statement, mobilized government funding to provide ARV treatment and routine HIV testing. However, Botwana is a unique country in terms of its wealth, governance, and relationships with aid donors, which complicates this finding. Detailed research on the process of securitization in Botswana is needed, including a history of the HIV/AIDS – national security nexus, to understand whether Mogae's statements did indeed securitize the Botswanian epidemic.

lack of clear data or examples to support the idea that HIV/AIDS can threaten a state's political, economic and military security. Although this lack of data did not prevent securitization in the U.S. and UN, it was an important criticism of securitization in both cases. Furthermore, outside of the U.S. and UN, the lack of data may present a greater barrier. The comment that the links between HIV/AIDS and national security are "a bit unrealistic" by a DFID advisor suggests that the lack of data is a barrier to securitization in the UK (Ingham 2004: para. 1).

A bias against addressing non-traditional threats to security played a large role in resistance to securitization in the U.S. and UN, and is a likely cause of resistance to securitization in other countries. Another explanation may be that in many wealthy donor countries aside from the U.S., health and development are already political priorities for government action. While not on par with the national security of these states, there may be less need in these states to drive HIV/AIDS up the political agenda by linking the pandemic to national security considerations.

However the most salient way to explain why securitization has been limited to the U.S. and UN is not found in the numerous reasons why other states have not securitized the disease, but in the commonalities between the successful cases of securitization. The clear common factor between the two cases of securitization was the involvement of U.S. actors. The work to produce NIE 99-17 was obviously based within the U.S. intelligence community, while in the case of the UN, the U.S. Ambassador and delegation to the UN led efforts to securitize HIV/AIDS at the UNSC. This suggests a much stronger tendency to link issues with national security considerations in the U.S. than in other countries.

Answering why the U.S. would be more likely to link issues with national security considerations requires an anthropological investigation that is beyond the scope of this thesis. King (2002) argues that the current linkage of global health issues to state security interests is a modern expression of the long-standing alignment of public health with state security and economic interests. The "emerging diseases worldview" (described in Section 5.1,) combines these historical ideological connections with growing American anxiety about globalization, to produce a persuasive narrative about the threat of emerging diseases, including HIV/AIDS (King 2002: 767). This narrative

was developed in the U.S., and specifically targeted U.S. policymakers through its appeal to economic and security interests. Ingram (2005b) further observes that the linking of global health to national security in the U.S. may be attributed to the emerging diseases worldview, U.S. global economic and military interests that may be impeded by disease outbreaks, and experiences of September 11th and the 2001 anthrax attacks. (Cooper (2006) also discusses links between emerging diseases and changes in U.S. defense policy during the George W. Bush administration.) Furthermore, as the world's sole remaining superpower, with global security interests and unparalleled ability to project force, the U.S. generally places a strong focus on security as the most critical issue in world affairs. This focus on security in the U.S. is likely stronger than in countries with more regional and local security interests, as well as limited abilities to project force beyond their borders. Because of this, linking issues to national security interests is likely more effective in the U.S. than in other countries of achieving the aim of raising an issue higher on the policy agenda. Because this linkage is effective, it may be pursued more often in the U.S. than in other countries.

6.4.2 African militaries

A number of African military leaders have publicly stated that HIV/AIDS represents a threat to the security of their armed forces. Major General Bakwena Oitsile of Botswana argues that if "the security forces become weaker due to ill health, the countries' constitutions could easily be challenged. The political structures that that ensure democratic governance could be threatened" (Kaiser Daily HIV/AIDS Report 2003: para. 1). Victor Simunja (2001: para. 1), Namibian Deputy Minister of Defence, similarly said that HIV/AIDS is "affecting security and military establishments to the core." The rates and impact of HIV/AIDS in the South African armed forces has also received extensive public attention (Hosken 2004; Meyer 2004; Heinecken 2001c and 2003). For the purposes of this thesis, while these are not cases of securitization where emergency measures have been adopted by states, African military involvement in fighting HIV/AIDS is an important component of the nexus and illustrates the complexity of gauging the impact of the pandemic on African militaries.

Martin Rupiya (Interview), a former member of the Zimbabwean armed forces and senior researcher at the Institute for Security Studies in South Africa, argues that most

African militaries have recognized the problem of HIV/AIDS. Rupiya (Interview) argues that militaries in Africa have been able to take the lead in addressing HIV/AIDS because national governments have devolved HIV/AIDS policies down to the military and other sectors. Rupiya (Interview) describes the armed forces as "go getters," working with "a disciplined, isolated community" that has helped create successful HIV/AIDS prevention programs.

Agnes Binagwaho, executive secretary of Rwanda's National AIDS Council, confirms that the military is leading the fight against HIV/AIDS in Rwanda. Binagwaho states: "The outside help [from DHAPP] has been critical… I think our best AIDS program is the one run by the military. The military here in Rwanda have done it the right way from the beginning" (Donnelly 2004: para. 4). Rupiya says that "the militaries are well ahead of many sectors in their own societies" in addressing HIV/AIDS (Goering 2006: para. 7). Rupiya continues to argue that:

> The military's inherent structure of discipline and following commands… has helped ensure regular condom distribution, regular AIDS testing and that HIV-positive soldiers take their anti-retroviral drugs. And because military readiness is key to national security, militaries have made controlling AIDS a priority. In many cases, 'the armed forces have had a greater response' to the region's AIDS pandemic than national governments… (Goering 2006: para. 8)

While Rupiya does argue that HIV/AIDS is affecting African militaries, Rupiya believes that talk of African militaries being "hollowed out" is exaggerated. He explains that military programs to prevent and treat HIV/AIDS are often ahead of civilian HIV/AIDS programs in the same country. Military leadership in addressing HIV/AIDS is actually resulting in African militaries acting as "change agents" and providing a positive example of leadership against HIV/AIDS for other government sectors (Rupiya Interview). This strong response Rupiya suggests, combined with rejecting HIV-positive recruits and reassigning HIV-positive troops, has greatly reduced the implications of the disease for national security and African militaries (Rupiya Interview). Stuart Kingma (Interview) offers a more skeptical perspective on this success. Kingma argues that by rejecting HIV-positive troops from military service, armed forces have reduced rates of HIV, but that this is not the same as instituting programs to prevent and treat HIV/AIDS. He says that many militaries have yet to institute these programs, which will undermine progress against the disease in both military and civilian populations. Rupiya (Interview)

concludes by warning that the DHAPP is the primary source of HIV/AIDS aid to African militaries and that the military progress in fighting the disease to date is "only happening with this outside aid" (Rupiya Interview). In is important to note that other countries have been less forthcoming about the impact of the disease on their militaries. Garrett (2005: 27) recalls that the "first public acknowledgement of HIV's devastating toll on the Zimbabwe National Army (ZNA) came in 2004, with China's expulsion of a third of the ZNA officers sent to the People's Republic of China (PRC) for advanced training, due to their HIV infection status."

This brief review of HIV/AIDS policies outside of the U.S. finds that the securitization of HIV/AIDS since 2000 appears to have largely been an American phenomenon. Neither other major donor countries, nor states highly affected by HIV/AIDS, have formally framed the disease in security terms, or sought to specifically address the national security implications of the pandemic. The factors that resisted securitization in the U.S. and the UNSC, including a lack of direct evidence, a bias against addressing non-traditional threats to security, and a lack of need to securitize issues that are already government priorities, likely contributed to the absence of securitization in other countries. However presence of U.S. actors in both cases of the securitization of HIV/AIDS suggests that linking issues with national security considerations is more common and beneficial in the U.S. policy environment. Despite the lack of securitization of HIV/AIDS outside of the U.S. and UN, many African militaries work with the U.S. DHAPP to limit the impact of HIV/AIDS on military populations. This interest from both African and U.S. armed forces suggests that the HIV/AIDS – national security nexus will continue, especially the focus on HIV/AIDS among armed forces, despite an absence of widespread securitization of the disease.

