THIS BOOK IS TESTIMONY TO THE EMERGENT NATURE OF HUMAN SECURITY AS AN idea, as a useful construct and as an operational strategy. The aim is to showcase new directions that may enrich the human security agenda. Some human security discourse is still rooted in the traditional language of the aid-agency/UN development/economic growth models, often hostile to the corporate and business sector, and sometimes negligent of sustainability and climate change issues. Another limited and outmoded approach is an exaggerated focus on Western interventions, especially military ones, as a 'solution' to problems in poor or conflict-prone areas.

'Human Security' was introduced as a construct by the UNDP in 1994. The inherent combination of law-enforcement and people-centred humanitarianism has striven to provide an umbrella to both protect people from threats while empowering them to control their destinies. But with accelerating economic globalisation and information flows there is a need to revisit the concept. A new paradigm of Sustainable Human Security is required. This book argues that proponents of a human security approach should welcome efforts to remove the barriers between enterprise, corporations, aid and development agencies, government agencies, citizen groups and the UN; and work towards multi-stakeholder approaches and solutions for vulnerable populations. Such an approach is clearly vital in responding to the imperatives of concerted action on issues such as climate change, HIV, terrorism, organised crime and poverty. The agenda may have changed, but it remains true that almost all human tragedies are avoidable.

This book examines a number of global problems through the lens of human security and the needs of the individual: global governance; health; the environment and the exploitation of natural resources; peace and reconciliation; the responsibility to protect; and economic development and prosperity. In the latter case, the role of business in the human security pantheon is promulgated. There are many reasons why businesses may want to engage with the needs of vulnerable populations – not least the fact that companies cannot function without secure trading environments. In addition, there are growing demands for corporate responsibility and citizenship from markets, customers, shareholders, employees and, critically, communities.

This book throws new light on the human security agenda. It will be essential reading for anyone involved in the debates on human security as well as for practitioners and scholars in international affairs, global governance, peace studies, climate change and the environment, healthcare, responsibility to protect and corporate responsibility.

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4

The securitisation of HIV/AIDS

Human security, global health security and the rise of biopolitics

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HIV/AIDS is a pervasive threat to the health and life of many individuals, especially in the high prevalence regions of sub-Saharan Africa, where 20 million people have already died from the disease and 22 million are currently living with the disease (UNAIDS 2009a). There is no question that this disease reduces the quality of life of those infected and those around them. It limits the socioeconomic development of those communities and countries where HIV/AIDS prevalence is high. It has resulted in declines in life expectancy of up to 25 years in the hardest hit African countries. While HIV/AIDS affects individuals, it is also having a negative political, social and economic impact on many communities and as such is undermining the human security of the region. The setting up of UNAIDS in 1996, the first and only United Nations organisation to deal with a single disease, is evidence that this disease has been recognised as a barrier to human development as well as a threat to human and health security, particularly in sub-Saharan Africa. In 2000 the UN declared HIV/AIDS a threat to peace and security in sub-Saharan Africa, thus acknowledging that health is linked to both human and state security. Since the securitisation of HIV/AIDS in 2000, a number of powerful international initiatives have emerged to fight HIV/AIDS. These include the Global Fund to Fight HIV/AIDS, Tuberculosis (TB) and Malaria (The Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR), which has led to the rise in biopolitics.

The incorporation of health security into the security agenda

Over the last quarter of a century the traditional view of security as state-led and related to military protection of territory and the maintenance of peace has been challenged by a human-centred view of security where individual rights and welfare are a priority. This shift in emphasis coincided with the break-up of the USSR, the end of the cold war and a deepening of the international health crisis associated with the HIV/AIDS pandemic. The global acceptance of the human development paradigm and the subsequent signing of the Millennium Development Goals by world leaders in 2000 have demonstrated that, in the 21st century, most governments and international organisations regard human security together with health security as essential elements of state security.

