

Securitizing the HIV/AIDS Issue in Asia¹

by

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1. Introduction

This chapter discusses the significance of understanding the growing HIV/AIDS epidemic in South, Southeast and East Asia as a security issue. Drawing upon concepts identified within the Copenhagen School, it further proposes a framework for 'securitizing' the issue of HIV/AIDS with reference to specific 'securitizing actors', 'speech-acts' and indicators of securitization. In this regard, it contributes to the evolving body of work within the Copenhagen School, which has not always been specific about indicators of securitization or speech-acts, and which has not included HIV/AIDS as an area of non-traditional security.

At the brink of the third decade of the HIV/AIDS epidemic, the disease has claimed more lives than any armed conflict in recent history (AWOG, 2000). As shown in Exhibit 1 below, in 2003 three million people died from AIDS and five million people were newly infected by the HIV virus (UNAIDS, 2003a). The total number of people living with HIV/AIDS in the world in 2003 was approximately 40 million (UNAIDS, 2003a).

Exhibit 1 HIV/AIDS infections and deaths in 2003

Number of people living with HIV/AIDS	Total	40 million (34 – 46 million)
	Adults	37 million (31 – 43 million)
	Children (under 15 years)	2.5 million (2.1 - 2.9 million)
People newly infected with HIV in 2003	Total	5 million (4.2 - 5.8 million)
	Adults	4.2 million (3.6 - 4.8 million)
	Children (under 15 years)	700 000 (590 000 - 810 000)
AIDS deaths in 2003	Total	3 million (2.5 - 3.5 million)
	Adults	2.5 million (2.1 - 2.9 million)
	Children (under 15 years)	500 000 (420 000 - 580 000)

Source: AIDS Epidemic Update 2003, UNAIDS (2003a)

Where prevalence of HIV/AIDS infections amongst the adult population exceeds one per cent, the disease has been seen to affect economic development and gains already made in

poverty reduction (Guinness and Alban, 2000; Arndt and Lewis, 2000; Robalino *et al.*, 2002; UNAIDS, 2002). Moreover, HIV/AIDS has been seen to be especially prevalent amongst personnel in the national armed forces, police forces and also amongst peacekeepers, with serious implications for international and domestic capacities to implement law and order (Foreman, 2002; Schneider and Moodie, 2002; UNAIDS, 1998a).

That HIV/AIDS seriously threatens several dimensions of security, was formally acknowledged by the United Nations (UN) Security Council, in July 2002 when the Council classified HIV/AIDS as an international security issue (Resolution 1308). HIV/AIDS was the first health issue debated by the UN Security Council and one of the few non-traditional security issues on which the Council has adopted a resolution (see Wurst, 2000).

Thus far, most of the devastation of the epidemic has been in sub-Saharan Africa (Dixon *et al.*, 2001a; Jamison *et al.*, 2001; Carballo *et al.*, 2000). However, it should be noted that prevalence of the disease in several countries of South, South East Asia and also East Asia, is rising dramatically (WHO, 2003; UNAIDS 2002, 2003a). The World Bank estimates that almost one quarter of the total number of people living with HIV/AIDS already live in these Asian regions (World Bank, 2002). India's National AIDS Control Organization (NACO) acknowledges that India has some four million people living with HIV/AIDS (NACO, 2004), the second largest population of persons living with HIV/AIDS in the world (WHO, 2002). By the year 2010, it is expected that without intervention, some 37 million people in India may become infected by the HIV virus (World Bank, 1999a). A study published with the approval of the Chinese Ministry of Health concedes that China is also on the brink of a major epidemic, which if left unchecked could lead to a population of some 15 million people being infected with the HIV virus by 2010 (Gill and Morrison, 2003). Cambodia and Myanmar are already faced with national adult prevalence rates² of more than one per cent (UNAIDS, 2003a).

As various countries in Asia are faced with the possibility of a devastating epidemic, they have mostly³ also been fortunate to be part of the second rather than the first wave of

² This refers to number of people aged between 15-49 years who were believed to be infected with HIV, out of the total population of people aged between 15-49 years in each country.

³ Thailand was amongst the first countries in Asia to face a HIV/AIDS crisis and has very successfully managed to curb the spread of the disease (See Abrams, 1998). Thailand may be regarded as a part of the first wave of countries to experience the HIV/AIDS epidemic.

countries hit by the epidemic⁴, mainly in sub-Saharan Africa. Asia and the international community have a window of opportunity to learn from the first wave of countries hit by the disease. The experience of the first wave countries suggests that to curb and manage a HIV/AIDS epidemic, the general population has to be mobilized to focus on HIV/AIDS, to understand the seriousness of the disease and to change behavior. Moreover, effective management of HIV/AIDS requires substantial changes in key socio-political relationships and in the processes of policy formulation. It requires massive mobilization of social, technical and financial resources. National responses to the disease must be quick and regularly adapted. As Peter Piot⁵ notes, "AIDS forces us to do business differently, this is not only about personal behavior change, but also about institutional behavior change" (2003). Such changes are difficult to implement in the case of most governments and populations. They are particularly challenging in developing countries where there are a multitude of problems.

In this regard, the notion of securitization put forth by the Copenhagen School has considerable appeal as a means of initiating efficient response towards curbing the epidemic. The extent and rapidity of changes necessary to manage HIV/AIDS are generally accepted and implemented in situations of war or in more easily visible crises such as SARS. Elevating the issue of HIV/AIDS to the level of a security issue will be extremely useful in rallying together policy-makers and the population. As Stephen Lewis⁶ noted recently, "If the African leadership, early on, had not been consumed by denial and fear, if the industrial nations, early on, had made resources available, if the world had been energized around the pandemic as it has been energized around Afghanistan, Iraq and terrorism (...) then millions of people would still be alive today" (Lewis, 2004).

While the notion of securitizing the HIV/AIDS issue is attractive, the process of securitization remains uncertain. Who are the 'securitizing actors'? HIV/AIDS is a disease that reaches deep into the private sphere, and is riddled by notions of irreligious and immoral behavior. How might the government be persuaded to become a securitizing actor? While security must be voiced by political and governmental actors, are public agents alone able to

⁴ The first wave of countries to be hit by the HIV/AIDS epidemic include South Africa, Botswana, Lesotho, Senegal, Uganda, Thailand, Zambia, Zimbabwe and Haiti amongst others.

⁵ Executive Director of UNAIDS and Under Secretary-General of the United Nations

⁶ UN Special Envoy to Africa for HIV/AIDS

diffuse the message of securitization effectively? What are the necessary 'speech acts' of various actors? And how do we know when HIV/AIDS has been securitized?

The second part of this chapter discusses the growing HIV/AIDS epidemic in East, Southeast and South Asia in greater detail and outlines the potential impact of the HIV/AIDS epidemic on human, military and economic security if left unchecked. The third part is devoted to initiating a framework for securitizing the HIV/AIDS issue.

