The securitization of HIV/AIDS in Thailand and Myanmar.

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Thesis Summary

In January 2000 the United Nations Security Council met to discuss HIV/AIDS. It was the first time the Council had convened solely to consider the security implications of health, a non-traditional security issue. This thesis examines the Copenhagen School theory of securitization, a formulaic tool proposed to bridge the conceptual gap between traditional narrow definitions of security and wider, non-traditional interpretations of the concept. Following a review of the literature, two conclusions are offered; first, that at the heart of the 'radically constructivist' process of securitization is the construction of an existential threat which employs the realist logic of threat and defence. The second conclusion is that this construction amounts to a suasive process in which fear of a proposed threat and its consequences must be invoked within an audience. The application of the theory to health issues, including HIV/AIDS, has facilitated important critiques of the ethical consequences of the security linkage and the invocation of fear related to infectious disease is problematic. Using data collected during 13 months in Southeast Asia, this thesis investigates whether securitization of HIV/AIDS took place within Thailand or Myanmar following the seminal events at the UNSC. Fifty qualitative interviews were conducted with elite actors in the HIV/AIDS response, including from the United Nations, and the thesis concludes that securitization at the domestic level did not occur in either country. Instead, HIV/AIDS securitization at the UNSC was part of a strategic campaign to mobilise resources for dealing with the epidemic from globally powerful actors. In Thailand and Myanmar, civil society organisations defined the domestic epidemic responses and, being largely comprised of PLWHA, assumed a rights-orientated approach to disease management and rejected the threat-defence logic of securitization that could jeopardise their interests.

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed (candidate)

Date 10 March 2015

1. STATEMENT

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s). Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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2. STATEMENT

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Acknowledgements

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Abbreviations

3DF	Three Diseases Fund
AIDS	Acquired Immune Deficiency Syndrome
AIHD	ASEAN Institute for Health Development
ARV	Antiretroviral treatment
ASEAN	Association of South East Asian Nations
CDC	American Centers for Disease Control and Prevention
CIA	Central Intelligence Agency of the United States of America
CSO	Civil Society Organisation
DPKO	UN Department of Peacekeeping Operations
FAR	Foundation for AIDS Rights
GF	Global Fund
GIPA	Greater Inclusion of people with HIV/AIDS
GPA	Global Programme on AIDS
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use
IMF	International Monetary Fund
INGO	International Non-Government Organisation
IP	Intellectual Property Law

KAP	Key affected population
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MCCM	Myanmar Country Coordination Mechanism
MDG	Millennium Development Goal
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NAC	National AIDS Committee
NAP	National AIDS Programme
NAPAC	National AIDS Prevention and Alleviation Committee
NGO	Non-Government Organisation
NHRC	National Human Rights Commission of Thailand
NHSO	National Health Security Office in Thailand
NLD	National League for Democracy
PEPFAR	President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PLWHA	People living with HIV/AIDS
PPM	Parallel Process Model of drive theory
PSI	Population Services International
PWID	People who inject drugs
RMO	Ratana Metta Organisation
SLORC	State Law and Order Restoration Council
SPDC	State Peace and Development Council
STI	Sexually transmitted infection
SW	Sex worker
SWING	Service Workers In Group
TACBD	Thai Action Committee for Burmese Democracy
TNP+	Thai Network of people with HIV/AIDS
UHC	Universal Healthcare Coverage
UK	United Kingdom
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNDPO	UN Department of Peacekeeping Operations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNSC	United Nations Security Council
US	United States of America
USD	United States (of America) Dollar
WHO	World Health Organisation
WTO	World Trade Organisation

Chapter 1. Research Design and Methodology

This doctoral thesis investigates the management of HIV/AIDS in Thailand and Myanmar (formally known as Burma).[1] Between 31.4 and 35.9 million people are currently living with HIV/AIDS, a disease that is uniquely stigmatised and difficult to control (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2012, p.8). HIV/AIDS is a politically sensitive subject; it is an infectious disease that is widely associated with drug use, discrimination, and deviance, but the real impact of the epidemic is far more complex and inspiring. Data collected during 13 months of fieldwork in Southeast Asia revealed a surprising and nuanced picture of each country response, one that was different from the official policy documents of Thailand, and one for which little official data currently exists in Myanmar.

HIV/AIDS has attracted an unprecedented financial investment by states and private sector actors. In 2014, the USA proposed annual spending of 29.7 billion USD on HIV/AIDS, of which 6.5 billion would be invested in global projects (Kaiser Family Foundation, 2014a). But despite massive funding since its clinical discovery in 1981, there remains no cure or vaccination for the disease. In addition to its incurability, two epidemiological qualities make the epidemic particularly problematic: first, the Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS), is primarily transmitted through sexual intercourse or transmission of blood, placing people who have sex more often, or who use injected drugs, among the most at risk. As a result, the virus is

[1] In 1989, the newly installed State Law and Order Restoration Council of Saw Muang officially changed the English language name of the country from 'The Union of Burma' to 'The Union of Myanmar'. The change was part of a nationalist campaign that altered more than 600 place names, including that of the capital city of Yangon (formally Rangoon) (Steinberg, 2010, p.10). As the Council attempted to distance themselves from the Colonial influence of the British (Philp & Mercer, 2002), they claimed that these versions better reflected the traditional, Burmese-language names used prior to British administration. Refusal to adopt the new names became a sign of political resistance and protest that was headed by Aung San Suu Kyi's opposition party, the National League for Democracy (Beyrer, 1998, pp.42-43; Steinberg, 2010, p.10). Following her release from house arrest and amidst political reform, Daw Aung San Suu Kyi has referred to her country as Myanmar and so, acknowledging the political struggles it represents, this thesis also sees fit to adopt the new terminology.

uniquely associated with 'deviant' behaviours and endemic stigma and discrimination create significant barriers to combating and controlling the disease (UNAIDS, 2007a). Second, the virus has a long incubation period, typically infecting people for many years before symptoms manifest. This means that an epidemic can take hold silently within a population, reaching high prevalence rates before detection and making efficacious responses difficult. These qualities have contributed to the pervasive fear that characterises the disease.

HIV/AIDS has played a major role in introducing health to the subject of International Relations, partially as a result of widespread claims that high prevalence could be responsible for state failure and regional insecurity, including in Southeast Asia (Elbe, 2006; Davies, 2009, p.16). Since the American CIA investigated the *Implications of the AIDS Pandemic* in 1987, the potential link between security and HIV has been studied by high-level political institutions and security analysts. Linking HIV/AIDS and security has both mobilised a massive global response to the epidemic and reflected a growing diversity in the types of issues that are considered under the banner of 'security'. This thesis uses as its theoretical foundation the Copenhagen School theory of securitization, by which any issue can be constructed as a matter of security (Buzan, Waever & de Wilde, 1998); through empirical examination of discourse, policy, and action on HIV/AIDS, it finds that a process of HIV/AIDS securitization took place at the United Nations Security Council Meeting on HIV/AIDS in 2000 and investigates whether the epidemic has also been framed as a security issue in Thailand and Myanmar.

The Thai national response to HIV/AIDS has been lauded by the UN for its pragmatic and effective policies (UNAIDS, 2000a, p.3; Fordham, 2004, p3; National AIDS Prevention and Alleviation Committee [NAPAC], 2009, p.35). In the 1990s, the rapidly developing Buddhist country invested millions of baht into HIV prevention, implementing nationwide policies that included a '100% Condom Programme' intended to prevent the massive commercial sex industry from becoming a conduit for the disease (Ainsworth, 2003, p.16). These early campaigns succeeded in curtailing a potentially devastating epidemic; today there are approximately 445,000 people living with HIV or AIDS (PLWHA) in Thailand and 240,000 of these have

access to state-subsidized antiretroviral (ARV) treatment (Hahn, 2013). In neighbouring Myanmar, UNAIDS estimates that 216,000 people are currently living with HIV/AIDS, most of whom do not have access to treatment (Murphey, 2013). Surveillance in Myanmar is poor and official data are unreliable; however, after decades of oppressive military rule, newly implemented political reforms have facilitated access and research in the country and insight into the epidemic is much needed. Whilst Thailand has been recently classified as a middle-income country, Myanmar remains one of the poorest in the world; in 2000, the World Health Organisation ranked its healthcare system one of the worst globally, second only to that of Sierra Leone (Tandon, Murray & Lauer, 2000, p.21). Civil society organisations (CSOs) surveyed for this research estimate that up to 65% of PLWHA in Myanmar do not have access to treatment (Swe, 2012; de Groote, 2013), but it is likely that if the current reforms continue, new research and data will reveal a national epidemic more severe and far reaching than currently estimated.[2]

In the first part of this thesis, the conceptual framework for the following empirical investigation is outlined. The Copenhagen School theory of securitization forms the theoretical and methodological basis of this enquiry and in the first three conceptual chapters its utility and application is examined. Securitization theory is a formulaic tool to determine what constitutes a security issue, based on the radical idea that no issue is essentially a security problem but instead that security is a status created through a process of social construction (Buzan, et al., 1998). The theory holds that a securitizing actor must convince their audience that a certain issue (e.g., HIV) poses a threat to the survival of some referent (e.g., environment, global health, or state) that warrants an extraordinary, urgent response (Buzan et al., 1998, pp.23-24). A securitized issue is one that is perceived as being so serious that it legitimises the use of extraordinary power, such as curfews, military intervention, or

[2] Civil society organisations are defined as the array of non-governmental and not-for-profit organisations that include community organisations, unions, charitable groups, faith-based groups, and professional associations. In the context of Myanmar and Thailand, international and domestic non-government organisations are considered as civil society groups unless they are agencies of the United Nations, in which case they are referred to as such, or as INGOs (International non-governmental organisations).

emergency rule. Thus, security is about invoking fear of an existential threat and legitimating extraordinary responses. Although it has been criticised for being Euro-centric and for reinforcing paradigms that favour the most articulate, powerful actors (Hansen, 2000; Wilkinson, 2007), securitization theory has achieved enduring success, partly due to its applicability to both traditional and non-traditional fields of security studies (Buzan et al., 1998, p.195). However, the central role of fear, which must be invoked as part of the persuasive speech act and threat construction, lacks scholarly attention in the extensive existing literature. In conceptual Chapters 2, 3, and 4, the current literature on securitization is reviewed and the thesis offers two conclusions; first, that securitization theory, although "radically constructivist" (Buzan et al., 1998, p. 35), has at its conceptual core a logic of threat-defence and survival that is manifest in the centrality of the existential threat to the securitizing process. It is determined that security according to the Copenhagen School is essentially about the construction of an existential threat and this construction is problematized in the application of the securitization framework to HIV/AIDS, which has ethical and practical implications that are outlined in Chapter 4. The second conclusion is one with which this thesis can contribute a new theoretical position to the literature; it is determined that the construction of the existential threat requires the utilisation of fear appeal rhetoric, more commonly studied in the psychological literature on advertising and public health management.

The second part of this thesis presents empirical research based on 13 months of fieldwork in Thailand and Myanmar. To begin, the successful securitization of HIV/AIDS at the United Nations, an elite international organisation, is documented. The thesis then investigates whether this high-level securitization of HIV/AIDS translated into similar processes of securitization at the national and domestic level of the two country case studies, Myanmar and Thailand. These chapters are drawn largely from qualitative data collected during fifty semi-structured in-depth interviews with elite actors and leaders of the HIV response in each country. The research uses securitization both as a methodology and, drawing from Curley & Siu-lun's (2008) work on Southeast Asia, as a "point of departure for commentary and critique" (p.4) of security in the region. In this

function, securitization theory facilitates a depth of contextual analysis that gives rise to some of the more significant and original empirical research contributions made in this thesis, specifically those drawn from the fieldwork that is outlined in Chapter 7 and Chapter 8.

1.1. The Research Question

Since its development in the 1990s, the Copenhagen School framework has offered an enduring and stable foundation for the conceptual widening of security studies, facilitating the inclusion of myriad non-traditional issues into security discourse and analysis. These non-traditional issues include health and infectious disease, the most prominent of which is HIV/AIDS. HIV/AIDS was securitized in a process that culminated in January 2000, when the United Nations Security Council (UNSC) held a meeting dedicated to the epidemic. UNSC Meeting 4087 was the first time that the Council had met solely to discuss a specific disease as a threat to national and international security and it has been called a "watershed" event in the securitization of HIV/AIDS (Elbe, 2006, p.121). The meeting, at which securitization claims were articulated by authoritative and influential actors, was also a key event in the codification of the international HIV/AIDS securitization norm (HASN) that has been identified by Vieira (2007, 2011). Meeting Chair, US Vice-President Al Gore, told the Council that, "AIDS is one of the most devastating threats ever to confront the world community" while UN Secretary General Kofi Annan explained that, "AIDS is causing social and economic crises which ... threaten political stability" and linked the disease to poor governance and conflict (United Nations Security Council [UNSC], 2000, p.5). HIV/AIDS was explicitly presented to Council Members as being an urgent and severe threat to a range of referent objects including political, economic and social stability. However, there has been criticism of the empirical claims that were used to securitize HIV/AIDS at this meeting (Barnett & Prins, 2006) and doubts cast regarding the levels of persuasion achieved among Council Members (Rushton, 2010). Furthermore, despite conducting a securitization process within a prominent and influential international body, there is little evidence that the securitizing rhetoric employed at the United Nations affected

or appeared in the national responses of member states, indicating a failure of norm internalisation (Finnemore & Sikkink, 1998).

UNSC 4087 is widely regarded as a seminal point in the securitization of HIV/AIDS and the broader field of health (e.g., Feldbaum & Lee, 2004; Garrett, 2005; McInnes & Lee, 2006; Elbe, 2006), but there remains little application of the framework to empirical cases of HIV/AIDS securitization at the UNSC or in national responses. In an attempt to contribute to the current literature, this thesis undertakes a detailed analysis of the external and internal conditions that affected this securitization, beginning with the following question:

i. Has the securitization of HIV/AIDS at the UNSC translated into securitization within Myanmar and Thailand?

The UNSC is an elite and high-level international organisation and norm-setter in global public health which possesses the authority and credibility to articulate securitizing claims and to influence world politics. The objectives of this research are to determine through empirical study whether the securitization of HIV/AIDS has taken place in Thailand or Myanmar following success at the UNSC, and to broaden the scope of inquiry by using the securitization framework for analysis; as Waever (2003) explains, securitization theory "does not point to one particular type of study as the right one. ... [It] operates as a conceptual apparatus and with this a number of different kinds of questions can be asked" (p.21). Accordingly, this research investigates the complex political and social dynamics that affect the process of securitization and in doing so, seeks to contribute to a deeper understanding of its effects and application outside of the Western liberal democratic system (Wilkinson, 2007; Bilgin, 2011). To conduct the empirical studies that are central to this thesis, it is necessary to further develop the research question and the following lines of inquiry are used to guide and facilitate the research:

ii. What constitutes securitization in practice?

iii. What are the contextual and facilitating conditions that affect securitization?

iv. How does securitization of HIV/AIDS manifest in practice and what are its effects?

1.2. Securitization as a Methodology

To utilise these research questions, this thesis must first determine what is meant by securitization of HIV/AIDS, how it would manifest, and how it could best be identified in practice. The Copenhagen School theory of securitization is examined and its essential components are outlined in the conceptual chapters, from which a methodology for analysis can be drawn (Buzan et al., 1998). Chapter 2 and Chapter 3 comprise a review of the psychological and security literature, finding that securitization is a form of fear-appeal. These chapters conclude that securitization consists of a performative suasive process in which fear is used to persuade audiences of the existence of an existential threat that faces a given referent object. One of the more significant findings documented in this thesis is that fear is an integral part of the securitization process, performing as a facilitating condition, an indicator of successful securitization, and a by-product of securitization. This is outlined in Chapter 3 and is problematized in Chapter 4.

A review of the literature on securitization and securitization of HIV/AIDS (Chapter 2 and 4) finds that the process can have both positive and negative effects on HIV/AIDS responses. The five "ethical dilemmas" of HIV/AIDS securitization identified by Stefan Elbe (2006, p.119) were used in the fieldwork as indicators of securitization in practice. These dangers are:

i. Framing HIV as a matter of state security risks pushing responses away from civil society and toward military and intelligence organisations that are not well suited to dealing with a health issue

ii. Securitizing HIV/AIDS could lead to violation of the civil liberties of PLWHA

iii. Securitization could make international responses to HIV/AIDS the "function of narrow national interest rather than of altruism"

iv. Securitization could lead states to prioritize AIDS funding for their elites and armed forces because these agents play a key role in maintaining traditional security

v. Securitizing HIV/AIDS relies on the portrayal of the virus as an "overwhelming threat", and in doing so, "works against on-going efforts to normalize social perceptions regarding HIV/AIDS" (Elbe, 2006, p.119)

These five issues served as a useful set of indicators for the identification of securitization in practice and provided the foundation around which interview prompts and investigation could take shape. Where appropriate, interviewees were prompted to consider these indicators by raising the issues with which they are associated. These include: issues of normalisation and perceptions of PLWHA; the role of the state and civil society organisations in defining responses; the civil liberties and human rights of people with or affected by HIV/AIDS; the allocation of funding and treatment of at risk groups; and the use of threat-defence logic and fear appeals in HIV/AIDS responses. The saliency of Elbe's proposed 'dangers' was confirmed by the responses of expert interviewees during fieldwork, many of whom independently raised similar concerns, particularly about potential violation of human rights and appropriation of national responses by (unsuitable) agencies of the state (see Chapter 7 and 8).

The use of securitization as a methodology provides a useful framework for identifying the securitization of a non-traditional issue in the field. However, like all methodologies, it is limited and key aspects of the securitization framework become problematic during methodological application. In their assessment of securitization and HIV/AIDS, McInnes & Rushton (2010) draw attention to the difficulty in tracing causal linkages as distinguishable from the effects of other influencing factors, which leaves many studies of applied securitization vague and "impressionistic" (p.240). Empirical application is also considered by Wilkinson (2007), who refers to the model as constrained by a 'Westphalian straitjacket' (p.10) that shapes its

inherent normative dimensions; in addition, Wilkinson (2007) points out that the distinction between normal and extraordinary politics which is central to the securitization model is not clearly outlined by the Copenhagen School. This leads her, and other scholars, to debate the applicability of the framework outside the "liberal European-centric" democratic political system (Vuori, 2008; Emmers, Greener & Thomas, 2008, p.63; Curley & Herington, 2011, p.150).

This research offers a series of empirical case studies of securitization that take place outside the Western liberal democratic realm. Similar studies were conducted by Vieira (2007), who documented the unsuccessful internalisation of HIV/AIDS securitization in Botswana, Mozambique, and South Africa following successful securitization at the international level, and by Curley & Herington (2011), who investigated securitization of avian flu in Southeast Asia. Curley & Herington (2011) note that:

> Vietnam and Indonesia provide useful contexts in which to interrogate the universality of the construction of security issues as is usually modelled in the paradigmatic version of securitization studies. Neither case is a liberal democratic state of the type frequently present in European securitization studies. (p.150)

Certainly, one benefit of adopting the case study methodology, as Curley & Herington (2011) do, is that case studies can provide a "richly detailed portrait of a particular social phenomenon" (Hakim, 1987, p.61); in this case revealing the details of social and political contexts that differ from state to state, and that differ from those of Western liberal democratic systems. Chapters 7 and 8 in this thesis investigate the national epidemic responses of Thailand and Myanmar and include contextual information about governance and societal values which, as in Vieira's study (2007), ultimately made the securitization of HIV/AIDS unsuccessful at the domestic level. The specific cultural conditions that make these cases a useful addition to the current literature also at times created a problematic research environment, or limited the applicability of the securitization model; this is explored in more detail below.

To begin the investigation, it must be established what securitization would 'look like' in practice and outside of a liberal democratic political system; to facilitate

this, the methodological approach advocated by Curley & Siu-lun (2008) is adopted. In this approach, securitization is used as a "departure point" for a wider analysis that allows the analyst to "build hypotheses around indicators of securitization" and to study resistance and resisting actors, assessing factors that determine the likelihood of securitization and desecuritization (Curley & Siu-lun, 2008, p.5). As Waever (2003) states, "a major importance" of securitization theory is "to show the effects" (p.21) of the process when it occurs, and through application of this framework it is possible to also address the third and normative part of the research question above, by asking: what are the effects of securitization of HIV/AIDS in these contexts?

Curley & Siu-lun (2008, pp.5-6) outline a framework of seven areas for investigation by researchers that would guide contextual analysis and reveal important conditions and power dynamics that accompany securitization in practice and that determine the significance of these effects. Their framework can be categorised into two parts: the first involves an investigation of the nature of the agents involved in a process of securitization; specifically, the nature of the threat, referent object, and perceptions of the existence of each; the nature and motivations of the securitizing and desecuritizing actors, and the nature of the frame or concept of security that is invoked (asking, for instance, is it human, traditional, or non-traditional security?); the second is the practical process by which that securitization takes place, its facilitating conditions, and its outcomes (Curley & Siu-lun, 2008, pp.5-6). This latter part of the framework prompts researchers to ask whether securitization occurred and how its outcomes manifest and can be measured; it also leads the researcher to consider the normative implications of this securitization (successful or otherwise) (Curley & Siu-lun, 2008, pp.5-6).

By using this analytical framework as an approach to guide empirical research of the international system and of securitization in Thailand and Myanmar, this thesis investigates the practice and outcomes of HIV/AIDS securitization within each context and finds that in both cases, the internalisation of HIV/AIDS securitization norms was unsuccessful. Through the collection of primary qualitative data outlined in Chapter 7 and 8, it is revealed that the securitization

process was curtailed in both Thailand and Myanmar by civil society and rights advocacy groups who feared the manifestation of the same dangers predicted by Elbe (2006). Thus, the power-laden political and social contexts are explored throughout the empirical chapters of the thesis, where securitization provides a "departure point" for wider contextual analysis, as intended by Curley & Siu-lun (2008, p.5). Also studied are the effects of securitization; those that are hypothesised (Elbe, 2006) and those that are avoided (Chapter 8).

1.3. Fieldwork

Data collection for this research took three forms; first, through reviews of the literature and secondary data. Preliminary research using secondary data comprised a review of security and securitization literature, which concluded in the identification of operational indicators by which to identify securitization in practice. This research also included a study of the epidemiology of HIV/AIDS (both social epidemiology and virology), and the political systems and history of Thailand and Myanmar, with an emphasis on civil society. This was essential prior to the fieldwork because interviews are "inextricably and unavoidably historically, politically, and contextually bounded" (Fontana & Frey, 2005, p.695); preliminary research was thus used to establish cultural and country-specific knowledge that is crucial for understanding the wider social and political contexts in which securitization could take place in Thailand and Myanmar. This equipped the researcher with knowledge that would prove essential for conducting successful data collection in the field.

Following this research, primary data for the thesis was collected during a period of extended fieldwork (13 months) in Southeast Asia, between May 2012 and June 2013. During this time, qualitative data was collected through fifty semi-structured interviews with key informants, primarily in Bangkok and Yangon. This was transcribed into a digital document of approximately 50,000 words. The most authoritative primary sources of information are the key participants in the national and international response and, after a review of the literature, it is the voices of these key informants that provide the crucial data on the reality of what took place

on the ground. Leaders of non-governmental organisations (NGOs), international non-governmental organisations (INGOs), and government policymakers were selected because they are authoritative decision-makers who both shape and witness the national response, and who are best able to provide an accurate account that will allow the researcher to determine whether securitization took place and to what extent, and the context in which this occurred (such as the facilitating conditions, or the necessity of desecuritization).

In order to investigate the securitization of HIV/AIDS at the international level via the United Nations Security Council and Joint United Nations Programme on HIV/AIDS (UNAIDS), elite interviewing was used in combination with a review of the academic literature and analysis of policy documents. Primary data consisted of written correspondence with Lord Malloch-Brown, former Administrator to the United Nations Development Programme (UNDP), face-to-face interviews with the Country Coordinators of UNAIDS in Thailand and in Myanmar, and a telephone interview with Dr Peter Piot, founding Executive Director of UNAIDS.

Due to the time consuming and labour-intensive nature of in-depth interviewing as a method of data collection (Darlington & Scott, 2002, p.53), the sample size was limited by the resources available to the researcher. Initial estimations of the fieldwork schedule were subject to change once fieldwork had commenced and additional time in the field was required in order to establish a comprehensive sample size and to gain meaningful access to elite and other hard-to-reach participants. The process of chain referral sampling requires a significant investment of time but has beneficial results, such as access to elite sources that included the UNAIDS Country Representatives Eammon Murphey and Michael Hahn, and the director of the SWING sex-worker empowerment group, Surang Janyam.

Unforeseen factors affecting the fieldwork schedule included natural disaster and adverse weather conditions; a preliminary trip to Thailand in November 2011 to establish contacts was largely unproductive due to the severe flooding that made it impossible to access key informants in the capital and surrounding areas. Storms were also responsible for the loss of a hand written notation in Thailand during the

monsoon season. Fortunately, the majority of the data had been transferred to digital records, but the personal notes of the researcher, which included additional and contextualising information regarding the fieldwork, were lost.

1.3.1. Qualitative Research Interviews

This research adopts a qualitative methodology on the basis that such an approach is best suited to data collection where the participant is more expert than the researcher, and where the research is driven by broad questions rather than testing of hypothesis or theory (Ware, 2012). Qualitative research methodologies are designed to discover what can be learnt about a phenomenon in which people are the participants or subjects; they typically generate results that are not generalisable, but that provide a deeper understanding of specific situations and of the experiences of participants who lived those situations (Maykut & Morehouse, 1994, pp.39-40). Data collection in the "natural setting" through the use of interviews allows the researcher to "discover or uncover" what is to be known about the phenomenon under investigation in the context in which it takes place (Maykut & Morehouse, 1994, p.41). Such an approach suits the constructivist paradigm of the securitization theory at the heart of this research methodology.

Interviews are particularly useful when the phenomena under investigation, in this case securitization, cannot be directly observed but must be studied through the experiences or records of others; they are suited to retrospective investigation of events, such as the recollection of meetings or the effect of policy implementation (Darlington & Scott, 2002, p.49). Finally, interviews are "active", meaning that all interviews are interactional and interpretive, with a role for both researcher and participant (Holstein & Gubrium, 2000, p.140). Because interviews are active, they are also flexible; their "immediacy and relational quality afford considerable flexibility to the data collection process, both in terms of areas explored and the direction of the discussion" (Darlington & Scott, 2002, p.49). This flexibility is enhanced by the use of a semi-structured interview method.

1.3.2. Structuring and Recording Interviews

Interviews for this research were semi-structured, allowing the direction of the discussion to remain flexible. This approach is best suited to elite interviews and to those that are likely to be single occasions that cannot be repeated with follow-up interviews (Bernard, 2006, p.212). During fieldwork, written interview guides were prepared in advance of interviews. These consisted of a set series of questions that was modified according to the participant interviewed, so that questions appropriate to their specific experience could inform the direction of discussion.

Interviews typically lasted between forty and ninety minutes and, with the exception of three telephone interviews, were made face-to-face. Interviews were recorded using audio-recording equipment where appropriate, when permission of the respondent was granted. In total, twenty-three digital audio recordings were made of interviews. No interviews were digitally recorded in Myanmar for practical and ethical reasons discussed below. In both countries, all interviews were recorded at the time of delivery using handwritten notations. All interview records were transcribed by the researcher using word processing software as soon as possible following the interview, in order to maximise recall of additional information about the participant and their responses. This facilitated digital coding of the data and identification of themes and common subjects in responses, which subsequently guided further research and interview structure.

In Myanmar, due to the political sensitivity of both subject matter and the respondents' engagement with a foreign researcher, audio-recording equipment was not used. Ethically, it is important that "there is always power in the researcher role" and an inherent vulnerability of the interviewee (Darlington & Scott, 2002, p.51). This is of particular concern in the context of Myanmar where, until recently, cooperation with an external researcher could endanger the personal safety of the Burmese respondent, their associates, and the operation of their organisation. Whilst it is assumed that this risk has decreased following recent political reforms, including the dissolution of the main state censorship apparatus and an "opening up" of Myanmar to researchers (Renard, 2012), during the fieldwork in Myanmar, this researcher was subject to one incident of harassment from unidentified security

personnel on the way to a prearranged interview, in which an armed man asked for personal identification and information about the researcher. No explanation was offered to explain the request, so there is no evidence to suggest this was specifically related to the research activities. However, this incident does indicate that, despite substantial reforms since 2010, research and access to information in Myanmar can remain challenging.

Data from a number of interviewees was anonymised at their request, and this is listed in Appendix B. In order to anonymise data, all interview sources were assigned a randomised order and allocated a number. When anonymous sources are referred to in the text, this number is used and associated information can be found in the appendix (e.g., Source 31, 2013). Otherwise, interview sources are listed by the name and their full associated data can be located in the appendix (e.g., Lancelot, 2013).

1.3.3. Sampling

Selection of participants for interview was purposive, as it was determined by the purpose of the research rather than strict methodological mandate (Marvasti, 2004, p.9). This approach is particularly suited to research in which only a limited number of people are qualified to be interviewed (Maykut & Morehouse, 1994, p.53). The time-consuming and labour intensive nature of qualitative data-sampling also limited the possible size and selection of the data sample (Darlington & Scott, 2002, p.53). Additional influencing factors were that of language, access to interviewees through chain referral sampling, and the establishment of rapport.

A. Language. Participants were selected based on their experience of the topic under investigation and their ability to articulate this experience (Darlington & Scott, 2002, p.51). In the context of data collection in Thailand and Myanmar, this includes their capacity in English language. Although a Thai-to-English translator was used for two interviews (Muangmoonchai, A., 2013. a civil society activist in Thailand, and Ladaporn, K., 2013. at the National Human Rights Commission), all other interviews were conducted in English.

No formal exclusion of non-English speakers was made during the sample selection process, but in practice, interview participants were selected on the basis that they could communicate in English with the mono-lingual researcher. This selection was informal and arose from the process of chain referrals by which interviewees were selected; preliminary contact was made in English either by email or by telephone, thus limiting the initial respondents to those who could communicate in English. Where non-English participants were interviewed, these interviews were secured through referral from bi-lingual participants.

B. Chain referrals. The methodology employs chain referral, or 'snowball', sampling, in which participants are used to refer the researcher on to other respondents. Chain referral sampling methods are suited to conditions in which participants are hard to access, such as the socially stigmatised and elite (Atkinson & Flit, 2001). This research sampled from both, conducting semi-structured elite interviews as well as interviews with activists from stigmatised groups in key affected populations (KAPs). As a sampling technique, chain referral is particularly well suited to conducting qualitative research related to HIV/AIDS, in which key affected populations are often concurrently "hidden" and "illegal" populations, such as drug users and commercial sex workers (e.g., Faugier & Sargeant, 1997).

C. Rapport. The goal of interviewing is to understand the topic studied and development of trust between researcher and participant is an essential part of securing reliable and useful data (Fontanta & Frey, 2005, p.708; see also, Sulka (2007) for a discussion on ethnography and rapport). Building rapport is essential, particularly when addressing the culturally sensitive issues investigated within this thesis, but this rapport itself must be carefully managed. As Darlington & Scott (2002) observe:

> There are times when a strong connection between the researcher and participant can, if the researcher is not careful, impede the data collection process. As a sense of shared understanding develops, participants may take it for granted that the interviewer understands what they are talking about and skip over important aspects of their story. (p.54)

Cultural protocol that inhibits Thai respondents from making negative statements presented a significant challenge to getting clear answers during interviews.

Interviewees were often reluctant to be explicitly critical in the opening stages of the interview, especially of other groups working in their field. This form of 'politeness' could be partially overcome during the course of the interview, or interview sequence, as rapport was developed with the researcher. During the course of the fieldwork, mannerisms and culturally appropriate forms of behaviour were learnt and adopted by the researcher (such as the 'deep wai' used to greet superiors, gendered behaviour, and use of Thai language to supplement questions) to facilitate this process of rapport building. It was also useful to have conducted interviews with a number of civil society activists before gaining access to elite political actors, because during the course of the fieldwork it became apparent that civil society activists were more likely to be candid in their responses to politically sensitive questions, possibly because they were the leaders of their respective organisations and did not fear repercussions from political superiors.

1.3.4. Access

Myanmar has recently been called "probably the most obscure and obscured state in the contemporary world" after North Korea (Steinberg, 2010, p.1). This unenviable reputation stems from the military coup of 1962, which led to the installation of the military regime and authoritarian rule. According to regional expert Ronald Renard, after 1962, research in Myanmar stopped and research in Thailand started (Renard, 2012). Now, as the country experiences political reform, there is a new generation of early stage researchers operating in the field (Renard, 2012). However, although it is often well hidden, essential research and data collection has been undertaken by CSOs and INGOs operating inside Myanmar even during the most authoritarian years of the military leadership. In order to protect the survival of their organisations (and their staff), this research has been covert. Speaking on this subject, one anonymous participant referred to an INGO working in the country, saying: "good old _____ does a lot of research that they don't call research, that they *can't* call research" (Source 19, 2013).

Whilst political reform and an opening up of Myanmar might be evident in some quarters, the oppressive societal fear that results from decades of systematic

violence and authoritarian rule remains. In this research environment, face-to-face interviews are essential for data collection. Under the military junta, telecommunications surveillance and censorship was routine and often led to 'disappearances' or incarceration of civilians. Some research participants did not feel safe in 2012-13 using email or telephones to communicate (this was noted by civil society activist Jamie Uhrig, who was interviewed in 2013). In this environment, where written records are still subject to distrust (see Chapter 8), anecdotal evidence becomes valuable; indeed, when potentially litigious information such as injecting drug use (IDU) prevalence cannot be recorded, sometimes the only evidence is anecdotal. The study of qualitative rather than quantitative data, and collection through interviews and chain referral sampling, was an effective way to address these limitations.

Interviews conducted in Yangon were with CSOs and INGOs. Outside Yangon, in Bangkok and by telephone to the USA, interviews were conducted with activists with extensive previous experience in the country and with former CSO leaders who no longer worked in the country (Seng Raw, 2012; Rahman, 2013; Uhrig, 2013; Wai, 2013). In Yangon, interviews were conducted with sensitivity to the concerns of the participants, particularly where these were Burmese nationals. One interviewee was visibly distressed by the use of the phrase 'national security' within an interview prompt, responding that HIV "isn't an issue [of national security], but if it was, we couldn't talk about it. Our leaders don't see health as a security issue but [they] are guided by NGOs and INGOs" (Source 20, 2013). Foreign staff members of INGOs who were not subject to such concerns verified the respondent's answer that HIV/AIDS was not considered by the state to be an issue of national security, but this experience illustrates the extreme distress and fear that the military regime is still capable of inspiring, as well as the courage and generosity displayed by everyone willing to be interviewed and contribute to the research.

Research in Myanmar was possible because CSOs and INGOs were able, and willing, to provide expert accounts of the national response to HIV/AIDS that they had led. More than 30 government officials were contacted via email in the preliminary stages of this research in order to ascertain whether any could be

approached at a later stage for interview. No emails were returned. Without recourse to reliable data for analysis of official discourse on the subject of security, a study of HIV/AIDS in Myanmar requires a different methodological approach that focuses on the available data, obtained from civil society and INGO representatives, and that investigates HIV/AIDS securitization from this starting point.

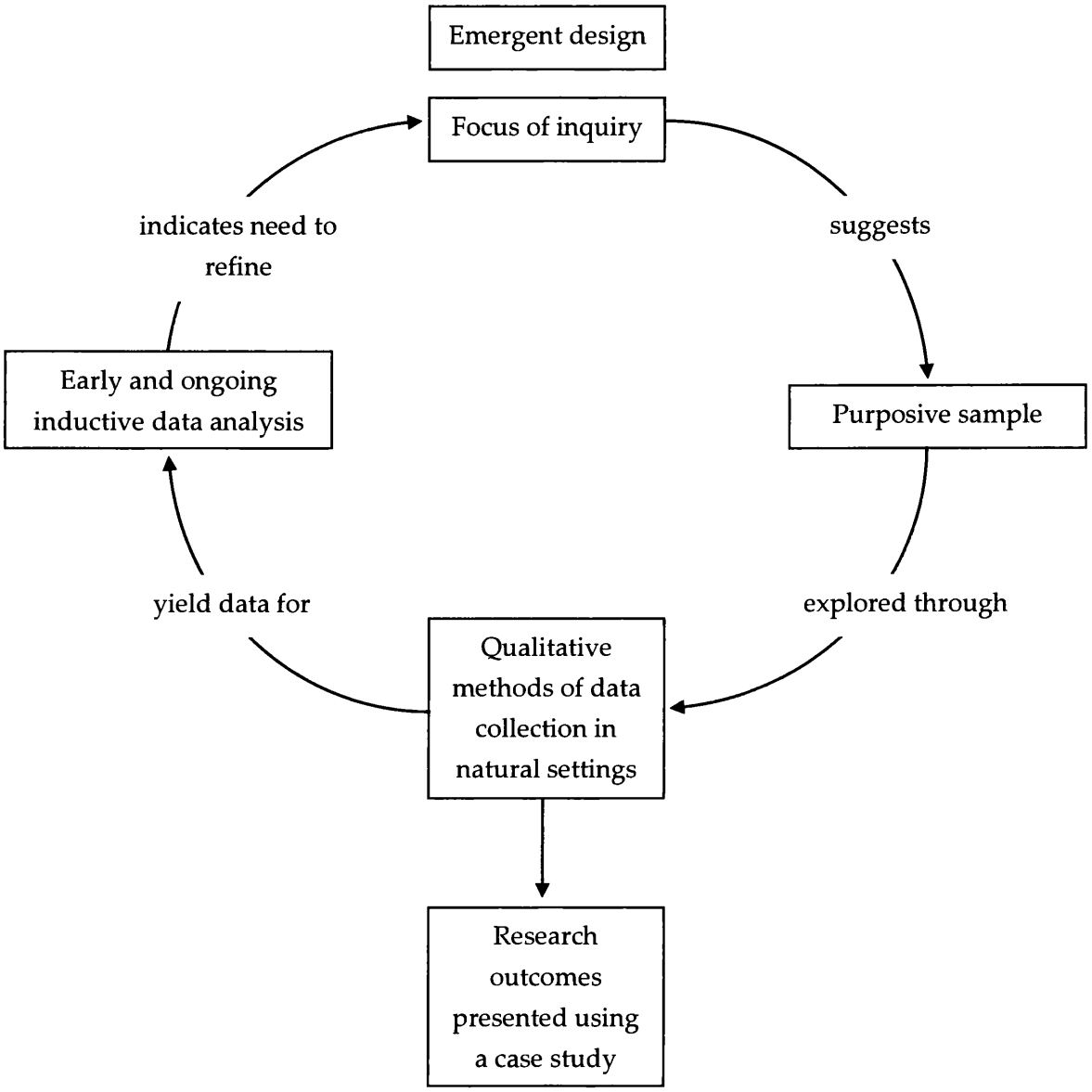
1.4. Analysis

Rather than adopting a narrow lens and studying elite discourse in either case study, this thesis utilises a broader framework of analysis, developed using the theory of securitization, Curley & Siu-lun's (2008) methodological approach, and the indicators of securitization outlined above (Buzan et al., 1998). By using this wider framework, and by identifying fear as a central component of securitization (Chapter 2), it was possible to identify both securitizing and desecuritizing moves in each country. The national responses of Thailand and Myanmar were investigated using lines of enquiry that were shaped by interviewees and that remained flexible through the data collection. Qualitative research is an inductive process in which analysis is ongoing throughout the research process; as Maykut & Morehouse (1994) discuss:

> Analysis begins when one has accumulated a subset of the data, providing an opportunity for the salient aspects of the phenomenon under study to begin to emerge. These initial leads are followed by pursuing the relevant persons, settings, or documents that will help illuminate the phenomenon of interest. (p.42)

The process of collecting and analysing qualitative data is, to an extent, cyclical, flexible, and dynamic.

Figure 1.



Characteristics of Qualitative Research (Maykut & Morehouse, 1994, p.43).

During fieldwork, this process of ongoing analysis shaped the direction of the research and of the data collection. Prior to commencing fieldwork, the emergent design of the data collection was based on preliminary research based largely on review of the relevant literature; using studies of the country-specific political, historical, and social context of securitization theory, and of the epidemiology of HIV/AIDS, the focus of inquiry was developed and a purposive

sample for qualitative data collection was drawn up, based on the categories of interview participants listed below.

Fieldwork began in Thailand, where qualitative methods of data collection (semi-structured interviews) revealed that civil society organisations were instrumental in shaping the direction of the state-response. In the initial stages of the epidemic, attempts by the state to securitize the issue in a traditional sense (e.g., by restricting movements of PLWHA, detailed in Chapter 7), served as a catalyst for the mobilisation of civil society groups who then, with the support of major donors from the international community (e.g., the Global Fund and UNAIDS), assumed a leading role in informing the direction of the state response. Early and ongoing analysis of this data was used in the selection of future interview participants that targeted the leaders of prominent civil society groups, including Raks Thai (Press, 2012), Foundation for AIDS Rights (Nacapew, 2012), and The Thai Network for PLWHA (TNP+) (Kestkaew, 2012; Tenni, 2012; Muangmoonchai, 2013).