The term 'human security' was first officially used in the 1994 *Human Development Report* (UNDP 1994) (Fourie and Schonteich 2001; Chandler 2008). The report claimed that 'Human security is not a concern with weapons—it is a concern with human life and dignity' (p. 22). According to the *Human Development Report*, this meant ensuring safety for people from both violent and non-violent threats to their security and well-being; succinctly expressed as 'freedom from fear and freedom from want' (UNDP 1994: 24). The report suggested that six indicators could be used to provide an early warning of threats to human security: food insecurity, job and income insecurity, human rights violations, ethnic or religious conflicts, inequality and military spending. Thus the report conceived human security in terms of the security of individuals as well as nation states. With the discourse that followed, the term 'human security' quickly began to be associated with the individual rather than with the state. According to Hubert (1999, cited by Fourie and Schonteich 2001: 1) human security 'is an alternative way of seeing the world, taking people as its point of reference, rather than focusing exclusively on the security or territory of governments'. This is a view supported by Poku *et al.* (2007: 1155): 'security today is more widely accepted to embrace insecurities driven by non-military challenges. Central to this view is the challenge of meeting the basic needs and aspirations of millions of people in Africa, Asia and beyond'. By 2009, human security was regarded as 'protection from direct and indirect threats to the personal safety and well-being of the individual' (Iqbal 2009: 126). Reference to 'the state' has been dropped as 'security' has been bifurcated into 'state security' concerning sovereign rights and 'human security' focusing on the individual and human rights (Chandler 2008; Owen 2008). In short, human security is about protection of the individual and entails taking preventive measures to reduce vulnerability and minimise risk regardless of state citizenship (Tadjbakhsh and Chenoy 2007). Human security has become a 'fundamental and inviolable right of all individuals' (Tadjbakhsh and Chenoy 2007: 451).

The suggestion that health is part of human security can be traced back to the publication of the first *Human Development Report* in 1990 (UNDP 1990) and the

unveiling of the Human Development Index. This alternative paradigm of development emphasised the role of good health and education in the development process. Within ten years the human development paradigm had become mainstream, informing development thinking and policy, which culminated in the international acceptance of the UN Millennium Development Goals (UNMDGs) all of which either directly or indirectly relate to improving the health status of people in the developing world.

The *Human Development Report 1994* (UNDP 1994) contained a discussion of human security, which suggested that, within the human development paradigm, human security comprises seven elements: economic, food, health, environmental, personal, community and political security (Glasius 2008). The report postulated that chronic threats such as hunger, disease and repression could undermine human security in the same way as sudden catastrophic disruptions such as war and internal conflict. While the authors of the report recognised that human security was a narrower concept than human development, they stressed that 'human development is the means through which human security is to be achieved' (Glasius 2008: 33). In May 2003, the Commission on Human Security's report *Human Security Now*, included health as one of its ten policy recommendations (Aldis 2008). The report stated that health security is 'at the vital core of human security . . .' and '. . . illness, disability and avoidable death are "critical pervasive threats" to human security' (Commission on Human Security 2003: 96). Many now recognise that health and in particular infectious diseases have national and global security implications (Bond 2008), as they are at the 'crisis end' of human development (Sen, cited by Glasius 2008) and are an integral part of human security.

Global health security and biopolitics

The unprecedented numbers of deaths caused by AIDS, the rapid global spread of SARS in 2003, the event of high-speed travel and the almost instantaneous reporting of health issues in the digital world have been some of the factors that have raised the profile of global public health. The WHO *World Health Report* 2007 (WHO 2007) addressed global public health security. This report defined global public health security as:

> the activities required . . . to minimise vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries . . . Global public health security embraces a wide range of complex and daunting issues, from the international stage to the individual household (WHO 2007: 1).

The report emphasises that global health security may have an impact on economic or political stability, placing public health very much within the human security paradigm. This is very much aligned to Foucault's concept of biopolitical rationality, with international organisations such as the UN taking on the role of a biopolitical power protecting and ensuring global public health security (Elbe 2008).

The spread of infectious disease across regions and international borders is not a new phenomenon and over the last 200 years various attempts have been made to control the international spread of public health threats. In 1996 WHO introduced a global system of epidemic alert and response. It is based on the concept of international partnership involving over 140 technical partners from more than 60 countries (WHO 2007). Known as the Global Outbreak Alert and Response Network (GOARN), its aim is 'the rapid identification, confirmation and response to outbreaks of international importance' (WHO 2007: 8). Between 2000 and 2005 there were more than 70 GOARN international outbreak responses. GOARN has a specialised surveillance network for dangerous pathogens including dengue fever, influenza and the plague.