6.5 Secret data: revision of HIV prevalence estimates among armed forces and peacekeepers

The final section of this chapter will examine a development that illuminates the complex role evidence has and continues to play in the HIV/AIDS – national security nexus. As well as examining why evidence of HIV prevalence among armed forces is

difficult to accurately ascertain, this section illustrates the role evidence has played in securitization and one resultant danger of the nexus.

During 2005-2006, a small number of publications called into question long-standing assumptions about extremely high HIV/AIDS prevalence among African armed forces. HIV/AIDS prevalence in these militaries was previously reported as 2-5 times higher than civilian populations, with some military units demonstrating 40-60%, and even 90% HIV prevalence. This data was used by securitizing actors in the U.S. and UNSC in support their arguments. However recent publications have argued that a significant downward recalibration of these estimates and assumptions is required.

Most militaries classify rates of HIV/AIDS within the military as a state secret and, as discussed in Chapter 5, the UNSC does not have the authority to test donated peacekeeping troops. Because of this secrecy, and an absence of reliable alternative data or studies, most authors before 2005 have relied almost exclusively on two reports: *AIDS and the military* (UNAIDS 1998) and the NIE 99-17 (National Intelligence Council 2000). The UNAIDS (1998: 3) report describes rates of HIV/AIDS among armed forces as "2 to 5 times higher than in civilian populations" and up to "50 times higher or more" in times of conflict. The data within the NIE 99-17 report was based on an unpublished 1999 report by the U.S. Armed Forces Medical Intelligence Center, and describes rates of HIV infection in seven African militaries as ranging between "10 to 60 percent" (National Intelligence Council 2000: 10). Of particular note in the NIE 99-17 report are estimated rates of HIV in the militaries of Angola and the Democratic Republic of the Congo of 40-60%, and in Tanzania of 15-30% (National Intelligence Council 2000). Because these were the only available published rates of HIV/AIDS within armed forces, they have been widely reproduced and cited as a component of the evidence on the nexus (Feldbaum 2005a; Singer 2002; Heinekin 2001a, 2001b; Elbe 2002, 2003; Tripodi and Patel 2002).

Since 2005, and based on a limited amount of new data, a number of authors have questioned whether these estimates are too high, in some cases, by significant margins. Garrett (2005: 25) writes that agencies including "the CIA and U.S. Defense Intelligence Agency (DIA), used indirect data to conclude that infection rates in some African militaries were as high as 75 percent. Such speculations appear to be off target."

Feldbaum et al. (2006a: 775) argue that "HIV prevalence among armed forces is equal to or slightly greater than civilian rates from the same country." Calling the idea that militaries have higher rates of HIV/AIDS than their civilian counterparts a shibboleth, Whiteside et al. (2006: 202, 206) contend that "HIV prevalence among new recruits is low and probably even lower than in civilians of the same age," but "expect prevalence to be higher among longer-serving soldiers than comparable civilian populations." de Waal (2005: 2) summarizes the situation regarding changing perceptions of HIV prevalence among armed forces:

> For about a decade, conventional wisdom among researchers and advocates has been that rates of HIV prevalence are typically two-to-five times greater among soldiers than comparable civilian populations. While HIV levels in military populations remain a controversial and inadequately-evidenced subject, we can say with confidence that this is not the case in sub-Saharan Africa. It may have been true at an early stage of the epidemic in that continent, when general population HIV prevalence was in the order of 2-5% while rates in some militaries were considerably higher...Such claims served a useful purpose in sounding the alarm and making armies take notice of the problem. Current data indicate that these elevated levels are not found in sub-Saharan Africa today.

These more recent analyses have been supported by denials from countries rumored to have high rates of HIV/AIDS within their militaries. For example, South African Defense Minister Mosiuoa Lekota declared that there was no AIDS crisis within SANDF (South African National Defence Force), and that "Just like the rest of South Africa, the defense force has members who are infected with the virus. This does not mean that we are experiencing major problems or facing a disaster" (Hosken 2004: para. 10). Richard Shaffer, director of the DHAPP, said he found no evidence of the previously reported high rates of HIV among militaries. "There isn't a military in Africa that has got much more than a one-third prevalence rate" (Donnelly 2004: para. 21). These opinions represent a significant recalibration of publicly available estimates of HIV prevalence among militaries, especially in Africa.

However, the situation regarding estimates of HIV/AIDS in militaries remains opaque. The downward recalibration of estimates is based on a small number of military studies, confidential or unpublished information, and guesswork. Whiteside et al. (2006: 202-203) write that their conclusions are "based on some limited data from the military, extrapolations from other data, and epidemiological logic." Garrett's (2005) conclusions are based on public statements as well as unnamed sources, while Feldbaum et al.

(2006a) is based on interviews with U.S. and African military officials. No comprehensive epidemiological surveys have yet been conducted or published to confirm this downward revision of estimates.

Assessing the situation is admittedly complex which adds to the difficulty of obtaining accurate data. Rates of HIV/AIDS within a military may vary widely based on "demographic structure of an army, its conditions of service and manner of deployment, and its HIV/AIDS programme" (Whiteside et al. 2006: 206). These complexities will largely determine how HIV/AIDS affects a military. For example, the strategic impact on a military of the loss of a new recruit versus the loss of a general varies enormously. Furthermore, the subject of HIV prevalence in militaries is highly politicized and governments may have a strategic interest in preventing the publication of accurate rates which may be embarrassing or signal weakness to a state's enemies. A confidential military interview carried out for this research yielded the observation that the greater the rate of HIV in a military, the more closed that military is about the information. The interviewee added that some militaries do not perform force-wide screening for HIV/AIDS because they lack the skills to manage such a large database. However the interviewee states that other militaries do not want to have precise figures of HIV rates, which allows those militaries to truthfully answer that that do not know the prevalence of HIV in their armed forces. Still other militaries describe reports of rates of HIV in their military as inaccurate, while refusing to provide actual rates of HIV prevalence (Military Interview). Martin Rupiya (Interview) says it is wrong to believe that accurate statistics are available in countries like Congo or Angola where there is very little medical infrastructure. General Carlton Fulford Junior, former Deputy Commander of U.S. European Command and Director of the Africa Center for Strategic Studies at the U.S. National Defense University, emphasizes the difficulties of obtaining accurate estimates of HIV prevalence in foreign militaries:

> Those numbers are the best that we have so keep that in mind. They are the best that we have and they are very, very, very questionable. Let me take Nigeria as a case in point... First of all the figure is about eight percent... Number two Nigeria doesn't test, so I don't know where that number comes from. I have zero faith in that number... we're working very hard on a country-to-country study to determine what is factual and what is anecdotal so that we can better deal with the challenge, and it's hard. Some countries are open, so refuse to talk about the issue, some don't have a clue and don't want to know what the real issue is. So when you see numbers like that, keep that in the back of your mind that that's

> very questionable and in many cases the problem is much, much worse than those numbers might show. (CSIS Task Force on HIV/AIDS 2005: 34-35)

The difficulties in ascertaining true rates of HIV/AIDS among militaries and peacekeeping forces have resulted in a situation where rumor and poorly understood studies are prevalent. As Bazergan (Interview) says: "there is no good data, so the issue gets played out in the media." A prominent example of this has been the inaccurate report that 89% of SANDF members who were tested were HIV-positive. This alarmingly high percentage was reported under the headline "SANDF unveils shock Aids data" (Meyer 2004: headline). The article continued:

> The combat readiness of the South African National Defence Force is under threat, with the latest results of an Aids project showing that an overwhelming 89 percent of those soldiers who volunteered for testing were HIV-positive... In the first six months of the project 1089 soldiers volunteered to be tested, of whom 947 were found to be HIV-positive. (Meyer 2004: para. 1)

This statistic was used in the article to contradict the South African military's assertion that 20-25% of its forces were HIV-positive.