In Myanmar, initial literature reviews and interviews with key informants revealed in the early stages of research that the national response to HIV/AIDS was led by civil society and INGOs rather than the state. Purposive sampling thus focused on participants from CSOs, a selection that was informed both by the focus of inquiry and by the barriers to accessing official political informants discussed above. Following initial fieldwork conducted in Yangon, primary data revealed how fear of state appropriation of the national HIV/AIDS response led to a concerted effort by these CSO agents to keep the epidemic, and public health in general, a non-political and desecuritized issue (Chapter 8). Following this first period of fieldwork in Yangon during November 2012, a relationship of trust was established with key members of prominent civil society groups. Significantly, initial contacts were made with a well-established Burmese CSO that enjoyed a prestigious reputation among INGOs as well as local CSOs and this facilitated access to a greater number of participants during the second period of fieldwork in Yangon, in 2013.

1.5. Reliability of Data

Analysts studying Myanmar are presented with data that vary significantly in their findings as well as their reliability; in *Context-Sensitive Development,* Ware (2012, p.23) illustrates this with an illuminating table comparing reported population figures for Myanmar that are published by various agencies, including the Asian Development Bank, World Health Organisation and UNICEF; their estimates for the year 2008 vary by more than ten million. The "paucity" of reliable data was only marginally improved by the concerted efforts of aid agencies attempting to deliver humanitarian assistance in the aftermath of Cyclone Nargis in 2008 (Ware, 2012, p.22). However, in light of recent political reforms, the opening up of the country to foreign investors and INGOs since 2010 should alleviate many of the barriers to reliable provision of data, particularly regarding demographic and economic data. Many international institutions are reviewing the available data for the country, including the World Bank that notes they, and other agencies, "are re-engaging with the Myanmar government" in an effort to "address the scarcity of reliable data for the country" (World Bank, 2014).

The qualitative research methodology adopted in this thesis provides strategies for dealing with the lack of access and the lack of reliable quantitative data. Qualitative research is well-placed to accommodate the "informed hunches" that often guide researchers facing such barriers in Myanmar because it provides an approach in which investigation can be directed where necessary (Taylor, 2008, p.219). Qualitative research also provides the type of detailed, in-depth knowledge that is based on trust and that comes from face-to-face observation and conversation with those best placed to describe the 'real' situation that is studied.

Despite the value of qualitative research for social science, in order to plan, implement and evaluate effective HIV/AIDS management, quantitative data must also be available. According to the CSO and INGO representatives sampled, Myanmar has in place a number of effective and comprehensive institutions that provide data and accurate reporting of the epidemic, as well as pragmatic coordination and implementation of response. These include the small state surveillance system established in 1992 (United Nations Office on Drugs and Crime

[UNODC], 2006, p.5), and the Myanmar Country Coordination Mechanism (MCCM), which hosts both state and non-state actors. From the MCCM, representatives from UNAIDS, Malteser International, Marie Stopes, and a local CSO were interviewed. Data from both the MCCM and UNAIDS were generally regarded as "good" or "reliable" by interview respondents (Lancelot, 2013; Murphey, 2013; Naing, 2013), but all interviewees expressed concerns about the reliability of data on the epidemic; as Peter Paul de Groote (2013), from Médecins Sans Frontières explained, it is a "very difficult" subject.

Agencies dealing with HIV/AIDS use forecasting models that are based on the limited data available to predict wider epidemiological patterns, including national prevalence figures (de Groote, 2013). This is supported by international organisations, including UN agencies, as a method of best practise in research. However, in the restricted operational environment of Myanmar, "it is not easy to verify results" of interventions (de Groote, 2013), nor it is easy to assess the accuracy of predictions. Serious challenges to empirical data collection arise at every level: comprehensive surveillance requires the physical infrastructure of an extensive and operational healthcare system and is essentially non-existent in many rural areas. Social barriers (i.e., stigma and discrimination, and a lack of available treatment) also affect primary routes of HIV incidence reporting, as individuals decline to access healthcare services or institutions that could report their infection.

At the secondary level, CSOs and organisations who do collect data, or who have the capacity to do so, face disincentives to accurate reporting; one interviewee explained that accurate figures on HIV/AIDS were "not often" reported to the government by a leading INGO (Source 10, 2013), as part of a strategy employed by the organisation to protect its own operations. Staff believed that the military regime was particularly sensitive to the issue of HIV/AIDS and as a result, intentionally downplayed their (substantial) involvement with HIV/AIDS programmes. Following extensive embedded fieldwork in the country, Ware (2012) also found "widespread suggestions that deliberate misinformation has been a regime survival strategy" (p.21), indicating that erroneous data reporting is institutionalised in both NGOs and in government offices.

1.6. Interview Participants

Fifty key informants were interviewed during the fieldwork period. Most interviews were conducted face to face in Yangon, Myanmar, or Bangkok, Thailand. Participants can be categorised into the following groups:

i. Government officers. Senior government officers with direct experience of managing or coordinating the national HIV/AIDS response through policy or service provision.

ii. International non-governmental organisations (INGOs). Country Representatives or senior advisers to international non-governmental organisations that have direct experience of specific country responses.

iii. Civil society organisations (CSOs). Directors, founders, or senior advisers of CSOs directly involved in HIV/AIDS programmes in the country. Here, civil society organisations are defined as the array of non-governmental and not-for-profit organisations that include community organisations, unions, charitable groups, faith-based groups, and professional associations.

iv. Activists. Independent or CSO affiliated activists with direct experience of the national response.

v. Media. Journalists with significant experience reporting on HIV/AIDS related issues in Thailand or Myanmar.

vi. Academics. Academics with expert knowledge of Thailand or Myanmar and issues directly related to HIV/AIDS in these countries.

vii. UN Agencies. Country representatives or senior managers with specific experience related to HIV/AIDS.

Participants represent a broad spectrum of key stakeholders in the national or international epidemic response to HIV/AIDS, although in Myanmar it was impossible to gain access to government officers for interview due to the sensitive nature of the research and the political system. The entire list of interviewees is attached in Appendices A and B; participants included:

- Six academics with expertise in the region and issues related to HIV/AIDS, including the director for the Asian Research Center for Migration, Chulalongkorn University.
- Five activists prominent in the civil society response to HIV/AIDS in Thailand or Myanmar.
- Three Directors or former Directors of INGOs in Thailand or Myanmar, including the Director the Thai Red Cross AIDS Research Centre.
- Six Directors within prominent CSOs in Thailand, including the Director of the Service Workers In Group (SWING), a leading agency for the empowerment of male, female, and transgender sex workers.
- 12 Directors, Country Representatives, or expert staff members in CSOs in Myanmar that provide HIV/AIDS programmes and services.
- Two current Country Coordinators for UNAIDS (of Thailand and Myanmar), one former Administrator of UNDP, and the founding Executive Director of UNAIDS.
- Two foreign media journalists, including Andrew Marshall, Reuters special correspondent for Southeast Asia.
- Five Government Officers for Thailand, including an Ambassador for the Royal Thai embassy in Yangon, a National Human Rights Commissioner, the Director for the International Health Policy Program (IHPP) at the Thai Ministry of Public Health, a former Senator for the Thai government and leading HIV/AIDS rights activist and the manager of the National Health Security Office Fund for HIV/AIDS and TB.

Chapter 2. Fear and Securitization Theory

This chapter examines securitization theory, as proposed by the Copenhagen School, as a framework for post-Cold War analysis of security. Through an exposition of the theory, indicators of securitization are set forth and provide the basis for the following empirical chapters, in which 'real world' instances of securitization are sought. Securitization theory offers a formulaic tool for the determination of what is and is not a security issue and is the dominant framework employed to explore the widening of security agendas in the post-Cold War context (Jones, 2011, p.403). The Copenhagen School takes as its premise the principle that no issue is essentially a security problem and that instead, security problems are created through a process of social construction and persuasion. During this process, a securitizing actor proposes that a certain issue comprises an existential threat to a referent object; if the audience is persuaded by these claims and are convinced that the extraordinary responses are warranted to mitigate the threat, then securitization has taken place (Buzan et al., 1998). Of the Copenhagen authors, Ole Waever was the "primary supplier" of the securitization approach (Buzan et al., 1998, p.viii) and in his own words, the model, "is an inter-subjective, political process of negotiating the possible acceptance of a specific kind of argument, a securitising move by a securitising actor" (Waever, 2003, p.12). Securitization is thus comprised of suasive speech acts and is essentially a process in which persuasive discourse is used to invoke a sense of "priority and urgency", framing an issue as an existential threat that requires immediate action beyond the boundaries of normal politics (Buzan et al., 1998, p.25; Waever, 2003, p.9). Through this suasive process, any referent object and any threat can, in theory, become a matter of security. Yet that is not to say that security does not have an *essential quality*; on the contrary, security is essentially about survival (Buzan et al., 1998; Waever, 2003) and specifically the fear of annihilation of the given referent object.

Crucially, security in this framework is the product of a constructive, discursive process of persuasion; an operation that resembles a process of negotiation between authoritative actors articulating persuasive claims about the

existence of existential threats, and the audience that is the target of these suasive speech acts (Stritzel, 2007). This persuasion constitutes the construction of security, which occurs when the language of security is used to present an issue as being an existential threat to the survival of the referent object. An example is outlined in Chapter 6, which details the way in which HIV was presented as an existential threat to the security of states at the United Nations Security Council, prompting Members to legitimise recourse to extraordinary action (UNSC, 2000).

The conceptual strength of the securitization model is that, given its radically constructivist approach to security, it is possible to consider a broad range of units as potential referent objects and threats (including infectious diseases like HIV) whilst still retaining a realist core at the heart of the theory. As a result, the theory has gained significant and growing attention within the security literature, proving an enduring formulation for the analysis of security in the post-Cold War environment. This chapter makes two conclusions that are central to the thesis; the first concerns the nature of security as defined by the Copenhagen School, and specifically its realist core. By examining securitization theory it is determined that, despite its credentials among wideners of the security agenda, the Copenhagen School model is based on a strict and narrow definition of what constitutes a security issue: at the heart of securitization theory is the concept of the existential threat and its inherent realist logic of threat-defence and survival.

The second conclusion of this chapter concerns the method by which this existential threat is constructed. According to the requirements of the theory, the successful construction of security occurs through a discursive process that invokes fear of a specific issue among the relevant audience and builds a shared, intersubjective understanding that the proposed threat warrants immediate and extraordinary action in response (Buzan et al., 1998, p.25; Waever, 2003, p.11). Rather than question the objective existence of any given threat in a securitization process, the Copenhagen School focuses analytical attention on the suasive process by which the audience comes to view an issue as a threat (Buzan et al., 1998, p.26). It is this social construction that provides the focal point of its framework and forms

the core logic of securitization theory, in which fear is an essential but under-studied element.

The persuasive processes of presenting an issue as being an existential threat, which requires convincing an audience of its urgency and then convincing that audience of the need for an extraordinary response outside the realm of normal political procedure, are the essential components of securitization (Buzan et al., 1998, pp.26-27). This chapter finds that the suasive acts inherent to existential threat construction are marked by their employment of fear, which is used as a tool by which persuasion can be achieved. The correlation between the psychological literature on suasive fear appeals and securitization is examined, with emphasis on the role of facilitating conditions that act as variables governing the likelihood of their persuasive success. Fear appeals are persuasive messages that employ fear as a means to invoke behavioural or attitudinal change (Witte, 1998, p.423) and their perceived efficacy has led to the substantial use of fear appeals in public health campaigns. In this thesis, the capacity to promote sustained risk averse behaviour through the application of fear appeals is problematized by examining the complexity of achieving the desired level and type of responsive action, in addition to the potential for negative outcomes specific to the management of HIV/AIDS, which is hindered by the invocation of unproductive fear.

Fear is pervasive in our expectations of governance and control, functioning as both a ubiquitous feature of daily life and as a means of political and security discourse; for instance, Altheide and Michalowski (1999) attribute the rise in the discourse of fear in popular media to its "taken-for-granted relevance as an appropriate feature of the effective environment" (p.477). Despite pervasive use, fear can retain its salience as a means of legitimating control and shaping social values, as well as a tool of governance, as examined by Robin (2004) in his study of political fear in authoritarian and tyrannical regimes. Security, conversely, derives its conceptual power from its exceptionality and removal from the everyday (Buzan et al., 1998). By identifying the construction of the existential threat as being the essential quality of the contested concept of security, this thesis examines the way in which fear is both a tool for achieving this construction and a mark of its success; to

accept the existence of an existential threat, according to the logic of the Copenhagen School, is to fear the risk posed by its occurrence and to fear the consequences of inaction. Having elucidated these arguments, Chapter 4 problematizes this fear where it occurs in relation to HIV/AIDS.

There exists a large body of literature concerning securitization theory; its conceptual strengths and limitations and its empirical applications have been investigated notably by critical theorist Jef Huysmans (1998, 2011), Bill McSweeney (1996), Michael Williams (2003, 2011), Lene Hansen (2000), and Stefan Elbe (2005, 2006, 2008). Numerous scholars have proposed correctives to enhance the securitization model and to address both normative and conceptual shortcomings (for example, Hansen, 2000; Balzacq, 2005; Stritzel, 2007; Ciuta, 2009). Key concepts at the heart of securitization theory have been subject to much critique, with particular emphasis on the suasive speech act, context, and actor-audience relationship (Balzacq, 2005; Stritzel, 2007). However, fear remains an essential part of the securitization process that warrants further analytical attention. With regards to HIV/AIDS, it is the fear component of securitization that has led to the most negative aspects of the epidemic response and thus the role of fear in securitization is particularly important. Whilst it is possible through securitization to gain crucial, high level political attention and financial resources, it can also have negative effects, such as the ethical dangers identified by Elbe above (2006). These are discussed in the following chapters which examine in detail the positive and negative outcomes of linking security, fear, and HIV. First, the current chapter examines the Copenhagen model of securitization and, in exploring the stages of this discursive process, highlights the essential role of fear in the construction of the existential threat and the suasive securitizing acts.

2.1. Securitization Theory

In the late 20th century, Barry Buzan, and later the Copenhagen School, made inroads into security theory that led to a distinct growth in the range of issues that could be legitimately perceived as matters of security (Buzan, 1983; Buzan et al., 1998). Security discourse increasingly featured non-traditional issues such as

identity, nationalism, religion, and environmental threats. The 'broadening' of the security agenda had been evident prior to the end of the Cold War, but following desecuritization of the bipolar conflict, the move to accept a wider range of 'non-traditional' security issues became more pronounced. Security has been called a "neglected concept" and an "essentially contested concept"; suffering from both a lack of conceptual analysis and enduring contestation over its meaning (Baldwin, 1997, p.9, 10). The Copenhagen School emerged against a background of an increasingly polarised debate in security studies to contest the wide versus narrow concept of security (Waever, 2003, p.8). Securitization theory was developed by the Copenhagen School as a potential "viable middle position" (Waever, 2003, p.8), in response to a question that was emerging at the conceptual core of security studies: what is security? This fundamental enquiry introduces the theory in Buzan, de Wilde & Waever's seminal work on securitization, *Security: A new Framework for Analysis* (Buzan et al., 1998, pp.21-47).

Inspired by the dissolution of the Soviet Union and with it the desecuritization of the East-West conflict, the *Security* authors sought to explain how and why societies came to accept certain issues as being, or no longer being, a security threat (Buzan et al., 1998). As Cold War tensions declined, the rhetoric with which each side presented the conflict changed and a different, non-securitized form of discourse emerged. Securitization theory accounts not only for the process of designating security threats, such as the competing superpowers of East and West, but also suggests that these issues can become de-securitized and can return to the "ideal" realm of ordinary or normal political discourse (Buzan et al., 1998, p.29). Williams (2011) makes a counterintuitive but convincing argument for the possibility of fear, usually associated with the increase of security logics, to act as a resource for desecuritization within liberal societies where it is viewed as a negative condition; this is supported in the following empirical chapters on HIV/AIDS responses, which detail the rejection of securitizing rhetoric by liberal civil society groups that were motivated by their desire to reduce fear of the disease.

In response to demands for conceptual engagement and calls to broaden the range of issues that could be considered 'security', securitization theory broke from

traditional narrow definitions of what can or should constitute an issue on the security agenda. It logically follows that if a security issue, such as the East-West conflict of the Cold War, can become a non-security issue in a relatively short period, then security itself must be an adaptable concept that is at least in part a result of social perceptions. The narrow definition of security also came under pressure as the politics of migration and minority ethnicity increasingly became a feature of post-Cold War international relations (see Curley & Siu Lin, 2008). Whilst strict traditionalists regard security to be limited to "the study of the threat, use, and control of military force" (Walt, 1991, p.212), by identifying security as a result of process (rather than objective threat existence), the Copenhagen School proposed to explain both the securitization and desecuritization of potentially "any issue" (Buzan et al., 1998, p.24) on the condition that its status as a threat/non-threat was accepted by a relevant audience. This logic allowed non-traditional types of security issue, such as HIV/AIDS, to be considered with the application of securitization theory, which demanded only that their existence as existential threats could prove convincing.

The widening of security agendas to include non-military threats was contested by traditionalists, including those who feared loss of coherence in the subject (Walt, 1991, p.213). The traditional package of security that ties state, military, and sovereignty has been credited with practical as well as analytical advantages in the contemporary political system; Michael Williams (2003) argues that traditional narrow concepts of security allow the desecuritization of issues that may otherwise act as a flashpoint for violence, such as identity or religion, although these claims are challenged by Waever (2003, p.27). A narrow interpretation of security may not account for military engagement that takes place for reasons other than national security of the sovereign state; for instance, the deployment of troops for UN Peacekeeping missions might be considered a matter of foreign policy rather than altruistic security interests. Rejecting this tautology, Waever (2003) summarises the position in its most extreme form as "the circular argument that security is about the state and military and should not be extended beyond this, because security is about the state and military" (p.27).

Instead of being confined to the narrow limits of military engagement or other traditional perspectives, what constitutes a security issue is, according to the Copenhagen School, a subjective matter based on the social values of the securitizing audience in any given context. As a result of this "radically constructivist" approach (Buzan et al., 1998, p.36), it follows that proponents of securitization theory must recognise that an objective conclusion to the question 'what is security' is impossible to answer. Instead, "securitizing actors can attempt to construct *anything* as a referent object [emphasis added]" or threat, provided that the relevant audience can be convinced that an existential threat exists (Buzan et al., 1998, p.36). However, as Waever (2003) states, "it is necessary to be able to discriminate and separate security issues from non-security. Actually, it is only by having a clear sense of *what is security* that it is possible to open up [the concept] without being swept away" (p.8). According to the theory, security is a discursive practice that is distinguished by its specific rhetorical structure; it comprises an enunciation of survival in the face of existential threat and the priority of action (Buzan et al., 1998, p.26; Waever, 2003, p.10). By using this definition as an analytical tool, it is possible to locate security actors and practises outside the traditional military-political realm without stretching the conceptual framework too far (Buzan et al., 1998, p.26). Thus, the radically constructivist theory maintains its conceptual coherence by focusing its definition of security in one essential quality, or component: the politics of the existential threat (Buzan et al., 1998, p.27). Using this essential core as the foundation for their studies, analysts are able to look beyond the traditionally narrow agenda toward new sectors, "without debasing the concept of security itself" (Buzan et al., 1998, p.27). It is in this core of security that we locate the invocation of fear as an essential but under-studied component of what makes security in the post-Cold War era.

The conceptual value of securitization theory is found in two unique contributions made by the Copenhagen School: first, that security at its core is about existential threats, and second that these threats do not have to be real in any objective sense, but instead they must be socially constructed through a process of persuasion between securitizing actor and audience. Thus, securitization theory

brings to the forefront of conceptual analysis a process that, in the traditional perspective, would be regarded as a mere "side effect, a secondary feature of security policy" (Waever, 2003, p.9). The persuasive process of constructing a security issue comprises the presentation of an existential threat to an audience and their acceptance of its nature as an issue that requires exceptional, urgent, and extraordinary action. This process could, from a traditional point of view, be seen as an inevitable characteristic of security engagement by the state but it is identified by the Copenhagen School as being the essential component of security. By identifying this core of security studies, the Copenhagen School develops a formulaic, analytical tool that can be applied to a wide range of "sectors" and used to identify security beyond that narrow military-political definitions employed by the traditionalists (Buzan et al., 1998, p.27).

The essence of the security issue is that it is a matter of survival and of exceptionality (Buzan et al., 1998, p.26; Waever 2003, p.9). At its heart, securitization is about persuading an audience of the existence of an existential threat to the survival of a given referent object and this persuasion is measured not by opinion polls or individual perceptions (Waever 2003, pp.9, 12), but in the award of consent, tacit or explicit, for an issue to be handled using exceptional means beyond the boundaries of normal political procedures. In dealing with a securitized issue this exceptionality is logical because a securitized issue is defined by its legitimation of the extraordinary response (Buzan et al., 1998, pp.21, 24, 25), but its measurement is problematic. The flexibility of the securitization framework to account for a range of securitizing actors and audiences also leaves the analyst asking what best defines these actors in practice and how can persuasion or consent be measured unless extraordinary action is taken? Analytical purchase can instead be found in the study of the constructive process itself and it is here that the functionality of fear becomes apparent.

Preceding the publication of *Security* (Buzan et al., 1998), Barry Buzan published his seminal work *People, States and Fear* in 1983 (and the revised edition in 2007) and is one of the first scholars to comprehensively address security as a social concept and to explore the implications of that perspective. In *People, States and Fear*

Buzan (1983) sought to "offer a broader framework of security" (p.20) in order to address the lacuna in existing security literature that failed to engage with the study of security as concept and that instead treated it as a subject "too narrowly founded"(p.14) in its traditional form. Writing during the Cold War, security studies "was composed mostly of scholars interested in military statecraft" for whom security and low-politics were dichotomous, issues that did not concern military force were not considered issues of security (Baldwin, 1997, p.9). To circumvent this dichotomy, Buzan et al., (1998, p.21) adopt for their framework the traditional military-political understanding of security in so far as it remains about survival; securitization theory recalls the traditional state-centric concept of security but widens the focus of the security lens to include non-state actors and referent objects (Vultee, 2010, p.34). The essentiality of the existential threat to the securitization process is tribute to this traditional threat-defence logic that underpins the theory. As Stritzel (2007, p.360) illustrates, the conceptualization of exceptionality as a distinct modus, invoked through the articulation of specific speech act rhetoric (see Buzan et al., 1998, pp.24, 28), reflects the realist distinction of security from other fields.

Abrahamsen (2005) critiques this distinction between normalcy and exceptionality (or emergency) that is at the heart of securitization theory by arguing that the essentiality of this binary serves to exclude "many of the processes and modalities whereby issues come to be feared and experienced as potentially dangerous" (p.59). Abrahamsen (2005, p.59) reasons that in most cases, issues are not likely to transition from (being perceived as) normal to exceptional in the direct manner fitting to the conceptual logic of the securitization model. However, the strength of securitization theory is its accommodation of a broader security agenda, made possible by the unique analytical focus of the Copenhagen School on social components of security and of the constructive process itself; the School advises analysts not to study what is security, but how security is made (Buzan et al., 1998). Abrahamsen's (2005) concerns that the more commonplace instances of security, including "mundane management of risk", are "not adequately captured" (p.59) by the securitization model recalls a critical approach from the Paris School, which

holds that security is about everyday practices rather than the exceptional practices that characterise the Copenhagen School (see, Case Collective, 2006). It is beyond the scope of this paper to draw conclusions on the true nature of security, if such a meaning could be found, but by accepting the Copenhagen School's call to study its construction it is possible to reveal both the power-laden nature of securitization and the effects of fear invocation that lie at the heart of this process.

2.2. Three Stages of Securitization

According to securitization theory, any given issue can be constructed as a security issue (Waever, 2003, pp.10-11). To do so, the issue moves through a series of stages that can be envisioned as a linear progression of politicisation and prioritisation. In the initial non-politicised stage the issue is not dealt with by the state and is not in any other way made a feature of public debate or decision. For HIV/AIDS, this non-politicised status existed globally before the virus was formally identified by the American Centers for Disease Control and Prevention (CDC) in 1981. Prior to its clinical observation, the virus existed in the wider population but, without classification by the medical profession, it was not in any way an issue for political discussion (see, for example, Prins, 2004, p.931).

The second stage, which precedes complete securitization, is that of 'politicisation'. A politicised issue requires government decisions and resource allocations; it is a feature of policy and of public debate and decision (Buzan et al., 1998, p.23). Issues that are politicised are subject to the political logic of being weighed against one another, allowing decisions to be made about which merit greater attention or allocation of resources. A politicised issue is subject to the established rules and conventions of the specific context in which it exists; for example, a politicised response to HIV/AIDS currently exists in the United Kingdom, where disease prevalence is subject to some political debate and public resources are allocated by the government to address health-care provision and related issues.

The final stage, at the apex of the securitization model, is that of the security issue. The status of 'security' is a more extreme form of politicisation and security

arguments are built upon the foundation of the preceding politicisation of that issue (Buzan et al., 1998, p.29; Waever, 2003). Here, at the apex of the hierarchy of importance and priority, are issues deemed to be existential threats that pose a risk to the survival of the referent object. With the essential quality of survival at the heart of security analysis, the Copenhagen School claims that is possible to dig into the practice of security and to reveal "a characteristic pattern with an inner logic" of that practice (Buzan et al., 1998, p.27). That inner logic is the production of security through constructive speech acts which frame "the survival of collective units and principles" as at risk from an existential threat and as demanding of immediate and "urgent" attention (Buzan et al., 1998, p.27). Whilst the referent object can in theory be anything, one of the conditions likely to facilitate successful securitization is that the size of the referent object places it on the middle-scale, such as states, nations, or other limited collectivities (Buzan et al., 1998, p.36). The Copenhagen School proposes that it is more difficult to conduct a successful securitization where the referent object is too large, such as the entire global community as threatened by meteor strikes or global warming (Buzan et al., 1998, pp.36-37; Waever, 2003).

To progress from a politicised to a securitized status, securitizing actors must convince a relevant audience that the proposed issue threatens the survival of a referent object and warrants differentiation from other, merely political, issues. The securitizing actor(s) responsible for articulating security claims are thus engaged in a negotiation with their audience; they utilise fear and the rhetoric of security, which is the rhetoric of survival, urgency and panic (Buzan et al., 1998, p.28), as part of their argument to raise a proposed threat to the level of sanctioned urgency, claiming that it is more important than all other issues. The requirement for a proposed threat to be not just substantive but *existential* amounts to a demand by the Copenhagen School that its severity should be so great as to warrant not just recognition but fear. For instance, when framed as a risk to human health, seasonal flu of regular severity is recognised as a risk to both groups and individuals, but it does not inspire the fear that is required to place it "on the agenda of panic politics" that defines a security issue (Buzan et al., 1998, p.34). The threat is constructed through securitizing acts as being existential and as demanding "urgent" attention

before a "point of no return" is reached, such as the securitization of environmental destruction that threatens the survival of a species, or human migration that threatens cohesion of national identity (Buzan et al., 1998, p.23). Thus, securitization theory demands that fear must be invoked and achieved in order for an issue to transition from being merely political to being considered as a matter of security.

An issue at the securitized stage is defined by the exceptionality of its nature and response; for a securitizing process to be complete, the audience of these acts must be persuaded that the existential threat is so great as to warrant breaking from normal political procedure in dealing with it (Buzan et al., 1998, p.25). Whilst a political logic entails weighing issues against one another in order to determine an appropriate level or mode of response, a security issue overflows this normal process of political assessment because failure to deal with an existential security threat will render future responses impossible. As the Copenhagen School explains, the logic behind this prioritisation is that "if we do not tackle this problem, everything else will be irrelevant, (because we will not be here or will not be free to deal with it on our own way)" (Buzan et al., 1998, p.24). For securitization to occur, between the securitizing actor and audience,

> The existential threat has to be argued and just gain enough resonance for a platform to be made from which it is possible to legitimize emergency measures or other steps that would not have been possible had the discourse not taken the form of existential threats. (Buzan et al., 1998, p.25)

Buzan et al., (1998) "do not push the demand as high as to say that the emergency measure has to be adopted; instead it is sufficient only that it *could* be adopted legitimately, given the preceding persuasion of the audience" (p.25; see also, Waever, 2003, p.11). Thus, securitization provides a platform from which it is possible to legitimise emergency measures or other steps, although the actual implementation of these measures is not a criterion necessary for securitization to be considered complete (Buzan et al., 1998, p.25). This nuance gives rise to analytical difficulties in assessing the success, or failure, of securitizing moves and leaves analysts to question: how is one to deem that emergency measures *could* be adopted, unless they are? (Stritzel, 2007, p.363). In practice, it is successful persuasion that defines completion of the securitizing process and without persuasion a discursive

framing or presentation of the existential threat remains merely a speech act; a constitutive part, but not a complete process of, securitization (Buzan et al., 1998, p.25).

In addition to the difficulty of assessing legitimacy without implementation of emergency measures, the definition of what constitutes normal political boundaries is problematic. Securitization is a discursive process that is successful once a securitizing actor has managed to legitimise, through argument, a response that could break free from the normal procedures or rules of a given system; an acceptance of the security argument would "enable a call for urgent and exceptional measures to deal with the threat" (Buzan & Wæver, 2003, p.491). Within different institutions or different political systems, the procedures and norms that constitute normal boundaries vary. In a liberal democratic system, the emergency measures legitimised by the acceptance of security status could include secrecy by the state and placing limitations on otherwise inviolable rights (Buzan et al., 1998, p.24). Contemporary manifestations of these measures invite criticism from western civil society and human rights groups who decry a break from normal procedures that protect civil liberties; for example, until 2009 the United States government imposed travel restrictions on visitors with HIV/AIDS and this was heavily criticised by human rights activists (Preston, 2009). Despite criticisms that its framework is overly centred on the western liberal democratic model (e.g., Wilkinson, 2007), the Copenhagen School seeks to allow for application of the theory to a variety of contexts and systems by stipulating only that emergency measures legitimise a break from "normal bounds of political procedure" and not what these "normal bounds" may be (Buzan et al., 1998, p.24). In empirical application of the securitization model, this thesis favoured a context-driven definition of political norms drawn from interviewee's own reported perceptions of what did and did not constitute a break from 'normal' procedure when dealing with HIV/AIDS (see Chapter 7 and 8). Indicators of HIV/AIDS securitization were adopted to facilitate the identification of securitization actors and practices in the empirical studies. These indicators (outlined in Chapter 4) include the potential violation of civil liberties that can arise following HIV/AIDS securitization and thus, here too the

influences of Western liberal political norms come into effect. To mitigate potential bias by the researcher, the definition of what constituted normal civil liberties was also defined as far as possible by the reports of elite interviewees with operational expertise in each of the case study countries.

The process of elevating an issue to the rarefied status of security entails an element of competition; it is a process in which issues or securitizing actors vie for attention and, as Waever notes, amounts to a sort of "trade-off against other concerns" (Waever, 2003, p.12). In their empirical study of the securitization of avian flu in Southeast Asia, Curley & Herington (2011) point out that "attempts to securitise global health discourses involve the securitisation of multiple and possibly competing referent objects" (p.162) that range from global public health, as advocated by the WHO, to the national economy. Curley & Herington (2011, p.162) found that in a quest for political legitimacy, the Vietnamese state undertook securitizing moves and chose to present the national economy rather than public health as a referent object. This problematic trade-off is one of the reasons that Copenhagen School, and Waever in particular, advocates desecuritization and a return of issues to the "ordinary public sphere" (Waever, 2003, p.12). This is problematic in two significant ways: first, there is a risk of detracting resources away from another cause that is equally if not more worthy (Elbe, 2006; Davies, 2009, p.135); losers in the competition might lack an articulate or authoritative speaker to perform the securitizing claims, or might suffer "silencing" in some other form (see, Hansen, 2000). Second, by competing for resources in this way, the speaker is perpetuating an ethos of hierarchy that reflects the model's realist conceptual core. Logically, it follows that if threats are conceptualised as being more or less worthy of limited resource allocation, then so too are referent objects. One of the dangers of securitizing HIV/AIDS identified by Elbe (2006) is that this environment may result in states prioritising security elites, obtaining health services and security for the groups deemed most important to state survival at the expense of other more vulnerable communities. At the international level, this threat-defence logic could, Elbe (2006) proposes, manifest in the adoption by states of HIV/AIDS policies and responses designed to safeguard their "narrow national

interests" (p.120) rather than any broader, altruistic concern for human welfare. According to Davies (2008, p.296), such dangers are already manifest in the World Health Organisation's response to pandemic disease, which amounts to containing infection in the poor world in order to protect the affluent West rather than the pursuit of global health security beyond the traditional parameters of the nation-state.

2.3. Securitization and the Theory of Fear Appeals

The second theoretical foundation that is established in this chapter concerns the method by which the existential threat is constructed during the securitization process: that of the fear-imbued suasive speech act. The Copenhagen School does not explicitly emphasise the role of fear in its outline of the constructive process, but refers instead to the "drama", "urgency" and "priority" that characterise both the suasive acts and the threat (Buzan et al., 1998, pp.25-29; Waever, 2003, pp.9-12, 19). The invocation of fear is an essential part of the speech act which itself forms the core of securitization and as Waever (2003) states, "prioritising and dramatising effects are systematically involved" (p.9) in the securitizing process. This thesis examines the suasive construction of security and finds that fear acts as a tool for persuasion, as outlined in Chapter 3, and is created as a result of the suasive speech acts; to be persuaded of the existence of an existential threat the audience has accepted a heightened threat perception and acknowledged a source of severe anxiety. For this reason, securitization and increased security is attributed to increased fear amongst audiences, a correlation that is problematized by Williams (2011) in his examination of securitization and the liberalism of fear and within Chapter 4 of this thesis.

Fear, with its unparalleled capacity to inspire innate and extreme biological responses, is a potent weapon in the hands of the powerful elite in governance (Hedges, 2010, p.16). Fear appeals are "persuasive strategies" that invoke fear in order to bring about behavioural or attitudinal change in the audience and are "some of the most common and popular persuasive strategies" in contemporary use by public health officials, media, and politicians (Witte, 1998, p.423). Political fear is

that which exists in the consciousness of the individual or collective (e.g., social groups, communities, nations) and influences their behaviour. The special properties required to evoke political fear are the same that are required of the existential threat in securitization; as Robins (2004) asserts, "to arouse us, the object of fear must belong to the realm of politics and yet somehow, in the minds of the fearful, stand apart from it" (p.4). In the discursive act of securitization, this arousal forms part of the fear appeal made by securitizing actors who target their audience with the claim that the object of fear is one of exceptional quality; it seemingly demands urgency and must be prioritised above all others. Only by demanding this special attention can the audience recognise the proposed importance (real or imagined) of the securitized threat. In a case of securitization, the demand for special attention takes the form of the suasive, securitizing, speech act that is essentially a fear-appeal; it is a claim in which an issue is presented as being an existential threat, as beyond the realms of day-to-day politics, as warranting a violation of normal political rules, and as requiring exceptional and immediate responses.

Although fear is always invoked in a successful securitization, it is not always manifest in a productive form. That is, the arousal of fear in an audience might lead to destructive behaviour, or aversion to the 'message' or claims of the securitizing actor. For fear to be manifest in a productive form, fear appeals must be accompanied by a set of responses that are offered to the audience as a means by which to mitigate or manage the fear that is invoked. For instance, whilst fear is invoked during the securitization process, in order to be useful as a political tool the audience must also perceive there to be a route or action by which the fear can be alleviated, such as the implementation of an emergency measure in response. This is outlined in more detail in Chapter 3, but here the following discussion of security construction through speech acts establishes a number of key similarities between the psychological literature on the Drive Theory of fear appeals and the Copenhagen School's theory of securitization. The "characteristic pattern" at the heart of securitization corresponds to typical drive-theory based fear appeals (Chapter 3; Buzan et al., 1998, p. 27), where drives are bodily states that the subject

attempts to reduce or eliminate through appropriate response; for instance, eating is a response to the innate drive of hunger. Drives can also be learned, like fear. Whether learned or innate, drive theories assume that subjects will attempt to reduce an experienced drive by adopting appropriate reduction strategies. Therefore, a fear appeal based on drive theory must both invoke fear in the respondent as a stimulus to action and also offer a solution with which the respondent can reduce the drive. In this respect, the conceptual logic of fear appeals is congruous to the logic of securitization theory, where the fear appeal takes the form of the suasive securitizing speech act and in which an extraordinary response can be advocated. The "specific rhetorical structure" of survival and priority of action that is the "distinguishing feature of securitization" thus mirrors that of successful fear appeals (Buzan et al., 1998, p.25), which invoke fear through propositions of dire consequences and offer solutions for the avoidance of these consequences.

Drive theory-based evaluations of fear appeals propose that reactions are an attempt by the audience to reduce the negative drive of fear that is elicited by the fear appeal; in securitization theory, the speech act or existential threat construction invokes fear as a drive that can be reduced through the legitimation of an extraordinary response. One crucial difference is that in the securitization process the adoption of response is not necessary for the act to be deemed a success (it is enough that the suasive claim has convinced its audience of the existence of an existential threat), whereas in the fear appeal literature outlined in Chapter 3, behavioural change is an indicator of success. Whilst there are contending psychological paradigms in the study of fear appeals, all drive theory models conclude that fear can elicit behavioural change among respondents who are seeking to avoid, manage, or minimise the perceived threat. Consideration of the nuanced variables affecting fear-appeal success would be useful in designing a successful fear-appeal, (and is essential according to Witte & Allen, 2000), but it is beyond the scope of this paper to engage with such a study of the psychological literature. It is sufficient, in considering the innate relationship between securitization and fear, to demonstrate the scholarly consensus that fear appeals can

be an effective tool for informational and behavioural manipulation (Sternthal & Craig, 1974; Witte & Allen, 2000; Ygram Peters, Ruiter & Kok, 2012) and to illustrate the congruity between the essential characteristics of securitization and the enduring features of fear-appeals.

2.4. Securitizing Speech Acts

Fear appeals and securitization are suasive processes that are completed through discursive acts. The defining feature of the securitization process, and that which sets it apart from other theoretical frameworks in security studies, is that here security is constructed through articulation of securitizing speech acts in which a specific rhetoric is employed to claim a modus of exceptionality (Buzan et al., 1998; Stritzel, 2007, p.360). The speech act, the productive component of security in the Copenhagen School model, is a focal point for much of the existing critique within the academic literature. These critiques include concerns that are normative (for example, Hansen, 2000), conceptual (Stritzel, 2007), or that consider the application of securitization theory to "real situations" (Balzacq, 2005, p.171; Stritzel, 2007; Curley & Herington, 2011). Both Balzacq (2005, p.171) and Stritzel (2007, p.367) argue that the functionality of the speech act within securitization theory is too limited to allow sufficient application to real world situations. Stritzel (2007) asserts that the situatedness of the speech act is undervalued by the Copenhagen School and that the theory employs a "too-static" (p.364) conceptualization of the speech act event. Balzacq (2005) offers a corrective in the form of reconceptualising securitization as an audience-centred process that is context dependent. These adjustments, it is hoped, will allow better application of the theory to empirical study.

The productive relationship between securitizing actor and audience is a characteristic undervalued in the Copenhagen School formulation of security; Stritzel (2007) calls for the authors to differentiate between the terms "process" and "speech act/utterance", which are employed "as if both were synonymous" (p.364). In reality, Stritzel (2007) points out, "the speech act itself, i.e. literally a *single* security articulation at a *particular* point in time, will at best only very rarely explain

the entire social process that follows from it" (p.377) and in practice securitization is "negotiated" (p.363) between the audience and securitizing actor. Furthermore, the utterance itself is not synonymous with the complete process of securitization which requires the persuasion of an additional body, the audience. Thus, the securitizing actor is made a dual entity of audience and enunciator (Stritzel, 2007, p.363).

A cohesive argument can be made for a wider definition of the speech act than that offered in the Copenhagen School's original formulation of securitization theory. A study of securitization that focuses on the discursive speech act, or performative utterance, as the essential component of the process can lead analysts to neglect the important influence of the wider external conditions in facilitating securitization. It also enables an artificially narrow definition of securitizing acts and "an overly linguistic rule-generating approach to determining securitization" risks marginalising the important roles of audiences, curtailing the scope of discourse that could be considered as part of securitization, and limiting the utility of the model as a tool for analytical study (Curley & Herington, 2011, p.147). Thus, the case has been made for a broadening of the speech act to include communication in visual or non-verbal forms (see Williams, 2003; Campbell, 2008); in their study of securitization in Vietnam and Indonesia, Curley & Herington (2011) suggest that "the application of a purely linguistic analysis" (p.145) of security deprives the analysis of hermeneutic depth and further problematizes the role of the audience.

In their analysis of fear in news and media discourse, Altheide & Michalowski (1999) found that fear of AIDS is part of a trend in framing of the issue within popular media and news communication. These communication forms comprise an essential mode of establishing social expectations about order, governance, and control within risk societies of the contemporary world (Altheide & Michalowski, 1999). Securitization is a process in which discourse generates security and is therefore affected by the external and contextual conditions in which it takes place; these conditions include non-direct speech acts that inform audience's interpretation of securitizing claims and that contribute to the success or failure of securitization moves. As Vultee (2010) concludes, there is a lack of scholarly

attention paid to securitization within communication or media studies, despite the "implicit relevance of news media" (p.33) to securitization.