2. The Rise of the HIV/AIDS Epidemic in Asia: Pathways of Transmission

At the end of 2003, Asia was home to an estimated 9 million adults and children living with HIV/AIDS (UNAIDS, 2003a). As shown in Exhibit 2 below, with the exception of Cambodia, Myanmar and Thailand, national HIV adult prevalence rates remain low in most countries in South, Southeast and East Asia. However, in vast populous countries such as India (0.8 per cent), China (0.1 per cent) and Indonesia (0.1 per cent), low national adult prevalence rates euphemize the seriousness of the problem⁷. National prevalence rates also obscure severe localized epidemics affecting large numbers of individuals. For example HIV/AIDS surveillance at antenatal clinics in three Indian states, each with a population of 50 million people or greater, reveals that infection rates are three per cent or higher (Chatterjee, 2003). Several major urban areas are also reporting HIV infection rates above three per cent (CIRA, 2003). In China, rates of HIV prevalence amongst injecting drug users (IDUs) in Xinjiang have been found to be 35-80 per cent and 20 per cent in Guangdong (UNAIDS, 2003a). In Henan, an estimated 500 000-700 000 individuals have been infected with HIV as a result of unsafe blood collection practices (Bates *et al.*, 2002).

More worryingly, analysts note that even national adult prevalence rates are likely to increase amongst Asian countries in the next decade, breaking out from currently localized epidemics into the general population (see Beyrer, 1998; Thompson, 2003; Kaufman, 2002).

Exhibit 2

Current impact of HIV/AIDS on countries of East, South, and South-East Asia¹

Adults and Children Living with HIV/AIDS in 2003	9 million
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⁷ The extended period of latency between HIV infection and initial manifestations of symptomatic illness may also obscure national prevalence statistics, especially where routine testing is not established and large segments of the population are not serviced by the healthcare system (Pharaoh and Schonteich, 2003). It should also be noted that several countries have been severely criticized for underreporting national prevalence of HIV/AIDS.

Adults and Children Newly Infected with HIV		610,000 – 1.1 million	
Adult Prevalence (%)		0.4 – 0.8	
Adult and Child Deaths from AIDS		330,000 – 590,000	
Country	Adult Prevalence² (% and magnitude)	HIV/AIDS Related Deaths	Numbers of HIV/AIDS Orphans
Bangladesh	<0.1 (13,000)	650	2100
Cambodia	2.7 (160,000)	12000	55000
China	0.1 (850,000)	30 000	76 000
India [*]	0.8 (4,580,000)		120,000 ⁴
Indonesia	0.1 (120,000)	4 600	18 000
Japan	<0.1 (12,000)	430	2 000
South Korea	<0.1 (4,000)	220	1 000
Laos	<0.1 (1,300)	<150	
Malaysia	0.4 (41,000)	2 500	14 000
Myanmar	<0.1 ⁵ (420,000) ⁶		55 000 ⁷
Nepal	0.5 (56,000)	2 400	13 000
Pakistan	0.1 (76,000)	4 500	25 000
Philippines	<0.1 (9,400)	720	4 100
Singapore	0.2 (3,400)	140	
Sri Lanka	<0.1 (4,700)	250	2 000
Thailand	1.8 (650,000)	55 000	290 000
Vietnam	0.3 (130,000)	6 600	22 000

1 Data from UNAIDS Country Factsheets (2002), except where noted. Statistics reflect trends as of 2001.

2 Percentages reflect the number of people aged between 15-49 years who were believed to be infected with HIV out of the total population of people aged between 15-49 years in each country, as of the end of 2001.

3 Estimated cumulative number of deaths in 2001.

4 Total estimated number of living orphans as of the end of 2001. These data reflect the number of children under 15 years of age who have lost their mother or both parents as the result of HIV/AIDS.

5 Based on CIA estimation of reproductive-age population.

6 From HIV/AIDS – South East Asia Region Factsheet, WHO. Magnitude as of 2003.

7 Source: UNICEF, 2000.

General trends characterizing the growth of HIV/AIDS epidemics in Asia within the last several years are shown in Exhibit 3 below. The first HIV/AIDS cases in Asia were detected in the mid 1980s (WHO, 2001) and generally first observed either in populations of injecting drug users (IDUs) or commercial sex workers (Beyrer, 1998, 2004)⁸. Acceleration of concentrated epidemics amongst these key high-risk groups is seen to stimulate the transmission of the disease into the general population within countries and into new countries and populations.

Exhibit 3

Principle epidemic trends for growth in HIV infections in Asia

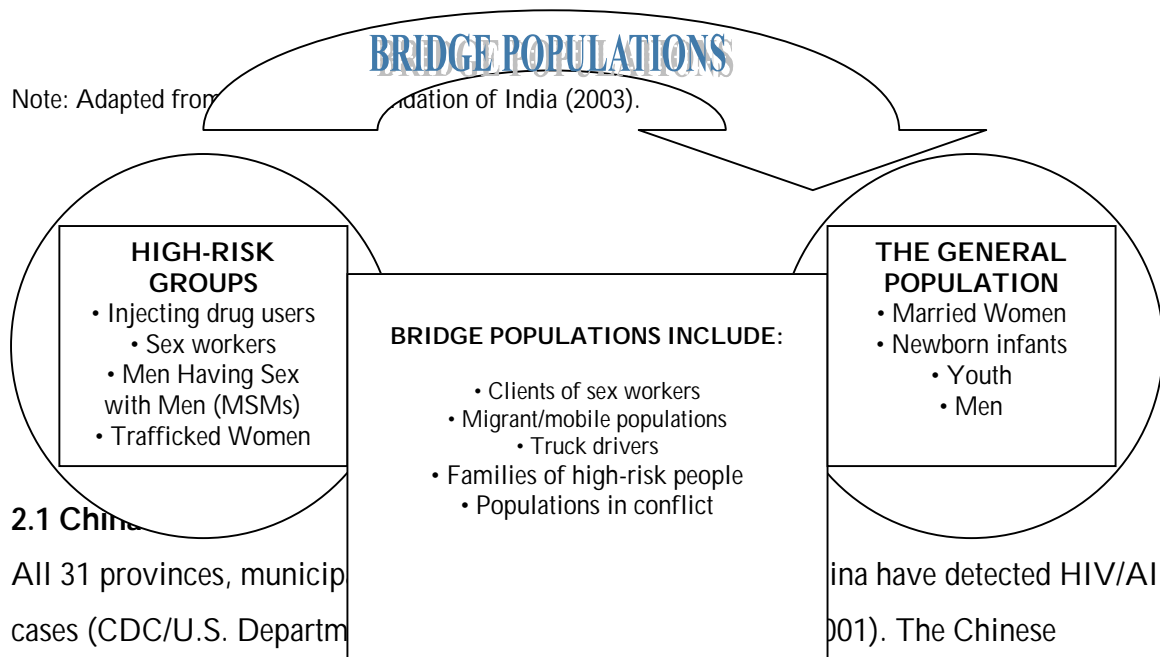
⁸ The patterns and prevalence of the major HIV-risk behaviors in Asia are different from other major geographic regions of the world. In sub-Saharan Africa, the predominant mode (over 95%) of HIV transmission in the sexually active population is via heterosexual intercourse. In "Western" countries, men having sex with men (MSM) and IDU groups continue to be the most prominent RBG involved in HIV transmission. In Asia, IDU, as well as FSW and their clients, are the most prominent RBG involved in HIV transmission (WHO Southeast Asia, 2003).

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| 1. Acceleration of concentrated localized epidemics in IDUs and commercial sex workers |
| 2. Dissemination of the virus from high-risk populations to general populations |
| 3. Rapid spread of HIV/AIDS into new countries and populations previously spared |

Note: Adapted from Beyrer (2001)

Potential channels of movement of the HIV virus from high-risk groups in Asia to the general population through 'bridge populations' are summarized below in Exhibit 4. It should be noted that the significance of different high-risk groups and 'bridge populations' varies substantially across Asian countries. Some recent key trends in HIV transmission, high-risk groups and 'bridge populations' in the two Asian countries where HIV/AIDS is likely to affect extremely large populations (China and India) are discussed briefly below.