In fact, this study had been conducted at an HIV/AIDS clinic setup by SANDF and the DHAPP (Military Interview). Those tested either suspected or already knew they were HIV-positive (Military Interview). These factors heavily biased the final result of 89%, rendering it specious. However, unlike scholarly publications, media reports did not consider how selection bias (self selected sample of soldiers) led to data that was not representative. It is because of national security concerns that rigorous scientific studies of the military prevalence of HIV are not conducted, scientifically reviewed, or published, which results in the issued being played out in the media.

The downgrading of estimates of HIV/AIDS prevalence among African militaries illuminates the differences in how global health and national security data is treated. Global health data is peer-reviewed, with the intent that published data will contribute to improved health. In contrast, data on the prevalence of HIV/AIDS in many militaries is either unwelcome or classified as a national security secret. Ken Bernard (Interview) describes this difference in approach to data collection and reporting:

> The real difference is how people deal with intelligence. Intelligence in the health world is always unclassified. It's always open source, it's always freely distributed as a matter of good conscience and, of course, in the security world, information is power and information is not be shared, except with allies or those who are co-sharing with you. And there's a huge amount of distrust between the health communities and the security communities on intelligence...

Overall, the continued classification of data on the prevalence of HIV/AIDS within the military has contributed to inaccurate and misleading reports in academic journals, mass media and intelligence reports. Furthermore, this has prevented the accurate evaluation of HIV/AIDS education and prevention efforts by such organizations as DHAPP, DPKO and UNAIDS. As Feldbaum et al. (2006a: 777) argue, "Countries classifying information on HIV/AIDS in their armed forces as national security secrets hinder the targeting, operation, and evaluation of HIV prevention and treatment programs for both soldiers and civilian populations that interact with them." The more recent downward revision of HIV/AIDS prevalence estimates among African militaries underscores the limitations of the data on HIV/AIDS among militaries and peacekeeping forces. This does not entirely suggest that the links between HIV/AIDS, the military and peacekeeping forces have lessened or are inconsequential. For example, UNAIDS (1998: 3) estimates that military prevalence of HIV/AIDS are "2 to 5 times higher than in civilian populations" is incorrect largely because civilian rates of HIV/AIDS have risen, not because military prevalence has significantly decreased, although some of the highest estimates appear to be inaccurate. What this demonstrates is that accurate assessment of the national security implications of HIV/AIDS must remain suspect because of the poor quality of this data.

Two major lessons emerge from this consideration of the evidence base for the HIV/AIDS – national security nexus. First, the history of data on HIV/AIDS among armed forces demonstrates major differences in the handling of information within and across the national security and global health communities. The classification of HIV/AIDS data among armed forces represents a potentially negative effect of the HIV/AIDS – national security nexus, that may be viewed as a specific example of Elbe's (2006a) warning concerning reduced transparency potentially resulting from securitization. This classification and secrecy around global health data undermines both HIV/AIDS prevention and treatment programs by preventing proper targeting and evaluation of programs. Keeping this data secret also contributes to inaccurate

assessments of the impact of HIV/AIDS in both news and intelligence reports. Second, the role of evidence in the history of the nexus and securitization has been complex. Data on HIV/AIDS among armed forces from UNAIDS and the NIE 99-17 report was used to support arguments for the securitization of the pandemic, but has now been questioned and partially discredited. However, the existence of evidence for the pandemic's impact on national security was never the main motivating reason for securitization at the UNSC or in the U.S. While evidence was used to support securitization, the process occurred for political reasons as described in Chapter 5. Because of the barriers to collecting accurate data on HIV/AIDS among armed forces, the limited role of evidence in the HIV/AIDS – national security nexus will likely continue.

6.6 Conclusions

The securitization of HIV/AIDS by the U.S. intelligence community and the UNSC contributed to a major rise in the international political status of the pandemic. In the wake of securitization, HIV/AIDS became a high politics issue which was frequently handled at the highest levels of government. Demonstrating this rise in political status was a marked increase in funding provided to fight the global pandemic across international organizations, UN agencies, foundations and bilateral aid from donor countries. While the transformation of HIV/AIDS into a high politics issue cannot be solely attributed to securitization, both Merson (2006) (the former head of the GPA) and Piot (United Nations Security Council 2001a) (current head of UNAIDS) cite the HIV/AIDS – national security nexus as playing a major role in elevating the political status of the pandemic.

Increasing the political status and funding for an issue is the main intended benefit of securitization. As Elbe (2006a: 120) clearly describes, "a successful 'securitization' of HIV/AIDS could accrue vital economic, social, and political benefits for millions of affected people by raising awareness of the pandemic's debilitating global consequences and by bolstering resources of international AIDS initiatives." As this chapter has shown, the securitization of HIV/AIDS did indeed result in increased political and financial commitments to fight the pandemic. Securitization at the UNSC and within the

U.S. intelligence community also legitimated "breaking of the rules" that had long kept health issues separate from the work of the UNSC and U.S. national security (Buzan et al. 1998: 33).

While the broad benefits of securitization on political attention and funding were significant, the specific results of securitization by the U.S. intelligence community and at the UNSC were more limited. In the case of the UNSC, the need to tailor action to the narrow issue of HIV/AIDS and peacekeeping focused UNSC efforts on an issue peripheral to the main drivers of the global epidemic and where the UN's ability to implement effective action to prevent transmission of the disease to and from peacekeepers was limited. Furthermore, securitization at the UNSC did not legitimize the breaking of longstanding rules that govern DPKO authority over testing and screening of peacekeepers, thus ensuring action on HIV/AIDS and peacekeeping operations would remain of limited efficacy. That securitization did not legitimize the breaking of these rules is not surprising, as the issue of peacekeepers and HIV/AIDS was not presented as an existential threat to peacekeeping operations, but as a means of linking the issue to the UN Charter. These political compromises allowed HIV/AIDS to be securitized by the UNSC, but also severely limited the UN's ability to effectively address the issue of peacekeepers and HIV/AIDS.

Similarly, specific U.S. action on the security implications of HIV/AIDS was limited even after three major U.S. intelligence publications examined the HIV/AIDS – national security nexus. Discussion of HIV/AIDS as a national security issue had elevated the disease into the realm of high politics and succeeded in generating emergency measures including the massive scaling up of U.S. funding for global HIV/AIDS in the PEPFAR program. However, most of this funding was not directed at the national security implications of HIV/AIDS, or even towards countries of strategic importance to U.S. interests. For the Bush administration, the national security implications of HIV/AIDS were less compelling than other foreign policy, political, and humanitarian rationales for addressing the pandemic. Thus while the broad benefits of securitization in both political attention and funding were clear, specific and effective action to address the HIV/AIDS – national security nexus was limited in both the U.S. and UN.