Securitization is studied in this thesis through the sociological approach identified by Balzacq (2005) in which it is best considered as a strategic or pragmatic process that takes place within a set of complex interrelated conditions that should be considered fundamental to understanding the construction of security problems. These circumstances include the context and social conditions in which securitizing actors and audiences exist, their power relations and the "psycho-cultural disposition" of each (Balzacq, 2005, p.1). Contextual conditions include popular perceptions and representations of the issue in news or other media and can be regarded as facilitating or hindering the success of suasive speech acts. As such, these conditions should be considered important both by securitization analysts and by actors who seek to implement their own process of securitization. However, these social and political conditions are understudied (Balzacq, 2005; Stritzel, 2007; Vieira, 2006), although there is a growing body of literature which questions the ability of the Copenhagen School's framework to address the role of wider contextual conditions as a variable affecting securitization success, including the empirical study of flu securitization by Curley & Herington (2011, p.145). Such a study, the authors conclude, "must take into account local factors which impact on the process of securitisation", not least because "the coherency of a securitizing act is reliant on a shared context between speaker and audience" (Curley & Herington, 2011, pp.148, 164).

A greater attention to contextual conditions could advance the theoretical development of securitization; specifically, examination of contextual conditions might alleviate some of the difficulties that arise in applying securitization theory outside of the liberal democratic context. For instance, because Buzan et al., (1998) "do not push the demand so high as to say that an emergency response has to be adopted" (p. 25), it is difficult to determine when exactly an audience is persuaded (Stritzel, 2007, p.363). Jones (2011) argues that this fixation on discourse rather than security practice is problematic when applied to Southeast Asian security analysis and identifies this as a reason why securitization theory cannot account for the gap

between the rhetoric of widening security agendas that is employed by many states in Southeast Asia, including Thailand, and the actual lack of implementation of this widening in practice. The emphasis on speech acts also becomes problematic when audiences are not the empowered agents imagined by the Copenhagen School, which are typical of a free and democratic population; as Stritzel (2007) asks, "what if a dictator is the securitizing actor?" (p.363). The matter of persuasion was succinctly problematized by Hansen (2000), who demonstrates the practical and normative difficulties of applying securitization theory in contexts where coercion, oppression, and a lack of agency distort the dynamics of the audience-actor relationship. Hansen (2000) used the example of gender-specific honour killings to illustrate the inherent assumption of the Copenhagen School that threats could and would be articulated by those at risk. In reality, the articulation of insecurity might be impossible or serve to exacerbate the insecurity of the referent object (Hansen, 2000). Empirical data collected from Myanmar shows this was evident with regards to HIV/AIDS; here, CSO leaders sought to minimise or avoid articulations of HIV as a security threat, fearing that doing so would invite intervention from the state which itself was a source of insecurity and threat (Chapter 8).

Speech acts within securitization theory are performative acts; as in the act of making a bet, through their utterance something is *done* (Austin, 1962, pp.5-6). Facilitating conditions are defined by the Copenhagen School as "the conditions under which the speech act works, in contrast to cases in which the act misfires or is abused" (Buzan et al., 1998, p.32). In the original work by Austin (1962), the external, social, and contextual conditions of a successful speech act were the first to be outlined in his lecture on performatives; according to his speech act theory, one of the facilitating conditions for the "smooth or 'happy' functioning of a performative [speech act]" is that "there must exist an accepted conventional procedure having a certain conventional effect, that procedure to include the uttering of certain words by certain persons in certain circumstances" (p.14). Thus dependent on the alignment of favourable "facilitating conditions", the speech act "is deeply sedimented and structured, rhetorically as well as institutionally" (Abrahamsen, 2005, p.58). A study of securitization, attempted or realised, must

subsequently include analysis of the contextual and external conditions in which it is located. Basing its model on the speech-act theory outlined by Austin (1962), the Copenhagen School considers conditions as important to the success of securitization processes and separates them into two categories: the internal grammatical conditions of the speech act and the external contextual and social conditions in which that speech act can be articulated, including the power or authority of the speaker (Buzan et al., 1998, p.32). However, with the success of achieving flexible application, the securitization model has forfeited its ability to sufficiently account for contextual factors in the securitization process, leaving the model unable to satisfactorily answer questions as to why and when some securitizations are successful and others are not (McDonald, 2008, p.572). Ultimately, although facilitating conditions go some way toward offering an explanation of causality in securitization, the theory itself rests on the premise of securitization as a performative act that is never fully explained by its conditions (Waever, 2003, p.32). Thus, these external conditions remain conceptually problematic.

The lack of causality is addressed by Balzacq's (2005, pp.192-193) expansion of securitization theory, in which he suggests that analysts should focus on the relationship between a variety of facilitating conditions that constitute the broader context of the securitization and the degree of its success. However, Stritzel (2007) critiques the conceptual basis of the Copenhagen School by problematizing the proposed causal link between securitization, which rejects the logic of objective threats, and the apparent existence of externally located facilitating conditions. Stritzel (2007) advocates a greater analytical interest in the external and contextual elements of securitization theory on the basis that the securitizing actor and "the performative force" (p.360) of the speech act both derive power from their broader discursive contexts. McDonald (2008, p.580) also advocates greater analytical attention to context when evaluating the impacts of securitization, suggesting that the analyst should focus less on the discursive production of security (as suggested by the CS) and instead look toward context as an important factor in creating this intersubjective phenomena. Engaging a real world application of the model,

McInnes & Rushton (2010, p.134) argue that the security threat presented by HIV/AIDS is dependent on wider contextualising features that have been widely ignored by the international community during the formation of knowledge norms that have aided and resulted from the securitization of the disease. In their empirical study of the securitization of infectious disease in Asia, Curley & Herington (2011) raised similar critiques, concluding that outside the liberal democratic arena, the processes of securitization (of infectious disease) rely on "fragile state legitimacy, use competing referent objects and utilise language that is heavily contingent upon the audience" (p.142). Their findings lend further, empirical, support to the proposition by Stritzel (2007) and Balzacq (2005) that the role of audiences in securitizing processes warrants further attention if the theory is to be empirically useful. Sjostedt (2008) also concludes that traditional mono-causal frameworks are not capable of assessing the complex nature of threat construction. Thus, proper analysis must consider "case sensitivities" and "intervening variables" (p.8); a view which has gained ground in recent years (McInnes & Rushton, 2010, p.244).

Facilitating conditions are particularly useful conceptual tools for studying securitization because "truth conditions" need not, according to the radically constructivist model, exist (Stritzel, 2007, p.361). According to the Copenhagen School, the success or completion of a securitizing act does not depend on the objective existence of a threat but instead on the intersubjective understanding created through a process of persuasive speech acts; as Buzan et al., (1998) state: "an objective measure for security can never replace the study of securitization, because the security quality is supplied by politics" (p.32). It is within these politics that an array of facilitating conditions come into effect to determine the likelihood of audience persuasion. The facilitating conditions of the speech act refer to:

> The demand internal to the speech act of following the grammar of security; the social conditions regarding the position of authority for the securitizing actor - that is, the relationship between speaker and audience and thereby the likelihood of the audience accepting the claims made in a securitizing attempt, and... [the] features of the alleged threats that either facilitate or impede securitization. (Buzan et al., 1998, p.33)

Drawing on the work of Balzacq (2005), Vuori (2008, p.70) adds an additional facilitating condition to the three outlined above by the Copenhagen School, proposing that the condition of the audience should also be considered as a factor determining the success or failure of the speech act. The causal role of external conditions suggested in the second and third of these conditions (the authority of the securitizing actor and the nature of the threat) is problematic for a post-structuralist reading of the securitization theory (Stritzel, 2007, p.366). Indeed, as Waever (2003, p.14) acknowledges, two of the main criticisms of securitization theory are located in the facilitating conditions of the theory; first that it ignores the question of power, and second that it underestimates the role of objective threats. However, whilst the importance of external conditions might create a tension with constructivist or post-structuralist interpretations of the theory, the social conditions do reflect those identified in Chapter 3 on fear appeals. Here, the condition of communicator credibility affects the success of both suasive articulations: fear appeals and securitizing speech acts. The third of these facilitating conditions, and specifically the features of the proposed threat, are explored in detail in Chapter 4.

Whilst the external conditions, or "empirical contexts", cannot ultimately determine the success of a securitizing move, they can "provide crucial resources" for actors attempting to persuade the audience of a securitizing claim (Abrahamsen, 2005, p.58). Assessed as a suasive act, the securitizing claim relies on such resources to gain traction amongst its audience. Here we outline three categories of facilitating condition; the authority of the speech act enunciator, the perception of threat consequences, and the role of the audience. First, the success of securitization as a suasive process depends on the authority of the speech act enunciator (Buzan et al., 1998). Despite the expansionist agenda of the Copenhagen School, in practice "it is not the case that anything and everything can be securitized" just as it is not so "that any 'securitizing actor' can attempt to securitize" (Abrahamsen, 2005, p.58). Instead, a securitizing actor must possess sufficient authority, though not necessarily in an "official capacity", to persuade the audience of the securitizing claim (Buzan et al., 1998, p.33; Abrahamsen, 2005, p.58). This authority may be "delegated or enforced" and comprises the "ability to define meaning so that their power capacity may come

close to a monopoly" (Stritzel, 2007, p.372; Curley & Herington, 2011, p.161). This relationship between authority and persuasion is problematized by Stritzel (2007), who advocates instead a theory of securitization in which power is conceptualised as "the ability to influence a process of meaning construction" that is both more structural and that allows an analysis of "hidden" (p.373) forms of influence. The "contested politics" of authority and the legitimacy to speak security is also shielded from analytical attention in certain contexts; within international forums such as the United Nations, states are favoured given the Westphalian assumptions upon which the international system operates (Curley & Herington, 2011, pp.161-2). From a normative perspective, the authority necessary for security articulation is also problematized by Hansen (2000), who critiques the securitization process as silencing and subsuming the articulation of non-dominant security narratives. Furthermore, Hansen (2000) concluded that securitization theory facilitates security analysis which fails to critically engage with power-laden systems of gendered insecurity.

The ability to articulate security is both a route to prioritising one's own agenda and also a mode by which an enunciator can reinforce their own power. Therefore, there is an inherent value in the ability of an actor being able to "speak security" (Vultee, 2010, p.34). This is evident in the international system where high level forums provide "fertile ground" in which states can make claims about their security interests, with no guarantee that these claims are motivated by concerns for humanitarian principles or by political agenda, despite the intention of alternative securitizing actors (Curley & Herington, 2011, p.150).[3] The "search for political legitimacy [to]...motivate securitizing moves" merits analytical attention (Curley & Herington, 2011, p. 161), and as Buzan et al., (1998) state, "in concrete analysis ... it is important to be specific about who is more or less privileged in articulating security. To study securitization is to study the power politics of a concept" (p.32).

Sternthal & Craig (1974) conducted meta-analysis of fear appeals in the

[3] See Curley & Herington (2011, p.162) for an explanation of competing securitization motivations; during the securitization of avian flu H5N1 in Southeast Asia, the Indonesian state securitized the virus in order to pursue its own national interests, contra to the agenda of the WHO which was also engaged in securitizing the virus.

psychological literature, outlining a relationship between levels of credibility attributed to communicators delivering the fear appeal and reported resonance of those appeals amongst respondents. According to the Copenhagen School, a positive relationship is also evident between securitization success and authority of the securitizing actor (Buzan et al., 1998, p.33). Additional studies discussed in Chapter 3 also found a causal link between increased levels of fear, communicator credibility, and achieved levels of audience persuasion, although this relationship becomes complicated and, according to some authors, potentially inverted when considering the correlation between fear levels and actual behavioural change rather than persuasion (Hewgill & Miller, 1965; Sternthal & Craig, 1974, p.26). As securitization success is regarded as the tacit persuasion of audiences and not as the invocation of behavioural change, these findings correspond with the theory of the Copenhagen School, in which the authority of the enunciator, or securitizing actor, is a facilitating condition (Buzan et al., 1998, p.33).

The second facilitating condition outlined here is that of the consequences of a threat, as perceived by the audience. In addition to the authority of the speech act enunciator, in securitization theory the perceived severity of the consequences arising from a proposed threat are integral to the success of its construction (Witte & Allen, 2000, pp. 591-592). The suggested responses, or consequences arising from lack of response, to a securitized issue are proposed here as additional facilitating conditions. According to the internal grammatical logic of the securitization process, it is fundamental that the threat proposed is not just extreme but *existential* (Buzan et al., 1998). In constructing the existential threat, the criteria outlined by the Copenhagen School are that the threat be the most urgent, the most deserving of attention and priority, and that, "if we do not tackle this problem, everything will be irrelevant" (Buzan et al., 1998, p.24). Whether or not the securitizing actor must offer or explain a defined course of action for response to the threat is not explicit in the model; instead, and in keeping with its intention to provide an applicable tool not restricted to specific contexts, the Copenhagen School simply concludes that recourse to extraordinary measures must be legitimated and not what those measures may entail (Buzan et al., 1998).

The literature on fear appeals concludes that where behavioural change is the intention of a fear appeal, the proposition of action or mitigating response is a crucial variable to their success (Sternthal & Craig, 1974; Soames Job, 1988; Witte & Allen, 2000). Audiences who feel fearful following a suasive fear-appeal will seek a route by which to mitigate that fear and it is in this space that the emergency measure can be proposed and legitimised. However, if education or absorption of information is the measurable outcome of success, rather than the adoption of specific behaviours (such as the legitimation of an emergency response), then the suasive fear appeal or securitization act could benefit from invoking heightened levels of fear amongst the audience because, according to the literature, humans are more receptive to such claims when in this aroused state (Sternthal & Craig, 1974; Soames Job, 1988; Witte & Allen, 2000). The Copenhagen School is explicit in its statement that extraordinary measures need not be adopted for securitization to be considered a success; instead it is sufficient only that an issue reaches a "platform" from which extraordinary measures may be legitimately enacted (Buzan et al., 1998, p.25). Whilst it makes empirical measurement of real world securitizations difficult, this omission by the Copenhagen School does invite the logical conclusion that, given the psychological literature on fear appeals, increased fear invocation is a route to increased securitization success, because securitization comprises only the suasive fear appeal act and not of behavioural change. However, in practical application it seems likely that if one were to design a securitization process it would be with the intention of achieving legitimacy for extraordinary measures, for instance when a political leader seeks to implement a public curfew, or to gain approval to engage in war in order to curtail a threat to national security. In these cases, the surveyed fear appeals literature suggests that the suasive act and proposition of the existential threat should be presented to the audience *in addition* to a route by which the threat can be dealt with and the fear thus managed and controlled. This is expanded in the following chapter.

Finally, the audience is crucial in security construction; it is they who must be convinced of the existence and severity of an existential threat and "the central role of the audience underlines that the theory is basically about security in an inter-

subjective sense" (Waever, 2003, pp.11-12). Despite this centrality, the power of the audience is left underdeveloped in the Copenhagen School theory and in the wider literature (cf. Balzacq, 2005; Stritzel, 2007, p.363; Curley & Herington, 2011). Although the actor-audience relationship is not fully developed in the articulation of securitization theory, it appears as if the Copenhagen School splits the securitizing actor into two parts: the speech act enunciator and the audience who chooses to accept this suasive act (Stritzel, 2007, pp.362-3). However, the power-laden dynamic of this dual unit is not given serious consideration in the theoretical framework offered by securitization theory. Nor is the identity of the audience clarified in a comprehensive way; according to the sociological approach outlined by Balzacq (2005), the audience is considered to be neither fully constituted prior to the securitizing process, nor wholly a by-product of that process. In empirical studies, the neglect of the audience as an important and constitutive unit in the securitization model limits the applicability of securitization model to non-risk society contexts (Curley & Herington, 2011, p.144) and it is difficult to clearly distinguish which audience is most relevant in studies of securitization in practice (Stritzel, 2007, p.363).[4]

Balzacq (2005) critiques the speech-act centred philosophical approach to securitization and proposes instead that the audience is not considered a formal entity posed typically in a receptive mode, but that it would be better understood as an emergent category that is shaped by, and is part of, the securitizing process. Balzacq (2005) concludes that securitization is limited by its unsuitability to dealing with audience-centred security constructions and proposes that the model move away from speech-act theory. Whilst addressing the under-valued concept of power in securitization theory and the role of facilitating conditions, Balzacq's (2005) conclusion that the audience is an emergent category in part constituted by the process itself further complicates the analyst's task in identifying that audience in empirical cases. This difficulty in the empirical application of the model is further exacerbated by a narrow interpretation of the 'speech act' in certain contexts; for instance, Curley & Herington (2011) suggest that "the application of a purely

[4] See McInnes (2005), for a more detailed explanation of risk.

linguistic analysis in non-democratic and transitional East Asian contexts does not adequately take into account the specific negotiated relationships between the 'audience' and political elites (or senders and receivers of speech acts)" and that as a result, the "corresponding analysis of empirical cases are devoid of hermeneutic depth and recognition of the situated audience" (p.145). As Waever (2003) points out,

> Although one often tends to think in terms of 'the population' or citizenry being the audience (the ideal situation regarding 'national security' in a democratic society), it actually varies according to the political system and the nature of the issue. (p.12)

In data collection for this thesis, the political system of Thailand adequately resembles the ideal democratic model inferred by the Copenhagen School, particularly where it was possible to record the articulation of alternative political narratives by CSOs that were in dialogue with the government. In contrast, in Myanmar the political environment was not conducive to studying official discourse and the theory could not be applied in any meaningful way to high-level political discourse due to the opaque and insular manner in which the political system of Myanmar operates. Instead, discourse, policy, and action of NGOs and CSOs were studied. These organisations had orchestrated the national response to HIV/AIDS in the absence of significant state intervention and, whilst non-democratic, the institutional cultural and practices of these CSOs more closely resembled the mode of governance envisioned by the Copenhagen School than that of the military dominated state (see Chapter 8).

2.5. Responsibility of Securitizing Actors

Although securitization theory was developed in order to facilitate an understanding of *how* anything could become a security issue, an important qualifier is that, according to its authors, not everything *should* be considered as such (Buzan et al., 1998, p.29). If freedom from fear is a condition of security, then securitization becomes a source of insecurity. To illustrate this, Chapter 4 examines the specific, largely negative, outcomes of HIV-related fear that include increased

barriers to health care services, stigmatization, and a loss of efficacy in prevention/treatment campaigns. By highlighting the nature of security as a socially constructed concept, the Copenhagen School imbues in securitizing actors a level of responsibility for their actions and emphasises the important feature of choice that underpins the decision to securitize an issue (Buzan et al., 1998, pp.29, 32, 212). The decision to deal with an existential threat is (by nature of the threat) removed from the realm of choice, because not to deal with it would be catastrophic (Buzan et al., 1998, p.24); but crucially, it is the speech act and not the objective condition of the existential threat that makes a security issue. Thus, securitizing actors who articulate these speech acts must assume responsibility for the framing that ensues.[5] This responsibility is awarded because, according to the Copenhagen School, "it is always a political choice to securitize or to accept a securitization" (Buzan et al., 1998, p.29) and "it is politically chosen which of the possible futures are realised", i.e., whether or not to securitize an issue (Waever, 2003, p.20). This reflects the radical constructivism at the heart of securitization theory, which is based on the premise that no issue exists objectively as a security threat unless or until it is constructed as such and the relevant audience is convinced of its exceptionality; as Enemark (2007) points out, although there are at least 1,400 species of infectious microbe known to cause disease in humans, not all are securitized; instead, "every society tolerates a certain degree of illness such that not all infectious diseases may reasonably be considered a security threat" (p.1). Thus, "use of the security label does not merely reflect whether a problem *is* a security problem, it is also a political choice, that is, a decision for conceptualisation in a special way" (Waever, 1995, p.65). Because security actors exercise choice in deciding when to employ the language of security and attempt securitization, a normative assessment of whether this is a fortuitous move can be conducted. It is to this end, "to ask with some force whether it is a good idea to make this issue a security issue", that the Copenhagen School created the securitization model (Buzan et al., 1998, p.34; Elbe, 2006, p.126).

[5] See Abrahamsen, 2005, for an account of Blair's securitization of under-development in Africa.

The normative nature of the approach adopted by the Copenhagen School is evident in its warning against the tendency "to elevate security into a kind of universal good thing" (Buzan et al., 1998, p.4). The authors, and Waever in particular, also advocate a preference for desecuritization that returns the handling of an issue to the procedural realm of normal, established political rules (Buzan et al., 1998, pp. 4, 29; Waever, 2003); in this and other nuances, the liberal democratic bias of the Copenhagen School is evident (Wilkinson, 2007). Whilst a return to normal political procedure may be preferable when a state is governed by functioning democratic rule, at times 'normal' means inept. This leads to the concern raised by Elbe (2006) in his exploration of the ethical consequences of securitizing HIV/AIDS, where he argues that one major benefit of securitization would be the power to force states otherwise reluctant to deal with HIV/AIDS to do so. In Chapter 6, the discussion of HIV/AIDS securitization by the United Nations realises Elbe's point and illustrates the significant gains to be achieved through tactical securitization of HIV/AIDS, although country responses outlined in Chapters 7 and 8 show that the good of securitization is not always evident.

2.6. Conclusion

This thesis problematizes the relationship between securitization, fear, and HIV/AIDS whilst highlighting the issue of securitizing actor responsibility for securitization outcomes. Those opposed to securitization of an issue can appeal to the audience to reject securitizing claims, or position their own competing claims as more deserving of the priority and attention of a security threat. For instance, the exceptionalism of HIV/AIDS has been challenged in Myanmar by civil society groups that feared appropriation of the issue by an authoritarian military regime would lead to violations of patient rights. These groups subsequently fought to oppose securitization and to keep HIV/AIDS in the 'neutral' space of health (see Chapter 8).

Securitization theory has been called "theoretically vague" and faced the charge that "it does not provide clear guidance for empirical studies" (Stritzel, 2007, p.368). The Copenhagen School does not propose that objective threats can be

determined nor should they be; instead, securitization theory provides an account of threat construction which serves as a flexible and formulaic analytical tool. Whilst recognising charges of conceptual vagueness, this chapter outlines the utility of securitization theory as a point of departure for the wider analysis of contextualising conditions and it explores the qualities that account for its enduring success in the field of security studies. In outlining the theory, two conclusions are made that are central to the thesis; the first is that the Copenhagen School, despite its "radically constructivist" approach (Buzan et al., 1998, p. 27) proposes a form of security that has at its core a realist logic of threat and survival. This is most explicit in the prominence of the existential threat, which is found at the centre of the model and its constituent speech acts. The second conclusion of this chapter concerns the method by which this existential threat is constructed; the suasive speech acts that constitute securitization are defined by their invocation of fear amongst the audience and, although the Copenhagen School does not refer explicitly to fear in the internal grammatical logic of the act, it does emphasise the role of "panic politics", the existential threat, and the "point of no return" (Buzan et al., 1998, pp. 24, 33). These rhetorical devices are found also in the psychological literature, in which they are referred to as 'fear appeals', and it is their quality and conditions that are the subject of Chapter 3.

Chapter 3. Manifestations and Applications of Fear

The purpose of this chapter is to examine fear as a drive that motivates and informs human behaviour. Having identified that fear is an essential yet under-studied component of the securitization process, it must now be established what form that fear takes, why it occupies a central role in the suasive construction of security, and how its effects are manifested. Central to this thesis is the understanding of fear as a drive. Drive theory holds that the human experience of fear is an aroused state that manifests in the need or desire for alleviation through adoption of appropriate action; similar drives include hunger and thirst, which are alleviated by eating or drinking. Humans experience three distinct neurophysiological responses to the drive of fear; to freeze, to flee, or to attack (Ellin, 1997, p.9; Öhman, 2000, p.111). Fear acts as a stimulant in all three responses and notably, even the freeze response is accompanied by increased attentiveness and hyper vigilance of the subject. This chapter explores the properties and manifestations of fear in both its productive and destructive forms and by illustrating the role of fear in political governance, the conditions determining productive fear responses are outlined. The psychological literature on fear-appeals is reviewed and it is here that the similarities between suasive securitizing speech acts and fear appeals in public health education are explored. The chapter concludes that fear-laden securitization can be destructive or productive and that in order for speech acts to be successful, they must both invoke fear and define responses by which the audience can mitigate that drive.

3.1. Fear as a Stimulus

The classic philosophical literature on fear identifies its two distinct manifestations in the action of individual human beings; fear as a productive force, and fear as a destructive or inhibitive force. It is in these forms that fear becomes the subject of this thesis, which attempts to delineate the conditions for invoking the drive in its productive form. Political theorists John Locke and Edmund Burke

advocate fear as a tonic for the apathy of pleasure and attribute to it the capacity to motivate human endeavour and productivity (Robin, 2004, p.4). For Montaigne (1575, trans.1877), fear has the potential to lead us into frantic, irrational, and destructive behaviour that can paralyse a person or stimulate hysterical responses akin to "madness" (p.67). In such cases, Montaigne (1575, trans.1877) proposes that there is no greater source of irrationality than fear, because "there is no other [experience] whatever that sooner dethrones our judgement from its proper seat" (p.67). This conclusion is found also in the contemporary literature of psychology, in which the application of fear appeals to incite behaviour change is problematized by the duality of potential outcomes; in some cases fear appeals provoke rational reactions that mitigate danger, whilst in others, subjects are led to irrational or debilitating responses that are neutral or counterproductive (Dillard, 1994). Thus, fear can serve as both a motivation for action and inhibit effective responses. As Montaigne (1575, trans.1877) concluded, "sometimes it adds wings to the heels ... sometimes it nails them to the ground, and fetters them from moving" (p.68).

When stimulated by external triggers, it is the function of fear to act as drive and to provoke in the subject an aversion toward potentially harmful situations, protecting the body from risky behaviour such as walking along a cliff edge or nearing a predatory animal. Physiological responses to fear are characterised by the activation of the autonomic nervous system which creates the powerful physical experience of arousal (Robin, 2004, p.4); within clinically normal humans, this arousal is recognised as fright. When presented with an imminent threat, the heart rate and blood pressure of the subject increases, usually accompanied by the release of adrenalin into the bloodstream, and it is this imbalance that characterises a drive. If the threat is not imminent, such as a stationary or distant predator, the common biological response is to freeze or become immobile, to increase attentiveness, and to experience a temporary decrease in heart rate (Öhman, 2000, p.111). In this state of heightened awareness the threat can be assessed and the subject is able to decide upon an appropriate course of action. During this process, the subject will assess the predictability of the fear stimulus and their own ability to engage in aversive behaviour. If predictability and the potential for aversion are gauged to be high then

fear is decreased, enabling action to be taken (Öhman, 2000, p.113). These important moderating factors are significant when evaluating the effectiveness of fear stimuli as a motivation for behaviour. In the psychological literature, persuasive messages that employ fear as a means to invoke behavioural or attitudinal change are called "fear appeals" (Witte, 1998, p.423). The use of fear appeals in public health is complicated by the difficulty of achieving the desired level and type of responsive action; for fear appeals to promote sustained, risk averse behaviour, they must invoke fear in the audience but also ensure that the audience is not paralysed or led to counterproductive behaviours, such as 'othering' or message rejection, through the mismanagement of this fear.

Fear stimuli usually threaten the physical or psychological integrity of the receiver and are classified within the literature into three categories; physical stimulus, animal stimulus, and social fear stimulus (Öhman, 2010, p.83). Physical stimuli encompass the intensification of any environmental phenomenon such as extreme temperature, noise, or sensation. The causes may be natural, for instance a thunderstorm, or manmade, such as violent conflict on a battlefield. Physical stimulation is of use when faced with an immediate threat, but once that moment has passed the initially productive reaction can become destructive and disabling for the subject. Depending on the individual response, extreme experiences of fear can result in trauma and psychological damage that outlast the experience of the stimulus itself, sometimes with severe consequences. For instance, subjects with post-traumatic stress disorder experience the potentially debilitating effects of fear in which initially beneficial physical responses to a stimuli manifest in long-term physiologically destructive effects beyond their control.

The second classification of fear stimuli is that of animal stimuli, which includes the fear of predation as well as contagion associated with microbial threat. Certain animal stimuli are believed to be innate to the human psyche, including poisonous insects or contamination with pests or disease (Öhman, 2001; LoBue & DeLoache, 2008), compared to fear triggers that are learnt through direct experience or through communication with other subjects. In this manner the final category – social fear – is constructed. This form of fear is closely related to the negotiations of

power and status that define social relations (Öhman, 2010, p.83); within human communities, this power determines our social status and brings tangible benefits such as access to resources and opportunities for reproduction and survival (Öhman, 2000, pp.112-3).

Humans possess the ability to effectively communicate learnt fear triggers through our unique use of complex language. As a result, those wishing to control large numbers of people can do so by using fear messages as a means of eliciting behaviour en masse. Fear can be socially constructed and invoked as a tool for governance through the process of securitization, which entails articulation of fear appeals that use a specific, security-bound rhetorical structure (see Buzan et al., 1998, p. 33); by conceptualising fear in this way, the properties of fear stimulus become significant because these stimuli must be harnessed in order to invoke the necessary reaction and to construct an effective fear appeal. As discussed below, the use of fear messages in health advertising has prompted a wealth of behavioural studies, undertaken to assess whether the specific types of fear experienced as a result of these messages have proved to be productive (in stimulating positive and healthy behaviour) or destructive, such as alienation, disengagement, and feelings of hopelessness (Blumberg, 2000; Ruiter, Abraham & Kok, 2001; Batrouney, 2004). Characteristics of the threat determine the nature and strength of the fear response that it evokes in the subject, and the likelihood of that fear being utilised in a productive manner. The immediacy of the threat and its predictability correlate to the intensity with which the subject experiences fear; in general, the closer the fear stimulus the more intense the response, whilst the less predictable its behaviour, the more likely we are to fear it (Öhman, 2000, p.113). This accounts for the heightened sense of fear invoked by situations or stimuli about which subjects have little prior experience or understanding. Fear intensity also correlates to the levels of control that the subject perceives itself to have over the threat; if this control is significantly low then anxiety becomes pervasive. However, if anxiety and uncontrollability continues for a sufficient amount of time, it may diminish into lethargy and depression on the part of the subject (Öhman, 2000, p.113). For those wishing to

utilise fear stimuli as a means of affecting subject behaviour, understanding the nature of fear triggers is of paramount importance.

3.2. The Sources and Manifestations of Fear

The fear of the unknown is intrinsically linked to the human innate and biologically driven fear of death. Prior to the mainstreaming of evolutionary biology and clinical psychology, Hobbes (1651/1998) wrote that the fear of death is integral to the human condition, because death is "the chiefest of all natural evils" (p.xxix) which we avoid impulsively through our animal behaviour. Hobbes philosophised extensively on religion in society, critiquing the role of the Church and personal faith as a barrier to the authoritative sovereign, and earning himself a reputation for heathenism (Geach, 1981). Like many after him, including Albert Einstein, Hobbes (1651/1998) associated the basic human disposition for religion with our unique ability to comprehend that our lives and deaths consist of an unknowable future that is shaped by "good and evil fortune" (p.71), the causes and roots of which are often a source of mystery.[6] The human desire to understand the causes of things, and especially of things that affect our lives in positive or negative ways, is "not to be found in any other living creatures", giving rise to the "perpetual fear" and unremitting anxiety which characterises human nature (Hobbes, 1651/1998, p.71). Humans share a need to understand or 'know' the causes and consequences of the phenomena that determine our existence and through our attempts to satiate this need, we find the presence of divinity. As Hobbes (1651/1998) wrote, "when there is nothing to be seen, there is nothing to accuse ... in which sense perhaps it was ... that the gods were at first created by human fear" (p.72). Here, Hobbes (1651/1998) refers to the gods of the Gentiles, which he later calls "ridiculous" but goes on to say

[6] In his 1930 article for The New York Times Magazine, republished in his book *The World As I See It*, Einstein (2007) wrote that "with primitive man it is above all fear that evokes religious notions - fear of hunger, wild beasts, sickness, death" (pp.25-28). He noted that such a "religion of fear" often serves a political purpose, being "stabilized by the formation of a special priestly caste which sets itself up as a mediator between the people and the beings they fear, and erects a hegemony on this basis ... [combining] priestly functions with its secular authority in order to make the latter more secure; or the political rulers and the priestly caste make common cause in their own interests" (Einstein, 2007, pp.25-28).

that the "one God, eternal, infinite" (in which he may or may not have truly believed) is born "from the desire men have to know the causes of natural bodies" (p.71). For Hobbes (1651/1998, p.72), belief in the divine is a practical and reasonable strategy for dealing with the state of perpetual fear and anxiety in which we are destined to live and for dealing with our innate desire to know how worldly phenomena, and our lives in particular, come to begin and to end.

That humans fear what we do not understand is an essential quality of our nature, and one that can be harnessed by those wishing to utilise the power of fear as a political tool. When constructing fear stimuli, making it unknowable and therefore unpredictable is an effective means of removing control from the subject and heightening the fear response (Öhman, 2000, p.113). When securitizing an issue, for which it needs to be presented as an existential threat, it is not uncommon to find that the rhetoric employed in speech acts echoes the language of "worst case analysis" commonly found in military planning (Edwards, 1999, p.312). Worst case analysis deals with unknown quantities and correlates to the securitization model in which "security is a dual statement about the future" dealing with hypothetical and counterfactual outcomes (Waever, 2003, p.20). The unknown quality of the future is a crucial part of building the saliency of a proposed threat issue. In *On Fear*, Montaigne (1575, trans.1877) referenced the Greek axiom of Epicurus, that "men are tormented by the opinions they have of things, and not by the things themselves" (p.315). That phenomenon of unknown character are most likely to inspire fear is established in the philosophical literature; as Burke (1792) wrote:

> To make a thing very terrible, obscurity seems in general to be necessary, when we know the full extent of any danger, when we can accustom our eyes to it, a great deal of the apprehension vanishes. ... Those despotic governments, which are focused on the passions of men, and principally upon the passion of fear, keep their chief as much as may be from the public eye ... all is dark, uncertain, confused, terrible, and sublime to the last degree. (p.82)

This vision of a mysterious, unknowable despot is reminiscent of an Orwellian dystopia in which confusion and arbitrary punishment is as much a tool for

cultivating political fear as any overt display of strength by the state.[7] Such tyrannical use of fear was a feature of the traditional Thai and Burmese monarchies, in which the exercise of cruel power upon 'ordinary' citizens was enabled by the conviction that royalty was a divine entity imbued with supernatural power (Quaritch Wales, 1931, p.21).

To lack knowledge about a source of threat or fear is to be disempowered; the rule of terror employed by Montesquieu's imagined despot is buttressed by his mysteriousness (Robin, 2004). Fear of a threat or object can prevent engagement with that object and discourages critique or analysis of its components, enhancing the fearsome and unknowable nature of its character. Conversely, to learn about and understand the forces that impact upon our lives, be they a virus or tyrant, is to gain power. Through understanding, a critique and deconstruction of the proposed threat is possible. Such a critique could, in explicating the threat, make it less fearful. Measures that prevent critique, such as the lèse majesté laws in Thailand or the secrecy and opacity of the military government in Myanmar, thus serve to enhance the inaccessibility and authority of these unknowable agents.

The terrible quality of the unknown is not limited to the realm of political governance; in the HIV/AIDS epidemic, the virus was a source of significantly greater fear before medical advances allowed experts to understand its modes of transmission and nature of infection. Even prior to the development of treatment (which allowed effective management of the virus by the HIV+ subject), knowledge alone could reasonably be expected to have reduced fear of the virus, partly by contributing to the enduring hope that treatments, vaccines, and cures may one day be found. For this reason, securitizing actors may see benefit in removing their proposed threat from the realm of public knowledge, presenting it as something too

[7] Fordham (2004) suggests that "the world of Thai AIDS is truly an Orwellian world", in which surveillance and interventions have been directed primarily at the private lives and practices of the "underclass" (p.3). He notes the lack of critical engagement with these fear-based systems of control, which he compares to the authoritarian Thai leadership of the 1960s and 1970s, pointing out that, whilst "the oppressive and unjust nature of these political regimes was clear to all, the oppressive nature of the regimes of surveillance and intervention engendered by the HIV/AIDS epidemic have been obfuscated by the power of biomedicine and public health, and by the claim that they are for the individual's own good" (Fordham, 2004, pp.3-4).

complicated or too extraordinary for the audience to understand. This phenomenon is discussed by Goldacre (2009) in a popular account of what he terms "bad science", where he argues that the mystification of science is used by pharmaceutical and beauty industries as a means of enhancing the fear invoked through their marketing campaigns.

The fear of death and of the unknown can be attributed to the biologically innate fear of physical harm. There is also evidence to suggest that the common fear of snakes and spiders is genetically embedded as a precautionary mechanism for avoiding creatures that endanger our survival (Öhman, 2000; LoBue & DeLoache, 2008). However, if an instinctive repulsion from biting insects is the manifestation of one type of fear, then at the other end of the scale is the complex, constructed type of fear that is born of and through cognitive conditioning and social training, and it is this learned, or shared, fear that is manifest in public discourse in contemporary society. Here, there is an "expectation that danger and risk are a central feature of the effective environment", and that fear will be experienced in daily life by the common populace (Altheide & Michalowski, 1999, p.476). Thus, fear as a learned and socially shared phenomenon can become part of the defining fabric of a social group and it is in this form that it is most easily manipulated as a tool of governance.

Fear as a tool for governance is rooted in complex manifestations of fear that, typically, do not make overt reference to the death or physical harm of individual subjects. In this case, fear stimuli are complex and are constructed using shared understandings of power, behavioural norms, and consequence. For instance, within established liberal democracies, sovereign power is still exercised through fear of capital punishment (e.g., in certain jurisdictions of the USA), but this direct correlation between submission to state law and avoidance of death or physical detainment is only one relatively small component of maintaining authority by the state. Instead, fear and fear stimuli are manipulated and embedded within the consciousness of subjects through subtle processes of shared experience and learning. Through these processes we learn to fear the authority of the state without necessarily experiencing that authority or coercion directly. The unique human

capacity for complex language facilitates this form of governmental control and in his classical study of the sublime and the terrible, Burke (1757, p.285) observes the significant power of words to affect and invoke our passions. It is our access to language that allows us to associate fear with a range of triggers far removed from the original stimulus (Öhman, 2000, p.113) and through a combination of shared and innate stimuli or triggers, fear becomes an effective and pervasive tool of political governance.

Significantly, not all human beings act to avoid death; some seek to advance death directly or indirectly through their actions and to end their existence through suicide or self-destructive behaviour. Observing fear in its destructive form, Montaigne (1575, trans.1877) wrote, "the many people who, impatient of the perpetual alarms of fear, have hanged or drowned themselves, or dashed themselves to pieces, give us sufficiently to understand that fear is more importunate and insupportable than death itself" (pp.69-70); in doing so, he accounts for those among us who, contra to Hobbes' assertion, seek rather than avoid death. Both Hobbes (1651/1998) and Montaigne (1575, trans.1877) agree that fear is capable of inspiring either destructive or productive behaviour and the self-destruction of Montaigne's studies is an outcome of helplessness and depression in the face of pervasive psychological stress. This stress arises from sustained exposure to a fear stimulus perceived by the subject to be uncontrollable and unavoidable (Öhman, 2000, p.111); as such, it fits with the logic of fear appeals outlined in contemporary psychological literature, which mandates that for fear to be effectively managed as a productive stimulus for behavioural control, it must be manageable by the subject and, crucially, the subject must be able to relieve the experience of fear by employing certain behaviours (see also, Dillard, 1994; Soames Job, 1998).

Self-destructive responses to fear are the very thing that Hobbes (1651/1998) hoped to avoid by the proposed management of fear within the Leviathan and are the reason that he advocates so strongly the implementation of a different, carefully constructed, and well managed form of fear to replace the pervasive and destructive sort that exists in the natural state. The distinction between destructive and

productive fear is central to Hobbes' philosophy on fear as a tool of governance; by purposefully constructing certain types of fear responses within a population, the Leviathan can unite mankind and prevent the chaotic state of competition, mistrust, and fear that makes life "nasty, brutish, and short", in the state of nature (Hobbes, 1651/1998, p.84).

3.3. The Liberal Perspective

When Montaigne (1575, trans.1877) famously lamented that "the thing in the world I am most afraid of is fear, that passion alone, in the trouble of it, exceeding all other accidents" (p.69), he expressed his conviction that it is fear, rather than death, which is the insupportable burden to mankind. Fear of the unknown, and of death and loss, are identified as intrinsic characteristics of human nature by every scholar studied within this chapter; where their views diverge is in how best this fear can be managed and what role it should play in the good governance of society. For Hobbes (1651/1998), the universal and selfish fear of death that leads to chaotic insecurity in the state of nature can be countered by the constructed fear of a Leviathan. By Hobbesian reasoning, fears that relate to the loss of one's 'world' also motivate human beings to cooperate and act in productive ways, allowing the creation of a peaceful and culturally rich society. For Montesquieu, terror was not the product of sovereign institutions of law and education, unlike the Hobbesian logic, but instead was the articulation of despotic desire, an aberration to be resisted and purged from society (Robin, 2004). Despite their diverging views on its origins, both Montesquieu and the counterrevolutionary Hobbes recognised the utility of fear as a tool of social control, and for both it was meant to "serve as the catalyst of political and moral awakening" (Robin, 2004, p.29). It is the obvious and unrivalled power of fear to stimulate emotional responses that accounts for its favoured application throughout history and in contemporary politics which have "internalised the culture of fear" (Furedi, 2005, p.131).