Exhibit 4
Movement of the HIV Virus from High-Risk Groups to the General Population



2.1 China

All 31 provinces, municipal districts, and autonomous regions have reported HIV/AIDS cases (CDC/U.S. Department of Health and Human Services, 2001).

China have detected HIV/AIDS cases (CDC/U.S. Department of Health and Human Services, 2001). The Chinese

government has identified three distinct HIV/AIDS epidemics in China (Chinese Ministry of Health, 2003). Approximately 68 per cent of HIV positive individuals are identified as IDUs located largely in the southern and western parts of China. 10 per cent have been infected through heterosexual intercourse (identified largely as intercourse between commercial sex workers and their clients), 10 per cent infected through unsafe blood donation practices and the remainder through unclear modes (Chinese Ministry of Health, 2003).

While most infection have thus far been found amongst IDUs, dramatic growth in the numbers of HIV infections in recent years is largely due to the expansion of the commercial sex work industry and an increasingly mobile population which serves as a 'bridge population' between sex workers and the general population.

With the growth of the Chinese economy, some 120 to 130 million people from the rural areas have migrated to the cities in search of work (World Vision, 2003; CDC, 2003). This 'floating population' (*liudong renkou*) (Thompson, 2003), comprises both young men and women highly susceptible to HIV infection. For young women in this 'floating population', the lack of economic opportunities have meant that many must join the commercial sex work industry on a full-time or part-time basis. A CDC/ U.S. Department for Health and Human Services report (2001) notes that "during direct interviews with a number of young women working as prostitutes, we confirmed the impression that they were young, from rural backgrounds, often having stopped school at or before 9th grade (when free schooling ends) and that they were then driven by economic forces into high-risk work". The mobility of these women, between cities and rural areas further increases opportunities for transmission of the disease to the wider population.

Presently, HIV infection rates amongst Chinese sex workers are still considered to be low, although this is likely to change. The Chinese Ministry of Health (2003) estimates that 1.32 per cent of sex workers were HIV positive in 2002. However infection rates in some locales is severe at 11 per cent in Guangxi and five per cent in Yunnan (Kaufman, 2002). There is low condom use amongst sex workers (10-15 per cent) (CDC/U.S. Department of State for Health and Human Services, 2001) and low awareness or knowledge of HIV transmission (Wu, 2002).

There is also increasing demand for sex workers as urban incomes rise and social barriers to extramarital sex particularly in urban areas are relaxed (CDC/U.S. Department of State for Health and Human Services, 2001, see also Gill and Morrison, 2003). A survey among local businessmen and traders in one province found that 95% admitted to recently having sex with a prostitute (CDC/U.S. Department of State for Health and Human Services, 2001).

HIV transmission amongst sex workers and in the general population is also likely to increase a result of large numbers of young, poorly educated males in a sexually active period of their

lives within the 'floating population' (Thompson, 2003)⁹. Thompson (2003) notes that they are easy targets for drug sellers, have ample opportunities to interact with sex workers and being far away from home are less constrained by the conservative mores of their home villages.

Indeed, rapid increases in the transmission of the disease may already be observed. At the end of 2002, the Chinese government documented 40,560 cases of HIV infection (Chinese Ministry of Health, 2003). In September 2003, the Executive Vice Minister of Health Gao Qiang addressed the UN General Assembly, informing them that 840,000 people were currently living with AIDS. While some of this dramatic growth may be attributed to increased efforts at documentation of HIV/AIDS cases, even projections built on official Chinese statistics, which are probably conservative, indicate an annual growth in HIV cases at 30 percent. Without intervention, China is likely to have the world's second largest population of HIV/AIDS carriers in the world by 2010 (Eberstadt, 2002).

2.2 India

India is expected to have the world's largest population of HIV/AIDS carriers by 2005. An overwhelming majority of the total reported national AIDS cases-96 per cent- were reported by 10 of India's 31 states (UNAIDS/WHO, 2002). The epidemics thus far have been focused very sharply in a few southern states. High prevalence states include Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, where the HIV virus is transmitted mainly through commercial sex work (UNAIDS/WHO, 2002), and Manipur where the virus is primarily transmitted through injecting drug use (Barnett and Whiteside, 2002; Solomon and Ganesh, 2002). 82.6 per cent of HIV/AIDS cases reported in India are transmitted through heterosexual sex, 4.4 per cent by IDUs, 4.0 per cent by blood and blood products and 1.8 per cent from mother to child. Modes of transmission accounting for the remaining 7.5 per cent remain unclear (Solomon and Ganesh, 2002).

UNAIDS surveillance data now suggests that the epidemic is moving beyond key high-risk groups such as sex workers and IDUs, and into areas previously less affected by HIV/AIDS such as rural areas (UNAIDS, 2003a). In July 2003, the Project Director for India's National AIDS Coordinating Agency (NACO), also acknowledged that "HIV/AIDS no longer affects

⁹ Male migrants are often away from home for 50 weeks in a year, living in single-sex dormitories and working

only high-risk groups or urban populations, but is gradually spreading into rural areas and the general population" (Kaiser Network, 2003).

As in China, the spread of the disease to the general population has partly been fuelled by severe increases in the transmission of the HIV virus within the sex work industry. Mumbai has the country's largest brothel based sex industry, with 60 000-70 000 sex workers (Gomare *et al.*, 2002). While in 1990 only one percent of Mumbai's sex workers was infected with HIV, by 1996 nearly three quarters of the city's sex workers were infected (UNAIDS, 1996). Similarly, a study in Surat found that HIV prevalence among sex workers had increased from 17 per cent in 1992 to 43 per cent in 2000 (Desai *et al.*, 2003).

Severe increases in prevalence rates amongst sex workers have been accompanied by the creation of large bridge populations in recent years. As in China, India has a large 'floating population'. According to the 1993 National Sample Survey in India, 24.7 per cent of the population had migrated, either within India, to neighboring countries or overseas. Applying this percentage to the mid-2003 population, approximately 264 million Indians are mobile. As one UNAIDS (2001) study notes with regard to India, "Being mobile in and of itself is not a risk factor for HIV infection. It is the situations encountered and the behaviors possibly engaged in during mobility or migration that increase vulnerability and risk regarding HIV/AIDS" (5). Most of the migrant workers often live in unhygienic conditions in urban slums. Long working hours, relative isolation from the family and geographical mobility may foster casual sexual relationships and make them highly vulnerable to sexually transmitted diseases (STDs) and HIV/AIDS (UNAIDS, 2001).

Migrant workers also tend to have little access to information on HIV/AIDS, voluntary counseling, testing and health services. Cultural and language barriers worsen their lack of access to such services. Returning or visiting migrants, many of whom do not know their status, may infect their wives or other sex partners in the home community (UNAIDS, 2001). Indeed, married men are an important bridge population found to be responsible for a large number of transmissions (Population Foundation of India/ Population Reference Bureau, 2003). Accordingly, Gangakhedkar *et al.* (1997) suggest that married women not having sex outside marriage are highly susceptible to HIV infection.

for long hours in difficult conditions (Thompson, 2003)

Truck drivers constitute another key bridge population transmitting the disease to the general population (USAID, 2003)¹⁰. India has one of the largest road networks in the world and two to five million long distance truck drivers and helpers (FHI, 2003). The extended periods of time that they spend away from their families place them in close proximity to high-risk sexual networks, and often results in them having an increased number of sexual contacts (FHI, 2003). During their journeys, the drivers often stop at 'dhabas', roadside hotels that usually provide food, rest, sex workers, alcohol and drugs. They pick up the women, use them and leave them at some other 'dhaba', where they are used by other drivers and local youths (Christensen, 2002). As a result, truck drivers are crucial in spreading STDs and HIV infection throughout the country. A study published in 1999 showed that 87 per cent of Indian drivers had frequent and indiscriminate change of sexual partners, and only 11 per cent used condoms (Kootikuppala *et al.*, 1999; See also Christensen, 2002).