Two serious, potentially negative aspects of the HIV/AIDS – national security nexus outlined by Elbe (2006) were the shifting of funding from civilian to military HIV/AIDS programs, and the abandonment of addressing the disease through a humanitarian and development framework in favor of a national security perspective. Peterson (2002) also feared that describing HIV/AIDS as a national security threat would relieve the West of their moral obligations to address health issues that did not impact on their national security. Findings on the genesis and implementation of the PEPFAR initiative demonstrate that these potentially negative aspects of the HIV/AIDS – national security nexus have not materialized within the U.S. response to HIV/AIDS. There is little evidence that the U.S. response to HIV/AIDS has or will take on an excessive focus on militaries or national security interests. Neither have descriptions of HIV/AIDS as a national security threat diminished the moral aspects of responding to the pandemic. In fact, the moral obligation created by the availability of ARVs in developed but not developing states was the key public rationale for the PEPFAR program. Nor has securitization at the UNSC resulted in a shift by UN agencies away from addressing the humanitarian aspects of the HIV/AIDS pandemic. Countries outside of the U.S. have refused to securitize HIV/AIDS, making it also unlikely that their response to HIV/AIDS will be securitized or primarily driven by national security interests. These specific fears about the negative impacts of securitizing HIV/AIDS have not materialized as a result of securitizations in the U.S. and at the UNSC.

Finally, the downward revision of estimates of HIV/AIDS prevalence data among African armed forces demonstrates both a negative impact of the HIV/AIDS – national security nexus and the generally poor quality of epidemiological data that has been used as evidence for the national security implications of HIV/AIDS. The differences in how data are treated between the national security and global health fields represent a major fault line in the HIV/AIDS – national security nexus, with the potential to limit cooperation and understanding of the links between disease and security. Classification of data on HIV/AIDS in armed forces, which Elbe (2006a) indicates may be a consequence of reduced transparency resulting from securitization, also has the potential to undermine public health by preventing the proper targeting, implementation and evaluation of HIV/AIDS prevention and treatment programs among both civilian and military populations. That the main epidemiological evidence for the HIV/AIDS – national security nexus has been substantially revised also confirms the limited role

scientific evidence played in major securitization events. This chapter concludes that political currents and interests, even if unrelated to global health issues, played a more significant role in securitization than did scientific evidence on the HIV/AIDS – national security nexus.

Chapter 7: Conclusions and Recommendations

7.1 Introduction

While diseases have affected security interests throughout history, the latter half of the twentieth century was characterized by a separation of public health activities from power politics and state security. National security in the West was focused on winning the Cold War and exclusively studied "the threat, use, and control of military force" (Walt 1991: 212). Separate from security interests, public health developed into a humanitarian and technical field which was often normatively opposed to the politics of state interests and the Cold War. Then in the brief span of a decade, global health and the HIV/AIDS pandemic in particular, were transformed into high politics issues that were seriously debated by national and international security communities. Fidler (2004: 45) describes this as an unprecedented "revolution" where the "last decade has witnessed the previously obscure and neglected policy area of public health shed obscurity and neglect to become the subject matter of intense national and homeland security, foreign policy, and global governance debates." The policy process behind this linking of global health and national security through the HIV/AIDS pandemic, and what this has meant for global efforts to fight the disease, has been the subject of this thesis.

The purposes of this thesis have been to create a detailed history of the HIV/AIDS – national security nexus, locate this history within competing conceptual understandings of security, and to assess the role of global health actors in the nexus and the risks and benefits of using this nexus to promote global health action. After the introductory chapters, literature review and review of conceptual frameworks, Chapter 4 sought to reintroduce and examine older cases of securitization, Chapter 5 traced the history of the major securitizations of HIV/AIDS in the U.S. and at the UNSC, and Chapter 6 sought to understand the consequences of these securitizations.

7.2 The process and consequences of the securitization of HIV/AIDS

Based on the analysis of this research, a number of conclusions about the questions posed by this thesis may be addressed.

Where policy makers have framed HIV/AIDS as a direct threat to national security, and prioritized the disease as an issue of high politics, high-level political attention and funding for the fight against HIV/AIDS has accrued.

The clearest example of this is Thailand's response to HIV/AIDS in the early 1990s. The perception that HIV/AIDS threatened Thailand's military, economic growth and demographic future was a key factor in bringing the disease to the highest levels of Thai politics, where it was addressed by the Prime Minister and Ministry of Defense as well as other ministries. Thailand then crafted a successful multi-sector response to the disease that is described as one of the few success stories in the global response to HIV/AIDS. In Uganda, the threat HIV/AIDS posed to the Ugandan military and President Museveni's powerbase lead to Museveni's early and outspoken actions to address the disease. Museveni's high level leadership contributed to successful HIV/AIDS prevention programs that, by most accounts, reduced the national prevalence of the disease.

Thailand and Uganda are the only two developing countries to succeed in reducing their national prevalence of HIV/AIDS before the advent of ARVs. Treating the disease as a threat to their national security was a key factor in Thailand's, and to a lesser extent, Uganda's success. The political and financial resources generated by the securitization of HIV/AIDS in these countries greatly benefited their fight against HIV/AIDS, reduced the prevalence of the disease among Thais and Ugandans, and provided the first two success stories in the fight against HIV/AIDS among developing nations.

Even viewing HIV/AIDS as an indirect threat to national security, such as seems to be the case in the U.S. under the Bush administration, has elevated the disease to high politics in the U.S. and contributed to the PEPFAR program's large scaling up of resources to address the global pandemic. Similarly, consideration of HIV/AIDS at the UNSC was one of a small number of developments in 2000 that elevated HIV/AIDS to the highest levels of international politics and facilitated the increasing international political commitment and funding available to fight the pandemic. Thus, in these three

countries and at the international level, securitization and consideration of the national security implications of HIV/AIDS has generated strong political and financial support targeted at fighting the HIV/AIDS pandemic.

The policy response to the securitization of HIV/AIDS, to date, has been focused on enhancing public health action, with some attention to prevention and treatment among armed forces.

Against the expectations of some commentators, states that have securitized HIV/AIDS have responded by enhancing public health efforts to fight the disease. In both Thailand and Uganda, securitization resulted in strong government responses based in public health principles that worked to prevent the spread of HIV/AIDS among both civilian and military populations. Prevention among armed forces was a component of these responses, but not an overriding focus. Consideration of HIV/AIDS as a threat to U.S. national security was followed by the PEPFAR program, which supports public health prevention and treatment programs in 15 states and is generally unrelated to direct U.S. national security interests. Only the much smaller DHAPP program focuses funding specifically on prevention and treatment of HIV/AIDS among foreign armed forces and on ameliorating the national security impacts of the pandemic on U.S. interests. At the international level, the largest impact of the UNSC meetings on HIV/AIDS has been to aid the raising of political attention and funding for HIV/AIDS to their highest levels in history. The DPKO and UNAIDS efforts to address the issue of HIV/AIDS among UN peacekeepers also resulted from the UNSC meetings, but these efforts have limited political and financial support and are restricted to the specific population of UN peacekeepers. In these four important cases, consideration of the national security implications of HIV/AIDS resulted in enhanced public health-led efforts to address HIV/AIDS. A major fear, discussed by both Peterson (2002) and Elbe (2006a), of a militarized or intelligence community-driven response to HIV/AIDS, has not resulted from any of the securitization events to date. Indeed securitization of HIV/AIDS has so far predominately supported and enhanced public health action.