The management and utilisation of fear remains inherent to the construction of social expectations about security and about social order in contemporary society; fear communication is essential to the discourses of policing, control, and risk

prevention that constitute governance in the modern "risk society" (Altheide & Michalowski, 1999, p.476). Because they are suasive messages, the construction of fear appeals demands engagement by the audience and where the proposed threat is presented as being embodied in an enemy identity, there follows a process of 'othering' that enemy from the audience. In the UK, groups on the far right of the political spectrum often engage in an 'othering' of migrants who are presented as a threat to security of native citizens in terms of their cultural values as well as more tacit concerns about job and personal security. In her study of Islamophobia, Fekete (2009) draws parallels between the securitizing discourse of the McCarthy era and contemporary Europe, in which Communist "subversives" have been replaced by "Islamic radicals" (pp.102-106) as the source and rallying point of political fear. During the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003, the people of New York city experienced this 'othering' through the production of risk and discourses of blame, which attributed the disease to the population of Chinatown despite no cases in that area (Eichelberger, 2007). Ingram (2008) has also distinguished the ways in which foreign bodies are constructed in fear appeals as the source of HIV/AIDS infection in the UK, where an analysis of media coverage and migration reveals politicised discourse that attributes blame for infection to immigrants to the country. This is also evidenced in Chapter 7, which reports a similar process of external threat construction that took place in the early Thai response to HIV/AIDS, and in Chapter 8 where the same claims about the 'foreignness' of HIV/AIDS were made in Myanmar. The construction of enemy bodies as a source of microbial infection is a common feature in discourse on infectious disease and is the basis for widespread concern that securitization, which is based on fear appeals, leads to an 'othering' of human bodies and the construction of people rather than viruses as the source of threat (see Elbe, 2006).

The innate human desire for security lends itself to abuse by leaders willing to exploit fear as a means of gaining control. In his critique of contemporary American liberalism, Chris Hedges (2010) writes that fear "permits the government to operate in secret. [It] means we are willing to give up our rights and liberties for promises of security" (p.21). From this liberal perspective, the association between

political fear and repressive governance is well founded in historical precedence. In Asia in the 20th century alone, the experience of Myanmar under the military junta, Cambodia under the Khmer Rouge, or Mao's China, all provide examples of state orchestrated fear manifest in its most socially destructive form. To invoke fear, construct a threat, and to seek or use extraordinary power are key features of the securitization process through which leaders seeks to legitimise an extraordinary level of power or recourse to emergency measures (Buzan et al., 1998). The realm of security is the "agenda of panic politics", and in this realm of heightened priority and urgency, the checks and balances that exist to limit authoritative power are curtailed (Buzan et al., 1998, p.34).

In his sociological study of Thai monarchy and state, Quaritch Wales (1931) recounts the central role of fear in traditional governance that endured from the Ayutthaya Kingdom of the 14th century to the mid-19th century, ending only with the reforms of King Mongkut:

> The absolutism of the monarch was accompanied and indeed maintained by the utmost severity, kings of Aydhya practising cruelties on their subjects for no other purpose than that of imbuing them with humility and meekness. Indeed, more gentle methods would have been looked upon as signs of weakness, since fear was the only attitude towards the throne which was understood, and tyranny the only means by which the government could be maintained. (p.21)

The use of fear as a means of subjugating the population to absolute rule manifested in "the ingrained habit of fear and obedience [that] produced a deep reverence for all forms of authority" (Quaritch Wales, 1931, p.21). The effects of this traditional social organisation remain in force today and are critiqued by Andrew MacGregor Marshall (2011) in his essay *Thai Story*, an academic work that uses leaked American diplomatic cables to assess the political role of the supposedly apolitical modern Thai monarchy. In doing so, MacGregor Marshall (2011) violated Thailand's strict lèse majesté laws "on a massive scale" (p.15). Lèse majesté laws, under which at least two important sources for this research are banned in Thailand (MacGregor Marshall, 2011; Handley, 2006), are employed by some agents in the modern state as a political tool with which to quieten dissent and buttress the authority of traditional elites. The law is "increasingly used to prevent any questioning of

Thailand's established social and political order" and to consolidate their power (MacGregor Marshall, 2011, p.10). Thailand's lèse majesté laws are some of the strictest in the world and the fear they invoke serves to protect the monarchy and its affiliates from critique as well as criticism, to the detriment of furthering accountable governance as well as hindering academic and journalistic integrity in the country.

When done successfully, the construction of a threat is an extremely effective tool of governance because, through its use of fear, it both reinforces and enhances the authority of the constructor (or securitizing actor) and also inhibits its own deconstruction or defeat. Taking as his point of investigation the work of Senator McCarthy in the USA, Robin (2004) assesses the importance of restricting critical engagement with fear based messages if they are to remain effective as means of political control. In this case, Robin (2004) argues that the de-politicisation of fear during the McCarthy era freed intellectuals from their responsibility to question the repressive action of the state, which was engaged in securitization of communist ideology and exercise of extraordinary political power that critics later dubbed a 'witch hunt'. By defining the political fear felt by opponents to these events as being "the issue of an overheated imagination rather than a response to policies and practices" the need to question and oppose these policies was successfully ignored (Robin, 2004, p.15). Furthermore, by failing to acknowledge that our fears are political constructs, we instead conceptualise them as "intractable foes ... [that] can only be killed or contained" (Robin, 2004, p.6).

The mechanisms to limit power consolidation, and the systems that could prevent the abuse of extraordinary powers, are found in institutions that exist beyond the bodies of the state. In those states where the government makes fear a "deadly condition of everyday life", liberals advocate for the power of the terrorising rulers to be checked by various means, including fragmenting the power of government, building a pluralistic society, toleration, and the rule of law (Robin, 2004, p.14). In Shklar's (2004) vision of the *Liberalism of Fear*, it is the power of public organisations, such as corporate businesses, that divides social power and thus limits the "long arm" (p.158) of government. In Hedges' (2010) study of political

society in the USA, it is the ideologically liberal class that has traditionally served as a check to the power of the state. When any of these liberal institutions are weakened, a vital mechanism for opposing the abuse of political fear is lost. This, according to Hedges (2010), is precisely what is occurring in contemporary America where "the timidity of the liberal class leaves [political fear] especially prone to manipulation" (p.16). Hedges (2010) recounts the warning of C. Wright Mills, that "a decayed and frightened liberalism" is vulnerable and open to attack by the "ruthless fury of political gangsters" and he cautions the reader; if political fear is pervasive within the very institutions intended to challenge state power, then "it is much safer to celebrate civil liberties than to defend them, and it is much safer to defend them as a formal right than use them in a politically effective way" (p.9).

Destruction of the liberal state can occur precisely because of the aura of exceptionalism, urgency, and priority that defines the construction of security within the Copenhagen model of securitization. When experiencing fear of existential threat, the maintenance of normal political rule becomes secondary to the necessity of dealing with that threat (Buzan et al., 1998). It was by framing national unity as an existentially threatened referent that the military of Myanmar led a successful coup against the fractious government in 1962, and during recurring political protests in both Thailand and Myanmar, the state has deployed military forces to the streets in order to suppress protesters. The nature of securitization is such that to define something as 'security' tends to imply that its solution can, must, or will, be provided by the securitizing actor, usually the state (Waever, 1995, p.63). Thus the securitizing process serves as a constitutive process in multiple ways; concurrently constructing security and buttressing the authority of the securitizing actor or responder. In application, to invoke fear through securitization serves to mobilize the state to deal with the supposed threat and grants the state extraordinary power, including the right to override civil liberties through the declaration of a 'state of emergency', whilst simultaneously undermining the very institutions that could limit the power of that state and ensure the return of normal (democratic) governance. For this reason, with their normative slant toward liberal

democratic governance, the Copenhagen School advocates that desecuritization is the "ideal" (Buzan et al., 1998, p.29).

3.4. Socially Productive Fear

In its destructive form, fear inhibits the lives of subjects rather than aiding their advancement or peace, and those who suffer perpetual or unproductive fear are already victims in some respects, as Montaigne (1575, trans.1877) explained,

> Such as are in immediate fear of losing their estates, of banishment, or of slavery, live in perpetual anguish, and lose all appetite and repose; whereas such as are actually poor, slaves, or exiles, ofttimes live as merrily as other folk. (p.69)

Montaigne's observation is reiterated four centuries later in Booth's (1991) theory of emancipation in human security, in which freedom from fear is a central tenant of social and individual well-being. Socially productive fear, however, will not blind the sufferer to the nature of the threat, or at least will not create the paradox experienced by Montaigne's subject above. For Benson (1914), morally and socially productive fear "is the beginning of wisdom" (p.70) that can trigger critical engagement with the issue at hand, unlike fear in its disempowering form that is discussed above. Through this critical engagement, a rational and knowledgeable examination of the threat can be made and subjects are able to construct personal opinions and make informed choices as to the appropriate response to the proposed threat (Benson, 1914, p.67). Behavioural change born of such understanding is a more sustainable form of governance than that born of blind terror, because subjects have drawn the conclusions themselves and, as Benson (1914) wrote at the turn of the 19th century, it is socially more desirable because it encourages the "tranquil" "moral courage" (p.67) that is of true value to society.

Fear in its productive form stimulates effective, efficient behaviour that has positive consequences for human society. In *Leviathan*, Hobbes described socially and morally productive fear as that which aids good governance and creates peace not only at the collective level, but also within the autonomous individual (Hobbes, 1651/1998; Robin, 2004). But in order to be manifest in this desirable form, a fear

stimulus must meet two criteria; first, it must not be perceived to be unpredictable. Hobbes placed great emphasis on the need for citizens to understand the laws they are expected to obey, and not to feel that punishment by the state is ever arbitrary or obscure (Robins, 2004). Unjustness is easily recognisable as a component of awful and unaccountable greatness (Benson, 1914, p.49). Secondly, in order to be a sustainable and productive force for governance, aversion from the fear stimulus must be possible and exposure to the threat must be in some way within the control of the subject. Allowing the subject the opportunity to manage their behaviour in order to avoid the fear stimulus (for instance by choosing not to break a law and thus avoid punishment by the state), is crucial to both utilising fear as a method of controlling said behaviour and also to ensuring that fear does not transmute into helplessness, depression, and self-destruction (Öhman, 2000, p.111). Subsequently, this thesis examines productive fear as a motivation for health-related behaviour through the employment of fear appeals.

3.5. Fear Appeals and Public Health

Fear appeals are persuasive messages that invoke threat or arouse fear; their use in public health and consumer marketing has been extensively studied, generating a wealth of literature and empirical studies in the field but without significant analysis of how these appeals relate to securitization (see e.g., Witte & Allen, 2000; Ygram Peters et al., 2012). Fear appeals in psychological literature are almost exclusively concerned with public health issues, such as communications to reduce HIV/AIDS transmission, induce smoking cessation, or to improve dental hygiene (Dillard, 1994, p.302; Witte & Allen, 2000, p.592). For example, the 1987 UK 'tombstone campaign' used a poster that stated: "AIDS. Gay or straight, male or female, anyone can get AIDS from sexual intercourse. So the more partners, the greater the risk. Protect yourself, use a condom" (Appendix C). In her appraisal of the use of fear-appeals in sexual health education, Susan Quilliam (2009) referred to this campaign as typical of a "Fright Night" (p.253) style approach, referencing the iconic 1985 Hollywood comedy horror film of the same name. Utilising the popular iconography of horror, these appeals are designed to provoke fear in its productive

form in order to deliver information and prompt prescribed behaviours, such as risk avoidance or healthy lifestyle practises.

Health orientated fear appeals are used in state sponsored anti-smoking campaigns in the UK, where cigarette packages include the words "Smoking kills" and "Smoking seriously harms you and others around you" (Hammond et al., 2007, p.211). The conventional psychological literature on fear stimuli that is examined in this chapter determines that effective, productive fear is the product of stimulation accompanied by a possible recourse to evasive action (e.g., cessation of smoking). Without this 'way out', fear stimuli are likely to produce debilitating anxiety rather than adoption of positive behaviour. The possibility that fear may not be an effective means of producing risk-adverse health behaviour is of fundamental importance to the normative debate on political fear and public health, but one that suffers from a lack of inter-disciplinary attention between the psychological and political science literature. We must consider then, based on the explanations of fear stimulus and reactions outlined above, what characteristics distinguish a potentially destructive or productive response from the fear stimulus.

Dominant theories in the psychological literature hold that behaviour change is possible only when the audience of that appeal perceives there to be sufficient efficacy; efficacy refers here to the ability to negate harm through the proposed response, and the perceived ability for that response to be enacted (Witte, 1998; Ygram Peters et al., 2012, p.9). Fear appeal theories are based on the original fear-as-drive theory that was developed in the Yale Communication Research program during the last century. According to this paradigm, when fear is incited by a public health message it acts as a drive that the audience will seek to reduce through the adoption of avoidance measures, such as the practice of regular tooth brushing to avoid oral disease (Witte, 1998, p.425). In their seminal 1953 study of fear appeals in dental hygiene education, Janis & Feshbach of Yale University found that although appeals invoking stronger levels of fear were most effective at communicating facts about healthy dental behaviour, those same messages were more likely to affect positive behavioural change when they induced only moderate rather than strong fear about possible ill-consequences (Janis & Feshbach 1953; Hill,

Chapman & Donovan, 1998). Following this study, the professional medical establishment began to temper their use of fear appeals in the delivery of public health education and for decades there followed an institutional guardedness against their use (Sternthal & Craig, 1974; Hill et al., 1998). In addition, concerns about the ethical implications of invoking fear in public health campaigns may have contributed to the reluctance of many professionals to utilise overt or "gory" messages in their educational messages (Hill et al., 1998, p.5). However, as evidenced by the use of fear appeals in HIV/AIDS management that is documented in this thesis, the utilisation of fear appeals in public health continues.

Since achieving prominence in the mid-20th century, fear appeal theory has developed substantially. The influential theoretical frameworks informing fear appeals are outlined by Dillard (1994) as Drive Theory, the Parallel Response Model and the Subjective Expected Utility model, but important additional explanations have been offered, including Witte's Extended Parallel Process Model (Witte, 1998; Witte & Allen, 2000). The earliest to inform the literature of fear appeal study is Drive Theory, which predicts that information contained in a message evokes fear as an emotional reaction that acts as drive; the respondent seeks to alleviate their experience of this drive and that motivates a coping response which could, if steered, be the adoption of a healthy or productive behaviour (Craig & Sternthal, 1974, p.24). Following the initial establishment of Drive Theory, Leventhal's Parallel Process Model (PPM) was developed during the 1960s and 1970s (Witte, 1998, p.426). With PPM came a greater analytical attention to the unproductive outcomes of fear appeals and an attempt to locate the source of the irrational or "highly emotional response [that] may disrupt adaptive behaviour" (Sternthal & Craig, 1974, p.26). The Parallel Process Model assumes that fear appeals invoke two independent processes within the respondent; an attempt to reduce the danger faced and an attempt to reduce the fear they experience. Building on Drive Theory, PPM offers an explanation for the nonmonotonic relationship between fear levels and persuasion that were noted by Janis & Fesbach (1953), whereby initial increases in fear increase persuasion amongst the audience but subsequent increases, from moderate to strong levels, results in decreased persuasion (see also, Sternthal &

Craig, 1974). According to the PPM, the audience engages in both "fear control *and* danger control" as two separate processes, and fear control became "the scapegoat responsible for irrational actions" (Dillard, 1994, pp.298-301). For instance, "refusal to personalise the possibility of acquiring AIDS [sic] as a result of maintaining multiple sexual partners, lessens the fear of the virus, but not the danger" (Freimuth, Edgar & Hammond, 1987, p.39; Dillard, 1994, pp.298-9).

Although drive theory has lost some of its conceptual dominance in the field of clinical psychological studies (Witte & Allen, 2000, p.593), it remains a useful conceptual tool for understanding the utilisation of fear appeals in securitization processes which, unlike the empirical studies that inform the psychological literature, take place at the collective rather than individual level. The similarities are apparent in Dillard's (1994) explanation of drive theory, which mirrors the Copenhagen School's explanation of securitizing speech acts:

> Fear-as-a-drive was aroused by exposure to a message that detailed the gruesome consequences of failure to behave in accordance with the advocacy. Cues were provided in the message as to the 'appropriate response'. In a public health setting, fear appeals range in topic from dental care to sexually transmitted disease, but display a significant uniformity in their suasory message: 'If you value your health, then you should change your behaviour'. (p.302).

Such messages, when funded and delivered by the state (as in the cases studied by Hill et al., 1998; Wakefield, Freeman & Donovan, 2003), are examples of what Foucault dubbed the "era of governmentalisation" in which the welfare of populations is governed through the exercise of sovereign and disciplinary powers, including anti-smoking legislation or the legal requirement to wear seat-belts (Elbe, 2009, p.59). Despite criticism over their ethicality and practicality, fear appeals have remained prevalent in public health and a growing body of empirical research reporting a positive fear-persuasion relationship led to a resurgence in their use toward the end of the 20th century (Sternthal & Craig, 1974; Soames Job, 1988). This is particularly evident in Australia, where public health campaigns to reduce tobacco smoking have been much-studied for their use of fear appeals (e.g., Hill et al., 1998, p.8). However, the use of fear appeals to induce behaviour in the field of public health is a problematic and contested issue; public health researchers and

practitioners continue to contend that fear appeals are liable to backfire without careful management (Witte & Allen, 2000, p.591; Ygram Peters et al., 2012). It is the issue of management that is most salient to this thesis; the research here concludes that in order for securitization of HIV/AIDS to be productive, and to avoid negative impact on HIV management, fear that is invoked through securitization messages must be controlled. In Chapter 6, the securitizing fear appeals employed by the Director of UNAIDS were productive because the audience, UNSC Member states, were able to take action to mitigate their fear of HIV-induced insecurity by instructing Peacekeeper troops to deal with the issue.

3.6. Criteria Determining Fear Appeal Success

Fear appeals have "great potential" for stimulating behavioural change when they are employed correctly (Hill et al., 1998, p.8). Growing research into the mechanisms of successful fear appeals led to increasingly sophisticated models for their application during the late 20th century. This interest was in part due to their applicability to the field of commercial advertising, in which health-orientated fear appeals are still frequently found in the marketing strategies of companies selling pharmaceuticals, cleaning products, and a range of lifestyle-related consumable goods. Without engaging in an extensive review of the scientific literature, which is beyond the scope of this paper, the most commonly agreed variables of the fear appeal are explained below. The most significant conclusion to be drawn from this review is that the success of a fear appeal is determined by three variables: the level of fear invoked; the audience's perceptions of threat severity, which also relates to their own perceived susceptibility; and the perceived efficacy of avoidance responses, which relates to their perceived ability to reduce the threat and mitigate risk (Witte & Allen, 2000, p.591). Intrinsic to this issue of perception is the crucial role of both audience and fear appeal communicator. Drawing from securitization theory, these variables are akin to the facilitating conditions laid out in *Security: a New Framework for Analysis* (Buzan et al., 1998, p.33), where the Copenhagen School identifies the socially granted authority of the securitizing actor as a facilitating condition of successful securitization. In the psychological literature, the credibility

of the fear appeal communicator is also related to the level of persuasion they effect (Sternthal & Craig, 1974). Thus, audience perceptions are an important variable affecting success; the perceived authority of the fear appeal communicator determines the audiences' acceptance of their claims about threat severity, vulnerability, and efficacy of proposed responses.

3.6.1. Correlation between levels of Fear and Persuasion

Meta-analysis of fear appeal studies concludes that there is a positive correlation between increased fear levels and audience persuasion (Sternthal & Craig, 1974; Witte & Allen, 2000; Ygram Peters et al., 2012). Appraisals of fear appeals in the literature reveal that when appeals increase levels of utilised fear from low to moderate, persuasion of the audience also increases (McGuire, 1968; Sternthal & Craig, 1974). However, Drive Theory postulates that after a certain level of fear is reached, further increase in its intensity is likely to decrease the audience's acceptance of the message (McGuire, 1968; Sternthal & Craig, 1974, p.24). Thus the relationship is nonmonotonic; whilst initial increases in fear also increases persuasion amongst the audience, subsequent increases from moderate to strong levels of fear result in decreased levels of persuasion (see McGuire, 1968, p.191; Sternthal & Craig, 1974). In the securitization process, fear appeals are employed in the construction of an existential threat and the success of this process is gauged according to the Copenhagen School not by the behavioural change induced in agents or audience, but by the levels of persuasion amongst that audience (Buzan et al., 1998, p.25). Therefore, securitizing actors seeking to complete a successful securitization and threat construction could be advised on the basis of these meta-analyses to enhance the level of fear utilised in their construction of the existential threat, although they should be wary of invoking too great a fear, lest the audience reject the message (McGuire, 1968; Witte & Allen, 2000, p.593).

3.6.2. Threat Severity

There are two dimensions important to threat perception in this context: the audience's own perceived susceptibility to the threat articulated within the fear appeal and their judgement of the severity of that threat, or the magnitude of harm expected (Witte & Allen, 2000, p.592). In a securitization process, the Copenhagen School demands that the threat must be presented as "existential"; threatening the very survival of the referent object (Buzan et al., 1998, pp.5, 21, 23-27, 33). In this regard, the claimed severity of the threat is assured in the securitization speech act, although the audience's acceptance of that claim is not guaranteed.

3.6.3. Specific Recommendations

Increased fear is linked to an increased persuasion effect from appeals, but the relationship between fear levels and behavioural change is problematic (Sternthal & Craig, 1974; Witte & Allen, 2000). Whilst there is some positive correlation between fear levels and behavioural change induced by fear appeals, this link remains weak (Witte & Allen, 2000, p.602). Behavioural change is indicated by measuring subsequent intention to change by the audience following a fear appeal, or their compliance with the position advocated in the persuasive appeal, such as cessation of smoking or practising 'safe sex'. Significantly, the likelihood of behavioural change can be increased if specific recommendations are included with the suasive fear appeal message, and the audience should perceive these to be both achievable and effective in reducing the physical threat (Sternthal & Craig, 1974; Soames Job, 1988; Witte & Allen, 2000). Perceived efficacies of the behaviours or responses that are advocated in the fear appeal are a significant variable determining the success of that appeal; these perceptions are categorised in two ways: the audience's perception of their own ability to fulfil the actions required, and the perceived efficacy of those actions in averting the threat (Witte & Allen, 2000, p.592).

Whilst this thesis adopts the normative position that it is desirable for HIV/AIDS management to promote effective behavioural change and to mitigate the

risk of infection or transmission among subjects, it should be noted that HIV/AIDS securitization might be conducted by actors seeking to implement measures of control over populations, or that seek to break the bounds of normal political procedure for other reasons. Where the end goal is not to promote subject health, the necessity of invoking sustained and risk averse behaviour among subjects is no longer relevant, as construction of the existential threat should be sufficient to legitimate recourse to an extraordinary response.

3.7. Conclusion

There is significant capacity for mismanaged fear to become unproductive or, as illustrated in Chapter 4, to enhance negative and destructive perceptions of people associated with the proposed threat. This is particularly salient in the case of HIV/AIDS, where unproductive fear leads to stigmatisation of PLWHA and directly undermines efficacious responses to the disease. To avoid unintended and negative consequences, fear appeals should only be used when pilot studies have shown them to successfully deliver high-threat messages and to enhance efficacy (Witte & Allen 2000; Ygram Peters et al., 2012). Dillard (1994, p.297) proposes that the fear appeal should have two components: a part of the message that instils fear and another that assuages it. Without these components and without testing, fear appeals can backfire and invoke in the audience a defensive and counterproductive reaction (Witte & Allen, 2000, p.607).

This chapter has established that in order for fear appeals to be effective in prompting behavioural change or imparting information in a meaningful way, they must be accompanied by a set of actionable measures by which the audience can respond to the threat productively and mitigate the fear invoked. Without inclusion of suggested responses, such as smoking cessation, tooth brushing, or the use of condoms during sexual intercourse, the fear appeal is likely to backfire and provoke only anxiety and fear in its unproductive form. The productive fear appeal and response proposal must also be articulated by an actor with sufficient authority to persuade the audience of the severity of the threat and the efficacy of the proposed response. Chapter 6 explores a successful and productive process of securitization at

the international level, where the securitizing actor, the Executive Director of UNAIDS, possessed sufficient authority to convince his audience at the United Nations Security Council to adopt the extraordinary responses that he proposed. Before moving on to the empirical studies of fear appeals in action, the following chapter outlines the specific ways in which unproductive fear causes harmful responses to HIV/AIDS by exacerbating stigma and creating barriers to effective responses.

Chapter 4. Problematizing the Security-Fear-HIV Link

This chapter outlines the problematic nature of linking HIV/AIDS to security and the negative consequences of using fear appeals in HIV/AIDS related messages. Securitizing HIV/AIDS is problematized here and in the wider literature primarily because it undermines effective and ethical responses to the epidemic (for instance, see Elbe, 2006). HIV/AIDS is best managed through practical responses that are unhindered by stigma, discrimination, or unproductive fear and the most successful responses have been those that promote pragmatic and open discussion of the virus, that empower people living with or affected by it, and that recognise and meet the demand for socially and culturally appropriate interventions (UNAIDS, 2007, 2012a). Each HIV/AIDS epidemic differs depending on its locality and the unique epidemiological and demographic conditions that it assumes (The Lancet, 2004), but all are shaped by the social and cultural factors that determine vulnerability and susceptibility to the virus. These factors include gender inequality, income distribution, legal status, socio-economic status, and education (Whiteside & Sunter, 2000, p.38; Holden, 2003; Davies, 2009, pp.70-75). Perhaps most significantly, all epidemics engender stigma and discrimination that becomes a defining feature of their progression and mitigation. This chapter examines the reasons why it is possible to securitize HIV/AIDS and finds that the fear that is invoked by securitization is also a root cause for the 'exceptional' levels of stigma attached to the disease, which is intrinsically linked to the social aspects of the disease epidemiology (Parker & Aggleton, 2003, p.13). The utilisation of securitization rhetoric and fear appeals serves to enhance the processes of 'othering' that exacerbates stigmatisation and discrimination against PLWHA and it is an ineffective means of communicating educational messages about HIV/AIDS or promoting behavioural change and risk avoidance. After outlining the links between the epidemiology of HIV/AIDS and fear of the virus, the problematic relationship between fear and stigma is examined, emphasising the negative impact of stigma on effective HIV management.

4.1. Facilitating the Securitization of HIV/AIDS

As established in the preceding chapters, securitization consists of the construction of an existential threat through the use of suasive fear appeals and the rhetoric of survival, threat, and defence. As a potential existential threat, HIV/AIDS possesses many qualities that are conducive to its successful securitization; qualities that would be referred to by the Copenhagen School as "facilitating conditions" and that are examined in the previous chapter (Buzan at el., 1998, p.33). The Copenhagen School outlines facilitating conditions that can be separated into two categories; those related to the internal linguistic component of the speech act and those related to the external social conditions (Buzan et al., 1998, pp.32-33). Linguistically, the speech act must employ the grammatical rhetoric of security by proposing an existential threat and invoking the logic of threat-defence and survival (Buzan et al., 1998, p.33). Externally, the social conditions concern the authority of the securitizing actor which is defined by the relationship between speaker and audience and the nature of the proposed threat (Buzan et al., 1998, p.33). An examination of the epidemiology of HIV/AIDS and the most prevalent HIV-security claims reveals that all of these conditions have been met. The grammar of security has been adopted when discussing HIV/AIDS in influential discourse, including meetings of the United Nations Security Council (see Chapter 6), in which the epidemic was framed as a threat to national and international security and was presented in terms of human security as well as more traditional, statist frameworks. These claims have been reiterated and propagated by authoritative actors who are leaders in the global AIDS response and who possess considerable political power, including the World Health Organisation (WHO), various heads of states, and international NGOs and civil society groups. Finally, our perceptions of HIV/AIDS, which is an infectious microbial threat (as discussed in Chapter 3), facilitate its securitization.

In 1992, a report commissioned by the United Nations Global Programme on AIDS (GPA) found that HIV/AIDS is a unique issue that demands a unique globalised response, concluding that, "although other diseases, both past and present, share common features with AIDS, no other disease presents the same

threat to public health and challenge to science" (Knight, 2008, p.19). According to the report, the unique status of HIV/AIDS derives from a number of epidemiological and social factors: first, that "at least 75% of HIV transmission is through sexual intercourse, and that sexual behaviour is difficult to change and even to talk about" meaning that "moral and religious judgements have restricted a range of interventions, from public information and education in schools to condom promotion"; second, that the disease is "invariably fatal"; third, that "that AIDS primarily affects young adults in their reproductive and economically productive years, with serious consequences for families and communities"; and finally, "the fact that, although no country is safe from AIDS, rates of infection are increasing faster in the low-income countries, undermining the developmental and health gains of the past two decades – especially those in child health and life expectancy" (Knight, 2008, p.19). In addition, HIV is a 'slow' disease that typically takes years to manifest symptoms, making the epidemic hard to detect it its early stages. The unique epidemiological qualities of HIV/AIDS, which make it both threatening and difficult to manage, can thus be reduced to two facts: first, that it is spread sexually, and therefore engenders a great deal of stigma, and second that it has a long incubation period in which symptoms do not manifest but the host is contagious.

Epidemiologists refer to HIV epidemics as being 'low level', 'concentrated' or 'generalised', depending on prevalence (the percentage of people living with the virus) within the population. Low level epidemics are those in which HIV is largely confined to key affected populations, which are defined by their engagement in high-risk behaviour. "Very high transmission rates" are found in the following groups: people who inject drugs and who share needles, have anal sex, or have sex with many partners without protection (WHO & UNAIDS, 2011, p.9). Thus, the key affected populations identified by the WHO & UNAIDS (2011, p.9) are sex workers (SWs) and their clients, people who inject drugs (PWID), and men who have sex with men (MSM). Transgender people are also at higher risk of HIV infection within Asia and the Pacific, where new infections are highest among these and other KAP groups (UNAIDS, 2013, p.11); the enhanced vulnerability of these groups stems from both their increased exposure to the virus and from the social and economic

marginalisation and lack of agency that exacerbates risk of infection (Davies, 2009, p.71). At the low level stage of an epidemic, prevalence has not reached significant numbers within these groups. In a concentrated epidemic, HIV has spread rapidly within at least one of these KAPs, fuelled by high-risk behaviour, but is not yet established within the general population (WHO & UNAIDS, 2011, pp.4-5). In a generalised epidemic, transmission of the virus occurs independently of the KAPs but if intervention is practised, it can be expected that prevalence will drop within KAPs before dropping in the general population (WHO & UNAIDS, 2011, p.5).

Increased susceptibility to the virus and subsequent increased surveillance amongst KAPs means that HIV epidemics are often detected first within these populations but this is problematic; since the emergence of the epidemic, the stigma attached to HIV/AIDS has exacerbated existing social stigma and discrimination already directed toward KAPs, whose risky behaviours are often socially taboo and/or illegal. For example, UNAIDS found that Thailand and Myanmar currently legislate in ways that hinder the HIV response; both countries criminalise sex work in private or public (soliciting), maintain compulsory detention centres for PWID, and impose the death penalty for drug-related offences (UNAIDS, 2013, p.27). Myanmar also criminalises same-sex sexual activities between consenting adult males (UNAIDS, 2013, p.27) and possession of needles for drug injection is illegal. Punitive legal environments in both countries have a negative impact on the rights of KAPs and other vulnerable groups, hindering their access to HIV services including harm reduction facilities (UNAIDS, 2013, p.26). Furthermore, people affected by HIV/AIDS often fear that their infection will lead them to be associated with these groups in the eyes of others, discouraging them from accessing support services or disclosing their status, making onward transmission more likely.

The epidemiological characteristics of HIV/AIDS make it a disease that is particularly likely to invoke fear; as a result, it is also suitable for securitization and is likely to invoke stigma and discrimination. In his 1987 address to the UN General Assembly, Jonathan Mann, the founding director of the WHO programme on HIV/AIDS, perfectly outlined the characteristics of epidemic infection that are so problematic: first, the virus enters a community "silently and unnoticed" and

prevalence increases over many years before visible symptoms manifest; the second stage occurs usually after a number of years, when latent HIV infection triggers an epidemic of the visible opportunistic diseases that signify AIDS; the final stage is the political, social, economic and cultural response to the epidemic that is "characterised above all, by exceptionally high levels of stigma, discrimination and, at times, collective denial", and that Mann described as being, "as central to the global AIDS challenge as the disease itself" (Parker & Aggleton, 2003, p.13). This social response has existed since HIV/AIDS was first diagnosed in the 1980s. As a new pathogen, it inspired great fear and dread among the global community for two reasons; first, the virus appeared to be extremely lethal and it attacked and killed patients in an apparently quick, painful, and visible way. Second, the virus was new and very little accurate information about its origin, modes of transmission, or any other epidemiological qualities was available. Compounding these factors, there was no cure, no vaccination, no treatment, and, for almost five years, no accurate or accessible diagnostic test available. HIV/AIDS embodied the innate human fears of contagion, death, and the unknown. As Enemark (2007) suggests, "the health threats most suitable for securitisation are *outbreaks* of infectious diseases – specifically, those that inspire a level of dread disproportionate to their ability to cause illness and death" (p.8). Studying the psychological impact of HIV/AIDS, Philip Strong (1990) found that epidemics of infectious disease are often accompanied by a psychological epidemic of fear and initial reactions are often characterised by "waves of fear, panic, stigma, moralising and calls to action" (p.249). This was true of the early response to HIV/AIDS, and despite the concerted efforts of CSOs and activists, a pervasive and sometimes unproductive fear of the virus remains.

Exacerbating the fear and dread that characterised the early years of the emerging epidemic (see Shilts, 1988; Sontag, 1989; Strong, 1990), in Europe and North America the virus clearly affected members of already marginalised populations at a disproportionate rate, exacerbating stigma that has always been linked to the disease (Knight, 2008, p.8). Knowing now that HIV is transmitted through bodily fluids, and usually during sexual intercourse or via needle stick, it is

understood why people who have more or riskier sex, or who use intravenous injection, are most at risk of infection. Furthermore, the complex socio-political and gender-based vulnerabilities that enhance risk are also now better understood (Holden, 2003; Davies, 2009, p.71). But at the outset of the epidemic, emerging patterns of infection were among poor, racially distinct communities, in gay males, sex workers and their clients, and drug users, and this only served to exacerbate the stigma already attached to the virus. Concerning the origin of HIV, discredited but pervasive theories that the virus was manufactured by Russian or American Cold War scientists, or as part of a neo-colonial attack on Africa, as divine retribution for moral deviation, or that it came from human sexual contact with apes, all illustrate the embedded fear, stigma, and ethno-centric 'othering' that underpins much of our conceptualisation of the epidemic (see, for example, Whiteside & Sunter, 2000, pp.4-5; Knight, 2008, pp.8-9).

An additional epidemiological reason that HIV/AIDS is so likely to engender fear is that it is a "long wave" epidemic (Garrett, 2005). Once it has entered the body, HIV has an incubation period of multiple years, depending on variables that include health of the host and viral strain. In 2000, Whiteside & Sunter (2000, p.9) estimated that the incubation period in Africa was typically between six and eight years. During this time, people remain able to infect others through their bodily fluid and are particularly contagious following their own initial infection, before their body has recognised the invasive pathogen, and when viral load in the body is highest. This period, Pisani (2008, pp.132-133) observed, is likely to be the time in which the carrier is engaged with the high risk behaviours that exposed them to the virus in the first place, such a period of frequent sexual intercourse with varying partners. At the population level, the asymptomatic but highly infectious incubation period of HIV means that the virus spreads silently throughout a community, undetected until many years later when HIV progresses into visibly symptomatic AIDS (Whiteside & Sunter, 2000, p. 27; Parker & Aggleton, 2003, p.13). This makes it especially difficult to detect, to prevent, and to curtail an epidemic of HIV/AIDS.

In addition to the mode of transmission, patterns of infection, and the nature of the epidemic as a long wave event, the symptomatic manifestation of AIDS is also

a significant contributing factor to its stigmatization. Once it enters the human body, the virus attacks and destroys the CD4 cells of the immune system that are normally responsible for destroying invading pathogens. Without functioning CD4 cells, the body is unable to protect itself from microbial threats and the immune system cannot function. If HIV infection is left untreated, the number of CD4 cells in the body will gradually decline, leaving the host increasingly susceptible to disease. Acquired Immune Deficiency Syndrome (AIDS) is diagnosed following either the manifestation of an opportunistic infection or HIV-related cancer, or when the number of CD4 cells in the immune system drops below a certain level. In 2007, the WHO reported the clinical criteria for the diagnosis of advanced HIV (including AIDS) in adults and children over five as a CD4 cell count less than 350 per mm^3 of blood (WHO, 2007, p.9). A normal CD4 count in a healthy individual ranges from 500 to 1500 cells per mm^3 of blood (WHO, 2007, p.14). From 2013, the WHO recommended that antiretroviral treatment should commence before CD4 counts dropped below 500 cells per mm^3 of blood, following new evidence that early treatment is associated with reduction of viral transmission and lower mortality rates among subjects (WHO, 2013, p.92). Treatment using ARVs prevents or slows the destruction of the immune system and will reduce the likelihood of opportunistic infections in the host. Vulnerability to specific infections differs according to different stages of HIV infection, but the most common include bacterial diseases such as tuberculosis (TB) and bacterial pneumonia, fungal diseases such as candidiasis (causing yeast infections including chronic thrush and fungal meningitis), viral diseases such as herpes simplex and herpes zoster virus, and HIV-associated cancer such as Kaposi's sarcoma (Avert, 2013). Before treatment was developed, AIDS patients were visibly identifiable by the "enormous weight-loss" that typified the disease, often a result of "intractable, debilitating, inhuman, and humiliating" diarrhoea (Piot, 2012, pp. 131, 145), as well as the chronic fungal conditions and skin lesions that accompany advanced herpes and progression of Kaposi's sarcoma. The chronic and painful death that followed untreated infection, coupled by the "humiliating" and visible nature of both symptoms and the

perceived "moral transgression" that leads to infection, exacerbates the stigmatization of the virus and the people it affects.

4.2. Framing HIV/AIDS as Security

Curley and Herington (2011, p.143) argue that existing literature on the securitization of infectious diseases places too great an emphasis on the facilitating conditions of the diseases themselves and not enough consideration of the socio-political context in which securitization processes take place. In their study of HIV/AIDS vulnerabilities in post-conflict situations, Seckinelgin, Bigirumwami & Morris (2010) also conclude that meaningful analysis demands a "nuanced and multifaceted understanding of contextual conditions" (p.516). Although Buzan et al., (1998) suggest that both the "social conditions regarding the position of authority for the securitizing actor" and the "features of the alleged threats" (p.33) are facilitating conditions of the suasive speech act, other securitization scholars have criticised the lack of analytical attention awarded to the socio-political conditions that might determine securitization outcomes in practice (McDonald, 2008; Balzacq, 2005). This thesis attempts to provide an examination of the socio-political conditions in Thailand and Myanmar, as well the wider context of international security studies that provide a backdrop for the responses to HIV/AIDS in each case. Since the end of the Cold War, particularly following the development of human security as a label, infectious disease and health have increasingly become a matter of attention for security studies, shifting from the realm of 'low politics' to the agenda of priority and urgency that characterises a securitized issue (see Ingram, 2008; Davies, 2009; Price-Smith, 2009, p.6). Following the seminal UNSC Meeting 4087 on the security implications of HIV/AIDS, the disease specifically has been "widely discussed in terms of national and international security" (Vieira, 2007; McInnes & Rushton, 2010, p.225; Seckinelgin et al., 2010, p.515).

In his address to the United Nations Security Council in January 2000, US Vice President Al Gore framed HIV/AIDS as a threat not only to human security but also, explicitly, to the more traditional referent of the state, telling members that:

> No one can doubt that the havoc wreaked and the toll exacted by HIV/AIDS do threaten our security. The heart of the security agenda is protecting lives, and we now know that the number of people who will die of AIDS in the first decade of the twenty-first century will rival the number that dies in all of the wars in all of the decades of the twentieth century. When 10 people in sub-Saharan Africa are infected every minute; when 11 million children have already become AIDS orphans; when a single disease threatens everything from economic strength to peacekeeping, we clearly face a security threat of the greatest magnitude. (UNSC, 2000, p.2)

Although Gore went on to emphasise the "larger significance" of the meeting regarding its capacity to set "precedent for Security Council concern and action on a broader security agenda", in actuality the securitizing claims presented that day focused on the risk that HIV/AIDS posed in terms of statist, traditional frameworks of security (UNSC, 2000, p.2). This is a strategically sound approach for an actor attempting to securitize a non-traditional issue; Peterson (2002) found that when scholars articulate the link between disease and security from the human security perspective "their arguments remain at the margins of the security literature ... because their appeal to human security does not resonate with more traditional approaches to national and international security, which focus on physical threats to the state" (p.44). This traditionalist approach has been adopted by leading authoritative, norm-defining agencies like the UN and WHO, which frame HIV/AIDS as a threat to statist concepts of security using claims that have endured in the academic literature and that are outlined here; the first is that of HIV/AIDS as a threat to state stability.