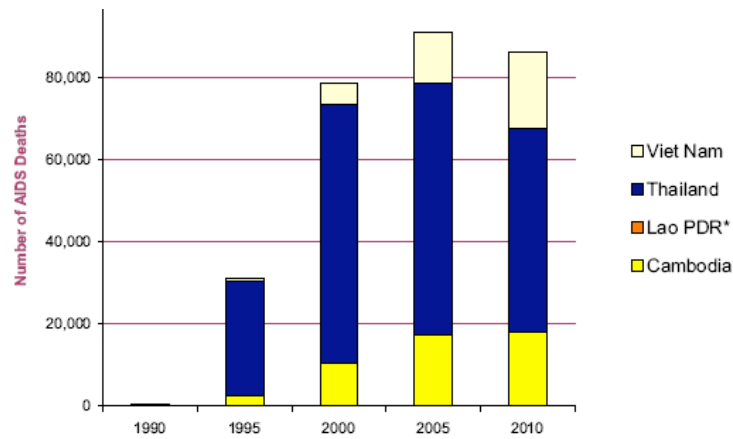
2.3 The Growing and Potential Impact of HIV/AIDS in Asia

As the HIV/AIDS epidemic spreads to the wider populations of several Asian countries, these countries, and to some extent the surrounding regions, are likely to experience multiple, devastating consequences. This section very briefly outlines three major consequences of the disease, which have been discussed in detail elsewhere (see Schneider and Moodie, 2002; Robalino *et al.*, 2002; Policy Project, 2003).

First, the projected impact of HIV/AIDS on human security by 2010 is considerable in those Asian countries already severely affected by the disease. As mentioned earlier, in India, 37 million people and in China 15 million people are expected to be infected with HIV/AIDS in 2010. Exhibit 5 shows the estimated and projected number of AIDS related deaths in Vietnam, Thailand, and Cambodia. While Thailand is likely to see a decrease in the numbers of AIDS related deaths, numbers in Cambodia and Vietnam are on the rise.

Exhibit 5 Estimated and Projected Numbers of AIDS Deaths in 4 Southeast Asian Countries

¹⁰ While they may be considered a sub-population of migrant workers, the size of this group and the unique modes and settings in which transmission of HIV/AIDS occurs through this group, has generally led to separate classification.



*Note: The number of AIDS deaths in Lao PDR is <200 in each projected year.

Related to these HIV/AIDS deaths, the disease also compromises the human security of another related group: orphans from families where one or both parents have lost their lives to the disease. Worldwide, more than 13 million children have already been orphaned by the disease (UNICEF/ USAID/UNAIDS, 2004). A joint report by UNICEF, UNAIDS and USAID, *Children on the Brink: Strategies to Support Children Isolated by HIV/AIDS* (2002) expects that in 2010, of the 106 million children who will have lost one or both parents, 25 million will have lost a parent to HIV/AIDS. As shown in Exhibit 6, in Thailand, Cambodia, Laos and Vietnam, there are likely to be 600 000 children orphaned by HIV/AIDS (UNICEF/UNAIDS/USAID, 2002). India already has an estimated 120,000 children orphaned because of AIDS (VHS, 1999). Between 1990 and 2000, the number of children orphaned to HIV/AIDS in the combined countries of South and East Asia increased from 39,000 to 790,000 (UNICEF/UNAIDS/USAID, 2002). While some of these children will be cared for through fostering situations, many will once again become a part of groups at high risk of HIV/AIDS infection. As Rau (2002) suggests, “The presence of children on the street and their need for money, food, shelter, and companionship all increase their chances of being drawn into casual sexual relationships or more formal commercial sexual exploitation” (Rau, 2002, see also Policy Project, 2003).

Exhibit 6

Projected AIDS Orphans by Country in 2010

Country	Total number of orphans (0–14) due to AIDS	Orphans due to AIDS as a percentage of total orphans
Cambodia	142,000	28%
Thailand	374,000	36%
Viet Nam	82,000	7%

Source: UNAIDS, UNICEF, and USAID (2002)

Second, widespread AIDS threatens economic security. HIV/AIDS selectively affects the most economically productive segments of the population. As shown in the cases of economic migrant populations in India and China (see above), young people, in their sexual, reproductive and productive prime are at the highest risk of HIV infection. The ILO estimates that at least 23 million workers in the prime labor force (aged 15-49 years) are infected with HIV, constituting three quarters of all adults living with AIDS. In Thailand for example, of the some 670,000 people living with HIV/AIDS, more than 85 percent fall in the most productive age group. Had the epidemic's growth not been arrested in Thailand, the country's working age population was expected to have been about 10 million smaller by 2015 due to HIV/AIDS (Bloom *et al.*, 2001).

The impact of high levels of infection amongst young, productive and highly skilled individuals compromises economic security on many levels. The most immediate impact is perhaps at the level of the household where HIV/AIDS treatment or death leads to substantial loss of income for the family. For example, a study of 116 households in Chiangmai in Northern Thailand, with recent experience of AIDS related deaths, suggests that the average yearly income of these households was approximately 53 per cent of the income of households experiencing no deaths (Pitayanon *et al.*, year unknown). A study of Indian AIDS patients notes that on average, AIDS patients spent 10-30 per cent of their annual income on drugs and medicines. As expected, individuals with a lower income as well as one child had a greater probability of severe impact than other households (Gupta, 1998). In Yunnan province in China, which accounted for 5 per cent of China's HIV/AIDS cases, it is expected that by 2010, an additional 300 000 people will fall into poverty as those infected with HIV experience AIDS. This is a 15 per cent increase in the number of those already living in poverty in the province (Herewerd *et al.*, 2002). In Cambodia, expenditure on HIV/AIDS was found to equal several times an extended family's annual income. In rural parts of Cambodia, the high cost of medicine and the rural credit system combined to make HIV/AIDS a significant cause of landlessness (ESCAP 2002c).

Where prevalence rates exceed one per cent, the cumulative impact of HIV/AIDS on various segments of society ¹¹ is manifest in national in sub-national economic growth rates.

(Schneider and Moodie, 2002). According to World Bank estimates, a prevalence rate of 8 per cent could reduce gross domestic product (GDP) by 0.4 per cent, compared with a no-AIDS scenario. In Yunnan province in China, the net loss to GDP of permanent/temporary non-participation in the labor market was 0.01 per cent in 2000 (Hereward *et al.*, 2002). Assuming a continued economic growth rate of 4 per cent per year in Yunnan until 2010, net loss of income due to HIV/AIDS is expected to rise to 0.43 per cent in 2010.