Many of the predicted potentially negative aspects of the HIV/AIDS – national security nexus have so far not materialized in countries that have viewed HIV/AIDS as a national security issue.

The majority of Peterson's warnings about linking HIV/AIDS to national security, and Elbe's potentially negative aspects of the HIV/AIDS – national security nexus, have not occurred in states that have securitized the pandemic. Specifically, Peterson's critique stated that there were no benefits of securitization, and that arguing that diseases were national security threats would relieve Western powers of their moral responsibility to respond to health crises. The cases of Thailand and Uganda demonstrate clear benefits of securitization in accruing political and financial support to fight the pandemic, as did the UNSC meetings on HIV/AIDS. The U.S. PEPFAR program's main public rationale was humanitarian and the program has little relation to U.S. national security interests, further indicating that the discussion of the national security implications of HIV/AIDS did not undermine arguments for moral responsibility.

Of Elbe's four dangers of securitizing HIV/AIDS[26], there is no evidence from the examples of securitization in Thailand, Uganda, U.S., or the UNSC that these dangers of securitization have occurred widely, or occurred as a direct result of securitization, with the exception of reduced transparency around HIV/AIDS data among military forces. State mobilization caused by securitization has been a major and positive factor in the Thai and Ugandan responses to HIV/AIDS. The securitization of HIV/AIDS in the U.S. has not removed the disease from cosmopolitan or altruistic frameworks, although DHAPP is addressing HIV/AIDS among military populations. Neither have these countries moved HIV/AIDS funding for access to ARVs towards armed forces and elites to the detriment of civilian populations. Finally, discussion of HIV/AIDS at the highest levels of government and international politics has contributed to a destigmatization of the disease. The experience of these countries bears a much closer resemblance to Elbe's (2006a) list of the benefits of securitization.

While Elbe's (2006a) negative aspects of securitization have not materialized during the time span of this thesis, they cannot be discounted. As the HIV/AIDS pandemic grows, new countries may view the disease as a threat to their national security. If these countries are prone to political repression and civil rights violations, such as China or

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[26] These dangers are: 1) excessive state mobilization to fight HIV/AIDS will undermine and override civil liberties; 2) securitization will move HIV/AIDS from a cosmopolitan and altruistic framework towards a state-centric national security framework; 3) securitization will cause funding and access to ARVs to shift from civilian populations to the armed forces and political elites; 4) describing HIV/AIDS as a threat to national security will increase stigmatization of those living with the virus. (Elbe 2006a)

Russia, the results of securitization may be significantly worse. Similarly if the pandemic becomes more directly linked to the national security interests of powerful nations, engagement on HIV/AIDS may be increased focused on limiting the strategic impacts of the disease, rather than on those most in need.

Other hazards of the HIV/AIDS – national security nexus, particularly the cosmopolitan – communitarian divide between global health and national security, and the classification of public health data, have been problematic.

While many of the anticipated adverse implications of securitization do not seem to have been realized to date, hazards in the HIV/AIDS – national security nexus remain. Differences between global health and national security, embodied in the cosmopolitan – communitarian divide, represent a fundamental, ongoing challenge of the nexus. In the history constructed by this thesis, these differences have undermined the ability of each community to constructively engage with the other to address HIV/AIDS and its implications for national security. The KGB HIV/AIDS disinformation campaign represents an egregious example of the unfettered pursuit of communitarian interests over cosmopolitan values. Differences in referent objects and culture led to the failure of securitization moves by the CIA in the early 1990s. Cultural differences between public heath and national security were also the cause of Ken Bernard's difficulty in linking HIV/AIDS to national security in U.S. policymaking circles. Furthermore, these cultural differences were a strong contributing factor to the backlash against the findings of the NIC 99-17 and the resistance to holding UNSC meetings on HIV/AIDS. The 2002 NIC *Next Wave* report exemplifies a national security perspective on the HIV/AIDS pandemic by focusing on countries of strategic significance to the U.S., rather than a global health and cosmopolitan focus on those countries with the greatest need. While none of the countries that have securitized HIV/AIDS has based their response to HIV/AIDS on their national security interests, the cosmopolitan – communitarian divide has and will continue to make cooperation between the global health and national security communities difficult. The different objectives and referent objects of the two communities will make genuine synergies of interest difficult to achieve, while the starkly different cultures of the communities will hinder understanding and cooperation.

A second, problematic challenge of the nexus is the radically different treatment of data between the global health and national security fields. While publication of epidemiological data is a mainstay of public health research, publication of data on HIV/AIDS among armed forces may be perceived as a threat to national security and thus a practice to be avoided. This is a hazard of the nexus, and is a consequence of reduced transparency associated with securitization (Elbe 2006a). Keeping public health data secret can have negative impacts on public health efforts. Specifically, the classification of data on HIV/AIDS prevalence among armed forces and peacekeepers undermines the targeting, implementation and evaluation of public health efforts to fight HIV/AIDS. Without accurate data, these three aspects of public health programs are compromised. Furthermore, secrecy surrounding HIV/AIDS data among armed forces seems to have resulted in the widespread publication of overestimates of prevalence data among African armed forces. The intelligence community's reticence about publishing sources and methods of analysis severely undermines the quality of data publicly available to assess the national security implications of HIV/AIDS and the impact of the disease on military populations. While conducting rigorous epidemiological studies on the HIV/AIDS –national security nexus is needed on both public health and national security grounds, the different treatment of data between these two communities represents a major challenge to cooperation.

The primary role of the global health community in the securitization of HIV/AIDS has been limited to the production of epidemiological data on HIV/AIDS, which has then been used by non-health policy actors to argue for securitization as part of their own policy agenda.

The primary role of global health actors in instances of securitization has been to produce relevant epidemiological data on HIV/AIDS. In Uganda and Thailand, HIV/AIDS prevalence data among military forces was the genesis of securitization in each country. Similarly, the publication of rigorous global prevalence data by UNAIDS beginning in 1998 provided the foundation upon which efforts to securitize the disease in the U.S. and at the UNSC were based. The production of relevant data on the HIV/AIDS pandemic by the global health community has been a critical contribution to efforts to understand the HIV/AIDS – national security nexus and securitize the pandemic. After the production of epidemiological data however, the role of global health actors in the

direct events of the securitization of HIV/AIDS has been limited. With rare exception have global health actors participated directly in arguing for the securitization of HIV/AIDS. Ken Bernard, Peter Piot, and the U.S. IOM are three examples of global health actors contributing to the events of securitization.

While epidemiological data has been the global health community's main contribution to the securitization of HIV/AIDS, epidemiological evidence has not driven the political events of securitization. Desire to drive HIV/AIDS up the policy agenda and ulterior political motives played a much stronger role than HIV/AIDS prevalence data in the cases of securitization in the U.S. and UNSC. Data was used by policymakers when it buttressed their claims, but there was no demand for rigorous, peer-reviewed studies of the nexus before political action was taken. Thus the importance of evidence, as well as global health actors, in cases where HIV/AIDS was securitized should not be overestimated.