Claims that HIV/AIDS poses a threat to state security are pervasive in the academic and policy literature on the disease (Price-Smith, 2002; Garrett, 2005; Enemark, 2007). The logic of these claims usually takes one of two forms: that high HIV/AIDS prevalence results in the "long-term depletion of human capital [that] will undermine national prosperity and effective governance, thereby diminishing the range of policy options available to the state" (Price-Smith, 2002, p.119); or that it will act as a stressor that exacerbates civil unrest, for instance as the population blames a failing political elite for inadequate management of the disease, or as infection in the labour force will cause economic decline (Price-Smith, 2002, p.120; Garrett, 2005). Observation of the progression of the epidemic since the 1980s,

including in the severely affected states of sub-Saharan Africa, offers no evidence of a direct link between HIV and civil unrest (Garrett, 2005, p.11). However, Garrett (2005, p.10) finds evidence that HIV is claiming the lives of parliamentarians and political leaders in countries that already experienced acute shortages of highly skilled personnel, such as lawyers, doctors, nurses, teachers, financial planners, managers, engineers, and technicians. Price-Smith (2009) also outlines empirical evidence in support of these claims, finding that the epidemic has the potential to "compromise prosperity, political stability and national security in seriously affected regions over the longer term" (p.93), especially in the context of poor governance. However, in their study of HIV in Africa, Whiteside, De Waal & Gebre-Tensae (2006, p.215) found that claims in which HIV/AIDS prevalence was linked to state insecurity were often based on the assumption that high prevalence reduced economic stability and that these assumptions were themselves based on economic models no longer suited to the contemporary context of many African states. Furthermore, in a review of the empirical evidence available, Barnett & Dutta (2007, p.217) found no conclusive evidence of a direct link between HIV and the fragility or economic vulnerability of states.

The second framing of HIV/AIDS as threat to statist security focuses on this purported link between infection rates and economic instability, which has been linked to wider insecurity both at the national and international level. HIV/AIDS disproportionately affects people in the professional classes and of a sexually active age, meaning that when prevalence exists in the general population it is usually highest within the most economically active sectors of society, creating a "youth-bulge" demographic through an accelerated death rate in adult populations (Garrett, 2005, p.11). This has led analysts to predict an adverse economic impact in countries with high prevalence, resulting from both depletion of productive labour forces and from a diversion of personal economic resources away from savings and into care provision (Whiteside & Sunter, 2000, p.85). Garrett (2005, p.11) also reasoned that the rising labour costs in the export industries of affected developing countries, such as mining in Russia and African states, will have detrimental impact for (rich country) foreign trading partners.

Another way in which fear of HIV/AIDS taps into prevailing anxieties about global threats is the proposed link between terrorism and epidemic disease in the developing world. Since 9/11, the USA has shown renewed interest in infectious diseases as a possible source of insecurity for the state, first in diseases in weaponised forms, and second in the potential for severely disease-affected (poor) communities to become 'breeding grounds' for terrorist recruitment. As Garrett (2005) points out, "since 9/11, many political analysts have asserted that the projected 42 million children, cumulatively, who will have been orphaned by HIV by 2010, constitute a fertile ground for terrorist recruitment" (p.23) and these linkages have been reiterated by others (Peterson, 2002, p.46). Whiteside, et al., (2006) found "no empirical evidence" (p.215) for the postulated links between increased HIV prevalence and increased crime rates in a society. Furthermore, they found that "there do not appear to be any empirical links between AIDS and terrorism whatsoever — the idea of people living with AIDS flocking to volunteer as suicide bombers collapses at the first scrutiny" (Whiteside et al., 2006, p.216). However, this hypothesis has existed since the first recognition of HIV/AIDS by developed, rich nations. A recently declassified report reveals that in 1987, the CIA were investigating potential links between HIV/AIDS in sub-Saharan Africa and the national security concerns of the USA, finding that the epidemic could lead to "anti-western" sentiment and increase susceptibility of affected communities to Soviet propaganda, leading them to "lash out at the West for what they view as inadequate assistance" (CIA, 1987). This logic endures; writing for the US Council on Foreign Relations, Garrett (2005) reiterated these concerns, finding that:

> There is increasing concern that the nexus of poverty, HIV/AIDS, and alienation from the West could provide fertile ground for anti-Western violence, possibly terrorism. There is no support to date for assertions that people infected with HIV, or the families and orphans of those who succumbed to AIDS, are likely to be engaged in acts of terrorism. Nor is there any but abstract support for potential links between anti-Western terrorism and the HIV/AIDS pandemic. As for the future, however, it is not inconceivable that AIDS-ravaged societies might spawn movements of strong anti-Western discontent, possibly leading to acts of violence. This would particularly be the case if the wealthy nations are perceived to have abandoned poor, HIV-afflicted states. (p.12)

It is noteworthy that the epidemic infectious disease burden falls heaviest in the developing world and in populations affected by poverty. The disease-terrorism link fits with the belief that underdevelopment creates 'breeding grounds' for terrorism, a logic that informs American foreign policy, development aid, and possibly the substantial investment in global HIV/AIDS responses by the US President's Emergency Plan for AIDS Relief (PEPFAR).

More prevalent than this proposed link between terrorism and HIV/AIDS is the claim that HIV/AIDS presents a specific threat to military, police, and security forces of affected states. Whiteside et al., (2006) outline the four forms in which this assumption typically appears: first is that military populations are assumed to have a higher prevalence of HIV than civilian populations, due to the culture and sexual behaviour of soldiers; second is that the epidemic is endangering the functioning of national military forces; third is that war and conflict contribute to the spread of the virus, particularly because of sexual violence during war; and fourth is that "AIDS has the potential to disrupt national, regional and international security" (p.201). In 2005, Garrett (2005) found "little evidence" (p.9) that HIV prevalence was higher in military rather than general populations, except where personnel were deployed away from their families for extended periods of time, and little evidence that HIV transmission increased during conflict except where rape was used as a weapon of war. In their "sober appraisal" (p.201) of the evidence, Whiteside et al., (2006) also concluded that a substantial revision of the military-HIV vulnerability claims is necessary. However, when HIV/AIDS was discussed by the UN Security Council in 2000, it was partly because the Council were persuaded that its Peacekeeper forces were at high risk of contracting and spreading HIV when deployed on missions (see Chapter 6 for more detail). When links are made between military forces and infectious disease, such as the attribution of STI and HIV infection to Indonesian Peacekeepers in Cambodia in 1993, or the 2010 Haitian cholera outbreak that followed Peacekeeper deployment, the high profile nature of the actors and the innate fear of the external invasion that they inspire add traction to the military-disease threat claim.

Despite their popularity, the HIV-security claims have not been uncontested. Critiques of the HIV-security linkage take two forms: those disputing the validity of empirical data or models on which these claims are based (e.g., Prins, 2004; Barnett & Prins, 2006) and those that concern the potentially negative outcome of HIV/AIDS securitization in practice (e.g., Elbe, 2006). Addressing the first of these critiques, it is important to note that despite a "paucity of strong field-work studies" and a lack of empirical evidence (Prins, 2004, p.932), there has been considerable financial investment in global HIV/AIDS responses that are based on the potential links between international security and the epidemic. During the course of this research, the author was told by one high-profile scholar who asked to remain anonymous that an academic paper submitted to UNAIDS was explicitly rejected because it undermined the entrenched HIV-security links on which UNAIDS policy was based. Furthermore, that author was also told by a member of the CIA that challenging the HIV-security link risked undermining the continued US government support of PEPFAR, which was funded to address the supposed links between international security and the epidemic. Such experiences might lead scholars to question the ethical implications of challenging the purported links between HIV and traditional security, given the massive levels of financial investment that could be dependent upon them.

The potential benefits of securitizing HIV/AIDS are huge. Because securitization entails the prioritisation of a proposed threat above all others, it is an extremely effective way of mobilising resources with which to deal with an issue. As will be discussed in Chapter 6, securitization of HIV/AIDS has been employed by leading international organisation UNAIDS in order to mobilise a global response. The strategic inclusion of HIV/AIDS on the agenda of the United Nations Security Council served two practical purposes; first, it mobilised political support and attention, forcing states and political leaders to confront what might otherwise be regarded as a politically unsavoury health issue, or a topic of relevance only to "deviant" and marginalised groups (Holden, 2003, p.17). Second, securitization of HIV/AIDS has mobilised more tangible, financial resources from the global community, originating from both private and government sectors. In 2013, the US

PEPFAR fund alone contributed 6.5 billion USD to the global HIV/AIDS response (Kaiser Family Foundation, 2014). The Global Fund, which has invested over 17 billion USD in the worldwide HIV/AIDS response (Kaiser Family Foundation, 2014), was established following Kofi Annan's call for a 7 to 10 billion dollar "war chest" to tackle HIV/AIDS (Ferriman, 2001, p.1082). Annan made this statement at the a 2001 special summit on AIDS that was convened following the seminal Security Council meeting in 2000 and it related explicitly to the securitization and the lobbying of UNAIDS and the UNSC (Piot, 2012, pp.289-290).

The unrivalled capacity for security issues to attract resources has been noted by hopeful securitizing actors and academics alike; Curley & Herington (2011) found that securitization of infectious disease "promises ... considerable resources for the defence of people's well-being; regardless of a state's attitude to public security" (p.142). Peterson (2002) outlines the prevailing logic that motivates many securitizing claims: "unless a link is drawn between epidemic disease and national security, not human security, security elites will pay little attention" (p.51). Garrett (2005) and Piot (2000) both concluded that securitization is the most effective way to gain attention and financial resources for disease control; indeed, Piot's (2012) strategic employment of securitization rhetoric from his position as Director of UNAIDS was conducted on this premise, based on his assertion that "in international politics there are only two things that count: the economy and security. As they say in France, the rest is just literature" (p.248).

4.3. The Negative Effects of Securitizing HIV/AIDS

In addition to its benefits, there are also myriad dangers inherent to the securitization process. "Linking disease and security is a means of highlighting a dire problem, capturing scarce resources, and accelerating national, international, and transnational responses" (Peterson, 2002, p.50), but the influx of financial resources has been proposed as a source of poor management and other negative impacts. Pisani (2008) argues that "the sheer volume of money now available washes away the need to use what we have well" (p.269) and it has been noted that the exceptional response to HIV/AIDS might have served to "syphon off resources"

from other important health and aid programs (England, 2007; Piot, 2012, p.263). As discussed above, securitization consists of prioritization and thus competition between issues, demanding that those which are most persuasively articulated as security threats are awarded the greatest allocation of resources in response.

Elbe (2006) outlined five "ethical dangers" (p.132) of securitizing HIV/AIDS that, during fieldwork, emerged as useful indicators of securitization in practice. These 'dangers' stem from the realist understanding of security that is at the heart of securitization theory, by which survival and exceptionality are at the heart of the otherwise 'radical' framework (see Chapter 2). Stritzel (2007, p.367) also pointed out that the centrality of exceptionality and the logic of threat and defence may be ethically problematic. The dangers that Elbe (2006) identified, although largely theoretical rather than based on empirical study, also resonated closely with the fears and concerns raised by CSO and NGO leaders interviewed for this research in Thailand and Myanmar (see Chapter 7 and 8).

The first is the danger that framing HIV as a matter of state security risks pushing responses away from civil society and toward military and intelligence organisations that are not well suited to dealing with a health issue (Elbe, 2006). In empirical Chapters 7 and 8, these concerns are outlined as primary determinants that shaped the nature of the civil society-led response to HIV/AIDS in Thailand and Myanmar. In Myanmar, the distinction between state and security apparatus was largely immaterial for most of the late 20th century when HIV/AIDS appeared. The authoritarian military junta was entirely unsuited to deal with the sensitive and complex issues surrounding HIV/AIDS, particularly according to the prevailing knowledge norms, which hold that effective HIV/AIDS responses accompany progression in human development and human rights (UNAIDS, 2012a, pp.5-6). Whilst an authoritarian state may in theory be better suited than its liberal counterparts to implementing the emergency measures of a security-based response (Porapakkham, Pramarnpol & Athibhoddhi, 1995, p.3; Pisani, 2008, p.261; Tenni, 2012), fieldwork in Myanmar revealed that the national response to HIV/AIDS had been led by CSOs (both domestic and international) precisely because they had rejected security-HIV links and downplayed securitizing rhetoric in order to

maintain control over orchestrating the response (Chapter 8). This was done because, as Elbe (2006) hypothesised, CSO leaders and AIDS activists feared that the state would be unsuitable for coordinating a response and that massive violations of human rights would occur if they were to do so.

Related to this is the danger that securitization could make international responses to HIV/AIDS the "function of narrow national interest rather than of altruism" and could allow states to "prioritize AIDS funding for their elites and armed forces who play a crucial role in maintaining security" (Elbe, 2006, p. 119). In their study of Avian flu securitization in Southeast Asia, Curley & Herington (2011) note that, "instead of promoting the global public health agenda of the WHO, the securitization of H5N1 has actually promoted states to securitize in self-interested ways, prioritising domestic rather than transnational (referent object) concerns" (p.165). A response based on the threat-defence logic of securitization, which favours the restrictive and narrow interests of the state, is not preferential to an altruistic response for two reasons; first, the threat-defence logic inspired by traditional conceptions of security hinders the potential for cooperation that is essential to dealing with infectious diseases, which are fundamentally transnational threats (Caballero-Anthony, 2008). Second, such a response undermines the ethical and humanitarian responsibility of rich states to deal with health issues that affect only their poorer counterparts. Securitization of infectious disease, Peterson (2002, p.46) argues, allows a state to ignore diseases unless or until they present an immediate risk to security or other national interests. There is a danger that health and infectious disease, like other "global threats" past and present, will simply become another form through which rich and developed countries can manifest their fear of the poor, 'other' that is a source of physical and moral contagion (Ingram, 2008a, pp.75, 78). To mitigate such risks, Davies (2009) advocates a globalist rather than statist perspective on global health, arguing that the former "tends to acknowledge a broader variety of health concerns because it is primarily interested in the issues that affect most people rather than the health issues that could affect the security of the state apparatus" (p.29). However, like Peterson (2002), Davies (2009) notes that "in practice, little progress has been made without

calling on traditional statist concerns and without representing health problems as potential threats to security and stability" (p.29). Despite the utility of securitization rhetoric in invoking a global response, Peterson (2002) also points out that students of global health should look to the case of environmental security to illustrate the potential negative consequences of securitizing non-traditional issues that transcend the usual geo-political boundaries of sovereign states, explaining that, "linking an urgent issue to security may raise awareness, but it likely also will hinder much of the cooperation that human security and public health advocates seek" (p.46).

A third potential danger of securitizing HIV/AIDS is that the invocation of exceptionality and emergency measures could lead to violation of the civil liberties of PLWHA (Elbe, 2006). As Davies (2009) explains, "there is an underlying tension in ensuring that health issues receive the attention of those engaged in 'high politics' without compromising the needs and rights of individuals" (p.29). Chapter 7 and Chapter 8, which detail the HIV/AIDS responses enacted in Thailand and Myanmar, reveal that this danger was a primary motivation for the mobilisation of civil society groups that have defined the national responses of both countries. Originally formed as self-help services made up of PLWHA (Tenni, 2012; Swift, 2013), these CSOs assumed a vital role in providing information and support to people affected by HIV/AIDS, before their work progressed into rights-based activism. While the operational environment for CSOs and NGOs is markedly different in Thailand and Myanmar, both countries have benefitted from the work of dedicated rights-based organisations. These groups have mobilised to provide support and protection of civil liberties that would otherwise be threatened or neglected by the state.

Finally, Elbe (2006) concludes that the threat defence logic at the core of securitization relies on the portrayal of the virus as an "overwhelming threat" and in doing so, "works against ongoing efforts to normalize social perceptions regarding HIV/AIDS" (p.120). A distinct feature of HIV/AIDS related CSOs is that often they are founded or staffed by PLWHA, in part because many groups were formed as support groups for PLWHA and later mobilised to undertake a wider remit of rights-based activism. Reflecting the centrality of their role, the Greater Inclusion of People with HIV/AIDS (GIPA) has been codified as principle or norm in

the international response (UNAIDS, 2007a). As a result, civil society and activist groups are overwhelmingly orientated toward protecting or advancing the human rights of people with or affected by HIV/AIDS and the "goal of many of these groups has been to move away from the perception that people living with HIV/AIDS are dangerous 'outsiders' and a threat to society" (Elbe, 2006, p.130). Elbe (2006) outlines the potentially detrimental effect that the HIV-security logic can have on these ambitions but, developing this concern, this thesis examines how framing HIV/AIDS as a security threat also amounts to a process of 'othering', whereby people with or affected by HIV are seen as abnormal and are stigmatized. The 'othering' process undermines the effectiveness and ethicality of securitization based HIV responses; it is likely to amount to an ineffective method by which to communicate messages about HIV/AIDS and it can lead to the stigmatisation of PLWHA, causing discrimination against them and violation of their human rights.

4.4. Problematizing Fear Appeals in Public Health

Concerning the first of these issues, Slavin, Batrouney & Murphey (2007, p.136) demonstrated that fear appeals used in HIV prevention messages can lead to 'othering' which is shaming and judgemental and this acts as a mechanism by which fear messages are discounted by the audience, regardless of their actual risk. In this context, 'othering' is closely linked to shame about sexuality and HIV (Slavin et al., 2007, p.136). Essentially, fear appeals that link HIV/AIDS and security can lead to a denial of personal risk and aversion to HIV prevention measures. The use of fear appeals in public health is ethically fraught and practically complex. However, as outlined above, the suasive fear appeal is often utilised in public health messages in which abstinence from 'risky' behaviour is the intended goal. Early government responses to HIV/AIDS in the UK included a national campaign of fear appeal-based public health messages launched in 1987, which featured a tombstone and the slogan: "AIDS. Don't die of ignorance" (Appendix C). Television adverts were aired in which spectral music and gothic images were overlaid by a man's voice intoning:

> There is now a danger that has become a threat to us all. It is a deadly disease and there is no known cure. The virus can be passed during sexual

> intercourse with an infected person; anyone can get it, man or woman. So far it has been confined to small groups but it's spreading. So protect yourself, and read this leaflet when it arrives. If you ignore AIDS it could be the death of you. So don't die of ignorance. (UK Government Central Office of Information, 1987)

The advert refers to an accompanying leaflet sent by mail to every household in the UK, providing information about transmission of the virus. It is included in Appendix C. The rationale of these tactics is that such messages inspire fear in its productive form, motivating the subject to desist in harmful behaviour. But, as discussed above, fear is not always manifest in productive behaviour and can result instead in aversion and irrational, unproductive, or even actively destructive action. The subject blinded by terror cannot think in causal or linear terms about the eventual consequences of her actions; this is of use to Montesquieu's awful despot who fears intellectual challenges that could undermine the status quo (Robin, 2004, p.62), but it is not productive when the intention is to inspire careful consideration of long-term health risks associated with certain behaviours, such as smoking or drug use.

Fear related to public health issues is problematic for three broad reasons; first are normative concerns that a population existing in a state of pervasive anxiety and dread is not, in fact, secure. This follows from the broad concept of security as freedom from fear which features in the logics of human security, but is also closely related to the second problem, that pervasive anxiety is not conducive to productive health behaviours, particularly in managing health issues with complex social dimensions such as HIV/AIDS. Finally, using fear in public health messages and governance is likely to result in stigmatisation of people affected by the disease. This logic informs the position adopted by the United Nations and is found in established knowledge norms in the field of HIV/AIDS management: that stigmatization and discrimination related to HIV is identified as a barrier to effective management of the disease (UNAIDS, 2009a; UNAIDS, 2012a).

Assessing the practical outcomes of the fear-appeal approach, Batrouney (2004) conducted an investigation into the lasting effect of fear appeals used by the Australian state in their early state response to HIV/AIDS. In an attempt to educate

the public, the Australian government funded a series of television adverts that featured a solemn 'grim reaper' figure representing death, not dissimilar to the strategy used in the 1987 British campaign. In the study, Batrouney (2004) concluded that,

> Quite apart from the potential for a campaign like this to have devastating effects on the health and quality-of-life outcomes for people living with HIV, there is considerable empirical evidence to demonstrate that fear appeals in health promotion would not work, given the circumstances of the current epidemic. (p.1)

According to Slavin et al., (2007, p.136) fear appeals used for general HIV education may lead to scepticism about the safety, effectiveness, and tolerability of ARVs, possibly discouraging adherence to treatment regimens. In another study of fear appeals in HIV education, Blumberg (2000) finds that at the level of the individual, these appeals are capable of promoting subject disengagement and aversion rather than positive action and, more worryingly, can trigger the rejection of the message through "counter-argumentation" and "attention avoidance" (pp.787-789) responses. Empirical studies conducted by Witte & Green (2006), Terblanche-Smit & Terblanche (2010), Bastien (2011), and Soscia (2012) indicate a positive relationship between fear appeals and information delivery and behavioural change related to HIV prevention. However, high levels of fear related to HIV do not necessarily equate to safer sexual behaviour (Bell, Molitor & Neil, 1999), and Sherr (1990) found that using fear in HIV prevention increases anxiety among low risk groups, in this case HIV-positive men, but has little impact on (potentially) higher risk groups, in this case HIV-negative men.

The effectiveness and ethicality of using fear appeals in HIV prevention messages remains a contested issue, but when they are used fear appeals must be carefully designed and balanced in order to illicit a response that is productive for the objective of the campaign. Failure to achieve this balance can result in heightened levels of unproductive fear and has been linked to increases in risky behaviour among audiences (Batrouney, 2004). To be productive, fear appeals must be delivered by an authoritative, credible agent to an audience that feels susceptible to the proposed threat. The appeal should be accompanied by suggested responses

which the audience believes will mitigate the fear they experience. When accompanied by high efficacy messages and a perception of susceptibility within the audience, there is empirical evidence to suggest that fear appeals can be effective in attitudinal change and information delivery in HIV prevention (Green & Witte, 2006; Terblanche-Smit & Terblanche, 2010; Soscia, 2012). In their appraisal of fear appeals for HIV prevention in South Africa, where the epidemic remains a serious problem, Terblanche-Smit & Terblanche (2010) found that fear appeals were more effective than the prevailing informational appeals that sought to educate but not to induce fear among the audience. Their study concluded that when accompanied by high efficacy messages and high susceptibility of the audience, fear appeals could perform as a strong motivator, could influence attitudes about HIV/AIDS, and could improve knowledge about HIV (Terblanche-Smit & Terblanche, 2010).

Despite their potential benefits, fear appeals remain problematic for pragmatic and ethical reasons. The issue of audience susceptibility is particularly difficult; susceptibility of the audience is recognised as a significant variable in the success of fear appeals according to the dominant literature, but there is also evidence to suggest that employment of fear appeals in HIV messages can contribute to a process of 'othering', whereby the audience seeks to deflect the message away from themselves by denying their susceptibility or the severity of the threat. This 'othering' response has been recorded in the use of fear appeals for HIV prevention by Slavin et al., (2007) as a way in which audiences reject fear appeals through a process of "motivated reasoning" (p.131) in which they distance themselves from the distressing narrative of the fear appeal. This can occur in one of three ways, each correlating to the fear appeal impact variables identified above: in the first, audiences undermine communicator credibility or the authority of the enunciator; in the second, the information contained in that message is discredited; in the third, the audience discounts their own role through 'othering', positioning themselves as being 'not the intended' recipient of the fear appeal (Slavin et al., 2007, p.131). In their study, Slavin et al., (2007) found that unproductive consequences arise from fear appeals featuring treatment side effects from ART medication; a process of audience 'othering' took place in which respondents

declared that they were not the audience of the fear appeals but that some 'other' audience was. This process of 'othering' took place along a sero-divide between HIV+ and HIV- respondents, and the imagined, sero-positive 'other audience' was disparaged and envisioned as being irresponsible and threatening (Slavin et al., 2007, p.135). One respondent refers to the imagined intended audience:

> Yeah, but they're out there, there's quite a few actually. And, being able to look at this will make them think about what they're doing, if they're out there having unsafe sex, 'cause there are guys out there who are positive and who still don't care. (Slavin et al., 2007, p.135)

In this example, the 'other' is constructed not only as the intended audience of the fear appeal, distancing the actual respondent from the informational message delivered, but also as an embodiment of the threat. A similarly unproductive outcome was recorded among HIV+ respondents; those who identified themselves as the intended audience of the message also "saw themselves being used as the message" and experienced a sense of disempowerment and loss of agency that resulted in their disengagement with the message; one respondent told Slavin et al., (2007) "I always feel very attacked by them, so I never pay any notice 'cause they piss me off having those three letters in front of you all the time, it's like 'yep, thanks for reminding me'" (p.135).

The 'othering' and aversion recorded by Slavin et al., (2007) lessens perceptions of susceptibility and efficacy, reducing effectiveness of the message and potentially exacerbating stigmatisation, shame, and self-stigmatisation of HIV+ people. Furthermore, the process of 'othering' undermines the goals of many CSOs and AIDS activists who are working to normalise perceptions of PLWHA (as noted by Elbe, 2006), reinforcing widespread perceptions that HIV is something that happens to 'them' and not 'us'. This logic exists also at the international level, where it can be found in a critical deconstruction of foreign policy, donor aid, and migration law concerning HIV/AIDS in the global arena (Ingram, 2008a, pp.76-77).

In addition to being potentially destructive, the use of fear appeals for HIV education may not be sustainable. Advancement in treatment and the advent of affordable, effective anti-retroviral medication has added a problematic dimension to this relationship between fear and HIV/AIDS; a growing complacency amongst

people with, or at risk from, HIV has been observed and attributed to the availability of treatment (Slavin et al., 2007; Pisani, 2008, p.165). In San Francisco, a city that launched the safe-sex for gay men campaigns that came to define AIDS activism, condom use has fallen dramatically in recent years and Pisani (2008, pp.164-165) argues that this is because people are no longer scared of AIDS. HIV/AIDS is no longer a new threat and the lack of medical insight, testing or treatment that accompanied the first years (from its clinical discovery in 1981 until the mid-1990s when ART was developed) has been replaced by widespread availability of effective medication. Pisani (2008, p.165) reports a study in 2001 in which half of the men surveyed in San Francisco reported not using condoms despite being HIV positive, and a third said they didn't practice safe sex with a partner whose status they did not know; these figures have increased 20% since 1998.

In Thailand, complacency toward risk of HIV infection emerged as a central theme of the data collected during fieldwork. Professor Praphan Phanuphak, the virologist who diagnosed Thailand's first cases of AIDS in 1985, is director of the Thai Red Cross AIDS Research Centre at Chulalongkorn University. In interview, Dr Phanuphak (2013) stated that the availability of anti-retroviral treatment in Thailand was linked to complacency among the population, explaining that in 2004, the government announced that it would introduce universal access to treatment and this created complacency among Thais, "which is also bad because everyone feels relief and most people have complacency nowadays ... that complacency is linked to the ability to take ARVs". Professor Maneerat Rattanamha (2013), of Kohn Kaen University, contributed to an evaluation of national AIDS policy in 2011 and reported that as visible symptoms reduce and treatment is more widely available, fear has reduced and complacency amongst the population has increased. UNAIDS Country Coordinator Michael Hahn (2013) rejected the link between increased complacency and the availability of treatment but accepts that complacency exists, arguing that it is linked to the duration of the threat and the initial employment of fear appeals in the early years of the epidemic; he explained that it was not

sustainable to invoke fear and expect audiences to remain "on blood pressure 300" a decade later (Hahn, 2013).

Further to being an inefficient means by which to communicate educational messages about HIV/AIDS, or by which to reduce high risk behaviour, fear appeals in HIV discourse may also potentially fuel the stigma and discrimination attached to the epidemic and PLWHA. Stigma has been recognised by leading international agencies as one of the primary challenges in dealing with HIV/AIDS (UNAIDS, 2012a). It negatively impacts on response efficacy by undermining the ability of individuals to access services, causing governments to delay implementing or funding those services, and leading populations to tolerate this inaction (Peterson, 2002, p.63). In 2011, UNAIDS Executive Director Michel Sidibe said that discrimination and stigma related to HIV/AIDS "are undermining HIV responses across the world", amounting to a major barrier to effective national responses (UNAIDS, 2012a, pp.2-5). Former UNAIDS Director, Jonathan Mann, described HIV epidemics as "characterised by exceptionally high levels of stigma" that accompany political, cultural and economic responses to the disease; he told the Assembly that this stigma and the accompanying discrimination was "as central to the global AIDS challenge as the disease itself" (Parker & Aggleton, 2003, p.13). Peter Piot, founding Director of UNAIDS, has used the UN agency as a platform to reiterate claims that stigma is a primary and "continuing challenge" to effective epidemic responses (Piot, 2000). From the emergence of the epidemic in the 1980s, Piot (2012) had recognised the stigma attached to HIV/AIDS; in 2000, he told the United Nations that stigma remained top of the list of "the five most pressing items on this agenda for the world community" (p.145) in dealing with the epidemic and UNAIDS has continued to emphasise the important role of stigma in exacerbating the epidemic (Piot, 2000). In 2002 and 2003, HIV related stigma and discrimination was the focus of the World AIDS Campaign, which was then led by UNAIDS. The most recent strategic plan of UNAIDS, adopted in 2010, is the "Getting to Zero Campaign" which comprises three core goals: "Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths" (UNAIDS, 2010a).

This attention is warranted. As a result of its specific social dimensions, stigma is both intrinsic to HIV/AIDS epidemics and a uniquely destructive force in its management. At the core of effective HIV management are health care services that provide diagnostic services that precede treatment, with access to ARV medication that controls the virus and lowers rates of transmission, and with access to information, counselling and support that PLWHA to understand and effectively manage their condition. Crucially, these services and clinics also act as surveillance sites, reporting essential data on the epidemic to the state and to international agencies like WHO and UNAIDS. If these health care services do not exist, or are not used by the affected population (as in Myanmar, see Chapter 8), then effective HIV management is impossible.

Stigmatisation of HIV/AIDS and the key affected populations can reduce funding to these services and create a legal or social environment that hinders patient access. This is most explicit where harm reduction practises are linked to criminality; one barrier to effective HIV prevention that has been reported in both Thailand and Myanmar is the police practice of citing possession of condoms as evidence of employment in commercial sex work, or possession of needles as evidence of drug use (Tenni, 2012; Aung, 2012). In Thailand, needle exchange clinics that provide harm reduction services (including HIV prevention and treatment services) to PWID became the target of police looking to arrest drug users (IRIN, 2012). During the government's "war on drugs" in 2003, state security forces routinely violated the human rights of drug users and suspected drug users, who were subject to detention and violence; following the "crackdown", the government reported that 2,245 suspects had been killed (Amnesty International, 2003, p.6). Fear resulting from this campaign is likely to have increased high risk behaviour in the form of needle sharing, as PWID are discouraged from seeking clean needles, harm reduction, or health services (Vongchak et al., 2005; Tenni, 2012). The UNAIDS (2012a) report on policy and stigma states:

> Criminalization of people who are at high risk of infection, such as men who have sex with men, sex workers, transgender people and people who use drugs, drives them underground and away from HIV services. This increases their vulnerability to HIV. (p.5)

Socially, stigmatisation of people with HIV/AIDS and KAPs also creates a major barrier to the successful operation of HIV services. As a result of stigma and discrimination, "many people are afraid to get tested for HIV, to take up HIV prevention and treatment, to disclose their HIV status, and to participate in national HIV responses", in addition, "they also have little chance of getting legal redress for HIV-related harms" (UNAIDS, 2012a, p.5). Stigmatisation does not affect only the marginalised groups of PLWHA; in Thailand, a representative from the Ministry of Health observed that high-ranking individuals such as celebrities or "political officials and senior civil servants" are reluctant to register with the state as having HIV, as a "direct manifestation of the social stigma" that surrounds HIV/AIDS (Prakongsai, 2013). In Thailand, being HIV+ can have negative impacts on both personal and professional lives; Chapter 7 details how PLWHA face specific employment difficulties, for instance, candidates for judicial offices in Thailand must prove to the state that they are HIV negative (Ladaporn, 2013). Personal feelings of shame and depression are also a source of serious harm at the individual level and reflect wider societal stigmas; data from the UN *People Living with HIV Stigma Index* show that 65% of HIV+ people surveyed in Thailand felt ashamed of their HIV status and 17% had felt recently suicidal as a result; in Myanmar, 61% reported feelings of shame and 25% reported suicidal feelings (UNAIDS, 2012a, p.27).

Studying the psychological impact of HIV/AIDS, Strong (1990) concluded that in the UK the viral epidemic was accompanied by an "epidemic of irrationality, fear and suspicion" (p.253) among both medical professionals and the general population. This anxiety amounted to unproductive fear that was closely associated with "an epidemic of stigmatisation; the stigmatisation both of those with the disease and of those who belong to what are feared to be the main carrier groups" that "can begin with avoidance, segregation and abuse" but where "personal fear may be translated into collective witch-hunts" (Strong, 1990, p.253). Regarding the epidemic in Thailand, former senator Jon Ungphakorn (2012) explained that, "you find stigma and discrimination in the very professions it shouldn't be [in], for example the medical and legal profession". This view was corroborated by UNAIDS

Coordinator Michael Hahn (2013), who reported that, "stigma starts in the health sector really". The *UN Stigma Index* surveys found that 20% of respondents from Thailand and 9% of those from Myanmar reported that they had been denied access to health services because of their HIV status during the previous 12 months (UNAIDS, 2012a, p.23). During the same period, 12% in Thailand and 18% in Myanmar had been denied access to sexual and reproductive health services because of their HIV status (UNAIDS, 2012a, p.27). Despite geographical differences in epidemics (The Lancet, 2004), stigmatisation of KAPs and people affected by HIV/AIDS always accompanies the virus and stems from the universal human fear of death, contagion, and of the unknown. However, the means by which to address and reduce this stigma are context-specific and vary according to cultural and social norms, contributing to the difficulty of combating this and other social barriers to effective management (Parker & Aggleton, 2003, p.14).

In addition to medical services, epidemic surveillance is also compromised by stigma, discrimination, and unproductive fear. At the international level, countries are reluctant to report infectious disease outbreaks to the WHO surveillance programme, fearing economic and political losses, such as travel restrictions, or loss of trade and tourism, that could be incurred as a result (WHO, 2000). In 2003, the global SARS crisis had a brief but "substantial" negative impact on the economies of affected countries, resulting in an estimated 17.9 USD billion loss to the economy of China, or 1.3% of GDP (Price-Smith, 2009, pp.143-146). Had the pandemic lasted longer or been more severe, the impacts would have accelerated as labour forces were depleted by rising death rates and industrial export capacity reduced. These impacts arise from both the fearful quality of the affected state, which is imagined as a source of contagion to be avoided by others, and as a result of the actual loss of capacity as the population is affected with the disease.

Fear of HIV/AIDS also undermines surveillance and response at the national level. In interview with the Director of the International Health Policy Programme at the Thai Ministry of Health, it was reported that decentralisation of HIV/AIDS surveillance and reporting in Thailand had been affected by stigmatisation of the

disease because Provincial Officers were sometimes reluctant to acknowledge an "HIV problem" in their locality for fear that it would affect tourism and the economy of their wards (Prakongsai, 2013). In addition, the official data from the Thai state is derived from a national database on which PLWHA must register in order to access subsidised antiretroviral treatment; Prakongsai (2013) reasons that many people able to afford private purchase of their medication may choose to avoid registering their HIV status, thus skewing the national data. The WHO note that the quality of AIDS case-reporting varies significantly from country to country, reflecting differences in both the quality and extent of services and surveillance infrastructure, but also arising because "stigma and discrimination associated with the disease may contribute to the reluctance in diagnosing and reporting AIDS cases" (WHO, 2000, pp.109-110). In Myanmar, interviewees from leading CSOs that coordinated surveillance in the country uniformly reported the extreme difficulty of accurate reporting that arose from the lack of healthcare and service infrastructure. However, one INGO Country Director also spoke frankly about the danger of reporting too many cases of HIV/AIDS, for fear of "shaming" the government and inviting their retribution (Source 10, 2013).

In Thailand, the ASEAN Institute for Health Development (AIHD) *National AIDS Responses Report* in 2011 found that governmental budget support for surveillance and data collection had declined, contributing to problems with effective data use and reliability (AIHD, 2011, p.24). One CSO Director (Source 21, 2013), who asked to remain anonymous, suggested that clinics in certain political wards and targeting key affected populations (particularly antenatal clinics for teenagers) were deliberately underfunded or closed because of the stigma attached to these populations; as a result, the decline in government funding for medical services to rural and 'at risk' (stigmatised) populations had led to an artificial decline in reports of HIV and other STIs. Anonymous interviews with staff and agencies involved in the data collection for the AIHD report revealed an additional dimension to this problem; whilst working at a clinic reporting data directly to the AIHD office, staff were told by superiors that they had "better not" report the cases

of HIV in monks who presented at the clinic, because monks are "supposed to be celibate" (Source 15, 2013).

Stigma can also lead to discrimination that constrains the practical responses of those dealing with HIV/AIDS and attempting to provide services to affected communities. Piot (2012) highlights the important work of UNAIDS in combating some of the practical constraints on CSO activism that arise from stigma against PLWHA and key affected groups, explaining that, "because of the enormous stigma of AIDS, groups of people with HIV could not even rent a space to meet, so the UNAIDS office created a safe space for all kinds of community groups" (p.351). This was supported by data collected from fieldwork. In interview in Bangkok, Surang Janyam (2013), Director of the CSO, Service Workers In Group (SWING), explained that discrimination against the commercial sex workers who make up the employees and clients of SWING meant that it was difficult to rent a property for their office. SWING exists "to educate and improve the quality of life of sex workers in Thailand by disseminating accurate and useful information" that includes the provision of training, facilitating access to healthcare services, and the distribution of condoms (Janyam, 2013). When it was established in 2004, SWING initially experienced problems in renting property in Bangkok. A rent agreement was originally made for a property in the commercial/residential street, Soi Convent, but the following day the "situation changed" and they were told "it cannot happen"; Surang suspects this was a result of complaints from other businesses and landlords in the area (Janyam, 2013). Instead, the SWING office was relocated to its current premises above the 'Super Pu$$y Bar' in Patpong 1, the nearby entertainment district that is popular with transgender commercial sex workers, who are themselves at high risk of HIV/AIDS (Janyam, 2013). The current office rental was possible only because Surang personally knows the landlord and the new location is in an area already popular with sex workers and their clientele (Janyam, 2013). In a different case, a care centre for HIV+ children in Kohn Kaen, northern Thailand, was required by local planning officials to install a costly water treatment facility on the site at which children would live. The officials were concerned that sewerage from HIV+ children should not mix with that from the general population; although it is

hard to rationalise a fear of contagion in this form, the CSO directors paid approximately three thousand USD to have the machine installed so that they could operate in the town (Dunck, R., 2013).

4.5. Conclusion

This chapter outlines the unique epidemiological characteristics of HIV/AIDS that facilitate its securitization and that concurrently contribute to the difficulty of implementing effective management and responses. The transmission of the virus through sexual intercourse and behaviours often associated with 'moral' values and 'deviation' from social norms exacerbates the innate human fear of contagion and death that is invoked by the disease. In countries with restrictive legal environments, such as Thailand and Myanmar, punitive laws that target sex workers, PWIDs, and MSM, encourage stigmatisation and hinder efficacious responses to the epidemic. These measures also heighten vulnerability to human rights violations and viral prevalence among affected populations.

Fear appeals are often an ineffective means of communicating educational messages about HIV/AIDS or promoting behavioural change and risk avoidance. The utilisation of fear imbued rhetoric to describe or deal with HIV/AIDS can also enhance the processes of 'othering' that exacerbates stigmatisation and discrimination against PLWHA. Linking HIV/AIDS to security is problematic because it invokes fear and perpetuates a framework in which people affected by the disease are stigmatised and imagined as a source of 'threat'. Due to the social aspects of the disease epidemiology, stigmatisation is a "major barrier" to effective response (UNAIDS, 2012a). It also contributes to discrimination that constrains the practical responses of those dealing with HIV/AIDS and obstructs their attempts to provide services to affected or vulnerable communities. Stigma is found at all levels of society and its negative effects are pervasive in both institutional and individual management of the disease. It is directly exacerbated by the invocation of unproductive, poorly managed fear and any recourse to securitization rhetoric in the management of HIV/AIDS should consider these potentially detrimental effects. The ethical implications of the securitization of HIV/AIDS are important not just

because of the potential to cause harm and to hinder effective responses to the epidemic, but also because to securitize an issue is a political choice and thus the securitizing actor incurs a degree of responsibility for the decision to do so (Buzan et al., 1998, p.29). Fear innovation is linked to the exceptionality of HIV/AIDS and this is the subject of the following chapter, which details the efforts of marginalised civil society groups to mobilise a political response to the epidemic, paving the way for securitization and the unprecedented allocation of resources.