While there is less productivity due to HIV/AIDS, governments also forced to allocate more resources for health expenditures, and less to other national development projects. The World Bank has estimated that in many developing countries, one year of basic medical treatment can amount to 2 to 3 times the per capita GDP. In Thailand, one estimate has put the annual cost of basic medical care for each person living with HIV/AIDS at approximately US\$ 1,000 per person or about 25 times the Government's per capita health expenditures (Farooq 2000). A 1997 World Bank report on Confronting AIDS states that if India maintains its current levels of health care subsidies, a severe AIDS epidemic would increase government expenditure by about \$2 billion per year by 2010. If subsidies are increased to the 50 per cent level (to meet the rising costs of health for HIV patients) the same epidemic would increase annual government health expenditure by an additional \$30 billion (World Bank, 1997). Findings from simulations of AIDS impacts on GNP in India and China, at different levels of national HIV prevalence are shown below in Exhibit 7, confirming the tremendous impact of the disease on the national economy.

Exhibit 7
GNP Simulations to 2025 for China and India

		2025			
2000		No epidemic	Mild Epidemic	Intermediate Epidemic	Severe Epidemic
China					
HIV prevalence assumption (%)	0.07	0	1.5	3.5	5

Total GNP (USD billion)	9200	17 700	13 600	10 800	9 400
GNP per active person (USD)	10 800	17 700	13 900	11 200	9 900
India					
HIV prevalence assumption	0.7	0	1.5	5	7
Total GNP (USD billion)	3 700	10 300	8 000	5 200	3 900
GNP per active person (USD)	5 900	11 200	8 700	5 800	4 700

Source: Eberstadt (2002).

A third consequence of an HIV/AIDS epidemic is its impact on the armed forces and peacekeepers. These groups have been found to be particularly susceptible to HIV infections. Bloom *et al.* (2001) note that prevalence amongst peacekeepers in Cambodia has been especially high. This resulted from the confluence of soldiers and foreign cash in the setting, which led to a sex industry and the expansion of trafficking networks to supply women and girls to UN forces (Artenstein *et al.*, 1995, see also Beyrer, 1998). In Mongolia, a survey of 287 army recruits who had experienced sexual intercourse, 89.2 per cent said they had not used any prevention method (Cohen and Luvansambhu, 2002).

Several reasons explain why numbers of HIV infections are particularly high in the armed forces and amongst peacekeepers. According to UNAIDS (2003b) members of the uniformed services are predominantly young men and women who see themselves as invulnerable. Duty schedules and periods of deployment result in separation from families. Furthermore, with a steady income, service men and women are often considerably better off than those in surrounding communities and able to pay for sex or to attract those willing to have sex with them. Host populations are also often dependent on the military for food. Personnel in the armed and peacekeeping forces are seen as being in a position of power and authority by civilians, making relationships with personnel more attractive and lucrative (UNAIDS, 2003b).

Thus far, this chapter has discussed the extent and significance of HIV/AIDS prevalence rates in Asia. As mentioned earlier, the Copenhagen School does not consider HIV/AIDS an area of non-traditional security. While HIV/AIDS has been aggressively managed and is more easily treated in richer developed countries, any discussion on non-traditional security issues in Asia, with its many developing countries, must include HIV/AIDS. The majority of the countries of South, Southeast and East Asia are characterized by socioeconomic conditions,

which have contributed to the spread of the disease in sub-Saharan Africa. The large numbers of lives potentially affected, well beyond those infected, suggest that HIV/AIDS should be amongst the most significant security concerns for Asian governments in the next decade. The following section discusses the process of securitizing the issue of HIV/AIDS.

3. A Framework for Securitizing the HIV/AIDS Issue

This section proposes a framework for securitizing the HIV/AIDS issue. It considers 'securitizing actors', particular 'speech acts' which may promote securitization and the indicators of securitization. This analysis identifies interventions and actors whom/which it has been difficult to adopt/co-opt within the boundaries of normal politics. It draws upon the experiences of some Asian countries such as Thailand, which have already gone a long way towards securitizing the HIV/AIDS epidemic, as well as those which are beginning to take serious steps to grapple with the disease. The general progress of Asian countries towards securitization is discussed towards the end of this section.

3.1 Securitizing Actors

National governments must bear primary responsibility for initiating any effective response to control HIV/AIDS. National governments define national priorities, often have the legitimacy and authority to mobilize various sections of the population, and control a great part of the resources necessary to mount a campaign against the disease. However, while the national government is an 'initiating actor' in the process of securitization, there are two other groups of 'securitizing actors' central to the process. First, there are those actors who must actively persuade governments into securitizing the HIV/AIDS issue. HIV/AIDS is not an issue that easily securitizes itself in the way that diseases such as SARS did recently. The extended period of latency of the HIV virus and very importantly, the stigma that has come to be associated with HIV/AIDS have generally discouraged political actors from associating with the disease and putting forth a case for responding more aggressively to it (Piot, 2003).

In this regard, 'catalyzing actors' are critical to the securitization process. 'Catalyzing actors' must clearly be those who have already identified HIV/AIDS as a security issue. Actors with substantial influence over national governments such as the World Bank or the International Monetary Fund (IMF), and other national governments have a particularly important role to play in persuading affected national governments to securitize the HIV/AIDS issue in their country. Indeed, the U.S. government has already begun to do so with President Bush signing

the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (H.R. 1298). Thompson (2003) notes, "The United States government is actively engaging the Chinese government to curb the spread of HIV/AIDS in China, both bilaterally and through multilateral organizations, such as the United Nations and the Global Fund to Fight AIDS, Tuberculosis and Malaria". In a recent interview with the Fletcher Forum of World Affairs, the Administrator for the U.S. Agency for International Development (USAID) noted, "As you know, China does not normally get foreign assistance from the United States government. This is an exception to that rule. Congress has said that it is okay in this particular case (of HIV/AIDS)¹² because of the severity of the crisis that the world is facing"(Fletcher Forum of World Affairs, 2003: 26).

A second group of actors critical to effective securitization are those that will carry forth the message that HIV/AIDS is a security issue to the general population. Several actors outside the national government will also be necessary to formulate and implement new policy to manage the HIV/AIDS epidemic. Local governments and non-governmental organizations (NGOs) are central amongst this second group of 'implementation actors'. . In some Asian countries, community concerns are represented through other governmental or semi-governmental organizations (GOs) rather than NGOs. A key element of the securitization process will be for national governments to forge a nexus between themselves, local governments and key NGOs/GOs to co-operate and co-ordinate their efforts in the fight against HIV/AIDS.

Local governments, national governments and independent NGOs are not obvious bedfellows. Local and federal governments often have clearly defined jurisdictions in the area of health and are fiercely protective of encroachment into their territory by the other. NGOs and governments are often at odds against how public issues need to be managed. However, effective management of the HIV/AIDS epidemic requires co-ordination and co-operation between all three actors (UNAIDS, 2003c).

Co-ordination and co-operation amongst NGOs/GOs, national and local governments will prevent duplication of activities and facilitate more efficient use of resources. Local governments often have the unique capacity and experience to reach out to and work with local populations in managing the HIV/AIDS epidemic (Kelly, 2003). Similarly, local and particularly rural groups are able to express their needs to policy-makers in local government

¹² Parentheses not found in original quotation.

more easily than through national government (ibid.). Local governments also often have smaller bureaucracies to work through in establishing HIV/AIDS policies.