The limited role of evidence and global health actors in the history of the HIV/AIDS – national security nexus raises two major concerns for the global health community. First, global health has not been in control of the high-level politics surrounding HIV/AIDS and its securitization. Securitization, and the major political and financial benefits it generated, occurred with little global health discussion or direction. In the case of the U.S., the intelligence community initiated study of the national security implications of the disease. At the UN, the securitization of HIV/AIDS was driven by Richard Holbrooke and his concerns about U.S. dues to the UN and his political future in the event of a Gore presidency. In neither case did global health actors play a substantive role. As Garrett (2000a: 550) writes: "public health was on board the train, but clearly not in the conductor's seat." This should worry global health leaders, because the treatment of the HIV/AIDS pandemic has evolved with little direct input from global health. That this evolution has raised money and summoned political will to fight HIV/AIDS is good and indicates that other powerful policy communities are recognizing the relevance of HIV/AIDS to their work. However, a future evolution of the response to HIV/AIDS may not be as beneficial and global health leaders seem to be in little position to influence the debate.

The second concern is that the role of global health in producing epidemiological data relevant to the HIV/AIDS – national security nexus may be becoming more difficult to achieve. Data on HIV/AIDS among the armed forces has always been scarce, with even the most recent downward revision of estimates based on limited data and interviews. The perception that HIV/AIDS can present a threat to national security may make countries even less willing to conduct research, share or publish HIV/AIDS data among armed forces or peacekeepers. If research is conducted, it may be performed by the militaries themselves or in cooperation with DHAPP and kept classified. This raises the question of whether the global health community will even be able to contribute new epidemiological data about HIV/AIDS and national security to the debate on securitization.

7.3 Strengths and weaknesses in conceptualizing global health as a "security" issue

The four conceptual frameworks reviewed in this research, namely the Communitarian – Cosmopolitan Model, Models of Engagement, High – Low Politics Model, and Cause of the Transformation Model, have been relevant in this analysis of the HIV/AIDS – national security nexus. Each model addresses a different aspect of the nexus, and each has shown relevance in explaining certain events in the nexus. However, the application of these models has illuminated a number of strengths and weaknesses of current conceptualizations of the nexus.

Lee and McInnes' (2004) Models of Engagement describes a number of ways in which the public health community may interact with the national security community, and the effects of each model of interaction on the influence and independence of public health. This model is driven by a concern that the more powerful security community will only engage with certain public health issues that threaten state interests, leaving the major causes of disease and death in the developing world unaddressed. Three of the models of engagement offered, including supplicant, Trojan horse and independent actor, were found to correspond to certain events in the nexus. Public health as an independent actor characterized the role of public health in the production of epidemiological data in Thailand and globally by UNAIDS. The efforts of the IOM and Ken Bernard to link public health to U.S. national security are easily categorized as the supplicant or Trojan

horse model. These models are useful in weighing the relative benefits of each approach over the course of the events described. However a major failing of this model, in terms of its ability to explain the historical events of the nexus, is its omission of the possibility for independent security community action on HIV/AIDS. The early U.S. intelligence reports on HIV/AIDS, the KGB disinformation campaign, and the DHAPP are all examples of important events and activities in the nexus that were driven by the independent interest and action of the security community. Thus while the type of public health engagement with the security community is important, this analysis has shown that perhaps more critical to the history of the HIV/AIDS – national security nexus has been the influential actions of the security community on the pandemic.

An extension of the Models of Engagement to include the actions of the security community is thus warranted. As the KGB disinformation campaign makes clear, independent security community action on HIV/AIDS has not always been benign. Therefore a revised Models of Engagement should not only account for the actions of the security community, but the intention of these actions. A three-part framework for security community intentions to supplement the Models of Engagement could include categories for security community engagement that was:

1. malignly intended to pursue the objectives of the security community, (such as the KGB disinformation campaign);
2. intended to address the strategic implications of specific global health issues, (such as the U.S. intelligence reports on infectious diseases); or
3. intended to benefit both national security objectives and public health (such as the DHAPP).

Incorporation of security community involvement into the Models of Engagement would enhance this framework's ability to explain events in the nexus, as well as prepare the global health community for the likelihood of continued independent security community interest in global health issues.

The Communitarian – Cosmopolitan model, which focuses on the different referent objects, objectives and cultures of the national security and global health communities, was particularly useful in explaining critical differences between the dominant

perspectives of the two policy communities that, in turn, inhibited cooperation and action on the nexus. For example, the different referent objects and cultures of the two communities created major barriers for both the U.S. intelligence community and the UNSC in addressing HIV/AIDS, and played an important role in the failure of early U.S. intelligence reports to securitize the epidemic. Many of the difficulties encountered by Ken Bernard in introducing global health issues into the U.S. security analysis Bernard himself attributed to cultural differences between the communities. Finally the objective of the security community to pursue national interests clearly explains the perspective taken by the U.S. intelligence estimates on infectious diseases and HIV/AIDS. The Communitarian – Cosmopolitan Model provides a useful and simple dichotomy for understanding critical differences between the global health and national security communities. However, this model holds little predictive value and does not account for activities that bridge communitarian and cosmopolitan interests, such as the DHAPP. Thus this framework is best utilized as a descriptive framework for explaining past difficulties in bridging the national security and global health communities.

Similarly, the High – Low Politics Model provides a useful, descriptive shorthand for describing the relative priority given to public policy issues. Public heath has traditionally been relegated to low, or even "really low politics," while national security is almost synonymous with high politics (Fidler 2005b: 180). That each community is closely associated with the opposed categories in this model makes this framework a particularly accurate descriptive tool. A final unique advantage of this framework is that the high vs. low politics categories are terms understood and used by the policymaking community. Therefore the policymaking community may actually utilize these terms in explaining the increase in the pandemic's political status, providing a useful bridge between academic and policymaker analysis of the nexus. Despite these advantages, the High – Low Politics Model only provides a descriptive shorthand for the communities involved, and proves most useful in serving as the basis of next "cause of the transformation" model.

The Cause of the Transformation model is the most analytically ambitious of the conceptual frameworks on the HIV/AIDS – national security nexus. It does not seek to describe the nexus, or the differences between the two communities involved, but to explain the reasons behind the rise of HIV/AIDS from low to high politics. Fidler's

(2005a) three categories for explaining this transformation are: Revolution, Remediation and Regression. The revolution model posits that the traditional dichotomy of high and low politics has collapsed because of the recognition that health is a "pre-eminent political value for 21st century humanity" (Fidler 2005b: 184). This thesis finds no evidence to support this assertion. The second explanation is regression, whereby the worsening of HIV/AIDS and other global health problems has caused the rise in political status of the pandemic. While the extent of the pandemic must be considered a contributing factor to the transformation of the political status of HIV/AIDS, the final remediation model incorporates this perspective and provides the most robust explanation of the transformation of HIV/AIDS into a high political issue.

The remediation model argues that the transformation of HIV/AIDS into a high political issue is due to the increasing threat the pandemic poses to state capabilities and material interests. The traditional foreign policy hierarchy of issues remains intact, what has changed is the perceived relevance of HIV/AIDS to state national security and material interests. This remediation model is strongly supported by the evidence analyzed by this thesis. In nearly every case of successful and attempted securitization in this thesis, including Uganda, Thailand, U.S. intelligence studies of HIV/AIDS, and the DHAPP, HIV/AIDS was addressed primarily because it was perceived to threaten strategic interests. In the only exception at the UNSC, the strategic impact of HIV/AIDS on peacekeepers was critical to allowing the pandemic to be addressed, even through the full reasons for securitization were more complex. Thus the remediation model provides the most robust conceptual explanation for the rise of HIV/AIDS into a high political issue.