Chapter 5: AIDS Exceptionalism

This chapter examines the political context in which securitization of HIV/AIDS took place and finds that popular perceptions of the virus, public health norms, and political activism all defined the era of 'AIDS Exceptionalism' that preceded the seminal meeting of the United Nations Security Council (UNSC) in 2000. The early epidemic became subject to political mobilisation, contestation, and debate when civil society groups and 'AIDS activists' came to the forefront of coordinating national and international responses; it was this civil society-led response that would later be defined as "AIDS exceptionalism" (Bayer, 1991; England, 2008). The concept has evolved as human capacity to manage HIV improves, but although technological advances in treatment and testing have changed the epidemic, the narrative of HIV/AIDS as an exceptional and political issue has largely endured, eventually providing the conceptual framework for securitization of the disease (see Piot, 2005a; Smith & Whiteside, 2010). Through an examination of political, legal, and medical practice, the exceptionality of the disease is explored and critiqued in this chapter, concluding with challenges to the exceptionalist framework.

In terms of both policy attention and commitment of resources, the global response to HIV/AIDS has been unlike that of any other health issue; over 4.6 billion USD was spent by the American PEPFAR programme on HIV/AIDS specific interventions in 2013 alone (The United States President's Emergency Plan for AIDS Relief [PEPFAR], 2014; Kaiser Family Foundation, 2014). This unique response is founded on the premise that the disease requires management "above and beyond 'normal' health interventions" (Elbe, 2009, pp.4-5; Smith & Whiteside, 2010, p.1). When it emerged in North America and Europe, AIDS affected homosexual men first and most visibly, followed by concentrated prevalence within other already stigmatised groups (Whiteside & Sunter, 2000, p.1; Ingram, 2013, p.437). Partly as a result of this initially concentrated prevalence, political leaders failed to act swiftly in addressing the emerging epidemic during the 1980s (Shilts, 1988). Instead, the response to HIV/AIDS was led by civil society groups and activists for whom the

sensitivity and stigma of AIDS related issues (such as homosexuality) provided a focal point for political mobilization, rather than a barrier to action (Holden, 2003, pp. 17-18).

One origin of AIDS exceptionalism that is still evident in modern responses is the moralisation of viral transmission, which was identified early in the epidemic as occurring through sexual intercourse, leading to "sexualisation" of the disease (Prins, 2004, p.934). Facing political reticence but possessing significant capacity, civil society groups, and in particular those from the LGBTI community, were able to take a formative role and to advocate a specialist approach to HIV/AIDS. The response they advocated ensured that the epidemic was handled differently from other infectious diseases or public health issues and, in its early phase, AIDS exceptionalism meant that traditional public health responses to managing infectious disease were challenged and rejected by activists concerned by potentially invasive state-led responses. In particular, emphasis was placed on rights-based campaigns to oppose mandatory testing and reporting of infections, quarantine or restrictions on movement for PLWHA, and criminalization of transmission. AIDS exceptionalism therefore arose from a fear that the civil liberties of people with or at risk from HIV/AIDS would be violated unless the epidemic was addressed as a unique type of health issue in which human rights were prioritised over the adoption of traditional responses to infectious disease, in which the state implements restrictive policies informed by the threat-defence logic of traditional security paradigms. Below, the study of the early HIV/AIDS response in Thailand will illustrate the saliency of these concerns by examining the 1990 'AIDS Bill' that proposed the invocation of authoritarian control over people living with HIV/AIDS, including quarantine and border controls.

AIDS exceptionalism is an important concept that must be understood in order to investigate the global response and security claims related to the virus, but despite its centrality, there is little attention paid to the phenomenon in current securitization literature. This chapter examines initial responses to HIV/AIDS following its clinical discovery in Europe and North America, establishing the contextual social and political background against which the subsequent

international securitization of HIV/AIDS occurred. Early AIDS exceptionalism is significant because through securitization an issue "is drawn into a particular (realist definition of a) mode of dealing with it which is marked by exceptionality" (Stritzel, 2007, p.366); in one sense, securitization of an issue represents an intensification of its political status, but in an equally important way, securitization is opposed to politicisation because it removes that issue from the "normal haggling of politics", instead demanding that it "be dealt with decisively by top leaders prior to other issues" (Waever, 2003, p.12). In the following outline of AIDS exceptionalism, it becomes evident that early politicisation of the virus established the conceptual foundations that would later make possible the removal of the issue from the "normal bounds of political procedure" (Buzan et al., 1998, p. 24).

5.1. The Evolution of AIDS Exceptionalism

Since the clinical recognition of its first cases in 1981, AIDS has been handled differently than other infectious diseases (De Cock & Johnson, 1998, p.290). According to Bayer (1991) the public health protocol employed under normal, pre-AIDS circumstances would have entailed:

> Mandatory compulsory examination and screening, breaching the confidentiality of the [patient-doctor] clinical relationship by reporting to public health registries the names of those with diagnoses of 'dangerous disease', imposing treatment, and in the most extreme cases, confining persons through the power of quarantine. (p.1500)

In many ways, these forms of public health response reflect a traditional framework of security in which the state implements emergency measures over its population in order to ensure survival in the face of a threat. However, infectious disease and health issues in general are not often suited to these kinds of responses and this is particularly true of HIV/AIDS, where effective management requires a human-rights and development based approach in which stigma and discrimination is actively reduced rather than exacerbated by authorities (UNAIDS, 2012a). As documented in Chapter 4, restrictive legal and medical environments that penalise or disenfranchise PLWHA are a barrier to efficacious responses to the epidemic. The growing movement to promote "health as a human right" is premised on these

same arguments, which hold that "public health programmes should be treated as potential burdens, even violations, of human rights until proven otherwise" (Davies, 2009, p.67). The traditional public health response, in which "limitations on the 'rights of the few' for the 'good of the many' had often been used as a justification for infectious disease control" also undermine the attainment of holistic health, which comprises the "realization of three factors, physical, mental and social well-being" (Davies, 2009, p.67). In dealing with HIV/AIDS, activists and civil society groups feared that traditional public health responses would lead to discrimination and violations of the rights of PLWHA, undermining their health for the purported 'good of the many'. Writing a decade after the clinical discovery of HIV, Bayer (1991) observed a definitive rejection of public health tradition by civil society groups, in favour of a new style of response which he termed 'exceptional'. Thus, AIDS exceptionalism in its early form meant political movement and campaigns for "*not* invoking public health powers" that were traditionally used to deal with infectious diseases (Ingram, 2013, p.437). The enduring success of these campaigns and the rights-based logic of exceptionalism are exemplified by the anonymous surveillance systems and emphasis on clinical confidentiality that is still evident in contemporary responses to the virus (De Cock & Johnson, 1998, p.290).

The politicisation of the medical response to HIV/AIDS is regarded in itself as a mark of exceptionalism (Bayer, 1991) although it may be true that public health management of any disease has always required a political component, without which wide-scale interventions would be impossible (Burris, 1994, pp.259-260). The politicisation of HIV/AIDS was an integral step in the construction of the AIDS exceptionalist framework. Through the early efforts of civil society groups, the epidemic was made a matter of public rather than private debate and became the subject of policy at the national and international level; essentially, from the 1980s onward HIV/AIDS was framed as an exceptional disease that warranted extraordinary measures in response, thus bringing the issue into the political sphere. This politicisation embodies the stage preceding the securitization of an issue when, according to the Copenhagen School, the matter becomes "part of public policy, requiring government decision and resource allocations" (Buzan et al., 1998, p.23).

Politicisation is a less intense state than securitization, and at this level the issue is still "open" to discussion and the type of measures pursued remains "a matter of choice" (Buzan et al., 1998, p.29). Here, politicisation was the first stage of exceptionalism and arose in response to the novel epidemiological characteristics and complex politics of the virus (Ingram, 2013, p.477), as well as fear within affected communities that their civil liberties would be at risk if they did not mobilise to reject a traditional public health approach.

In recent years, the appearance of HIV/AIDS on the global political agenda is indicative of its continued exceptionality (Ingram, 2013, p.436), manifest in the creation of disease-specific institutions such as UNAIDS in 1996, the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002, and PEPFAR in 2003 (Smith & Whiteside, 2010). The progression of HIV/AIDS from national to international concern (and from exceptionalism to securitization) was facilitated by epidemiological and political conditions; in the 1980s and 1990s, the severity of the global epidemic became increasingly evident and shifted from concentrated to general populations; at the same time, conceptual understandings of security were opening up to include a broader range of definitions of security threat (see Vieira, 2007, pp.143-145). However, the encroachment of politics and political concerns into the realm of health professionals has not been without critics and as Burris notes (1994), AIDS exceptionalism has been met with consternation by some in the medical establishment who lament: "why can't we just cut the politics and the rights talk and get back to the science, to what works...?" (p.252). This assumption, that the medical or scientific aspects of public health response can be separated from the societal and rights-based issues, is indicative of a traditional approach that has been challenged by the advent of AIDS exceptionalism and the growing movement in support of "health as a human right" (Davies, 2009, pp. 70-75).

Epidemiologically, the most problematic and exceptional characteristic of HIV is its mode of transmission, which occurs through the exchange of bodily fluid. Blood and semen are the most common routes of transmission so infection occurs primarily through sexual intercourse, meaning that people with a greater number of sexual partners are most at risk. Anal intercourse is the most likely to facilitate

transmission (see, for instance, Whiteside & Sunter, 2000, p.11), so male to male sexual intercourse is a particularly high-risk behaviour and MSM are a key affected population with typically high prevalence of HIV/AIDS (WHO & UNAIDS, 2011). The most sexually active people within a population are typically most susceptible to HIV/AIDS and vulnerability is also linked to lower socio-economic status, which exacerbates both the risk of acquiring HIV and the negative impact of the disease on subject health (Holden, 2003, p.25). Often experiencing a combination of these vulnerabilities, sex workers and injecting drug users are at higher risk of infection than others (Holden, 2003, pp.25-26). The specific vulnerability of people who have multiple sexual partners and of MSM further complicates the social epidemiological aspects of the disease because both groups face stigmatization associated with the male heterosexual norm that is dominant in most societies. These epidemiological factors contribute to the moralisation and stigmatization of both the virus and its carriers.

Some advocates of AIDS exceptionalism regard the stigma attached to HIV/AIDS as indicative of its exceptionality (Piot, 2005a), but the novelty of this stigma remains contested. Historical analysis reveals similar types of popular reaction to other epidemic diseases which occurred in the developed world until recently, and which inspired collective reactions ranging from vilification to romanticisation (Sontag, 1989, p.23). As Burris (1994) notes, "in their prime, cholera, tuberculosis, and syphilis were all badges of vice and dissipation" (p.252) and as such, all inspired their own form of stigmatization or unique public perception. Nor is politicisation of disease novel to HIV/AIDS (Burris, 1994); sexually transmitted diseases were endemic during the last century and, although relatively little-known now, syphilis and gonorrhoea were subject to wide-scale public health interventions by the United States government during the 20th century. Interventions included modifying public drinking fountains and removing door handles from naval vessels in an attempt to reduce casual transmission (Sontag, 1989, p.27). However, following the politicisation of HIV/AIDS, this disease has assumed dimensions that are exceptional to contemporary public and global health responses, including the legislation and rights advocacy examined below.

5.2. Civil Society

It has been established in the preceding chapter that the inherently social and political nature of HIV/AIDS is due in part to the epidemiological characteristics of the disease. When it emerged in the developed world and subsequently gained international recognition, HIV/AIDS affected gay male communities first and most visibly. The disease was initially misclassified as affecting *only* gay men and before the acronym AIDS was adopted by the American CDC in 1982, the terms "Gay Related Immune Deficiency Disease" (GRIDS), "gay plague", and "gay compromise syndrome" were widely used (Brennan & Durack, 1981; Altman, 1982; Warner & Greene, 2007, p.94). As a result, the epidemic was "linked into existing discourses of protest and discrimination" from the gay community, whose recent politicisation had affected a successful struggle with the medical establishment over the psychiatric definition of homosexuality as a pathological disorder (Krieger & Fee, 1993, p.1478; Prins, 2004, p.934). With newfound agency and in response to AIDS (Holden, 2003, pp. 17-18), gay communities campaigned hard to create new protocols for dealing with HIV/AIDS in the medical context. Concurrently, the politicised nature of LGBTI civil rights at this time meant that HIV/AIDS was inextricably linked with a politicised discourse; perceptions of HIV/AIDS as an 'LGBTI issue' served as both a catalyst and a barrier for action.

In its early stages in the developed world, HIV/AIDS was exceptionalised and politicised due to the mobilisation of locally based, pre-existing activist groups primarily within LGBTI communities. Traditional or invasive public health responses were stridently opposed by "an alliance of gay leaders, civil libertarians, physicians, and public health officials [who] began to shape a policy for dealing with AIDS that reflected the exceptionalist perspective", concerned with protecting the rights and autonomy of individuals (Bayer, 1991, p.1501). Thus, civil society, sympathetic public health officials, and politicians created for HIV/AIDS a new type of epidemic response, driven by a fear of both the virus and the potential for traditional responses to violate human rights and become detrimental to those affected by the disease. The exceptionalist response that arose was designed to

protect their civil rights, characterised by "making HIV a special case that demanded confidentiality and discouraged routine testing and tracing of contacts" that would be typical of a normal public health response (England, 2008). The result was the creation of an exceptional response that would come to define HIV epidemics within the most powerful institutions of the world (Smith & Whiteside, 2010; Bayer, 1991; Oppenheimer & Bayer, 2009; Prins, 2004, p.93). So great was the role of these CSOs and activists in shaping the response that Ronald Bayer, the author who first coined the term AIDS exceptionalism, declared that, "the embrace of exceptionalism must be understood in broad political terms, as representing in large measure, a singular victory on the part of gay men, their community based organisations and their allies" (cited in Smith & Whiteside, 2010, p.2).

The AIDS exceptionalism framework arose from a fear that state-led responses would rely on forms of traditional public health interventions that were neither suitable for dealing with the novel HIV virus nor compatible with Western liberal democratic values of human rights. This fear may have been unfounded; Bayer (1991, p.1500) observes that the most coercive types of public health response have rarely been implemented and it is questionable whether responses could be sustainable or effective without the tacit popular consent of the people they affect (which is unlikely to be gained if civil liberties are too much oppressed) (see also, Burris, 1994, p.5). However, there existed a viral epidemic that was "terrifying" and "mysterious" (Smith & Whiteside, 2010, p.1) and regardless of the likelihood of these coercive measures coming to fruition, the fear of draconian public health responses by state authorities was real enough to affect a unique form of response that was led by distinct groups (Bayer, 1991; Oppenheimer & Bayer, 2009).

Although AIDS activism has moved beyond the LGBTI community in which it started in the USA and Europe, civil society groups and people living with HIV/AIDS are a defining feature of the contemporary response throughout the world. The origins of this non-state, exceptionalist response are typically attributed to North America and Europe, from where it is thought to have spread globally through the influential knowledge-norm distributors of the UN and international aid networks (Vieira, 2007; Whiteside & Smith, 2010). The inclusion of civil society

groups in high-level political discourse on the disease is now one signifier of the contemporary exceptionalism of HIV/AIDS; the formalisation of participation for civil society groups, PLWHA, and AIDS-activists in influential donor agencies is evident in the GIPA (Greater Inclusion of PLWHA) policies that are adopted by these institutions, including UNAIDS and regional networks (Asia Pacific Network of People Living with HIV/AIDS [APN], 2004; UNAIDS, 2007). However, data from Thailand and Myanmar indicate that the early responses to HIV/AIDS in both of these countries were shaped by the mobilisation of civil society groups that formed initially as support and self-help groups for PLWHA before adopting human-rights and political campaigns (Tenni, 2012; Swift, 2013). Their mobilisation was partly motivated by fear that a state-led response would lead to violation of human rights and the imposition of oppressive public health interventions. This is particularly noteworthy in Myanmar, where the epidemic and related activism emerged against a backdrop of repressive authoritarian rule in which human-rights campaigning and the organisation of civil society groups was extremely difficult and sometimes dangerous.

Responses to the HIV/AIDS epidemic reveal disparity in social and economic power both at the domestic and international level. Although HIV/AIDS disproportionately affects developing countries, the international response and medical management of the HIV virus, (diagnosis, development of testing, and treatment), has been led by the resource-rich developed world, frequently referred to as the "global North" within development literature (Sachs, 2010, pp.xv-xx). AIDS, and the HIV virus that causes it, existed for decades prior to its identification by the American CDC in 1981, but its origins remain unknown; the virus was certainly present within the African continent during the 1970s, but it was not until visible cases appeared in American and European communities that diagnosis and global recognition occurred (Whiteside & Sunter, 2000, p.6). Despite their marginalised status, the gay men who first fought for HIV/AIDS exceptionalism in these affluent countries remained "vastly influential in comparison to the bulk of voiceless victims then proliferating, unheralded, in the poor world" (Prins, 2004, p.934); their agency and resources allowed gay civil rights groups to rise to

prominence in the international response to HIV/AIDS and to demand political and medical attention for dealing with the emerging epidemic. However, the concentration of early infections within these communities also slowed and complicated political responses to the epidemic which, at the time, remained concentrated in groups of homosexual men, injecting drug users, migrants, sex workers, and a few "innocent" victims of contaminated blood transfusions (Holden, 2003, p.17; Ingram, 2013, p.438). In the USA, the initial characterisation of HIV as a concentrated epidemic isolated from the general population gave rise to the term "4 H's", referring to "Heroin users, Haitians, Hookers and Haemophiliacs" (Gilman, 1987, p.87). The visibility of AIDS within affected communities in the early 1980s, coupled with a dearth of information about the routes of transmission, bred widespread fear and raised the profile of the emerging epidemic both within and outside those groups most affected (see Shilts, 1988). As a result of the social conditions (namely stigmatization and marginalisation) surrounding the most severely affected groups, the fear invoked by HIV/AIDS did not refer only to the virus. Instead, people visibly affected by HIV and AIDS became the source of fear and stigma as their bodies and behaviours were perceived as threatening others.

Despite a sense of fear surrounding the new illness, political reluctance to mobilise an appropriate response stemmed from perceptions of AIDS as a disease linked to sexualised, "deviant", or "abnormal" behaviour (Holden, 2003, p.17). Prins (2004, p.933) observes that valuable time was lost in the critical early years of the epidemic, when there was a failure to act pragmatically with public health responses. Whilst this presented an opportunity for civil society groups to step into the forefront of the epidemic response, it also translated into a lack of official recognition of the issue and a lack of state investment to deal with the emerging epidemic (Prins, 2004, p.933). In Chapter 6, an interview with former UNAIDS Director Dr Peter Piot illustrates how these problems could be circumvented by the securitization of HIV/AIDS, which removes the responsibility for handling the virus from "the normal haggling of politics" and awards it immediate and urgent attention (Buzan et al., 1998, p.29). However, where governments did act on HIV/AIDS, their interventions were sometimes inappropriate responses that

undermined the work of civil society groups; state-funded responses that utilised fear appeals, such as the Australian 'grim reaper' and UK 'tombstone' campaigns (detailed in Chapter 4 and included in Appendix C), are salient examples of fear-based securitizing messages that undermine the work of civil society groups attempting to normalise perceptions of PLWHA and protect their civil liberties.

5.3. Exceptionalism in Practice

The early exceptionality of AIDS was illustrated by the unique conditions that accompanied blood testing for the disease (see Bayer, 1991; De Cock & Johnson, 1998). Traditional public health protocol advocates testing of populations during an epidemic to facilitate a state-led response based on wide-scale reporting of prevalence, but from the creation of the first HIV tests in 1985, screening became a contested issue with legal and political complexities. Anti-testing activism in North America is a salient example; prior to the production of effective treatment, some rights groups doubted the value of sero-testing outside of the blood transfusion setting (Branson, Viall & Marum, 2013). At the 1985 International AIDS Conference in Atlanta, activists demonstrated loudly and distributed stickers, badges and posters that read "NO TEST IS BEST" (Berger, 1996, p.717; Jaffe, 2009, pp.229-30; Piot, 2012, p.149). Opposition to testing arose because diagnosis of HIV or AIDS at this time did little to serve the patient. Without recourse to treatment, medical professionals were unable to alleviate the chronic fungal infections, skin diseases and acute diarrhoea that were typical symptoms of late-stage disease progression; these conditions, that were often debilitating and dehumanising for patients, would not respond to pre-ARV treatment and, in addition to physical suffering, patients would experience the "psychological burden" of knowing their status in the absence of effective therapies (Oppenheimer & Bayer, 2009, p.989). Infected with a contagious and poorly understood virus, patients also faced discrimination and stigma from others, including the healthcare professionals employed to serve them. In 1989, Sontag (1989) wrote a moving account of the hopelessness felt during the pre-treatment epidemic, when "testing positive for HIV...is increasingly equated

with being ill" (pp.32-33), and when being ill meant one was at risk of losing employment, losing the freedom to emigrate, and losing social status.

In Thailand, a Programme Officer for Raks Thai, a prominent CSO, explained that prior to the production of affordable medication in 2006, "people finding out their HIV status had more negatives than positives. They couldn't receive treatment and they were going to be additionally stigmatised, as well as having all the health problems... and if you were a sex worker, then you weren't allowed to work either" (Press, 2012). In this restrictive environment, with few productive outcomes from a positive test, Press (2012) asked, "why would you want to be tested?" The development of effective treatment and production of affordable generic medicines has been a seminal event in HIV/AIDS management, but despite an ongoing global campaign to increase access to treatment, in order for the UN to reach its goal of "universal coverage" by 2015, an additional 15 million PLWHA must still gain access to medication (UNAIDS, 2013c, p.5). Where access to treatment is not yet universal (defined at below 80% coverage), the same dilemmas regarding testing remain. In a study of migrants unable to access ARV treatment in the UK, Thomas, Aggleton & Anderson (2010) published a paper titled "If I cannot access services, then there is no reason for me to test", in which they critique the barriers to early testing and treatment that arise as a result of confusion about health care entitlements (by both migrants and care providers) and fear of deportation from the UK.

An additional barrier to uptake of testing is the criminalisation of HIV transmission that exists to varying degrees across the world, including in the UK and other parts of Europe where transmission from a person aware of their status can be tried in court as a case of 'grievous bodily harm'. In states where it is possible to take legal action against people deemed to have knowingly infected others, acknowledgement of one's own status can become physically as well as psychologically dangerous. The rationale behind criminalisation of transmission is to both discourage transmission and to provide recourse to justice for those infected by others, but there are myriad ethical dilemmas in determining cases of intent or negligence, or legislating to require subject disclosure of HIV status. Concerns over

potential violations of human rights and the vilification of PLWHA contribute to the position taken by leading institutions, including UNAIDS, that do not endorse criminalisation (UNAIDS, 2013a). The issues at the centre of the criminalisation debate are consistent with those that informed early AIDS exceptionalism; specific legal protections designed to ensure privacy and autonomy, and to counter discrimination against PLWHA, are founded on the logic that HIV presents a special threat to the human rights as well as the physical health of the people it affects. The legal concessions working both 'for' and 'against' PLWHA have contributed to the exceptionality of the epidemic (Burris, 1994), as public health traditions and civil liberties are threatened or overridden.

Despite the advent of treatment, testing for HIV remains exceptional in public health tradition. The stigmatization of both HIV infection and the behaviour that puts people at risk (namely sexual contact, male to male sexual intercourse, injecting drug use, and commercial sex work), creates barriers to testing as people decline testing for fear of negative association with these behaviours (UNAIDS, 2007a, p.9; UNAIDS, 2012a). This stigma is rooted in the same perceptions that Sontag (1989) identified in the pre-treatment years, when "'infected but not ill', that invaluable notion of clinical medicine...is being superseded by biomedical concepts which, whatever their scientific justification, amount to reviving the antiscientific logic of defilement" (p.32). In practice, this fear of defilement leaves many people afraid to visit facilities where testing takes place for fear of being recognised by others, even if these facilities also provide the treatment they need. Social perception and stigma continue to present a significant barrier to the uptake of HIV testing, even in 2014 when early diagnosis can mean the difference between a chronic but treatable condition, or death (UNAIDS, 2007a; UNAIDS, 2012a). In interviews with health care providers in Myanmar, respondents told the author that HIV positive people living in poverty would incur considerable financial cost in order to travel to health care facilities outside of their local area in order to avoid the risk of identification within their community (Aung, 2012; de Groote, 2013). There may also be valid reason to doubt the confidentiality of services inside those facilities, as staff members are likely to include members of the local community (Aung, 2012). The

'exceptional' legal protections and human-rights advocacy of AIDS exceptionalism are measures intended to reduce such barriers to testing and treatment (Burris, 1994, p.253; Davies 2009, pp.70-75).

Part of the AIDS exceptionalism response codified in the 1980s and 1990s is that norms and good practise for HIV testing advocate counselling for patients as part of the testing process, in some circumstances both before and after tests are administered (WHO & UNAIDS, 2007). The accepted best practice guidelines issued by international norm-setters WHO and UNAIDS regard counselling and testing as inseparable within the clinical setting, and state that: "Post-test counselling is an integral component of the HIV testing process. All individuals undergoing HIV testing must be counselled when their test results are given, regardless of the test result" (UNAIDS & WHO, 2007, p.39). This demand arises because of the exceptional levels of self-stigmatization and psychological burden that are associated with diagnosis of HIV, but the advent of new forms of testing have challenged the logic of this approach. It is now possible for individuals to purchase tests from internet suppliers and to complete these tests in the privacy of their own home. This technology has the potential to increase uptake of testing, but it does mean that people testing for HIV are doing so without the presence of a medical professional. In interview, the Country Coordinator of UNAIDS in Bangkok observed the way this has changed HIV testing in the contemporary context:

> Look at China now; the whole [men who have sex with men] community are buying their HIV tests on the internet, people have more tools to operate, I don't have to get all my courage and go to the doctor ... they look at me funny ... give me a lecture ... take blood ... I am told I have to come back in a week, I come back in a week. Now I just have to press a button and I get my HIV test by post and I put the stick in my mouth and in one minute I know if I am HIV positive or not. It has pros and cons. (Hahn, 2013)

Opinion on the use of home testing is divided. De Cock & Johnson (1998) wrote that "caution is clearly required" when addressing the (then new) technology that made home-testing possible, but also noted that "the reticence around the concept of self-testing contrasts with modern approaches to self-diagnosis or screening for other conditions such as [breast cancer], home pregnancy testing, and melanoma

awareness" (p.291). While some believe that self-administered tests are a way to increase awareness of HIV status amongst individuals (which has positive effect on personal and population-wide management of the disease), others are concerned about the application of testing without access to counselling; Hahn (2013) points out the similarities with other sensitive health issues in the past:

> People go nuts now if you say that we should have HIV tests in the pharmacy. I was a young doctor when they started selling pregnancy tests in the pharmacy and the same headlines ... women will be committing suicide, the husbands will kill the women if they find out they are pregnant ... a huge negative campaign and nothing happened!

Hahn's response illustrates the evolving social and cultural sensitivities that govern our experiences of medical conditions, using female reproductive health as a salient example of changing societal attitudes in the 20th century. The sensitivity of the issues related to HIV, in particular the 'high-risk behaviour' through which many people are infected, fuels the exceptionality of the disease and further complicates treatment and prevention measures, including testing. Perceptions of people with or at risk from HIV/AIDS as being more vulnerable than people affected by other diseases may also impact on the types of responses that are adopted in epidemic management. This should be considered in future policy making, as social attitudes and medical technologies develop and as vulnerability and power shifts. For instance, in Hahn's anecdote about the vulnerability of women following a positive pregnancy test, the implied societal values of gendered power are quite obvious. But in the exceptionality of testing for HIV/AIDS, the need to critically evaluate the power and agency of PLWHA remains salient and in order for this to take place, the continued role of PLWHA in rights-based activism and policy-making is essential. Significantly, even civil society groups and activists who advocate normalization of PLWHA recognise the need to exceptionalise some aspects of the disease management, including testing and clinical confidentiality. From the Thai Network of People Living with HIV (TNP+) in Bangkok, activist Jui Kestkaew (2012) stated in interview: "they shouldn't have specific human rights protection for people with HIV/AIDS but there are some issues that are special [for PLWHA], like blood testing". This view, indicative of mainstream HIV responses among Thai and

international CSOs, reveals the extent to which exceptionalism for AIDS remains embedded in accepted responses to the epidemic, even amongst civil society groups who explicitly advocate normalisation of PLWHA.

5.4. Challenges to Exceptionalism

AIDS exceptionalism in its early stages was defined by the special circumstances surrounding testing and privacy and encouraged the rejection of traditional public health interventions in favour of protecting the autonomy and rights of people affected by HIV/AIDS. This framework was effectively challenged with the breakthrough in treatment to prevent mother-to-child transmission (MTCT) of the virus (Oppenhiemer & Bayer, 2009, p.989). By testing pregnant women for HIV and administering antiretroviral medication, it became possible for HIV+ women to give birth to HIV- children. Thus, testing became an important route by which to prevent transmission to children, and with the lives of unborn foetuses at risk, exceptionalist logic that reduced the likelihood of testing their parents came under intense criticism.

From the outset of the response, Bayer (1991) had predicted that AIDS exceptionalism in its original form would not be durable, as "the effort to sustain a set of policies treating HIV infection as fundamentally different from all other public health threats will be increasingly difficult" (p.1503). Bayer (1991) proposed that the decline of the early exceptionalist argument would arise in the face of medical advances such as MTCT prevention, increased treatment, the reduction of anxiety, and less-than-predicted fatalities. Both Bayer (1991) and Burris (1994) note that in terms of incurability and mortality, AIDS has not wreaked the death toll that many proponents of exceptionalism had predicted. Ingram (2013) also observes that levels of exceptionality and emergency related to HIV/AIDS are declining as the "stabilisation" (p.444) of the epidemic occurs. Improved knowledge of HIV and its modes of transmission have reduced fear of the virus, as understanding (in theory) allows individuals to manage their risk of exposure.[8] Just as Bayer (1991, p.1503)

[8] Education about modes of transmission and behavioural risk are crucial in reducing HIV prevalence, but do not alone constitute an effective response. Individuals who understand

predicted that exceptionalism would decline if the epidemic affected only certain (marginalised) population groups, Burris (1994) also observed that when viewed as a result of behavioural risk and social conditions, HIV "seems much less exceptional than when we think of it as a sudden viral invader" (p.262). The fear and anxiety once inspired by the virus has declined, as understanding and management of the epidemic increases and particularly as new and more effective treatments become available.

Despite these challenges, AIDS exceptionalism has endured as a framework for positioning HIV on the policy documents and political agendas of governments because it is an effective route by which resources and power can be garnered to deal with an issue, and because the narrative of exceptionalism had become established within the discourse of AIDS activists. Before the Copenhagen School had codified its model of securitization in the late 1990s, Bayer (1991) summarised the campaigning of exceptionalist AIDS activists as a constructivist process that has distinct resemblance to the securitization process:

> The broad political context within which decisions will be made about the availability of resources for prevention, research, and the provision of care will be affected by the changing perspective on AIDS. The availability of such resources has always been the outcome of a competitive process, however implicit. In the beginning, the desperate effort to wrest needed resources from an unresponsive political system in the context of a health care systems that failed to provide universal protection against the cost of illness compelled AIDS activists and their allies to argue that AIDS was different and required funding commitments of a special kind. (p.1503)

The alliance to which Bayer (1991, p.1503) refers had constructed HIV as an exceptional issue in order to attract a share of the finite resources available. Leading UNAIDS, Piot would engage in the same process by constructing HIV as an exceptional disease unlike other health issues and as uniquely deserving of the money and attention of world leaders. The special significance of Dr Piot's

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their exposure to risk may not be empowered to manage that exposure, for instance when sex workers risk infection through sex they must also be sufficiently empowered to negotiate condom use with male partners or clients and have access to those condoms and knowledge of how to use them effectively.

campaign, which is discussed in Chapter 6, was that he identified an extraordinary platform to which AIDS could be anchored: the United Nations Security Council. By linking HIV with security in this globally revered institution, Piot knew that he could engender the exceptional financial and political response that was required to tackle the epidemic (Piot, 2013).

The securitization process attracts resources because it positions the proposed threat at the apex of a hierarchy of priorities that otherwise concern the audience; in the case of HIV, securitization at the level of the UNSC required members to accept that HIV was of greater salience than other, non-securitized health issues such as malaria or breast cancer. To accept that security exists within a hierarchical framework of competing concerns, as according to the foundational logic the Copenhagen School, is to accept that those not achieving the prioritised status do not merit as many resources or as vigorous a response. Instead, resources are invested in dealing with perceived existential threats and can be diverted from other (perhaps equally compelling) issues that have not been successfully securitized. The diversion of resources from non-securitized health issues has raised concerns among many analysts in the global health arena (e.g., Elbe, 2006; McInnes & Lee, 2006; Davies, 2009). In the past decade, there has been a backlash against the exceptionality of the international AIDS response, with specific attention paid to the amount of resources that this approach has engendered; according to critics, these are disproportionate to the burden of disease (England 2007, 2008; Smith & Whiteside, 2010). In his assessment of AIDS exceptionalism and the response it engenders, England (2008) states that disease-specific funding has detrimental impact on the organisational structures and economies of aid-recipient countries, for many of whom HIV aid "often exceeds total domestic healthcare budgets". It has also been argued that more than three decades into the epidemic, epidemiological data no longer supports the case for exceptionalism, with fewer people than expected falling ill or dying as a result of HIV (Bayer, 1991, p.1503; England, 2008).

After initial fears of an uncontrollable pandemic in the global North proved unsubstantiated, HIV/AIDS did not feature on the agenda of international politics until the creation of UNAIDS in 1996 (Smith & Whiteside, 2010, p.3). Despite early

predictions of a widespread epidemic, prevalence in developed countries did not reach significant numbers within the general population, instead remaining concentrated within the easily distinguishable groups first identified as being at increased risk of infection (Beyer, 1991, p.1503). The proposed links between poverty, economic instability, and HIV have faced serious critique (England, 2008), and the empirical evidence underpinning HIV-security claims has been called into question (Barnett & Prins, 2006). Perhaps most convincingly, with modern technological advancement in medicine the exceptionalist policies that complicate testing and diagnosis may now be widely regarded as hindering access to treatment and effective response rather than protecting people affected by HIV/AIDS (Smith & Whiteside, 2010, p.3).

In its contemporary state, the global HIV/AIDS epidemic may be best dealt with not through an exceptionalist framework but, conversely, with normalisation of the virus and of its treatment and diagnosis. From the outset, normalisation of *people* living with HIV/AIDS has been a foundational feature of civil society campaigns, even when their demands to exceptionalise legal protection for these people constituted the extraordinary. Normalisation of testing would contravene the early types of exceptionalism advocated by civil society and rights groups, but may be demanded in coming years because, with medical advances in treatment and prevention, routine HIV/AIDS testing can now reasonably be expected to increase the number of people who know their status and are able to manage their condition, thus reducing the risk of infecting others (De Cock & Johnson, 1998; Pisani, 2008).

Testing as part of routine medical services offers significant potential benefits in terms of increasing early diagnoses (which lead to higher survival rates and less costly medical regimes) and acts as an effective intervention to prevent transmission. Recent research undertaken in the HIV Prevention Trials Network 052 study shows conclusively that treatment is an effective method for prevention of new infections, as PLWHA who adhere to treatment regimens are able to lower their viral load so far as to make infection to others significantly unlikely (WHO, 2012). Where it can be linked to provable reduction in transmission, normalisation

of testing and routine testing of pregnant women for HIV/AIDS has been advocated by De Cock & Johnson (1998), and routine HIV testing for key affected populations and high risk groups may become an increasingly popular demand among CSOs as well as epidemiologists (Pisani, 2008).

5.5. Conclusion

In conclusion, AIDS exceptionalism defined the political and social context which later facilitated the securitization of HIV/AIDS within the global community. This is particularly true within the professional, political and medical establishment that had been most involved with the exceptionalist campaigns. Following its emergence in the global North during the 1980s, HIV/AIDS was an epidemic that demanded political attention, public health intervention, and specific policy. The disease was subject to a unique form of political mobilisation by civil society groups and non-state actors that has since come to define the global response. The result of this activism was initially a form of AIDS exceptionalism characterised by a rejection of traditional public health interventions, with new, disease-specific policies that emphasised patient autonomy, clinical confidentiality, special legal protections, and enhanced levels of privacy and rights protection for people living with or affected by HIV/AIDS. In its more recent form, AIDS exceptionalism has led to the creation of a well-funded disease-specific global response that, as explored in the following chapter, became the framework for the next stage of securitizing HIV/AIDS.

Exceptionalism has led to significant advances in the management of HIV/AIDS; it is an outcome of greater civil society involvement in public health management and policy making and, since the 1994 Paris AIDS Summit, the greater involvement of people with HIV/AIDS has been formalised through the adoption of GIPA policies among international norm setters including the UN and Global Fund, with positive effect on the response in general (APN, 2004, p.3; UNAIDS, 2007). The exceptional public health approach employed to deal with HIV/AIDS has also helped to contain the epidemic within key affected populations and to raise substantial funds for dealing with the disease globally, helping to secure ARV

access for millions of PLWHA who would be otherwise unable to afford treatment. Annual reports published by UNAIDS show that in many regions, rates of new infections have declined in recent years and access to treatment is increasing (e.g., UNAIDS, 2011a; UNAIDS, 2012; UNAIDS, 2012a; UNAIDS, 2013b).

Possible additional benefits of the exceptionalist approach include the de-formalisation of medicine and the greater involvement of patients with their individual care, leading to a cultural shift in which patient-doctor communication is enhanced (De Cock & Johnson, 1998, p.292). Exceptionalism may also have contributed to greater patient autonomy, greater respect for informed consent (related to testing) and increased patient advocacy for HIV/AIDS as well as other diseases (De Cock & Johnson, 1998, p.292). As a precursor for securitization, exceptionalising HIV/AIDS amounted to politicisation of the virus, raising the profile of the disease and increasing the resources allocated to dealing with it. Because denial, reticence, and 'silence' borne from the sexualisation and stigmatization of the virus are significant barriers to effective programmes and policy making, this advocacy and awareness-raising has challenged some of the major barriers to dealing with the disease. In this respect, exceptionalisation can be considered a positive, or at least necessary, part of affecting an efficacious global response to HIV/AIDS. However, with medical advancement that enhances the quality of treatment and its effectiveness, claims to exceptionalism that are deemed too reliant on outmoded rationale, or that complicate or hinder access to tests and treatment, are not sustainable. The alternative and more recent manifestation of AIDS exceptionalism focuses on access to treatment and the allocation of funding and resources, and this features in the Chapter 6, which explores how exceptionalism has been successfully employed in the UN-led global response.

Chapter 6: Securitization at the United Nations Security Council

It has been established in the thesis so far that fear is an essential component of security, which amounts to the construction of existential threats through the use of suasive speech acts, namely fear appeals. Chapter 3 concluded that fear can be productive or destructive and that existing literature on the psychology of fear appeals identifies a number of variables by which the productivity and success of appeals are determined. These variables are concurrent with the "facilitating conditions" of securitization theory that are proposed by the Copenhagen School (Buzan et al., 1998, p.31). The authority of the speech actor, the severity of the threat, and the inclusion of proposed evasive or defensive responses within fear appeals all increase the likelihood of the audiences' persuasion and, in instances of securitization, of their legitimation of extraordinary power or violation of normal boundaries in dealing with the proposed threat.

HIV/AIDS was the subject of a concise and strategic process of securitization that was led by UNAIDS Executive Director Dr Peter Piot, with US Ambassador Richard Holbrooke as its "architect", and US Presidential candidate Al Gore as an authoritative securitizing actor (Piot, 2013). The process culminated in January 2000, when the United Nations Security Council convened its 4087th meeting that was dedicated to addressing "the impact of AIDS on peace and security in Africa" (UNSC, 2000). By bringing HIV/AIDS to the Security Council, Piot and his colleagues had already succeeded in framing the epidemic as a security issue and had made an unprecedented link between health and traditional security. The meeting also served as a platform from which further securitization could occur and the following chapter examines how inclusion of HIV on the UNSC agenda mobilised the resources and attention of national leaders and heads of state. This mobilisation was Piot's intention and was made possible because his securitizing speech acts, and those of his supporters at the meeting, met the criteria for fear appeal and securitization success; they possessed the authority to articulate the

claim and to convince the audience of the existence of the threat, they invoked fear of a threat that the audience perceived as severe and as threatening their own interests, and they offered a "way out" or solution, in the form of a three point efficacious response that included Peacekeeper troop mandates that were subsequently enacted (Buzan et al., 1998, p.33).