For example in China, local governments have been found to be more pro-active and efficient in setting up regulations to respect the rights of those infected with AIDS. For example, in 2002, the local legislative department of Suzhou, East China's Jiangsu Province, issued a special regulation on the prevention and control of HIV/AIDS and sexually transmitted diseases (STDs). The regulation stipulates the rights and duties of those infected with HIV/AIDS and provides for legal redress in cases of unfair treatment of HIV/AIDS victims (China Daily, 2002). The national government had begun drafting a similar regulation three years earlier. The first draft of the regulation was also issued in 2002. However, a disease control division director at the Ministry of Health noted that it would still take a while for the Ministry of Health to organize officials and experts to carefully proof the draft before it is given to the State Council and the National People's Congress for final approval (ibid.).

NGOs/GOs also have special competencies in curbing a HIV/AIDS epidemic. They are often forerunners in managing HIV/AIDS in various countries (see Bensmann, 2003). NGOs also often have unique access to groups such as sex workers or IDUs, which are often responsible for transmission of the disease into the general population, but whose activities constitute criminal offences under several national laws. Additionally, collaboration between governments and independent NGOs to combat HIV/AIDS has also been found to be much less costly than expanding government mechanisms (World Bank, 1999b).

In India, NGOs started working on issues of HIV/AIDS several years before governmental organizations and have considerable experience working with vulnerable groups (SIDA, 2003). This is increasingly recognized by the Indian National AIDS Control Organization (NACO) which acknowledges that "flexibility and innovative approaches enable NGOs to access constituencies that the state apparatus sometimes finds difficult to reach. They often represent realistically, the needs of even the most marginalised and vulnerable populations" (NACO, 2004). NGOs are seen by NACO to be "primary allies and critical partners" and NACO has already embarked on several projects through which it seeks to reach high-risk groups through NGOs (ibid.).

While NGOs/GOs working on issues of HIV/AIDS are generally important, it should be noted that NGOs/GOs representing people living with HIV/AIDS (PLWHA), or individual PLWHA who are openly committed to the fight against HIV/AIDS, are a particularly invaluable and indispensable sub-set of 'implementation actors' in the securitizing process. Few 'speech-acts' will be as convincing for the general population as those coming from PLWHAs, particularly where PLWHAs are prominent social figures. PLWHAs also provide insights into the needs and psychology of individual behavior, which few other actors can contribute to the process of effective policy making to control HIV/AIDS (UNAIDS, 1999).

A third group of 'implementing actors' are faith-based organizations (FBOs). In Cambodia, since 1998, Wat Norea Peaceful, an FBO started and run by monks, has supported AIDS orphans and worked to reduce the stigma faced by people living with AIDS. Importantly, they also facilitated a participatory planning process, which then led to the development of a three-year HIV/AIDS strategy for the community. Wat Norea Peaceful has also conducted sensitization and advocacy training workshops in monk teaching institutions. Similarly, in Thailand, monks, through the Sangha Mehta Project, provide counseling and care to large numbers of people living with AIDS, during home visits. They also train other monks and nuns about HIV/AIDS, help to set up support groups, educate villagers about HIV prevention and care for AIDS orphans.

The importance of FBOs in managing HIV/AIDS has now become well established, given their long history of service in communities, their moral authority and in some cases the financial and organizational resources they command (Green, 2001; Leibowitz, 2002). These features will be useful in transmitting the message that HIV/AIDS is a security issue to the general population. The inclusion of FBOs is also critical because some such organizations may transmit messages which are explicitly contradictory to the securitization of HIV/AIDS such as discouraging followers from using condoms.

A fourth group of 'implementing actors' is the media. Kofi Annan recently noted in his January 2004 address to global media leaders, "If there is one thing that we have learned in the two decades of this epidemic, it is that in the world of AIDS, silence is death. As broadcasters, you can bring the disease out of the shadows and get people talking about it in an open and informed way. In Thailand, the widespread publication of sentinel survey results by the mass media is seen to have been one of the most important catalysts for HIV/AIDS policy development in this country (AIDSCAP, 2003). The independence of the commercial mass media is also seen to give credibility to government information about the epidemic

(ibid.). According to one representative of an international HIV prevention agency in Bangkok said. "It (the mass media) provides the only forum for the national policy dialogue necessary to reform societal norms to combat HIV" (cited in AIDSCAP, 2003). An equally potent means of communicating the seriousness of HIV/AIDS is through movies, dramas and the personal appeal of movie stars. Countries such as India, where Bollywood movies reach extremely large segments of the population, are likely to benefit greatly from further involvement of such the media.

Finally, the business sector and labor unions are also important 'implementing actors'. HIV/AIDS, as mentioned earlier in this chapter is a disease that primarily affects those in their productive prime. Businesses and labor unions are important points of outreach to populations at risk (ILO, 2001). Private enterprises are also often able to provide important and severely lacking financial and managerial resources to implement effective HIV/AIDS programs (ILO, 2003).

Various groups of 'securitizing actors' discussed above are shown below in Exhibit 8. The complex range of actors involved in the process of securitization is indicative of the equally complex processes through which an issue is securitized. These processes are discussed below.

Exhibit 8
Securitizing actors for HIV/AIDS

Initiating Actor	Catalyzing Actors	Implementing Actors
National Government	International Organizations Other National Governments	Local Governments NGOs/GOs Faith Based Organizations Media Private Enterprises Labor Unions

3.2 The Processes of Securitization: Mechanisms of Persuasion and Negotiation

The Copenhagen School suggests that the process of securitization is similar to that in language theory which is called a 'speech act'. "By saying the words, something is done (like betting, giving a promise, naming a ship" (Waever 1988; Austin 1975:98ff.)- Buzan *et al.*: 26). In describing the 'speech act' further, Buzan *et al.* (1998) note that "the security speech

act is not defined by uttering the word security. What is essential is the designation of an existential threat requiring emergency action or special measures and the acceptance of that designation by a significant audience" (27).

Further description or examples of the 'speech act' are limited and the precise nature of a 'speech-act' remains somewhat obscure within the Copenhagen School. Such ambiguity is somewhat expected since the School also does not discuss at length those making the 'speech-act', the 'securitizing actors'. The nature of the 'speech-act' is intimately linked to the person or group making it, and is strongly shaped by their resources and influence over their 'significant audience'. This chapter identifies four sets of securitization processes specific to the issue of HIV/AIDS, drawing upon the discussion of 'securitization actors' in section 3.1.

One key process explored here is the communication that must occur between the national government (the 'initiating actor') and the wider population. The speeches (by political leaders) that will largely characterize this process closely conform to the 'speech-act' described by the Copenhagen School. However, other processes of securitization, particularly those between 'catalyzing actors' and the national government, and those between the government and 'implementing actors' cannot closely conform to a 'speech-act'. Though the Copenhagen School is not specific about what constitutes a 'speech-act', there is the suggestion of a unilateral transmission of a message, a 'speech'. Important processes between the national government and 'catalyzing actors', between the national government and 'implementing actors' are likely to be more successfully managed through an interactive process, involving persuasion and negotiation. In this regard, this chapter, in discussing securitization processes specific to HIV/AIDS, uses the broader term 'processes of persuasion and negotiation'. Speech-acts may be considered a part of this broader set of interactions.