7.4 Final Observations

In their major work on securitization theory, Buzan et al. (1998: 23) define "security" as a "move that takes politics beyond the established rules of the game and frames the issue either as a special kind of politics or as above politics." The authors differentiate between issues that are nonpoliticized, politicized, and securitized. In theory, securitized issues are dealt with above the "normal haggling of politics" and thus decisively by top leaders (Buzan et al. 1998: 29). Edkins (1999: 11) actually calls securitization a form of "depolitization" because "issues of 'security' are more removed

from public debate and decision than issues of 'politics…" The evidence presented in this thesis provides an opportunity to comment on this question of securitization vs. politicization, and to evaluate the type of politics that has resulted from the securitization of HIV/AIDS.

This thesis has argued that securitization of HIV/AIDS has occurred in Uganda, Thailand, the U.S. and at the UNSC. While the case of the UNSC was complex, in each country case study, HIV/AIDS was argued to be an existential threat to a referent object which justified the use of emergency measures, thus meeting Buzan et al.'s (1998) criteria for securitization. In each case, discussion of HIV/AIDS broke the rules that had traditionally defined how each government addressed health issues, and transformed the response to the pandemic in terms of political priority and funding. However, in none of these cases did HIV/AIDS rise entirely above politics, to be considered apart from public debate. Nor did securitization of HIV/AIDS serve to "silence opposition" or serve as the basis to address the pandemic "with less democratic control and constraint" (Buzan et al. 1998: 29). The case studies examined in this thesis instead suggest that securitization transformed treatment of the pandemic from low politics into an issue that was more properly politicized in relation to its perceived impact on each state.

This raises the question of whether HIV/AIDS was actually securitized or only politicized. There is little question that, in the cases discussed in this thesis, HIV/AIDS meets the criteria for securitization outlined by Buzan et al. (1998). However, the pandemic was not treated in the same manner as more traditional security threats, such as an imminent terrorist or nuclear attack, would be approached. It may be argued that this difference is evidence that the pandemic was politicized rather than securitized. This thesis argues that this perspective is not persuasive. Equating the pandemic with an imminent military attack ignores the longer timeframe of the HIV/AIDS threat, and the need to use non-military means to mount a successful response to the disease. The absence of high-priority, emergency national security meetings on HIV/AIDS is entirely appropriate to the perceived threat the diseased posed to these states, and not convincing evidence of a lack of securitization. Thus, securitization of HIV/AIDS did move the disease beyond the previously established "rules of the game" into high political status, but did not elevate the disease above the day to day political process because such a response was not necessary. In the case of HIV/AIDS, securitization resulted in a

politicization of the epidemic which was commensurate with the perceived threat the pandemic posed.

A final and separate observation concerns the role of technology in transforming a perceived threat to national security. Technological advancement has often held the potential to alter threats to security or military balances of power. The development of ARVs to treat HIV/AIDS, and associated efforts to drastically reduce the price of these drugs for persons in highly affected and poor countries, may represent technological and social changes that strongly alter the perception of the national security impacts of HIV/AIDS.

While debate about the political, military, social and economic impact of the pandemic (all reasons cited as justification for impact on national security) will likely continue in future, the availability of effective and relatively affordable treatment for the disease may be transforming affected government's perceptions of the threat of HIV/AIDS. In 2000 when many of the securitization arguments were made, ARV treatment had been developed but was too expensive for all but a few elites in affected developing countries. Governments fearing HIV/AIDS might cause political, economic or social instability, or weaken their militaries, had few options other than to prioritize actions to prevent further spread of the disease. By 2008 however, ARV treatment costs had been drastically reduced and some progress had been made on distributing the drugs in developing countries. Consequently, governments may begin to be less likely to consider HIV/AIDS as a threat to national security as ARVs become more available and relatively affordable to treat the disease. Even if HIV/AIDS were to cause political, economic, or social instability in a country, and this thesis has argued that there is little evidence to date that this has occurred, the opportunity to provide ARVs widely would likely ameliorate the severe social or political impacts of the disease. Thus, it may be increasingly unlikely that HIV/AIDS is perceived as a threat to the national security of states in future.

7.5 Recommendations

In this analysis of the history of the HIV/AIDS – national security nexus, the remediation model has most accurately described the nature of the relationship between global health and national security. The nexus has shown that, when HIV/AIDS was successfully linked to the strategic and material interests of a state, that state has responded with increased political attention and funding. The robustness of this remediation model holds important implications for strengthening efforts to address HIV/AIDS and global health issues more broadly.

First, the global health community should accept the remediation model as accurately describing the basic underlying structure of the relationship between global health and national security. The expectation that high-level national security policy makers will seriously address global health issues because they cause human suffering, even on a massive scale, is not supported by this thesis. Global health practitioners who argue that global health programs are as important as traditional national security issues because they kill millions of people are simply not taken seriously within the foreign policy and security communities. Accepting the remediation model is critical to avoiding unsuccessful engagements such as Sandra Thurman's presentation of humanitarian impacts of HIV/AIDS to the U.S. National Security Council. However, when global health issues have been convincingly linked to national security considerations, ie. securitized, or are linked to the material interests of states, rapid governmental action on global health has resulted. Accepting this relationship, and the continued existence of the traditional foreign policy hierarchy of issues, will enable global health actors to more convincingly engage with the foreign policy and national security communities. Acceptance of the remediation model is the price of admission to the "situation room" and engagement with the foreign policy and security communities.

The continued existence of the traditional foreign policy hierarchy does not however mean that there have not been seismic shifts in the political relevance and status of global health. Fidler's "revolution" has occurred and has changed the landscape of global health. Previously uncommon linkages between global health issues and national security, foreign policy, military and intelligence communities have become common and politically salient. Diplomatic and military efforts to address global health problems have increased, as have academic programs on global health at schools of international

relations.[27] The increased relevance of global health to other powerful communities will present increasing opportunities to seek areas of mutual interest and cooperation. The global health community should not retreat into its technical, anti-state interest, and politically-isolated past. Instead the public health community should knowledgably engage with the foreign policy and national security communities to better address global health needs, while understanding these other community's interests and objectives. Engagement is critical if the political and economic aspects of global health problems are to be successfully addressed.

The shape of this engagement with foreign policy and national security interests will likely take forms that are both comfortable and uncomfortable for the global health community. Cases where diplomacy acts to aid global health, such as U.S. State Department efforts to restart polio vaccination in Northern Nigeria, will be easily welcomed. Cases where the U.S. military seeks to win hearts and minds through public health interventions will not be welcomed by many in global health. While the benefits and risks of each form of engagement may be debated, what is most critical is the ability of global health practitioners to positively shape the engagement to the benefit of global health. This will require global health leaders who understand the remediation model and the communitarian – cosmopolitan divide, and who can effectively promote the interests of global health in the arena of high politics. The global health community must also start training such leaders. It is too rare a global health practitioner, such as Ken Bernard, who can straddle the worlds of global health and national security successfully. Schools of global health will continue to provide technical training in epidemiology and biostatistics, but must expand their education to include basic training in international relations. In many cases, this can be simply accomplished. Many of the leading schools of global health, including the London School of Hygiene and Tropical Medicine, the Johns Hopkins Bloomberg School of Public Health, and the Harvard School of Public Health, are co-located with excellent schools of international relations. Stronger links and joint-teaching between these sister schools would greatly improve the ability of global health students to understand the political and economic ramifications of global health problems, and to work across disciplines to improve global health. A new

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[27] Such programs include the Whitehead School of Diplomacy and International Relations Center for Global Health Studies, Johns Hopkins School of Advanced International Studies Global Health and Foreign Policy Initiative, and the University of Denver's Josef Korbel Graduate School of International Studies Global Health Affairs program.