United Nations Security Council Meeting 4087 (UNSC 4087) signalled a "watershed" in the international response to HIV/AIDS, marking the first time that the Security Council had engaged with disease as a security issue (Elbe, 2006, p.121). UNSC 4087 both indicated the success of securitizing claims about HIV/AIDS (McInnes & Rushton, 2010, pp.227, 244) and acted as a platform from which further securitizing moves were made. At the meeting, HIV/AIDS was framed in terms of traditional, military security concerns and the Peacekeeping Operations for which UNSC Members are legally responsible were used as a "hook" to engage the Council with the non-traditional issue of health (Piot, 2013). Piot also employed the internal linguistic conditions of the speech act, using Peacekeeper Operations as the "possible way out" demanded by the "grammar" of the securitizing speech act (Buzan et al., 1998, p.33). It had a significant impact; the meeting was the first time that a non-military issue had been awarded international security threat status by the UNSC (Vieira, 2007, pp.149-150). However, through a series of in-depth interviews and discourse analysis of policy documents, this chapter problematizes these securitizing claims and reveals complex motivations for bringing HIV/AIDS to the Security Council, beyond its dimensions as a security threat. It also examines the method by which Piot constructed the threat, outlining the way in which fear was invoked and managed through the provision of efficacious responses in order to ensure success of the securitizing process.

The process of framing HIV/AIDS as a security issue took place at the level of international institutions of global governance, led by the United Nations and the multi-lateral institutions and systems with which United Nations organisations work, including the World Health Organisation, the G8, and the World Bank. But while the first UNSC Meeting on HIV/AIDS can be regarded as an indication of accepted securitization of HIV/AIDS at the level of international political

institutions, the translation of this rhetoric to domestic responses and the endurance of the security-HIV linkage have proven limited. The construction of HIV/AIDS as a threat to traditional concepts of security, (namely the stability of states, their economies, and their military forces) was effective enough to bring HIV/AIDS to the agenda of the UNSC and led to multiple HIV/AIDS related Resolutions and Presidential statements, including Security Council Resolution (SCR) 1308 on HIV/AIDS and Peacekeeping Operations in 2000, SCR 1325 in 2000, SCR 1820 in 2008, SCR 1888, 1889, and 1894 in 2009, SCR 1960 in 2010, and SCR 1983 in 2011. But there remains doubt in the academic community that Member States were ever entirely convinced by these claims (McInnes & Rushton, 2010); Richard Holbrooke, then US Ambassador and key speaker at Meeting 4087, recalls that there was a lack of consensus among permanent members of the Council, particularly from Russia who, "didn't want to violate the standard rules of the Security Council" by discussing an issue they considered to be only of internal concern to the state (PBS, 2005). Piot (2013) also recalled this contestation in interview, when he noted that the opportune timing of the meeting during a quiet period of the UNSC schedule was crucial in securing the agenda and suggested, "Maybe if this had been in the middle of the year it could have been totally undermined by all the other members".

The issue of persuasion remains contested and it may be impossible to ever fully discern whether Members of the UNSC were convinced by the securitizing rhetoric of the meeting or whether they were motivated by humanitarian (or other) concerns. At the sub-state level, fear of HIV/AIDS is not solidified around the propensity of the virus to affect security but rather about the impact it has on personal health and societal stability, reflecting a framework more akin to that of human security. Data from key participants in the response to HIV/AIDS in Thailand and Myanmar, which is presented later in this thesis, suggests that securitization was not evident at the national level although its impact can be seen in the increased availability of resources from both internal and external donors. The findings from Thailand (detailed in Chapter 7) are particularly significant because Thailand has been close to the operations of the UNAIDS since it was established and has been lauded as a "visionary leader" and a "model" for the

global response (United Nations Development Programme [UNDP], 2004, p.29; UNAIDS, 2009; UNAIDS, 2012d). It could therefore be expected that if UN securitization of HIV/AIDS had disseminated from the supra-state to state level, it would appear in the policy and implementation of the Thai national response. This is not the case. Instead, both Thailand and Myanmar have ignored or rejected the proposed links between HIV and traditional security concepts that were discussed at the Security Council, favouring instead a human security and human rights orientated framework when dealing with the disease.

Studies on the securitization of HIV/AIDS typically identify UNSC Meeting 4087 as a turning point in the global response, if not a mark of successful securitization of the virus (Feldbaum & Lee, 2004; Garrett 2005; McInnes & Lee, 2006; Elbe, 2006); it was the first time the Security Council had convened a meeting solely about a non-traditional security issue. McInnes & Rushton (2010, p.227) note that as late as December 1999, Secretary General of the United Nations Kofi Annan had rejected requests to bring HIV onto the agenda of the UNSC, yet less than two months later the Security Council convened on its first meeting of the millennium to discuss the virus as a "security threat of the greatest magnitude" (UNSC, 2000, p.2). There is currently no detailed examination of the diplomatic manoeuvring that led up to this seminal meeting or to the subsequent UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001. This chapter examines the political and social context in which UNSC securitization of HIV/AIDS was possible and awards particular attention to the facilitating conditions that allowed this to occur; for the suasive acts of securitization to succeed, the criteria outlined in Chapter 3 must be met. The tactical use of fear appeals and security rhetoric employed by Dr Piot at UNAIDS and the inclusion of efficacious measures in the securitizing claims that offered Council Members an actionable response are examined below.

Reviewing the literature and available documentation, which include detailed minutes and speech transcripts from these UNSC sessions, key actors involved in this process were identified and interviewed. After contacting Lord Malloch-Brown, who attended the meeting in his former capacity as Administrator of the United Nations Development Programme, Dr Peter Piot was identified as

"the person most at the heart of it all" (Malloch-Brown, 2011). This was corroborated by UNAIDS Country Coordinator for Thailand, Michael Hahn (2013) who referred to Dr Piot as "*the* insider on what happened and why" and told the author that "he had the strategy, it was his idea, and he managed the whole thing" Hahn (2013) suggested that Dr Piot regarded this meeting and the subsequent UNGASS session to be "the big milestone" and the "jewel" in the securitization of HIV/AIDS. Dr Peter Piot was contacted for interview and the following explanation of the securitizing process leading up to the UNSC meeting is based on his account to the author and on the available records, including his memoir *No Time To Lose* (Piot, 2012, p.148).[9]

6.1. Construction of the Security Threat

The evolution of HIV from political issue to security threat did not occur until the mid-1990s. This thesis finds that UNSC Meeting 4087 was part of a specific strategy lead by Dr Piot to mobilise the extraordinary response needed to address the epidemic, although these responses were subsequently not always controlled by UNAIDS (the largest financial contributions to the global response are channelled through external bodies including PEPFAR and the Global Fund). After his appointment as Founding Director of UNAIDS in 1995, Piot began what he referred to as a "strategy" of promoting HIV/AIDS as a matter of urgency and priority for world leaders, building on the foundations of AIDS exceptionalism in order to frame his approach (Piot, 2013). In his memoirs he recalls, "I felt [UNAIDS] should become the world's advocate for AIDS, mobilising desperately needed resources" (Piot, 2012, p.220). His securitizing rhetoric is evident in a statement made in 1999, in which he used UNAIDS as a platform from which to prompt action from the government of Myanmar, who were at that time reluctant to acknowledge their internal epidemic; at a press conference in Bangkok, Piot announced, "we need to concentrate our efforts on Burma, convince the government this is a matter not only involving the people but of national security" ("Burma Rejects UN Fears" 1999).

[9] Piot's memoir includes a chapter titled, *The Tipping Point*, which details the process of taking HIV/AIDS to the Security Council in 2000.

Although neither Myanmar nor Thailand adopted this rhetoric within their internal discourse on HIV/AIDS, the securitization of HIV/AIDS that Piot orchestrated at the international level did mobilise an unprecedented global response to HIV/AIDS (UNAIDS, 2012c, p.5; Kaiser Family Foundation, 2014) and was made possible by the existing framework of civil society activism and theory of AIDS exceptionalism that was outlined above.

The model of securitization is linear, with 'security' as a status at the apex of priority and concern; accordingly, securitizing claims are built upon the foundation of the preceding politicisation of an issue (Buzan et al., 1998, p.29). Dr Piot is a vocal advocate of AIDS exceptionalism and has used the rhetoric and the established claims of AIDS exceptionalism to lobby global leaders for greater involvement and commitment to HIV/AIDS. This is a strategy that he credits with quantifiable output, concluding that the success of Uganda's epidemic response was due in part to, "the urgency of countrywide mobilization" (Piot, 2012, p.241). In keeping with the internal grammatical criteria of the speech act outlined above, framing the disease as a matter of absolute priority was a central tenet of Piot's securitizing moves and he remains explicit in his use of fear appeal rhetoric when speaking about HIV/AIDS; for example, in 2005 in his address to the UNSC, Piot (2005) told Members that "the threat posed by the AIDS epidemic has not dwindled. Indeed, it continues to outstrip our worst fears" (pp.2-3).

In order to deliver a successful suasive claim, fear appeal, or securitizing act, the enunciator must possess sufficient authority to convince the audience to accept that claim. In securitization theory, this authority, or "relationship between speaker and audience" is one of the "social conditions" that the Copenhagen School identifies as a facilitating condition (Buzan et al., 1998, p. 33). The literature on fear appeals finds that the authority of the message communicator affects the audience's perceptions about the credibility of the message, the severity of the proposed threat, and the efficacy of proposed responses. As Director of UNAIDS and a renowned virologist and social epidemiologist, Dr Piot possessed the authority with which to deliver convincing securitizing claims. However, his suasive speech acts were also disseminated through other authoritative actors and agents. In order to provide the

level of resources deemed necessary by UNAIDS, Piot believed the disease would have to be addressed not only as a health issue but also as an issue of development, economics, and security, requiring UNAIDS to engage with international agents such as the World Bank and IMF, as well as national agencies within Member States. In addition to articulating the HIV-security link through UNAIDS, Piot specifically sought other authoritative platforms from which to deliver his securitizing appeals, and lobbied individuals with authority to act as securitizing actors.

In interview with the author, Dr Piot (2013) explained how he sought to identify a suitably authoritative multilateral institution with which to pitch his claim to more resources for HIV/AIDS. In one sense, UNAIDS provided this authority, but Piot also saw an opportunity to use UNAIDS, a new UN body, to construct an understanding of the virus that would be sustained in influential policy circles, explaining that "the key issue there is that it's the first serious body that takes it on that sets the tone, and then others will follow" (Piot, 2013). Piot hoped to influence actors beyond those already engaged with HIV/AIDS; in his written account of the formation of UNAIDS during the 1990s he states, "we had no chance to defeat the epidemic unless we pulled out [*sic*] of the 'ghetto' of AIDS doctors, researchers and activists, and built a broad coalition" (Piot, 2012, p.248). Being part of the UN system "gave UNAIDS legitimacy, potential access to top leaders, and a platform from which to deliver policy guidance" and Piot was aware of the importance of setting precedent and disseminating international norms for dealing with the epidemic. Of the USA, Piot (2012) wrote, "we knew the United States was key. It was both the most powerful and the richest nation in the world, and it set trends and framed the way other countries envisioned problems" (p.263). In locating an authoritative multilateral institution as a platform from which to launch his securitizing rhetoric and action, Piot viewed the UN Security Council as the only body with sufficient power and authority to enact change amongst UN members. He noted that the UNSC was set apart from other UN bodies that had "no teeth", because its decisions are, "in theory", binding (Piot, 2013). According to Piot (2013), the UNSC was the only institution "really taken more or less seriously".

Piot identified not only authoritative platforms, such as the Security Council, and actors, such as the United States, but also individuals. UN Secretary-General Kofi Annan was identified in this capacity as, "one essential person...we didn't just need him on board, we needed him to become the world's AIDS advocate" (Piot, 2012, p.249). With authoritative figures speaking the language of security and HIV/AIDS, it was possible to disseminate the message to other influential actors; Piot notes that in 1999, "we also forced all the major aid agencies to discuss AIDS for the first time ... with African ministers, activists, and business leaders, at a meeting convened by UN Secretary-General Kofi Annan" (Piot, 2012, p.271). This strategy worked, following the UNSC meeting on HIV/AIDS in 2000, Piot (2012) notes that "for years to come, presidents and prime ministers would tell me, 'if AIDS was debated in the Security Council, this must a serious problem'" (p.275).

UNSC meeting 4087 was arranged by then-US Ambassador to the UN, Richard Holbrooke. Although his central role in the meeting and as an AIDS activist is well documented (Sternberg, 2002; PBS, 2005; Barnett & Prins, 2006), research for this thesis reveals that Holbrooke was specifically targeted and lobbied by Dr Piot as part of his securitization strategy. Piot (2013) described Holbrooke as "a bulldozer" who could bring HIV/AIDS to the UNSC despite "enormous resistance from just about everybody" and targeted him as an authoritative individual who could advance the campaign to securitize HIV/AIDS.

Publically, Holbrooke attributed his commitment to high-level HIV/AIDS activism to two personal experiences; his observation of Peacekeeper troops buying commercial sex and "spreading AIDS" in Cambodia, and a trip to Lusaka, Africa in 1999 (PBS, 2005). This latter trip was made in his capacity as US Ambassador when he visited the Great Lakes region in order to assess ongoing violent conflict. There, he was taken to visit the Fountain of Hope Day Care Centre for children with HIV and following this he recalls, "I came up with the idea that we should hold a special session of the Security Council on HIV/AIDS" (PBS, 2005). This personal experience is identified in the literature as a seminal moment in the securitization of HIV/AIDS; Campbell (2008) calls it the beginning of the "formal securitization of HIV/AIDS" (p.1) by the United Nations, and McInnes & Rushton (2010, p.227) refer to it as a

starting point for the securitization of HIV at the UN. The newspaper *USA Today* reported an interview about the Lusaka tip with Holbrooke's travel companion, Senator Russ Feingold, who said, "what Richard Holbrooke did on that trip has to be one of the seminal events that led to an increased focus on AIDS in Africa" (Sternberg, 2002).

In interview for this thesis, Piot (2013) explained how he had recognised the influence of Holbrooke and had lobbied him individually in order to bring AIDS to the UNSC platform, as part of the UNAIDS strategy to promote HIV/AIDS:

> I had met [Holbrooke] a few times and it kind of clicked between us and I think it was early November, he made a trip with Security Council members to the Great Lakes region because of all the war and all that was going on, as the Security Council does regularly. And I made sure that wherever they went, in every country, they would run into people living with HIV and AIDS activists or UNAIDS staff. It's a classic activist approach.

Piot's strategy, facilitated by his networks of people on the ground and civil society, had worked. As Holbrooke returned from Africa, convinced that HIV/AIDS demanded the exceptional response advocated by UNAIDS, he contacted the United Nations Secretary General Kofi Annan by phone. Senator Feingold told journalists, "I watched him call up the Secretary-General (Kofi Annan) and tell him we have to have a Security Council meeting on AIDS" (Sternberg, 2002). It is noteworthy that Annan was not initially convinced by the proposal and according to Feingold, he replied, "We can't do that. AIDS isn't a security issue" (Sternberg, 2002), indicating that, like the Russian contingent at the UNSC, the Secretary General was sceptical of the inclusion of a non-traditional security issue on the Council agenda. In interview with the author, Piot acknowledged this initial reluctance from Annan. However, within two months the Security Council would hold a meeting dedicated to HIV/AIDS. Piot (2013) recalled:

> Then when they came back [Holbrooke] gave a press conference about the war and the unrest in the Great Lakes region but also he said, but there is one problem that kills even more people, and that's AIDS – wherever we were, we came, we saw [AIDS].

The account given by Piot reveals his strategic influence that preceded Holbrooke's intervention. By confronting the Ambassador with the bodies of PLWHA, Piot had

utilised a visual display of people suffering with HIV/AIDS in order to lobby Holbrooke and to gain his support as an 'HIV advocate'. In an epidemic characterised by biopolitical and socio-economic segregation, collapsing the distance between powerful people without HIV/AIDS and disenfranchised people with HIV can be achieved by the literal use of HIV+ bodies for political ends. This might be considered a form of fear appeal, although it is more likely that it invoked a humanitarian concern within Holbrooke that motivated his subsequent use of securitizing language at the UNSC.

6.2. Severity of the Threat

Piot advocated a multilateral response to HIV that from the outset addressed social as well as medical conditions as being fundamentally important to controlling the epidemic (Piot, 2012). In part, this was driven by the nature of UNAIDS as an institution; due to the myriad social and economic impacts of the virus, many of which are culture or gender-specific, HIV/AIDS featured on the agendas of multiple UN agencies before the creation of UNAIDS in 1996. Among others, UNICEF, UNESCO, and UNFPA were competing to take ownership of their niche area in the epidemic, and UNAIDS - the Joint United Nations Programme on HIV/AIDS - was established in order to coordinate a unified response from the UN (Pisani, 2008, p.13; Piot, 2012, p.207). The potential of the newly created UNAIDS agency was to enact change on a global scale because, Piot (2012) reasoned, "making global recommendations was the sort of work that only a multilateral agency could do, as it is in principle not bound by the interests of a particular nation or industry" (p.204).

The suasive nature of a multisectoral, multilevel threat was utilised by Piot in his securitization campaign. Piot and Holbrooke presented HIV/AIDS as a threat to the Members of the Security Council by linking it to the concerns of the influential Member States, explaining that it was both in their interest to prevent insecurity in Africa and their legal responsibility to ensure that Peacekeeper troops did not spread or contract HIV. When HIV/AIDS became feared not just by those most vulnerable to infection (often the poor and marginalised), but by a wider

population, this fear could stimulate the adoption of a proactive, resource-fuelled response. The perception that HIV affected people and institutions beyond the marginalised "other" allowed an effective practical response to take shape because it engaged a range of actors. These actors were motivated to respond not solely from compassion or humanitarian concern for the 'other', but because they sought to alleviate their own fear of economic instability in markets, political unrest or civil disorder, or illness and disability among military recruits. As a fear appeal, this framing of HIV/AIDS as a multisectoral threat constitutes the persuasion of audience that the threat is severe and they personally are susceptible. In addition to increasing the likelihood of fear appeal success, by framing HIV/AIDS as a multisectoral security threat it was also possible to mobilise the wide range of actors that are needed to effectively tackle the epidemic.

From an epidemiological perspective, there is no 'single' HIV/AIDS epidemic but rather many epidemics that require tailored responses (Smith & Whiteside, 2010). The nature of HIV is that each geographically or demographically defined epidemic is shaped by the specific cultural and social conditions in which it exists and spreads, and therefore each has a "different dynamic and course, each varying from city to city, village to village, community to community" (The Lancet, 2004). Such complex circumstances raised the demands on any organisation attempting to orchestrate an effective response. The international institution that preceded UNAIDS was the WHO's GPA, which "never addressed AIDS solely as a medical problem" under the directorship of Jonathan Mann, who had worked with Piot in Zaire as part of Projet Sida (Knight, 2008, p.15). Dr Piot's personal experience of social epidemiology, gained during the discovery of Ebola Zaire in the 1970s, informed his later position that HIV/AIDS was a multisectoral threat (Piot, 2012, p.69).[10] Piot (2012) has stated that when designing an epidemic response, "anything

[10] From the outset, the UN bodies established to address HIV/AIDS have dealt with social, political, demographic and cultural issues as well as the medical aspects of the disease. Social epidemiology places emphasis on the importance of social and behaviour conditions as affecting disease vectors and transmission: e.g., in his account of managing the first clinical response to Ebola Zaire, Dr Piot highlights the important breakthrough that came from assessing the reasons why funerals resulted in infection peaks. The epidemiological team found that corpse washing rituals provide a vector for transmission, and this culturally

with the word *only* doesn't work in AIDS" (p.241) and he is a strong advocate for a multisectoral response. The official policy of UNAIDS is to frame HIV/AIDS as a multisectoral issue, a position that has been challenged in recent years for its effectiveness and empirical basis (England, 2008). However, the perception of HIV/AIDS as an issue requiring multisectoral and multilateral responses continues to inform mainstream epidemic management.

From his authoritative position as the Director of UNAIDS, Piot did not engage in securitization of HIV/AIDS because he believed the virus posed any immediate threat to military capability, contra to what was discussed in the UNSC minutes (Hahn, 2013). Instead, in his own words, Piot (2013) sought to "bring AIDS to where big decisions are made and where there is power". Recognising the potential authority and influence of the UNAIDS office, Piot and his team sought to engage the interest of world leaders and to bring the AIDS epidemic to their attention as an issue to be feared and as an issue with direct, negative consequences for their own interests. Elizabeth Pisani (2008), who worked as an epidemiologist with a background in journalism, was employed by UNAIDS in its initial years and detailed her experiences manipulating statistics in order to raise awareness of the epidemic. A chapter in her semi-autobiographical book on "the AIDS industry" is titled *Cooking Up An Epidemic* and explains how her journalistic training was used to "beat up" stories and data from epidemic, with the intention of lobbying more funds from "rich countries" by "infecting them with the same urgency" felt by the staff at UNAIDS (Pisani, 2008, pp. 20-21; see also, Smith & Whiteside, 2010).

After its launch, Piot directed UNAIDS to engage in explicitly securitizing HIV in order to attract funding, attention, and other resources from global leaders. Referring to this lobbying, Piot (2012) states, "in international politics there are only two things that count: the economy and security" (p.248). In the late 1980s, he had approached the World Bank to lobby for their investment in the global AIDS response, but had failed to convince them that the plan would be cost effective, or to sufficiently couch each intervention in terms of positive economic impact (Piot,

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specific information both contributed to their understanding of the virus, and formed part of their successful containment response (Piot, 2012).

2012, p.209). He described this as, "a mistake I tried not to make again" and his later success with the UNSC suggests that he became skilled at framing issues in the language that best appealed to their audience (Piot, 2013).

Securitization requires an audience to accept that an existential threat exists, to be fearful of the threat and its implications, and to accept that its severity and urgency warrants a break from normal procedure. In this case, the Security Council members had to be persuaded that HIV presented a threat to security so great as to warrant the unprecedented inclusion of a health issue into the remit of the Council and of such severity that the resulting mobilisation of resources would be legitimated. The securitizing claims of Dr Piot, Ambassador Holbrooke, and their supporters, were that HIV/AIDS merited inclusion on the agenda of a body traditionally concerned with a narrow definition of security. It was widely understood by this time that, "AIDS wasn't just a health issue: it was a development crisis that was damaging the future of entire societies" (Piot, 2012, p.251) and the established links between development, poverty, and health were useful in facilitating the securitization of the virus, which had already transcended the domain of being "merely" a health issue (van Donks, 2008, p.245; Davies, 2009, p.72). This contextual knowledge of HIV/AIDS was buttressed by the rhetoric of fear and catastrophe employed at Meeting 4087, where World Bank President James Wolfensohn told Members that "AIDS is not just a health issue. AIDS is not just a development issue. It is also an issue that affects the peace and security of people in the continent of Africa and throughout the world" (UNSC, 2000, p.8). Illustrating the new, multisectoral nature of HIV/AIDS as a security issue, Wolfensohn was the first President of the World Bank invited to speak at a meeting of the Security Council.

Health, and specifically disease, were an exceptional and unprecedented meeting topic for the UNSC in 2000. In order to bring the disease to the UNSC agenda, Piot chose to frame the epidemic in terms of traditional security and appealed to the traditional understandings of security employed by the Council. Whilst this risks undermining the legitimacy of human or health security as frameworks in their own right (Peterson, 2002; Elbe, 2006), it remains an effective

way of fast-tracking a health issue onto the agenda of security concerns (Davies, 2009, p.19). Kofi Annan set the tone of the Meeting 4087 when he stressed the links between HIV and warfare in his opening address to the Council:

> But nowhere else [outside Africa] has AIDS yet become a threat to economic, social and political stability on the scale that it now is in southern and eastern Africa. The impact of AIDS in that region is no less destructive than that of warfare itself. Indeed, by some measures it is far worse. (UNSC, 2000, p.4)

This approach was also employed by Wolfensohn, who likened the virus to war and linked it to state instability with ramifications for international security, telling the Council: "this problem is more effective than war itself in terms of destabilizing countries" (UNSC, 2000, p.8). Piot referred to war in his address, stating, "War is one of the instruments of AIDS, as rape is one of the instruments of war. Conflict and the resulting movements of people fuel the epidemic" (UNSC, 2000, p.11). Malloch-Brown also drew direct comparison between the traditional security concern of war and HIV/AIDS, telling the Council that:

> Africa is under siege. Many times more people are being killed by the disease in sub-Saharan Africa each year than in all the world's wars. This is a new security front line and I congratulate Richard Holbrooke for the vision to go beyond old definitions to bring to this table a discussion of the world's most dangerous insurgency. (UNSC, 2000, p.9)

In addition to these explicit comparison or linkages, militaristic language and metaphor was also employed as an indirect way to invoke the framework of traditional security. Presiding over Meeting 4087, US Vice-President Al Gore also referred to the "front line of defence" against HIV/AIDS and defended the inclusion of the disease on the Council agenda by saying that, "many have called the battle against it a sacred crusade. The United Nations was created to stop wars. Now we must wage and win a great and peaceful war of our time — the war against AIDS" (UNSC, 2000, p.7). Malloch-Brown, was also explicit in his use of the military metaphor, stating, "We must view this as a war on three fronts: first, the classrooms and clinics of Africa; secondly, the families of Africa; and, thirdly, international action — the critical support needed to back Africa's front line" (UNSC, 2000, pp.9-10).

Military metaphors are often used to describe medical conditions and treatment and remain in use; at the African Summit on HIV/AIDS, TB and other infectious diseases in April 2001, Kofi Annan called for a "war chest" fund to tackle AIDS (Ferriman, 2001, p.1082). This rhetorical device fits with the threat-defence logic identified by Elbe (2006) in his study of securitization and corresponds to popular contemporary understandings of disease from the Western medical perspective; for instance, with cancer both individual treatments such as chemotherapy and public health campaigns to reduce 'unhealthy lifestyles' are described as 'wars' and 'battles' fought against the disease. The widespread use of military metaphor in medicine can be traced to the invention of optical microscopy and subsequent advances in cellular pathology in the 19th century, including the seminal discovery by Robert Koch that microorganisms are a source of disease (Sontag, 1989, p.9). Imagining the virus as a minute but deadly "external invader" of the healthy body is an enduring feature of epidemic responses to infectious disease and the traditional military metaphor may have assisted Piot in his persuasion of the Council in 2000.

6.3. Solutions and Efficacious Responses

Invoking the military metaphor is a useful way of stimulating fear of HIV/AIDS as a security issue, but this fear and attention must be managed in order to promote an effective response. As outlined in the chapters above, fear appeals that 'backfire' are liable to create an aversion or distancing effect in their audience rather than leading to productive behavioural change or the acceptance of suasive claims. Despite these risks, the need to provoke attention for HIV/AIDS is arguably greater than with other epidemics because the unique stigmatisation of HIV/AIDS leads to silence, denial and a lack of action. In many ways, the existing fear of HIV/AIDS that stems from the epidemiological qualities examined above leads to an unproductive fear and aversion that can be countered by productive, well-managed fear appeals through securitization. For instance, Elbe (2006) identifies one of the benefits of securitizing HIV/AIDS as the ability to prompt action from governments that would otherwise remain silent or immobile on the issue; securitization is a way

of "breaking the wall of silence" (p.132) that surrounds HIV/AIDS (see also, Ferriman, 2001, p.1082). Elbe (2006) argues that at the internal level, governments can be mobilised to deal with HIV/AIDS by shifting the issue to the security agenda because, "securitization of HIV/AIDS has also allowed some states to shift responsibility for addressing the issue from ministries with only very little political clout to political bodies with greater influence on the political process" (p.132). Breaking the silence was an explicit aim of the UNSC Meeting 4087, according to Meeting President Al Gore, who told the Council that:

> We know that the first line of defence against this disease is prevention, and prevention depends on breaking down the barriers against discussing the extent and risks of AIDS. That is one purpose of this historic Security Council meeting. Today, in sight of all the world, we are putting the AIDS crisis at the top of the world's security agenda. We must talk about AIDS not in whispers, not in private meetings alone, in tones of secrecy and shame. We must face the threat as we are facing it right here, in one of the great forums of this earth, openly and boldly, with urgency and compassion. Until we end the stigma of AIDS, we will never end the disease of AIDS. Let us begin by resolving to end the stigma associated with AIDS. (UNSC, 2000, p.6)

Framing HIV/AIDS as a security issue rather than solely as a health concern allowed UNAIDS to influence the policy of high-level politicians and, at times, to override the position taken by Ministers of Health unwilling to address HIV. Where HIV/AIDS is wrongly attributed to distinct and isolated groups, the virus can be rejected as a potential source of fear via a process of 'othering'. At the individual level this can result in aversion to fear-based public health appeals in which audiences are alienated from the message, believing it to apply to some 'other' group, but not them (Slavin et al., 2007). A similar rationalisation can also occur at the level of policy discourse when political leaders claim that either the disease or its perceived vectors do not exist within certain populations. For instance, in 2007, Iranian prime minister Mahmoud Ahmadinejad claimed in an address to Columbia University that homosexuality did not exist among Iranian citizens; during the 1990s South African President Thabo Mbeki maintained the controversial belief that the HIV virus was not linked to AIDS; and for a short period the military rulers of

Myanmar claimed that HIV did not exist within their country, claiming instead that it was a "foreign" virus (Levy & Scott-Clark, 2002, p.360).

By framing the epidemic as a security issue at an authoritative UN institution, HIV/AIDS was awarded a level of urgency and importance and this allowed Piot to circumvent lower-level authority figures and to override their reluctance to deal with the politically sensitive issue. In interview, Piot (2013) recalls:

> I wanted to go beyond health, because the body that is governing health in the multilateral system is the World Health Assembly, but most Ministers of Health in these days were dead set against doing anything about AIDS. So that was one of my biggest problems. So I had to go around that. And that's where the idea of the Security Council came in.

The Copenhagen School recognises that one potential benefit of securitizing an issue is that it becomes "so important that it should not be exposed to the normal haggling of politics but should be dealt with decisively by top leaders" (Buzan et al., 1998, p.29) and the UNSC meeting of January 2000 was both a sign of successful securitization and an act for further securitization in itself; Dr Piot (2013) recalls:

> That debate ... opened quite some doors, ironically because when I sometimes met with heads of state and so on, they say 'Oh [HIV] was discussed in the Security Council, it must be serious' I mean it's ridiculous but that's the way it goes.

The meeting, which included the UN Secretary General Kofi Annan, US Ambassador Richard Holbrooke, US presidential candidate Al Gore, and World Bank President James Wolfensohn, signified both that HIV was a matter of national and international security and also further legitimated this framing in the minds of others. By invoking a fear of HIV/AIDS as a security issue as well as a health issue, UNAIDS was able to motivate actors who would otherwise refuse to, or be unable to, respond to the epidemic.

It is outlined in Chapter 3 that to be productive fear appeals should include a set of proposed responses by which the audience can mitigate the fear or sense of threat they encounter. In the securitization of HIV/AIDS at the UNSC, Member States were presented with claims that HIV/AIDS posed a threat to national and international security, but that it could be avoided and managed through their

efficacious actions. Piot's own address to the Council in Meeting 4087 was almost entirely dedicated to what he called the "good news" about HIV/AIDS, which was that "we know now what works: two decades of experience have identified the essential elements of effective strategy" (UNSC, 2000, p.11). Piot assured Members of their own efficacy, telling them, "we are far from powerless against this epidemic. In countries where strong political leadership, openness about the issues and broad, cross-cutting responses come together, the tide is turning, and clear success is being demonstrated" and, "Members of the Council, the challenge is formidable but so too are the technical, financial and political resources of the international community" (UNSC, 2000, p.11).

The strategy that was proposed to the Security Council had three components; first that HIV/AIDS was considered a security issue, despite its 'non-traditional' status. This had been achieved by the (albeit contested) inclusion of the disease on the Council agenda, but reiteration of the significance and importance of this inclusion exemplifies its importance; meeting President Al Gore told the Council:

> The powerful fact that we begin here today by concentrating on AIDS has a still larger significance: it sets a precedent for Security Council concern and action on a broader security agenda. By the power of example, this meeting demands of us that we see security through a new and wider prism and, forever after, think about it according to a new and more expansive definition. (UNSC, 2000, p.2)

From the UNDP, Malloch-Brown spoke to "congratulate" Holbrooke for "the vision to go beyond old definitions [of security]" (UNSC, 2000, p.9). By including disease on the agenda of the UNSC, it was expected that essential resources and attention would be dedicated to the global response.

The second component of the response strategy proposed at UNSC 4087 was outlined by Piot, who gave four model examples of productive responses in place in Africa (UNSC, 2000, p12). The first was concerned with the "aggressive" protection and promotion of human rights and the reduction of stigma; second, the mobilisation of support to governments, civil society groups and "actions involving people living with HIV"; third, the prioritisation of HIV/AIDS and a significant

increase in the commitment of resources and "more rational financing"; and fourth, the increased involvement of the private sector, which should "work in concert with Governments to balance the difficult issues of intellectual property rights with the urgent need to develop and make available life-saving drugs and other commodities" (UNSC, 2000, p.12). This last point might reveal an important additional motivation for bringing HIV/AIDS to the UNSC, as explored below.

The third component of the HIV/AIDS response strategy that was presented to the UNSC was that of Peacekeeper Operation management. The UNSC is responsible for the mandates that govern United Nations Peacekeeping operations and Piot saw this as an opportunity to link HIV directly to the practical work of the UNSC. In interview for this research, Piot explained that he intended to appeal to the legal responsibilities of the Security Council for managing Peacekeeper forces; in his words, he used Peacekeepers as a "hook" with which to bring HIV/AIDS to the attention of the Members (Piot, 2013). The functionality of peacekeepers, a vital institution of the UN Security Council, was also framed as a referent object; their capacity and liability for infection became sources of fear in relation to HIV/AIDS.

Prior to UNSC Meeting on HIV/AIDS, there had been widespread criticism of the UN Peacekeeping operations following the deployment of troops (the largest ever contingent) to Cambodia in 1993. Peacekeepers had been blamed for a peak in HIV and other sexually transmitted diseases among the local population; concurrently, infection rates among troops also increased and were detected once these personnel had returned to their home countries (Soeprapto et al., 1995). Troops on this deployment were well paid and were encouraged to mix with locals, facilitating the rate of sexual interaction between the two groups (commercial and otherwise) (Soeprato et al., 1995, p.1304). After visiting the country, Ambassador Holbrooke condemned the drunkenness and employment of sex workers by troops and their conduct received extensive and unfavourable attention in the international media, particularly after the Under-Secretary-General for Disarmament Affairs leading the mission, Yasuhi Akashi, dismissed criticisms by reportedly saying, "boys will be boys" (Independent, 1994; PBS, 2005; Lynch, 2005, p.A22). Security Council Members were aware of this recent criticism and, capitalising on this

concern, Piot highlighted the detrimental impact that HIV prevalence could have on the military capacity of Member states; he also offered a pragmatic solution for managing the issue in future.

Piot's Peacekeeper-HIV linkage took three forms: peacekeepers as a vector for disease transmission and the legal and ethical responsibility of the UNSC to prevent this; Peacekeepers as being at risk from HIV and the impact on their military capacity; and Peacekeepers as a potential resource in HIV prevention programmes. In interview, Piot (2013) explained,

> The Security Council is responsible for Peacekeeping operations and here the UN has a direct responsibility and liability about the behaviour, in a sense, of lots troops and I knew that at least there were accusations that in Cambodia Peacekeeping troops had contributed to the spread of HIV. ... So there were a number of hooks to bring that in. And also the combat readiness as they call it, for troops. And so I tried to put it in that framework.

It appeared evident from the situation in Cambodia that Peacekeepers were at risk from HIV/AIDS infection; prevalence rose from 0.5% to over 3.6% among troops following their deployment (Soeprapto, 1995, p.1304). These findings also fit with the prevailing (although not uncontested; see Barnett & Prins, 2006) knowledge norms that military personnel were at significantly higher risk of HIV than general populations, so their proposed role as a vector for transmission was persuasive (e.g., Singer, 2002). Al Gore explicitly repeated the link between Peacekeeper vulnerabilities in his address to the Council, stating that, "a single disease threatens everything from economic strength to peacekeeping, we clearly face a security threat of the greatest magnitude...[HIV/AIDS] strikes at the military and subverts the forces of order and peacekeeping" (UNSC, 2000, p.6).

Peacekeepers are an institution that defines the character of the UN Security Council and personnel are explicitly portrayed as the referent object in this speech act. Their proposed vulnerability to HIV/AIDS amounted to a weakening of the force of the Security Council and of the Member States from whose military forces they were sourced. In their individual speeches to the Council, Members reiterated the claim that HIV/AIDS presented an existential threat to Peacekeeper forces and thus to the security of the state; Mr Chowdhury, representing Bangladesh, stated:

> In many sub-Saharan countries, nearly half of the armed forces are affected. Civilian law enforcement is slumping as AIDS takes its toll on its personnel. This has threatened safety, security and law and order both within and beyond national boundaries. African military and civilian police personnel play a crucial role in peacekeeping. Their vulnerability to infection affects the defence of peace. (UNSC, 2000, p.16)

The solution that was offered to this 'threat' was the employment of Peacekeeper forces in HIV/AIDS management and prevention programmes; Peacekeeper forces were framed as a potential resource in the war against HIV. Gore stated, "humanitarian aid workers and military and police forces that are well trained in HIV prevention and behaviour change can be a tremendous force for prevention as long as this is made one of their priorities" (UNSC, 2000, p.11). Dr Amathila, representing Namibia, agreed:

> It is important that the training of the military and police forces covers HIV/AIDS prevention and understanding of how to protect themselves. Peacekeepers, military observers and relief workers need to be well briefed on the implications of HIV-risk behaviour, through education on prevention. (UNSC, 2000, p.14)

Thus, Peacekeepers became both a source of threat or insecurity and a potential route by which to manage and mitigate that threat. Subsequent events at the Security Council show that this response was accepted; following the meeting in January, the UNSC met in July 2000 and unanimously adopted Resolution 1308 on HIV/AIDS and International Peacekeeping Operations. In that Resolution, the Council recognised "the need to incorporate HIV/AIDS prevention awareness skills and advice" as part of training, and it expressed "concern at the potential damaging impact of HIV/AIDS on the health of international peacekeeping personnel, including support personnel" (UNSC, 2000c, pp.1-2). The Council requested that Member States increase efforts, including international cooperation, "to assist with the creation and execution of policies for HIV/AIDS prevention, voluntary and confidential testing and counselling, and treatment for personnel to be deployed in international peacekeeping operations" (UNSC, 2000c, p.2).

In July 2000, Ambassador Holbrooke stated that the US would refuse support to any Peacekeeping resolution that failed to take into account the risk of HIV/AIDS (McInnes, 2006, p.322). In October 2000, UNSC Resolution 1325 invited

Member States "to incorporate ... HIV/AIDS awareness training into their national training programmes for military and civilian police personnel in preparation for deployment, and further requests the Secretary-General to ensure that civilian personnel of peacekeeping operations receive similar training" (UNSC, 2000d, p.2). Subsequent practice employed by the UN Department of Peacekeeping Operations (UNDPO) included the distribution of one million 'awareness cards' to all Peacekeepers, the appointment of a senior HIV officer to each UN peace support operation, and the establishment of awareness training programmes in more than 60 countries by 2005 (McInnes, 2006, p.323). Evaluation of these programmes is available from UNAIDS document, *On The Front Line*; a progress report on HIV programmes with Peacekeepers prepared for the United Nations Security Council (UNAIDS & UN Department for Peacekeeping Operations, 2011).

The empirical evidence behind claims that armed forces are at exceptional risk of HIV infection have been called into question in recent years (e.g., McInnes, 2006, pp.320-21; Whiteside et al., 2006). So too have claims that HIV is linked to a rise in criminality or instability within states, one of the principle arguments made for bringing HIV to the UNSC in 2000 (McInnes, 2006, p.318). However, in their critical analysis of securitization claims regarding HIV/AIDS, analysts identify that military forces have been particularly efficient in conducting HIV responses (McInnes, 2006; Whiteside at al., 2006, p. 209). McInnes (2006, p.321) observes that in Thailand, the armed forces have been active in preventing the spread of HIV. This suggests that although the securitizing claims employed by Piot to 'hook' HIV/AIDS into the UNSC agenda may not have been substantiated by recent evidence, the identification of Peacekeeper forces as a tool in the prevention and response programmes had genuine legitimacy.

6.4. Motivations and Contested Claims

Piot's motivations for bringing HIV/AIDS to the Security Council primarily concerned the direction of high-level attention and resources toward the epidemic, rather than any objectively real security threat. According to Hahn (2013), Piot

intended the meeting to send a clear message about the multisectoral impact of HIV/AIDS and to let world leaders know that:

> It's not health, it's a global issue that can be discussed in the Security Council. And that was the whole intention I guess ... It was never to say 'if you are not careful then all your armies will drop dead' he is too clever, he knew that wouldn't happen.