As mentioned above, a key process of securitization is one through which the national government is able to communicate the HIV/AIDS threat to the wider population. Regular campaigns and speeches in public fora by all levels of political leaders, particularly the highest levels of leaders, are central to the process of securitization. Similar processes have already begun in some Asian countries and have been seen to be particularly effective in contributing to the fight against HIV/AIDS. Cambodia's political leadership is widely credited for its role in managing the epidemic in that country. Prime Minister Hun Sen of

Cambodia has made regular statements on the seriousness of the epidemic, such as, "AIDS is even more serious than war. First the father is dead, then the mother is dead and later the children die of AIDS, too." Pitak Intrawityanunt, former Deputy Prime Minister of Thailand has said, "One of the key lessons from our HIV/AIDS experience is that the leadership must recognize the devastating scale of the epidemic and be willing to discuss openly the enormity of the HIV/AIDS problem" (cited in UNICEF, 2003). The U.S. Deputy Assistant Secretary for Health and Science noted that Thailand is one of the "prime examples where leaders through assessment of potential devastation that HIV/AIDS could wreak on their societies made a conscious decision to not only speak out as national leaders, but to make accountable the coterie of ministers (...) to have their entire governments speak out (...) This allowed leaders in other sectors of the society - such as the religious community and the business community - to do likewise" (cited in Porter, 2004).

A second and third group of securitization processes are those which must occur between 'catalyzing actors' and national governments and between national governments and 'implementing actors'. International organizations such as the UN have sought to encourage national governments to fight HIV/ AIDS by discussing the issue in high-level fora, most notably during the UN General Assembly's Special Session on AIDS in 2001. The World Bank and the IMF have sought to encourage national governments to act on HIV/AIDS by insisting on effective inclusion of programs to fight HIV/AIDS in poverty reduction strategy papers (PRSPs)¹³ (IMF/World Bank, 2002). They have also insisted on monitoring and evaluating the creation of partnerships between national governments and other national stakeholders to fight HIV/AIDS (IMF/World Bank, 2002). Other national governments, such as in the U.S., have tied provision of foreign aid to effective national responses to HIV/AIDS (Radelet, 2003).

National government may use a variety of mechanisms to communicate with and influence 'implementing actors' to participate in the securitization process. Meetings where various actors can convene to express their views and to work towards cooperation and coordination are an important first step. It should also be noted that national governments often control the flow of resources to local governments (Rueschemeyer and Evans, 1985). In some cases national governments are dependent on the cooperation of some local governments for

resources (see *The Economist*, 1993). National governments also provide funding for GOs, NGOs and FBOs in some cases, and GOs, NGOs, FBOs, media, labor unions and businesses benefit greatly from national government endorsement of their work (see Streeck and Schmitter, 1985). As with most negotiations between these groups, the history of relationships and the relative influence of one group over another are likely to structure the dynamics of persuading potential 'implementing actors' to join the process of securitizing HIV/AIDS.

In China, in recognition of the absence of widespread urgency about HIV/AIDS, the government has spoken of its determination to encourage the media to reflect the seriousness of the disease (AVERT, 1997). In addition to encouraging the media directly, it has very recently attempted to prevent other groups, such as local governments, which have in the past, in provinces highly affected by HIV/AIDS such as Hennan, to arrest journalists publicizing the HIV/AIDS issue in these areas. A recent circular from the national government has also ordered all local governments in areas hit hard by the disease to prioritize the HIV/AIDS issue and to establish AIDS prevention and treatment working committees (Yardley, 2004).

A fourth process involves the interaction between 'implementing actors' and the wider population, to widely disseminate messages on the seriousness of HIV/AIDS. This process is somewhat similar to the communication between the national government and the wider population in that it also involves numerous 'speech acts' and campaigns by 'implementing actors'. However, because many 'implementing actors' are relatively more accessible to the wider population, this process is likely to involve greater interaction with the population and will also include grass roots level discussions and conferences.

Various processes of securitization and the specific mechanisms of persuasion and negotiation that may be used in each case are summarized below in Exhibit 9.

Exhibit 9

HIV/AIDS: Processes of securitization and mechanisms of persuasion and negotiation

¹³ PRSPs are the mechanism that the Bank and the Fund now use for providing development assistance and debt relief to a large number of developing countries (IMF/World Bank, 1999).

Processes of Securitization	Mechanisms of Persuasion and Negotiation
National Government & Wider Population	Speeches, Campaigns
National Government & Catalyzing Actors	Conditional provision of resources, high level and publicized discussions of HIV/AIDS
National Government and Implementing Actors	Conditional provision of resources, high level and publicized discussions of HIV/AIDS
Implementing Actors and Wider Population	Speeches, Campaigns, Grass-roots conferences, discussions.

3.3 Indicators of Securitization

The ultimate goal of securitization must be heightened awareness of HIV/AIDS, appropriate behavioral change amongst the wider population, and an improved quality of life for those already affected by HIV/AIDS. Indicators of such change may include a wide range of statistical measures such as growth rates of national/sub-national HIV/AIDS prevalence and disability-adjusted life years (DALYs) saved (See Roberts *et al.*, 2003). However, it should be noted that such goals are not immediately achieved or observable. While awareness, behavioral change and an improved quality of life are useful long-term indicators, this chapter identifies a set of indicators, which will be useful in monitoring and adapting the process of securitization in the short-term.

It is important to note that the interventions suggested do not encompass the entire range of efforts necessary to manage the HIV/AIDS epidemic. This chapter focuses on some of the most critical developments necessary to fight the disease and those which are achieved specifically through an effective securitization process. In this regard, interventions suggested include those which reflect and/or require substantial change. The creation of new structures, new partnerships, new strategies and the mobilization of new resources are discussed. These changes are seen to be the outcomes of leadership, compromise and commitment from the national government and also the result of the formation of strong partnerships between the national government and various 'implementing actors'.

First, the creation of one national authority for HIV/AIDS, responsible for policy formulation and co-ordination is critical to mounting an effective campaign against HIV/AIDS (UNAIDS, 2003c; Piot, 2003). The creation of such an agency is important because already overburdened and relatively rigid civil service structures may not facilitate urgent and specialized action necessary for effective HIV/AIDS management. While governments may attempt to 'fast-track' HIV/AIDS matters through the regular bureaucracy and government departments, they must still be 'fast-tracked' through multiple unavoidable procedures and

circumscribed by various institutional constraints related to government regulations on employment, disbursement of funds and adoption of resolutions. The creation of a national authority relatively free of these institutional constraints and focused on HIV/AIDS will be useful in overcoming some of the key challenges faced by national governments in managing HIV/AIDS.

While such an authority must be formalized by the national government, a key feature of this authority must be its multisectoral mandate. Indeed, while several countries have formed a national authority at the suggestion of the WHO, such authorities have not always been effective in creating a multisectoral mandate. NGOs/GOs and local governments are particularly important in shaping effective policy response and must be identified as formal partners with the national government in managing the national AIDS authority. No one partner should seek privileged ownership of the national AIDS authority and in this regard, the authority may also be useful in transcending any existing rivalries between these key actors and in serving as a neutral mechanism for combating HIV/AIDS (UNAIDS, 2003c). The authority should also reach out and remain accessible to other 'implementing actors' such as the business sector, FBOs and the media.

A second key indicator of effective securitization is the creation of a national HIV/AIDS action framework that drives the alignment of all partners. While this may seem an obvious first step towards managing an impending epidemic, few countries have managed to produce a strategy which drives the alignment of all partners and which incorporates the various important aspects of managing the HIV/AIDS epidemic (Piot, 2003). Where an effective national AIDS authority, with a multisectoral mandate is established, the problem may be partly resolved and the authority may even be expected to produce an action framework, that drives the alignment of all partners.