In the second half of the 20th century, the international community through the WHO agreed a set of International Health Regulations (1969) to achieve the maximum protection against the global spread of disease with minimal disruption to trade and travel. This was based on the notification of six diseases (cholera, plague, relapsing fever, smallpox, typhus and yellow fever) and the imposition of international border controls. But compliance was patchy and rapid international travel nullified many attempts to control disease at international borders. So in 2005 the International Health Regulations were revised and brought into force in June 2007. These revised regulations define a health emergency as an 'extraordinary event' that could spread internationally or might require a coordinated international response (WHO 2007). The regulations are no longer limited to the six notifiable diseases listed above, but instead focus on illness or medical conditions that could present significant harm to humans. Such threats to public health may include epidemics of infectious diseases, as well as threats to human health from natural disasters and chemical emergencies. States are still required to report significant public health risks, but instead of the standard international border response, context-specific measures to stop spread will be agreed with the WHO and applied to populations deemed to be at risk. But these initiatives have come far too late to halt the global spread of HIV/AIDS.

The securitisation of HIV/AIDS

Until January 2000, the global HIV/AIDS pandemic, which had killed millions of people and had infected many millions more since the disease had been formally identified in 1982, had been regarded as a medical problem associated with behavioural and cultural factors (Iqbal 2009). However on 10 January 2000 this was to change. On that day the UN Security Council discussed the HIV/AIDS pandemic and declared the disease a threat to international peace and security in Africa

(McInnes 2006; Elbe 2008; Selgelid and Enemark 2008). This meeting of the UN Security Council proved decisive in placing the global HIV/AIDS pandemic on the international security agenda, resulting in the 'securitisation' of HIV/AIDS (Elbe 2008). UN Security Council Resolution 1308 asserted that if left unchecked HIV/AIDS 'may pose a risk to stability and security' in Africa. It also stated that the spread of the disease was 'exacerbated by conditions of violence and insecurity'. The Resolution expressed concern for peacekeeping forces, as both victims and vectors of the disease. While the issue of HIV/AIDS and human welfare was identified as a threat to security by Resolution 1308, it was framed in the language of political and state security, thus demonstrating the tension evident at that time between state security and human security.

Resolution 1308 is historic as it was the first time that a health issue or disease had been officially framed as a risk to international peace and security. In the years since, the notion that HIV/AIDS is a threat to human security has become commonplace (Selgelid and Enemark 2008). This 'securitisation' of HIV/AIDS challenges traditional state-centred concepts of human security and has contributed to an alternative conceptualisation of human security which stresses human welfare and rights. As a result the international agenda on human security has been infused with what Foucault labelled 'biopolitical rationality' involving concern for the welfare of populations which is associated with strategies aimed at collectively increasing life expectancy and decreasing morbidity levels (Elbe 2008). Human security and in particular health security has become a fundamental right of all individuals regardless of state citizenship (Tadjbakhsh and Chenoy 2007).

By identifying an infectious disease as a security threat the UN not only challenged the existing security paradigm, but also raised the profile of global health issues. According to Selgelid and Enemark (2008: 457) an infectious disease can be branded as a security threat when it 'threatens the existence or stability of society and/or when emergency measures are required to address it'. The fear that infectious diseases engender among populations often leads policy-makers into rapid decision-making which is emotionally driven. This is particularly the case when the infectious disease is new, spreads rapidly and kills significant numbers of people in a short time, as happened with the SARS (Severe Acute Respiratory Syndrome) outbreak in 2003. Thus, acknowledging that an infectious disease is a security issue gives a sense of urgency to the health of communities with the expectation that both international and national policy-makers will give the disease a high priority and provide the necessary resources required to tackle it.