WHO initiative on global health diplomacy, and the 2006 Oslo Ministerial Declaration (2007) on foreign policy and global health, launched by seven Ministers of Foreign Affairs, are also welcome attempts to better understand the linkages between global health and foreign and security policy.

In addition to leadership, the role of global health in producing epidemiological data and its influence should be addressed. Epidemiological data, however flawed, on HIV/AIDS among armed forces was a critical initiator to securitization efforts in Thailand and Uganda. However this thesis found little evidence that epidemiological data was a driving component of policy in the HIV/AIDS – national security nexus at the UNSC or the U.S. Epidemiological data on HIV/AIDS was used to provide support for securitization, but only when the data supported pre-existing policy objectives. Because of this, the global health community should accept that programs to address high political issues, such as HIV/AIDS now is, will not be entirely driven by evidence. Politics will always play a role, as it does in national security, economic, foreign policy and environmental policy. However, global heath practitioners have the opportunity to inform and shape policies by conducting rigorous research on the national security and foreign policy impacts of global health problems. Paradoxically, the lack of evidence-driven policy in the HIV/AIDS – national security nexus to date may have created more demand for this research as the interactions between global health and national security communities deepen. Rigorous research on, for example, the impact of the HIV/AIDS epidemic on state stability, armed forces, peacekeeping operations, and democracy would likely find a very receptive audience in both the national security and global health communities. This represents a strong opportunity for the global health community to substantively contribute to our understanding of the HIV/AIDS – national security nexus, and the broader relationship between global health and foreign policy.

In the view of this thesis, the HIV/AIDS – national security nexus should elicit more optimism than concern about future efforts to improve global health. The links between global health, national security and foreign policy have contributed to the rapid elevation of global health into high politics, where global health issues have received political attention and funding unrivaled in the history of public health. Downsides to this nexus do exist, although these are not predominantly the risks typically associated with the nexus. This thesis has found that in countries where HIV/AIDS was securitized,

enhanced public health action against the disease followed. There is little evidence that securitization undermined humanitarian rationales for addressing the disease, nor did securitization result in approaches to the pandemic led by security services or the police. While such potentially negative impacts of securitization cannot be ruled out, this thesis argues that the larger barriers to successful cooperation between global health and national security communities are the communitarian – cosmopolitan divide and divisions over the uses of data between the communities. In particular, the communitarian – cosmopolitan framework describes a deep divide between the global health and national security communities which will continue to impact on their interactions, from the interpersonal to global levels. Better understanding this divide is the first step to more constructive relationships between the global health and national security fields.

In many ways, the securitization of HIV/AIDS and other recent events have returned public health to a more politicized environment reminiscent of the period before the 1950s. Given the scale and human impact of many global health challenges, high level political action would seem a welcome and necessary context to address them. A technical, non-political perspective, to which some in global health aspire, neither accurately describes the true nature of global health, nor the most likely strategy to rally sufficient political and financial support to successfully address them. Whether the global health community can successfully navigate its newfound role in high political circles, to achieve real gains in global public health while maintaining its independence and humanitarian perspective, will be a key challenge in the years ahead.

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Appendix A: Interviews Conducted[28]

C. Ross Anthony, Director RAND Center for Domestic and International Health Security. Personal interview conducted: 1 July 2004.

Roxanne Bazergan, HIV/AIDS Policy Adviser with UNAIDS and the UN Department of Peacekeeping Operations. Phone interview conducted: 10 May 2006.

Judith Bello, Executive Vice President Pharmaceutical Research and Manufacturers of America. Personal interview conducted: 3 April 2003.

Dr. Kenneth Bernard, Senior Advisor for International Health U.S. National Security Council. Personal interview conducted: 22 June 2004.

Dr. Chris Beyrer, Director, Johns Hopkins Center for Public Health & Human Rights. Personal interview conducted: 31 March 2003, email interview: 27 October 2005.

R.P. Eddy, Chief of Staff to the United States Ambassador to the United Nations. Personal interview conducted: 29 June 2004

Leon Fuerth, National Security Adviser to U.S. Vice President Al Gore. Personal interview conducted: 3 April 2003.

Laurie Garrett, Senior Fellow for Global Health, Council on Foreign Relations. Personal interview conducted: 10 October 2005.

Representative James Greenwood, United States Congress. Personal interview conducted: 25 June 2004.

Dr. Betty King, United States Ambassador to the United Nations Economic and Social Council. Personal interview conducted: 10 January 2003

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[28] The position titles of each interviewee are based on their employment relevant to the subject of the thesis. This employment was not always their employment at the time of the interview.

Dr. Stuart Kingma, Director of the Civil-Military Alliance to Combat HIV/AIDS, and Medical Advisor to the Global Programme on AIDS and UNAIDS. Phone interview conducted: 14 June 2006.

Dr. Nicole Lurie, Co-Director for Public Health at the Center for Domestic and International Health Security RAND. Personal interview conducted: 1 February 2003.

Ambassador Princeton Lyman, U.S. Ambassador to South Africa and Nigeria, andAdjunct Senior Fellow for Africa Policy Studies, Council on Foreign Relations.Personal interview conducted 24 June 2004.

Dr. Andrew Marshall, Director of the United States Department of Defense's Office of Net Assessment. Personal interview conducted: 2 April 2003.

Dr. J. Stephen Morrison, Executive Director, HIV/AIDS Task Force and Director, Africa Program at the Center for Strategic and International Studies. Personal interview conducted: 2 April 2003.

Dr. Vinand Nantulya, Senior Technical Advisor to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Personal interview conducted: 14 March 2003.

Dr. Justin Parkhurst, Lecturer in Health Policy, London School of Hygiene and Tropical Medicine. Personal interview conducted: 25 November 2005.

Dr. Ram Rangsin, Assistant Professor, Department of Military and Community Medicine, Phramongkutklao College of Medicine. Email interview conducted: 3 December 2005.

Martin Rupiya, Senior Lecturer in War and Strategic Studies, Department of History, University of Zimbabwe, and retired Lieutenant Colonel, Zimbabwe National Army. Phone interview conducted: 15 May 2006.

Nazanin Samari-Kermani, White House Fellow, United States Department of State. Phone interview conducted: 17 January 2005.

Ken Thomas, Deputy Director for International Affairs, White House Office of National AIDS Policy. Phone interview conducted: 4 April 2004.

Mary Lou Valdez, Deputy Director for Policy, United States Office of Global Health Affairs. Personal interview conducted: 3 April 2004.

Kathy Ward, Deputy Director International Crisis Group. Personal interview conducted: 4 April 2003.

Dr. Gillian Woollett, Vice President for Science and Regulatory Affairs, Biotechnology Industry Organization. Personal interview conducted: 1 April 2004.

Confidential Interviews

U.S. Government personal interview, 2003.

U.S. State Department Official personal interview, 2003.

U.S. Intelligence Officer personal interview, 2004.

U.S. Military phone interview, 2005.