Amongst various issues that the framework must incorporate, two are of particular significance, and require considerable. Cooperation and coordination between social and political actors. Evidence that these issues are being resolved also serve as important indicators of securitization. First, the framework should emphasize and identify methods and agencies which must be involved in mainstreaming HIV/AIDS into major national development agendas. Evidence of mainstreaming include the inclusion of HIV/AIDS, its impact and possible strategies to curb the epidemic on the policy agendas of various line

ministries. HIV/AIDS issues must also be included in national development reports such as PRSPs. Furthermore, HIV/AIDS must be a key priority in the national government's interaction with international partners. Active lobbying in the World Trade Organization (WTO) (for many countries) and with relevant national governments on matters of securing anti-retroviral drugs and other resources are also indicative of effective mainstreaming of the HIV/AIDS issue.

Second, the action framework must emphasize the importance of establishing standardized national monitoring and evaluation (M&E) practices for prevention, care and treatment of HIV/AIDS. The absence of a common M&E operational framework in most countries has crippled efforts to increase capacity for quality assurance, national oversight and adequate use of M&E for policy adaptation (UNAIDS, 2003c). This has been difficult both for national actors as well as for the investment priorities of international donors. Agreement on this matter amongst social and political partners, and the operation of standardized M&E systems are a fourth indicator of securitization.

Aspects of a framework for securitization discussed in Section 3 of this chapter are summarized below in Exhibit 10.

Exhibit 10
Elements of a securitization framework for HIV/AIDS

Securitizing Actors	Mechanisms of Persuasion and Negotiation	Indicators of Securitization
Catalyzing Actors	Speeches; Campaigns; Conditional provision of resources, High level and publicized discussions of HIV/AIDS; Grass-roots conferences and discussions.	
International Organizations		
Other Governments		Falling levels of HIV/AIDS prevalence, increase in DALYS
Initiating Actor		
National Governments		Creation of a National AIDS Authority
Implementing Actors		Creation of a HIV/AIDS Action Framework that drives the alignment of all partners
Local Governments		Mainstreaming HIV/AIDS into all national development agendas.
NGO/GOss		Creation of a national monitoring and evaluation system
Faith-based Organizations		
Media		
Private Enterprises		

3. Progress Towards Securitizing the HIV/AIDS issue in Asian Countries

Several of the processes and initiatives identified above as securitization processes, and indicators of securitization, may already be observed in various Asian countries with regard to addressing HIV/AIDS. Many of the actors discussed as securitizing actors are also actively involved in addressing HIV/AIDS. An Asian country which has been highly successful in managing the HIV/AIDS epidemic and has gone a long way towards securitizing the HIV/AIDS issue is Thailand. Thailand's national government has been widely credited for its placing the country on a war footing in addressing the HIV/AIDS epidemic (Porapakham *et al.*, 1995). A concerted effort mobilizing a vast array of societal and international resources and constantly infused with urgency and momentum from the leadership has also yielded extremely positive results for this country which is now beginning to experience a decline in the numbers of infections and deaths related to HIV/AIDS (see Exhibit 5 above).

Examples of other Asian governments which work closely with NGOs (i.e. in India) and FBOs (i.e. in Cambodia and Thailand) which have been highly involved with educating the wider public on HIV/AIDS were also mentioned above. A large number of Asian countries have also already formed national coordinating agencies for HIV/AIDS and many of them have sought to incorporate multisectoral inputs into these organizations. In an effort which may be seen to catalyze securitization, the ASEAN countries in November 2001 adopted the 7th ASEAN summit declaration on AIDS, which calls on member states to "strengthen regional mechanisms and increase and optimize the utilization of resources to support joint regional actions".

In China, the leadership, until very recently, has been extremely reluctant to speak or acknowledge HIV/AIDS as a national problem. However, in May 2004, the government announced a policy which will require considerable mobilization of social and financial resources. The "Four Free" policy in poor and rural areas provides free testing; free treatment; free school for "AIDS orphans;" and free treatment to prevent mother-to-child transmission of HIV. To enact this new policy, China will have to follow through by infusing the energy of national policy-makers to other quarters of government and society. If this new policy can be enacted, China will go from having one of the most closed HIV/AIDS policies in Asia to having one of the best such policies in the world.

These are encouraging and important developments towards securitization. It will be important for various national governments to move further quickly to systematise and to develop a comprehensive set of processes and initiatives, including all or many of the securitization actors, processes and indicators discussed above. While there is great promise that they will do so, and some countries such as Thailand have already gone a long way towards this end, this is still not evident in many countries.

Securitization is also likely to benefit from consistency on the part of governments. Notably, in a rare interview with the Myanmar Times in 2001, Secretary One of the of the State Peace and Development Council, Lt. General Khm Nyunt, said, " HIV/AIDS is a national concern. If we ignore it, it will be the scourge that will destroy the entire race." He also noted immediately following that Myanmar was a religious and conservative society, and it is against national culture to promote condoms in public". In India, the government looked askance at the allocation of USD 100 million to fight HIV/AIDS in India by the Bill and Melinda Gates Foundation. While the government was understandably angered by what it saw to be a donation based on unfounded figures on the numbers of Indian HIV/AIDS infections, its reaction negated the seriousness of the epidemic in India, sending very confusing signals to the wider population. India's health minister at the time, Shatrughan Sinha, criticised Mr. Gates for "spreading panic" (Harding, 2002). There was little acknowledgement of the important benefits these resources could bring to addressing the disease even amongst the large numbers of HIV/AIDS cases acknowledged by the government.

4. Conclusions

This chapter explains why HIV/AIDS is a security issue for the countries of South, Southeast and East Asia and proposes a framework for securitizing HIV/AIDS. As mentioned, HIV/AIDS is not an issue that easily or immediately appears on policy agendas. As Peter Piot notes, "AIDS stands almost alone in human experience. Many diseases and natural disasters create their own brutal equilibrium, a self-regulating mechanism that eventually enables society to cope, if not to overcome. AIDS, thus far, seems different" (2003).

In this context, the notion of 'securitization' has tremendous potential. However, as noted earlier, the Copenhagen School does not provide extensive discussion of 'securitizing actors', 'speech acts' and indicators of securitization, preferring perhaps to leave these matters to those investigating specific areas on non-traditional security. Indeed, specific indicators,

processes and indicators identified in this chapter, are primarily relevant to HIV/AIDS. However, categories identified within the broader group of 'securitizing actors', particularly the role of 'catalyzing' and 'implementing actors' are likely to be applicable to a wide range of non-traditional security issues. If an issue needs to be securitized, those able to do so have not yet acknowledged the seriousness of it and 'catalyzing actors' are necessary. Few issues can any longer be dealt with by national governments or by anyone agency and a host of 'implementing' collaborators are likely to be more important than the Copenhagen School suggests by way of its limited discussion of these actors. Accordingly, the processes of securitization will involve not only unilateral messages imposed by an actor but a broader range of mechanisms for persuasion and negotiation important in interactions between social and political partners.

While this chapter identifies various aspects of a framework for securitization, this is an initial attempt. Further research particularly in Asian countries and on co-operation and coordination between various social and political groups will be useful in identifying a more complete framework, tailored to the Asian context.

Such research is also likely to benefit from recent developments in policy to address HIV/AIDS in several Asian countries. Many Asian countries have begun to recognize the seriousness of the HIV/AIDS issue and to take important first steps towards securitizing the disease. These are promising developments. The speed with which they are able to develop comprehensive strategies and to fully securitize the HIV/AIDS issue will be critical to averting the serious disaster which the HIV/AIDS epidemic implies for Asia in the next decades. .

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