Yet it was 20 years after HIV/AIDS had been identified by the medical community as a new disease and its transmission routes understood that it was designated a security threat. This delay may be due to the fact that HIV/AIDS is 'the quintessential long-wave event' (Merson *et al.* 2008: 476), with the period from initial infection to acute illness and death of many years. It does not fit the profile of a new disease which kills people quickly and results in panic, often irrational, among the population. By contrast, HIV/AIDS can be considered an 'attrition' disease; the damage to individuals and society from the disease occurs over the longer term and affects all

aspects of society, including the functioning of traditional state-led human security mechanisms, such as the operation of government, the military, police and legal system, and threatens human welfare and human rights. The UN and others consistently highlight the fact that HIV/AIDS is potentially politically destabilising; the profound economic impacts of the disease on communities are linked to social and political insecurity (Fourie and Schonteich 2001; O'Manique 2005; McInnes 2006). As Peter Piot, then executive director of UNAIDS, stated in 2001: 'By overwhelming Africa's health and social 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'. For others, HIV/AIDS constitutes the biggest human security threat of the 21st century, as it poses a danger to the personal safety and well-being of the individual (Iqbal 2009). As HIV/AIDS threatens the security of both the state and the individual, many believe that 'this disease may be a special case worthy of securitization' (Selgelid and Enemark 2008: 462).

AIDS as a threat to state-level security in sub-Saharan Africa

Many suggest that the threat of HIV/AIDS to state-level security in sub-Saharan Africa has been overstated. While the UN has consistently highlighted HIV/AIDS as potentially destabilising (McInnes 2006), in the ten years since HIV/AIDS was declared a security issue by the UN it has become evident that it has not produced the instability and insecurity in sub-Saharan Africa that was expected. There has not been the collapse of state structures that many feared in the late 1990s. However it is clear that the HIV/AIDS epidemics coursing through sub-Saharan Africa are a major challenge to governance in most high prevalence countries, but this has barely been the subject of research (Barnett and Whiteside 2002). The impact of high morbidity and mortality rates from AIDS among members of parliament and ministers of state and the implications for good governance are unknown (Barnett and Whiteside 2002). But it is likely that the epidemic has weakened institutional structures and, in those countries most severely affected by the epidemic, may be responsible for creating 'fading' states rather than 'failing' states.

More is known about the impact of HIV/AIDS on the military and police. Until recently it has been accepted that rates of HIV infection are higher in the military and police forces than in the general population of sub-Saharan Africa (O'Manique 2005; Sagala 2008; McInnes 2009). The figures most often cited were that infection rates among the armed forces were between two to five times those of the general population (McInnes 2009). Such a high prevalence rate has two potential implications: first that high levels of HIV prevalence among military personnel would mean that the military could become a vector for the spread of the disease among the general population; and second that the high prevalence levels would be a threat to

military effectiveness and might mean that some countries would not have enough healthy military personnel to deploy as peacekeepers. This led the UN General Assembly in 2003 to launch a global initiative to raise awareness of AIDS in armed forces across the developing world (McInnes 2006). However recent data suggests that the relationship between soldiers and HIV is not straightforward and studies have failed to show dramatically elevated levels of HIV infection among the armed forces in sub-Saharan Africa (McInnes 2006; Becker *et al.* 2008). This suggests that the perceived threat of HIV/AIDS to the security of sub-Saharan Africa as expressed in UN Resolution 1308 has, in hindsight, been exaggerated.

AIDS as a threat to human and health security in sub-Saharan Africa

While the threat of HIV/AIDS to state-level security appears to have been exaggerated, the threat to human and health security in sub-Saharan Africa has been underestimated. This is exemplified by the links between HIV/AIDS, agricultural production and food security. HIV/AIDS retards agricultural production and threatens food security, putting unique pressures on agricultural systems (Hunter 2007). The connection between HIV/AIDS infection and agricultural production is real. In sub-Saharan Africa women are responsible for producing over 75% of the region's food. With the feminisation of the HIV/AIDS epidemics in sub-Saharan Africa through the 1990s (females comprise approximately 60% of cases in the region; UNAIDS 2009b), food production has been severely compromised as women become ill and die, or find themselves caring for sick relatives.

The link between HIV/AIDS and food security came to the attention of the world in 2002 when the UN mounted an appeal to the international community for immediate food and relief supplies for 14 million people in southern Africa at risk of starvation (O'Manique 2005). While food security was under pressure in southern Africa before 2002, the drought of that year tipped the high HIV prevalence region into famine at an alarming speed. The high levels of morbidity and mortality associated with hunger and malnutrition among adults infected with HIV/AIDS meant it was very difficult for the region to return to full food production when the rains did return to normal. This unusual famine was subsequently labelled as a **new variant famine** which was HIV/AIDS induced (de Waal and Whiteside 2003; Hunter 2007). HIV/AIDS-induced food insecurity and famine are examples of how this disease is affecting the human and health security of this region, leaving millions of people vulnerable to malnutrition and at risk of poor health.

The securitisation of AIDS and the rise of biopolitics

The securitisation of HIV/AIDS by the UN in 2000 assigned to this disease the urgency and importance traditionally only afforded to wars between states (Owen 2008). For some the securitisation of HIV/AIDS appeared to be a political exercise undertaken by policy-makers, particularly those associated with UNAIDS, to attract resources and political support in controlling the spread of the infection (Selgelid and Enemark 2008). Whatever the motivation for Resolution 1308, the result was the inauguration of a number of international organisations to fight HIV/AIDS including The Global Fund and PEPFAR.

The Global Fund was set up in 2002 as a major tool in the fight against HIV/AIDS, TB and malaria in developing and middle income countries. It is a public–private partnership between governments, the private sector, civil society and affected communities dedicated to attracting and disbursing resources to prevent and treat HIV/AIDS, TB and Malaria. The fund supports prevention, care and treatment programmes in 137 countries. To date The Global Fund has invested US$7.2 billion and provides 23% of all international funding for HIV/AIDS. In total 60% of its funding went to programmes in sub-Saharan Africa.

PEPFAR is the USA's initiative to combat the global HIV/AIDS pandemic. Following the signing into law of the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003, PEPFAR began its work in June 2004. The legislation approved expenditure of up to US$15 billion over five years. In fact spending over the period was US$18.8 billion. In July 2008, PEPFAR was re-authorised for a further five years, with funding up to US$48 billion over the five year period. PEPFAR focuses on 15 specific countries, all in Africa and the Caribbean (apart from Vietnam). Since 2008 PEPFAR has promoted a partnership framework model. The new partnership framework emphasises the role of host country governments in ensuring an effective and sustainable response to the HIV/AIDS pandemic.

UNAIDS, together with the Global Fund and PEPFAR, have implemented and coordinated a range of international HIV/AIDS interventions in what Elbe (2008) labels 'a kind of marketing strategy' which is associated with 'an epidemiological risk rationality' (Elbe 2008: 188) that has resulted in 'a risk-based bio-political security practice' (Elbe 2008: 189). Thus in Elbe's opinion the securitisation of HIV/AIDS has been responsible for the development of a global biopolitical economy of power dominated by the USA and other Western democracies, through these hugely powerful international organisations.

Conclusion

It is clear that in the last 25 years health security has become an important element of human security that mirrors the shift in development thinking and the dominance of the human development paradigm. The global HIV/AIDS pandemic has been instrumental in putting health at the centre of the human security debate as a consequence of the securitisation of the disease by UN Resolution 1308 in 2000. In 2000 the threat of the HIV/AIDS epidemic on state security appears to have been exaggerated; the predicted collapse in state structures in countries most severely affected by the disease did not occur. However the impact on human welfare and security was underestimated, with the impact on livelihoods little understood. An unexpected outcome of Resolution 1308 has been the rise to prominence of international biopolitical power concerning the health and well-being of populations in the developing world and in sub-Saharan Africa in particular.

The HIV/AIDS pandemic has changed the world we inhabit in many ways. For those living in high prevalence regions, the pandemic is not only a medical tragedy, it also retards human development and has produced fears of state insecurity and the reality of human insecurity including uncertainty of food production and in extreme cases famine. This disease connects human and health security at all scales and contributes to state insecurity. It has played a central role in the incorporation of health security within the new human security paradigm.

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