Regardless of whether the disease genuinely presented "a security threat of the greatest magnitude" as it was called in the January meeting (UNSC, 2000, p.2), the unanimous adoption of Resolution 1308 and the UN General Assembly Special Session on HIV/AIDS in 2001 served to further reinforce the security-HIV linkage that Piot would continue to resolutely and vocally advance (Piot, 2005a). Meeting 4087 thus enhanced the authority with which future securitizing claims could be made about HIV/AIDS. Hahn (2013) suggests that:

> I think for Peter it was the stepping stone to get it out ... of isolation ... He was fighting to keep [UNAIDS] alive and to expand it ... so for him it was the biggest stepping stone to get it out and to be a global issue and a security issue.

Piot's concerted effort to bring HIV/AIDS to the Council supports the argument that Meeting 4087 was not a reflection of genuine acceptance of the HIV-security link (Rushton, 2010); in reality, some members were absent and others protested the agenda. Piot (2013) explained that, "the Chinese did not show up – Russia remained silent, the Indian representatives said that this was absolutely not something to discuss at the Security Council. But on the other hand, you know, it happened".

The meeting was also possible due to its opportune timing; the sympathetic Democratic administration of the USA (see Vieira, 2007, p.150) held the rotating presidency at that time and achieved their own political gains by hosting a meeting dedicated to HIV/AIDS (discussed below). The organisational calendar of the United Nations also worked in favour of bringing HIV to the Security Council agenda because the meeting (held January 10th) was the first of the new millennium, close to the holiday season when many international diplomats were away from New York. Piot (2013) describes how this played to his advantage:

> Half of December and the end of the year, diplomats are all going home, in New York there is hardly anybody. So Holbrooke's office and me and a few colleagues in UNAIDS, we worked very hard between Christmas and New Year to organise [the meeting] and in a sense take quite a few people by surprise really when they came back.

Ultimately, the meeting was possible due to a combination of opportunity, skilful lobbying, and political manoeuvres by Piot at UNAIDS and his allies in the USA. It is noteworthy that after HIV/AIDS the UNSC did not repeat its commitment to any other single health issue, although it is possible that this reflects a failure of securitization, or conversely, the exceptionality of HIV/AIDS above other diseases. According to the Copenhagen School, the objective existence of the threat is not necessary for an issue to be securitized, although it is usually helpful (Buzan et al., 1998, p.24). As Rushton (2010) and McInnes & Rushton (2012) demonstrate, there is doubt over the extent to which Council members were truly convinced by securitizing claims, the actual level of fear about HIV/AIDS that was invoked by the claims of Piot and others, or their willingness to open the Council to non-traditional security threats such as health. As is typical of securitizations in empirical studies, it is difficult to gauge the level of persuasion achieved by these fear appeals. Instead, analysts suggest, it is fruitful to look to the conditions under which persuasion was attempted (Balzacq, 2005).

In addition to the process of securitization, which amounts to generating fear of an existential threat and the proposal of responsive measures, this chapter suggests that there were other noteworthy factors that influenced the UNSC handling of HIV/AIDS. These relate to the involvement of private sector actors in the distribution of medicines, as mentioned by Piot in his UNSC speech above (UNSC, 2000, p.12), and to the ongoing Presidential campaign of US Vice-President Al Gore who, along with political supporter Ambassador Holbrooke, was instrumental in organising the seminal meeting in January 2000.

At the time of Meeting 4087 there was an ongoing campaign to secure affordable access to HIV/AIDS medication, which had been developed and marketed for the first time in 1996. Highly Active Antiretroviral Treatment (ARV) medication initially cost around one thousand US dollars per month, making it

unaffordable for most PLWHA outside the developed world (Fisher & Rigamonti, 2005). Following WHO approval of these medications, the international response to HIV/AIDS that was led by UNAIDS shifted to focus on securing access to new treatments for PLWHA, the majority of whom lived in poor communities or states. Intellectual Property (IP) law restricted the production of medicines to the licence holders, but under a peculiarity of domestic law, Indian pharmaceutical companies were able to produce and supply generic copies of patent protected medication in India. World Trade Organisation (WTO) agreements on IP made it illegal to export these affordable generic medicines to other countries with high prevalence rates, and access to ARV treatment quickly became a flashpoint on which civil society and institutions converged. The campaign for access to treatment united activists from the developed and developing world (Ingram, 2013, p.439) and UNAIDS and UN Secretary General Kofi Annan were actively engaged in this campaign, using their influence with the 'Big Pharma' licence holding companies to lobby in support of affordable access.

There was also a significant ongoing political campaign that defined the wider context in which this lobbying and the UNSC meeting took place. At the time of Meeting 4087, the USA was in control of the rotating Security Council presidency: a position that grants some control over setting the meeting agenda. There was also an ongoing US Presidential campaign in which Vice President Gore was a candidate for the incumbent Democrat Party and the Clinton administration. The political dynamics of the UNSC Meeting were undeniable; election campaigns were already underway when Ambassador Holbrooke, a prominent Democrat, visited Africa and there was speculation that if Gore won the presidency, Holbrooke would hold a senior position in his administration (Packer, 2009). The political career ambitions of both Gore and Holbrooke are noteworthy in considering their decision to bring HIV/AIDS to the Security Council in 2000 (see McInnes & Rushton, 2010).

Holbrooke had found in Gore a "willing supporter" for his campaign to bring HIV to the Security Council (McInnes & Rushton, 2010, p.227), but the Vice-President's election campaign had been marred in 1999 by bad publicity related to his record on HIV/AIDS. Contravening the US led TRIPS agreements that banned

export of generic HIV/AIDS medicines, South Africa had made the decision to legislate for the distribution of cheap generic ARVs in order to tackle its severe and poverty-fuelled epidemic. In response, more than 40 pharmaceutical companies issued a legal challenge to the Government of South Africa in 1998 and successfully lobbied the Clinton administration, including Gore, to support their case. The USA subsequently applied pressure to South Africa, bringing the issue to high-level bilateral trade talks between the countries and placing South Africa on the Special 301 'watch list' as a precursor to implementing trade sanctions (Fisher & Rigamonti, 2005, p.7). This incited considerable negative attention from the media and media-savvy civil society activists at a time that was politically sensitive for the administration. Piot (2013) stated in interview:

> I think the reality is that Clinton and Al Gore were lobbying ... the South African government to drop a law that would allow generics in South Africa, they did exactly the opposite. I mean they changed afterwards, but when they were in power they were absolutely lobbying for Big Pharma. In South Africa there was this case of pharmaceutical companies against ... they were suing Nelson Mandela. And you don't have to be a genius in public relations to know that's not a brilliant idea.

Al Gore was serving as co-chairman of the United States/South Africa Bi-lateral Commission at this time and this, as well as his Presidential candidacy, meant he became one of the "main targets" of AIDS activists who supported generic ARV distribution (Fisher & Rigamonti, 2005, p.8). During his campaign tour in June 1999, Gore was loudly heckled by AIDS activists; demonstrators from civil society groups interrupted his speech chanting, "Gore's greed kills" and told the *Washington Post* newspaper that "Vice President Al Gore is doing drug company dirty work" (Babcock & Connolly, 1999, p.A12).

Whilst major pharmaceutical companies had commercial interests in protecting patents on their newly developed medicines, the issue of access to treatment for the world's poorest PLWHA was soon widely perceived as a human rights issue (Ingram, 2013). Instrumental to this, a new concept of the "global politics of health" was emerging within the international campaign for ARV access and middle-income countries and NGOs began announcing their support for the generic imports (Davies, 2009, pp.70-75; Ingram, 2013, p.439). Al Gore and the

incumbent Democratic administration were facing increasing opposition to their involvement in the South Africa lawsuit, fuelled by the media coverage and civil society activism that targeted Gore on his campaign trail. Inequity that arose due to treatment costs became an international human rights cause and the subsequent mobilisation of support and activism was labelled by Smith & Whiteside (2010, p.4) as an example of AIDS exceptionalism. For Gore and the US Democrat party, it meant that their position on the side of major pharmaceutical companies became a political crisis.

The response of the Democrats was to align with the humanitarian position favoured by their supporters and HIV/AIDS activists. In 1999, South Africa announced that the U.S. government would no longer apply pressure regarding the case, and civil society groups, activists, and the media claimed credit (Weissman, 1999). In the same year, President Clinton told the WTO that the USA, "would adjust its trade policies to enable poor countries, such as South Africa, to gain access to essential medicines" (Fisher & Rigamonti, 2005, p.9). In light of this political manoeuvring, the opportunity to preside over a Security Council meeting where he "came out as being against AIDS ... in favour of more treatment ... attention and funds" allowed Gore to boost his credibility as a presidential candidate (David, 2001, p.578). This was not empty political posturing; the decision by the USA and Gore to convene Meeting 4087 also had potentially critical legal ramifications. Whilst the USA had announced an end to its policy of pressuring South Africa on the subject of generic drugs, the law suit brought by pharmaceutical companies against South Africa was ongoing. During this contest, the meeting of the Security Council on Africa and HIV/AIDS sent a clear message to the international community that world leaders and the United Nations regarded HIV/AIDS to be a security issue. Not currently discussed in the literature is the fact that this meeting had legal implications for the access to treatment campaign, because the definition of HIV as a security issue potentially voided the legal agreements on which this lawsuit was based.

The legal case filed by pharmaceutical companies was made on the grounds that generic drug production violated intellectual property law in international

trade, as codified in the Trade Related Aspects of Intellectual Property Rights (TRIPS) agreements of the WTO. Significantly, in his autobiographical account of this case, Lord Malloch-Brown (2011) wrote that:

> A group of politicians and international officials lead by Kofi Annan at the UN and Bill Clinton at his foundation ... cleverly found a way out. They discovered a small provision in an international trade agreement (TRIPS) that allowed countries to break international copyright and manufacture locally without licence, in an emergency situation like war or national disaster. It became a vehicle for allowing the local manufacture of affordable AIDS drugs. (p.143)

The clause to which Malloch-Brown refers is Article 31 of the TRIPS agreement, which details a number of ways in which governments can grant Compulsory Licenses that overrule patent protection laws. Article 31 states that "in the case of a national emergency or other circumstances of extreme urgency", the requirement for a state to seek license for generic drug production from the patent holder is waived.

The inclusion of HIV/AIDS at the UNSC meeting in 2000 was a clear declaration, verified by Kofi Annan and the Member States, that HIV/AIDS constituted a national and international security threat. Declaration of HIV/AIDS as a security issue would further weaken the case of the pharmaceutical companies because, according to Article 73 of the TRIPS (1994) agreement:

> Nothing in this Agreement shall be construed ... to prevent a Member from taking any action which it considers necessary for the protection of its essential security interests ... taken in a time of war or other emergency in international relations [or] to prevent a Member from taking any action in pursuance of its obligations under the United Nations Charter for the maintenance of international peace and security.

Thus, the inclusion of HIV/AIDS on the agenda of the UNSC in January 2000 had far ranging implications in the broader political and legal context and Meeting 4087 represents a move by the United Nations to further the goal of universal access to treatment. The first coordinated campaigns for treatment by the United Nations were under the direction of Piot at UNAIDS, beginning with pilot programmes for the distribution of generic and donor-funded medication (Piot, 2012). UNAIDS was also engaged in lobbying executives from leading pharmaceutical companies,

including Ray Gilmartin of Merck and Ken Wag from Bristol-Meyers Squibb, using the same strategies employed by Piot in his lobbying of Holbrooke prior to the Security Council Meeting of January 2000 (Piot, 2012, p.307). At an institutional level, the UN supports universal access as part of Millennium Development Goal 6 and during his tenure as Secretary General of the United Nations, Kofi Annan vocally supported campaigns for access to medication and was personally in support of the South African government during their legal challenge; he congratulated South Africa when the pharmaceutical industry dropped the case in 2001 and had brokered the negotiations with Merck and Bristol-Meyers Squibb that began the settlement process (Swarns, 2001). It is noteworthy that the main securitizing actors who spoke at the January 2000 Security Council meeting were also part of the wider campaign to enhance universal access to ARV treatment. Whilst it may be impossible to prove which motivations most influenced the decision of Richard Holbrooke, Peter Piot, and Al Gore when they moved to address HIV at the Security Council, the impact of this meeting on the legal battle to secure access to affordable medication is significant. The literature to date does not engage with these external conditions against which UNSC 4087 was held, but they can advance our understanding of this watershed event in the securitization of HIV/AIDS.

6.4.1. Continuing the Rhetoric

Dr Piot continues to be a vocal advocate of AIDS exceptionalism and articulates fear appeals in which the epidemic is presented as an existential threat that warrants exceptional responses. In 2005, as Executive Director of UNAIDS, Piot delivered a speech titled "Why AIDS is Exceptional" to the London School of Economics (Piot, 2005a). Within the nine page transcript, he twice refers to nuclear weapons, telling the audience that the AIDS pandemic "needs to be recognised to be one of the most serious threats to our prospects for progress and stability – on a par with such extraordinary threats as nuclear weaponry", and that "AIDS is exceptional in so many ways that only an equally exceptional response will succeed – just as the exceptional threat posed by nuclear weaponry has led to the

development of exceptional responses" (Piot, 2005a, p.2). Piot (2005a) employed the logic of securitization by stating that choice had been removed, telling the audience, "we have no choice but to act in exceptional ways" (p.9). This is significant according to the logic of Buzan et al., (1998), for whom the issue of choice demarcates the boundaries between a politicised and a securitized issue:

> Politicization means to make an issue appear open, a matter of choice ... By contrast, securitization on the international level ... means to present an issue as urgent and existential, as so important that it should not be exposed to the normal haggling of politics but should be dealt with decisively by top leaders prior to other issues. (p.29)

Piot (2005a) framed the epidemic as having reached a "tipping point" (p.3), explaining that "it sets off a chain of devastation, a toppling of dominoes" (p.9) that suggests the threat is out of control. In his closing remarks he told the audience, "we have only one option", and "our basic choice is only whether we act exceptionally right now or later, when many more millions have died" (Piot, 2005a, p.9). In keeping with the established criteria for fear appeal success and in order to invoke productive rather than destructive fear, Piot (2005a) included demands for a specific response by which the threat could be mitigated. This response entailed a break from "the normal bounds of political procedure", and included "setting aside public expenditure ceilings" (Buzan et al., 1998, p. 24; Piot, 2005a, p.8). Piot (2005a) also stated that UNAIDS has emphasised the "urgency" (pp.8-9) of this point, telling the audience that "this pandemic is now too globalized, its impact too large, and the barriers to prompt action still too pervasive, for routine development approaches to suffice" (p.5).

6.5. Conclusion

In conclusion, Dr Piot orchestrated the inclusion of HIV/AIDS on the agenda of the United Nations Security Council in 2000 as part of his wider, UN-led campaign to raise the profile of the disease and to gain resources for an effective response. It was a calculated move designed to further his designs for a global response, rather than any reflection of the reality of HIV/AIDS as a security threat. In interview he explained:

> I thought okay, we need to get this on the Security Council agenda. And this was not based on any theoretical framework or vision in the sense of a political science analysis. Just on the base of the analysis ... where is the power? (Piot, 2013)

This securitization was an extension of the existing framework of AIDS exceptionalism that emerged through civil society activism when HIV/AIDS first appeared in the developed world. The primary securitizing actor, UNAIDS, was itself established on the premise that the disease is exceptional (England, 2008). Both the exceptionality and the proposed security dimension of HIV/AIDS face growing criticism (Barnett & Prins, 2006; Ingram 2013). For instance, Barnett & Prins (2006) propose that there exist "inverted triangles" (p.363) of discourse on HIV/AIDS and security, in which many claims are made on the basis of relatively little empirical evidence. Whiteside et al., (2006) have also challenged and dismissed the "accepted wisdoms" (p.217) that link HIV to military security, questioning the empirical evidence behind claims that military populations have a particularly high rate of HIV prevalence, that the epidemic endangers the function of military forces, that war and violent conflict exacerbate transmission of the virus, or that AIDS has the potential to disrupt national or international security. McInnes (2006) also questions the reliance on "limited evidence from the mid-1990s" (p.320) by those who claim that militaries are suffering significantly higher rates of infection. But despite these challenges or the lack of empirical evidence, the "narrow frame" of military security and HIV/AIDS facilitated the inclusion of the epidemic on the agenda of the powerful and influential Security Council; Dr Piot (2013) and his allies successfully presented HIV/AIDS to the Security Council by employing the logic of fear appeals and securitization, and used the Peacekeeper Operations of the Security Council as a "hook" with which to engage their attention.

In accordance with the Copenhagen authors, the objective existence of the HIV threat to security was not necessary for securitization to have taken place, provided that the securitizing actors possess sufficient authority to convince their audience that the threat exists, and that it is urgent, existential, and demanding of extraordinary response. As the founding Director of UNAIDS, Piot possessed this authority and the diplomatic channels with which to lobby key members of the

international political community. Although the framing of HIV as a security issue had some traction, the HIV-security link did not become the dominant framework by which the epidemic was subsequently conceptualised at the international or the domestic level, with only a few notable exceptions; in 2001 the International Crisis Group (2001) published a report titled, *HIV/AIDS as a Security Threat*, that framed the virus in terms of warfare and military conflict and in 2000, the US National Intelligence Council published a report in which HIV in Asia was presented as a potential threat to the security of the United States (Gordon, 2000). Ultimately, widespread recognition or repetitions of the security-HIV links were lacking, as is evidenced in the rest of the thesis and in the data collected from what Malloch-Brown and Piot might call 'front line' responses in Thailand and Myanmar. Instead, where HIV did enter security related discourse it was increasingly linked to Human Security and development issues, or subsumed into alternative dimensions of security.

Chapter 7. The Response in Thailand

In 1985, Dr Praphan Phanuphak made the first diagnoses of HIV/AIDS in Thailand. He told the author that during those early years of the epidemic, the disease was perceived as a potential threat to national security because of its high death rate and visibility among military recruits (Phanuphak, 2013). In contemporary Thailand the situation is different; military recruits remain subject to routine surveillance, but the current climate is one of complacency and the initial fear invoked by HIV/AIDS has declined. There has been a concurrent decline in political attention and resources to deal with the epidemic, although fear-based stigmatization still exists and is a barrier to the responses currently in place (Phanuphak, 2013). Phanuphak (2013) identifies the advent of combination antiretroviral treatment (ARV) as a pivotal moment in Thailand; affordable treatment became widely available from 2005, when the government announced that ARV provision would be included in the Universal Healthcare Coverage scheme, but this has contributed to complacency about the risks of HIV infection (Phanuphak, 2013; Rattanamha, 2013). The provision of subsidised ARV treatment was a victory for civil society campaigners who had worked to secure universal access to the treatment since its development in 1996 (Tenni, 2012) and the Thai response has been defined by their efforts.

Despite declining general concern about the epidemic and "great strides" in scaling up access to treatment (UNAIDS, 2013, p.19), UNAIDS estimates that there are between 400,000 and 490,000 people living with HIV/AIDS in the country, of whom an estimated 205,000 have no access to ARVs (Hahn, 2013). Prevalence among the general population has been in decline since 1996, but rates of new infection continue to increase within certain populations; adolescents, pregnant women, free-lance (non-brothel-based) female sex workers, and new military recruits aged 20-24, are all subject to increasing rates of infection (NAPAC, 2009, p.2; AIHD, 2011, p.3). In key affected populations, infection rates among MSM remains very high and there is no decline in their national prevalence (NAPAC, 2009, p.3; AIHD, 2011, p.3). Although targeted intervention programs in Bangkok have

reduced prevalence among MSM by 6% between 2007 and 2009, the figures are still disproportionately high; approximately 1 in 4 MSM in Bangkok are HIV+ (NAPAC, 2009, p.3; UNAIDS, 2013, p.13). Surveillance conducted at detoxification centres for people who inject drugs reports prevalence of 30%-40% among this group (NAPAC, 2009, p.3). International labour migrants who work in commercial sex or fishing industries are also at high risk of infection and vulnerability is exacerbated by barriers to accessing services, such as Thai illiteracy and limited education (NAPAC, 2009, p.3).

During the early 1990s, state-led responses targeted the high-risk female sex worker population with acclaimed success (e.g., the '100% Condom Use Programme'), but over time viral incidence has increased among the partners of these and other "high risk" individuals, signifying the advancement of the epidemic into the "general population" (Press, 2012); in 2005, 18.4% of newly reported HIV infections were related to sex work, but 43% occurred within the heterosexual "low risk" population (7.3% in people who engage in casual heterosexual sex or their partners) (Gouws, 2006, p.53). The spread of infection through heterosexual intercourse highlights realities about sexual behaviour in Thailand that do not fit with the image of chastity and sexual conservatism that typified "Western" research in the 1990s, when the epidemic first emerged (Fordham, 2004, p.144). Contemporary epidemiological data reveals behaviours that distinctly diverge from the traditional values of chastity, purity, and (female) virginity until marriage which are often extolled as being part of the idealised Thai national identity, but which more accurately reflect a "Western-derived morality" that characterises early Thai AIDS discourse (Fordham, 2004, p.144). Evident in recent data is the growth of HIV and STI infection prevalence amongst youth populations, consistent with reported increases in risk behaviour amongst youth, including sex-partner mixing among both males and females and sexual intercourse without condoms (Fordham, 2004, pp.147-149; National AIDS Committee [NAC], 2012, p.2). After marriage, infection from HIV and other STIs remains a significant risk and UNAIDS predicts that 1 in every 3 new HIV infections in Thailand in 2012 will occur within intimate partnerships (NAC, 2012, pp.xxi). Vulnerability is exacerbated by the widespread

availability of commercial sex that is "considered a normal activity for the majority of men" in some regions at least (Fordham, 2004, p.146). The practice of visiting sex workers, facilitated by the division of labour between rural and urban areas and the common practice of working away from home for long periods of time, makes commercial sex work a significant area of concern for HIV management in Thailand (Kestkaew, 2012; Nacapew, 2012; Press, 2012).

Thailand has been praised within the international community for its response to HIV/AIDS; following initial hesitancy during the 1980s, the government invested a significant amount of its domestic budget to dealing with HIV in a response atypical of other developing countries at the time (Ford & Koetsawang, 1991). In 1989, 90% of the total expenditure on HIV/AIDS was from overseas development assistance, compared to less than 28% by 1991, and 5% by 1996 (UNDP, 2004, pp.16-17). The potential economic losses arising from the effect of HIV/AIDS have been one reason for the state's early recognition and action on the epidemic. At UNAIDS, Hahn (2013) observed that "people were worried about image [of Thailand], because they rely on tourism", although this did not always translate into greater attention or resources from the state; for instance, following the coup of 1991, Health Ministry officials claimed that the previous administration had overstated the scale of the national epidemic and had "seriously affected tourism" as a result (Ford & Koetsawang, 1991, p.406; Clements, 1992, p.211). It has also been noted that regional government officials might be tempted to down play the size of local epidemics in order to avoid damaging their tourist industry (Prakongsai, 2013).

Data collected during elite-interviews in Thailand revealed that the state response was affected more often by economic concerns than by any other concept of security. However, the primary influence was that of the powerful and "vibrant" civil society organisations concerned with protecting the human rights of PLWHA (Tenni, 2012). There is a "strong history" of civil society in Thailand and HIV/AIDS activists and CSOs have mobilised to define the current epidemic response (Hahn, 2013). With the support of international donors including UNAIDS and the Global Fund, mainstream CSOs in Thailand reject the fear-appeals of early HIV/AIDS

campaigns and are working instead to normalise perceptions of PLWHA and to increase access to medication and healthcare services (Tenni, 2012). These campaigns are enacted around the new global movement that frames health as a universal human right (Davies, 2009; pp.70-72; Tenni, 2012).

7.1. The Early Response in Thailand

When HIV/AIDS was first identified in Thailand, the initial response of the government was to implement the type of public health measures outlined by Bayer (1991) and to utilise fear-based public health campaigns to raise awareness about the disease (Ungphakorn, 2012). The state adopted the logic of "imposing public health": a rationale by which they sought to "do what's best for public health regardless of what's best for the individual" (Press, 2012). The Ministry of Public Health adopted policies between 1988 and 1990 that gave little merit to the human rights of people with or affected by HIV/AIDS, instead modelling its legal and medical solutions on classical contagious disease control methods (Porapakkham et al., 1995, pp.8-9). In 1990, legislation known informally as the 'AIDS Bill' was drafted, proposing to introduce traditional public health responses including criminalisation of HIV transmission, compulsory testing, and restrictions on the movement of PLWHA (Ainsworth, 2003, p.15). Quarantine was proposed through the creation of "therapeutic communities" for infected persons, not dissimilar to the detention centres used in Cuba until 1994, which were based on guidelines from the American CDC for controlling leprosy or other communicable disease (Porapakkham et al., 1995, p.5).[11] It was also proposed that commercial sex workers would be tested and issued with "AIDS-Free" identity cards (Porapakkham et al., 1995, p.5).

Jon Ungphakorn (2012) a former Senator and leading AIDS activist in Thailand, recalled that the Bill would sanction detention of "uncooperative" HIV

[11] During the 1980s, the Cuban government tested the population for HIV and detained those found to be positive in 'sanatoria' centres. In addition to violating the human rights of detainees, this approach requires a high degree of governmental control, repeated population-wide testing, and testing for any person entering the country (see, e.g., Whiteside & Sunter, 2000, p.18). The response has contributed to the continuing low prevalence of HIV infections in the country to date.

positive people for up to six months. He also observed that the Bill was problematic because it was unclear whether the intention was to quarantine or penalise people with HIV/AIDS (Ungphakorn, 2012). The proposed AIDS Bill required new cases of HIV to be reported to the state within 24 hours; allowed for members KAPs to be tested without their consent; and made it a crime for an HIV positive person to donate blood, engage in prostitution, have sex without a condom, or have medical procedures without informing medical staff of their infection (World Bank, 2000, p.8). According to Ungphakorn (2012), these laws were "actually concerned, primarily, with restrictions [of PLWHA]" despite being framed under the pretext of securing "AIDS rights" and ensuring public safety. The draft bill represented what Bayer (1991) called the "traditional practises of public health" (p.1502), which curtail civil liberties through measures exemplified by mandatory testing, restrictions on movement, and quarantine. The danger of the threat-defence logic that underpins these proposed measures is that the virus and people living with HIV become conflated in perceptions of threat, increasing stigmatisation and undermining the efforts of civil society to protect human rights and normalise people living with HIV/AIDS (Elbe, 2006, p.120). The criminalisation of HIV and PLWHA also reflects a willingness by the state to extend its sovereign power by using penal sanctions and legislation for medical intervention, invoking the Foucauldian concept of biopolitical control through governance (see, Elbe, 2009). In effect, the proposed restrictions both violated the civil liberties of PLWHA and contributed to the epidemic of stigma and unproductive fear that accompanies HIV/AIDS (Strong, 1990).

The AIDS Bill faced popular opposition largely due to the efforts of newly mobilised civil society groups. These groups were supported by a number of government officials during the political administration of Prime Minister Anand Panyarachun (Ungphakorn, 2012), who was selected by the military to govern following the coup of 1991. At the start of the 1990s, the epidemic had "burst" into the general population in Thailand and public perceptions of the virus and of susceptibility shifted significantly (Porapakkham et al., 1995, p.12); as AIDS increasingly came to be seen as a threat to everybody, and not just to KAPs, civil

society groups gained traction with their rights-based and awareness-raising campaigns. As the epidemic shifted into the general population and awareness spread through media coverage of the disease, perceptions of susceptibility to the threat increased (Ainsworth, Beyrer & Soucat, 2003, p.15). Around this time, the "comprehensive national AIDS prevention and control program" for which Thailand is lauded by the UN began to take shape (Porapakkham et al., 1995, p.3; NAPAC, 2009). Following an initial period of denial about the emerging epidemic (UNDP, 2004, pp.7-8), the state under Prime Minister Anand prioritised AIDS intervention and implemented pragmatic policies, including an unprecedented inclusion of AIDS activists and CSOs within high-level policy-making circles to collaborate in the national epidemic response. It is noteworthy that whilst many Ministries of Health resisted the multisectoral approach that was advocated by the United Nations, Thailand was an exception and under Anand, the government orchestrated a "strong multisectoral response" (Knight, 2008, p.18). It has been suggested that this pragmatic response and Anand's decisive action was possible because the military-backed post-coup Prime Minister did not face "democratic constraints" or rely on support from lobby groups (Porapakkham et al., 1995, p.3).[12]

In 1991, prominent AIDS activist Mechai Viravaidya, who had earned the nickname 'Mr Condom' for his sexual health advocacy work in Thailand, was appointed by Anand in the newly created post of Minister for Tourism, Information and AIDS (Ainsworth et al., 2003, p.16). A series of highly publicised and pragmatic HIV/AIDS policies followed and when Anand's political successor reduced the HIV/AIDS budget by almost 50%, Mechai successfully lobbied for its reinstatement to almost the original amount (Clements, 1992; p.211). Mechai's appointment reflects the increasing cooperation between the state and HIV/AIDS civil society groups and activists, as well as the growing influence of these groups and their inclusion into the formal systems of government in the early 1990s. After multiple public meetings on the proposed AIDS Bill, the legislation was rejected thanks

[12] Following the coup which ousted democratically elected Prime Minister Thaksin Shinawatra in 2006, epidemiologist Elizabeth Pisani (2008) noted that "ironically", the military were able to implement a "more human approach" to HIV reduction programmes among IDUs, because they were "less beholden to voters, who are do often squeamish about doing nice things for injectors" (p.261).

largely to the campaign by the Ministry of Public Health, civil society, and AIDS activists, who had won support from the increasingly sympathetic media (UNDP, 2004, p.10). The failure of the AIDS Bill amounted to a response that fits definition of classical "AIDS exceptionalism" outlined by Burris (1994, pp.271-271), in which traditional public health measures of the state are rejected as part of broader movement to protect people from health-based legal discrimination. In 2007, a similar attempt was made to impose legal restrictions on PLWHA, under the 'The Act on Protection of HIV-Infected Persons and AIDS Patients'. The proposal was met with a comparable response from civil society and NGOs, including Foundation for AIDS Rights (FAR), which led a successful campaign against the law.

Arguably the most famous of Thailand's HIV/AIDS policy successes is the '100% Condom Use Programme'. The programme was launched under the leadership of Anand and Mechai Viravaidya in 1991, to ensure that brothel-based female sex workers used condoms during transactional sex acts (Porapakkham et al., 1995, p.15); it is applauded by UNAIDS and contributes to what the UN calls an "impressive and admirable" response in the country (UNAIDS, 2000a, p.3; NAPAC, 2009, p.35). However, as one high-level CSO activist explained, "a lot of people hailed it as a great response ... but it really wasn't very rights based" (Press, 2012). Interviews with CSOs in Thailand revealed the controversial nature of the 100% Condom Programme, which is criticised for disempowering sex workers and violating their human rights (Press, 2013; Tenni, 2012; Janyam, 2013). One senior technical adviser on HIV/AIDS policy referred to the programme as "disastrous" (Tenni, 2012). Despite reducing visible levels of HIV infection among sex workers in brothels (UNAIDS, 2000), the policy is problematic for rights campaigners. It was enforced by police who attempted to purchase sex without condoms at brothels and fines were imposed on the brothel owner if this was found to be possible (Renard, 2012). In practice, "owners were basically forced to implement mandatory testing for STIs and HIV and if the woman was found positive, she wasn't allowed to work, and if there was an increase in STIs, the employer was penalised for not having women use condoms" (Press, 2013). So the implementation of the policy was "incredibly top-down" and amounted to supporting the control exercised by

owners and police over the women employed at brothels; it also undermines the empowerment and rights-based approach to condom use and sexual health intervention that is advocated by leading CSOs (Tenni, 2012; Janyam, 2013). Furthermore, it is significant to note that despite the magnitude of the industry, prostitution and solicitation remains illegal in Thailand (Ford & Koetsawang, 1991) and informal involvement by police forces does not help to protect the rights of sex workers who are at risk of exploitation by brothel owners and clients; instead, "the government used criminalisation of the sex industry as a tool" by which to coerce sex workers into complying with the law (Tenni, 2012). As one interviewee (Source 21, 2013) stated:

> Sex workers don't know the meaning of 100% Condom Use policy. We laugh amongst ourselves. ... It would be okay if it was a good programme, with free condoms and education ... but [we] get nothing from this programme. A lot of people get money for research and reporting on the 100% programme and [they] make promises, but where are they now? ... We are very hurt.

Where the 100% Condom Use Programme might have had a lasting positive outcome is in inciting behavioural change amongst the clients of sex workers. At UNAIDS, Michael Hahn (2013) observed that police intervention in sex work and condom use has resulted in lasting behavioural change among men who buy commercial sex, who are now more likely to use condoms despite the decline in policy enforcement.

According to Hahn (2013), when the 100% Programme was implemented during the 1990s, the Thai state-led national response focused around two key messages that used fear-appeals. The first was that, "HIV is a death sentence [and] that there is no cure, only prevention" (Hahn, 2013); this was also referred to as the "AIDS = Death" campaign by Jon Ungphakorn (2012). The second message was that, "if you don't use a condom you can't go and have sex with a sex worker" (Hahn, 2013). These messages invoked the fear of death in order to deliver information ("there is no cure, only prevention") and behavioural change ("if you don't use a condom, you can't go and have sex with a sex worker") (Hahn, 2013). Fear has always been an "undercurrent" of the HIV/AIDS response in Thailand, originating

from the "early days" when the language of combat and of external threats was invoked to communicate messages about the epidemic (Press, 2012), but this has proved a problematic strategy; of the two messages above, the first is outdated since the advent of treatment and the second undermines stigma reduction efforts and normalisation.

7.2. Military Metaphors and Moral Contagion

As illustrated in the discourse of UNSC Meeting 4087, framing HIV as an external threat and utilising military metaphors is an effective way to invoke the fear and urgency usually associated with traditional security threats, partly because it enables the state to deal with a sensitive health issue in more familiar terms (Elbe, 2006, p.130). In Thailand, initial perceptions of the virus were that it presented a threat "alien to Asian culture", possibly because early cases were related to sexual contact with people living outside the country (UNDP, 2004, p.7). Some government representatives actively encouraged the idea that AIDS only affected marginalised populations and that it was a "foreigner's disease" associated with "lifestyles" unlikely to affect "good" or "decent" Thais (Ford & Koetsawang, 1991, p.406; Porapakkham, 1996, p.5; UNDP, 2004, pp.7-8). These framings facilitated the idea that HIV/AIDS was an external threat that arose from an infected 'other' to threaten the Thai nation and this is reflected in early policy; in 1989, the Ministry of Interior amended the 1979 Immigration Act to include AIDS, with the intention of preventing foreigners with HIV from infecting Thais by barring their entry into the kingdom and by deporting infected non-Thais from the country (Porapakkham, 1996, p.5). Perceptions of AIDS as a strictly external threat facilitated a "strain of militancy" in early Thai responses, and "some decision-makers pushed for stern, even punitive measures, to try and stop HIV at country borders" (UNDP, 2004, p.8). These types of responses are regarded now as being neither effective nor ethically sound, although travel restrictions and deportation of PLWHA remain in force throughout the world.[13]

[13] In 2009, President Obama repealed long-standing legislation that barred the immigration or entry to the USA of anyone living with HIV/AIDS, telling the media that the ban, which

Perceptions of HIV/AIDS as an external or military-like threat exacerbate the barriers to implementing an effective response. The logic that underpins these framings is one of 'threat and defence', in which the state is best suited to securing the survival of its internal population (Elbe, 2006). This was reflected in the language used to describe HIV/AIDS in popular campaigns; at Raks Thai, Brahm Press (2012) reported, "one of the main messages was "Fight HIV, Fight AIDS". ... They use these aggressive terms, and it's not really positive". Whilst this approach may help to mobilise government support for a politically sensitive issue such as HIV/AIDS, it might also engender state-led responses that are best suited to traditional security threats. For instance, securitization could lead to intervention from state rather than civil society or health care professionals. The military, police, or security forces of a state may be ill-equipped to deal with a situation in which the proposed threat is an invader virus carried within the bodies of non-combatant individuals (Elbe, 2006, p.139). However, it should be noted that the power held by military leaders might also facilitate positive responses to HIV/AIDS in Thailand. As stated above, the success of the HIV/AIDS response under Prime Minister Anand may have been possible due to his freedom from "democratic constraints" (Porapakkham et al., 1995, p.3). Tenni (2012) also noted that the introduction of generic ARV medicines, opposed by powerful international pharmaceutical companies, was headed by an ex-military health Minister, Mongkal Na Songkhla, who may have had greater autonomy due to his position within a military-led government.

Although fear of HIV/AIDS in Thailand might have been exacerbated by early fear-based messages from the state, Press (2012) proposes that it is also due to the assumption that the virus is a form of "moral threat". Thai responses to HIV/AIDS reveal culturally specific understandings of morality in relation to the virus; notions that are directly related to the centrality of Buddhism to national identity and the causal influence of karmic law, by which HIV infection and other

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had been imposed during the 1980s, was based in "fear rather than fact" (Preston, 2009). The ban also jeopardized the 2012 World AIDS Conference to be held in Washington DC, which traditionally serves as a platform for CSOs, PLWHA, NGOs, and AIDS activists as well as representatives from pharmaceutical and medical industry, political leaders, and high profile international institutions including UNAIDS.

inauspicious events can be attributed to the accumulation of bad karma (Fordham, 2004, p.75). Discussing the stigmatisation of PLWHA in Thailand, Press (2012) reports that Raks Thai has dealt with multiple cases in which parents have protested against the attendance of HIV+ pupils at their children's school. Press (2012) explains that "parents are afraid of their children getting HIV, but it's deeper than that. The assumption is that the parents [of the HIV+ child] had done something wrong, to give their children HIV. It's not just a disease, it's a moral contagion". This assumption also exists at the highest levels of the state. A member of the National Human Rights Commission, Khun Ladaporn (2013), explained how some government departments require HIV testing as part of employment applications, even where "HIV is not harmful or dangerous for work". The National Human Rights Commission has recently dealt with two cases involving testing-related complaints, one from the Royal Thai Police Force (in 2010) and another from the Office of the Judiciary (2009). In the latter, a complaint was lodged by the CSO, Foundation for AIDS Rights, regarding the requirement for applicants to take an HIV test before applying to become a judge. The Commission found that the test was part of a process in which applicants had to prove to an official committee that they are "good" and was accompanied by a criminal record background check (Ladaporn, 2012). The Office of the Judiciary claimed their ban on HIV positive judges was due to "the short life expectancy" of PLWHA, but the Commission reported that it was part of a requirement to prove adherence to social norms and reflects the widespread perception that PLWHA were promiscuous (Ladaporn, 2012).

In the 1980s and 1990s, the "natural instinct" of the Thai state was to use fear in its campaigns about HIV/AIDS, which manifest in the two messages outlined above: first, that AIDS is an incurable disease which leads to death; second, that HIV/AIDS is associated with immoral behaviour (Ungphakorn, 2012). Here, the first fear-appeal invoked the threat of death and the accompanying "morality messages" advocated avoidance responses such as, "if you don't play about with sex or needles, you won't get AIDS" (Ungphakorn, 2012). These messages were often displayed alongside images of attractive women in revealing clothes, in an attempt

to visually represent immorality (Ungphakorn, 2012). In addition to the problematic and patriarchal overtones of this type of imagery, the representation of danger using human bodies leads to fear of people assumed to be associated with HIV/AIDS and the fear of certain groups (i.e., sex workers, PWIDs, PLWHA, or women), rather than of the virus itself. Press (2012) recalls that early campaigns from the state and civil society groups would use:

> Images using cartoons, personified viruses, caricatures of HIV as devils or demons. It was supposed to be HIV as the disease, but people associated that with the people who caught HIV ... it ends up translating into 'Fight people with HIV'.

Some PLWHA groups claim that they were "traumatised" by the early fear campaigns which fuelled stigmatisation and discrimination against them (Ungphakorn, 2012) and this sentiment, coupled with a lack of understanding among the general public, led to the formation of self-help support groups by PLWHA during the early 1990s. As the epidemic stabilised without national devastation, government interest in HIV/AIDS declined and these activists and CSOs assumed an increasingly powerful role in shaping the national epidemic (Tenni, 2012).

The development of effective antiretroviral treatment in 1996 had a massive impact on civil society activism in HIV/AIDS. Comprised largely of PLWHA, activist groups unified around the campaign for access to treatment and members were able to contribute more, and for longer, as their own HIV became manageable. These groups campaigned on human rights issues related to HIV/AIDS and sought to address discrimination against PLWHA in its social and legal forms; in 1997, the Thai Network of PLWHA (TNP+) was formed as a national coalition of CSOs in order to strengthen their capacity. Anan Muangmoonchai (2013), a veteran activist with TNP+, explained that whilst general understanding about HIV/AIDS may have increased over time, discrimination still creates barriers to employment and violations of human rights; for instance, compulsory HIV testing as part of private sector employment has declined, but the practice still exists. Muangmoonchai (2013) also reports that some companies that enforce annual testing of staff blood samples do so without revealing the nature of the tests to staff and there have been

numerous recent cases in which HIV+ employees claim they were pressured into resignation once their sero-status was discovered. The Foundation for AIDS Rights dealt recently with a case in which the retail company HomePro was the subject of complaint after testing employees for HIV and dismissing anyone found positive (Nacapew, 2012). At the time of interview, the Foundation was also dealing with a complaint against a Christian university in which a nursing student had been tested for HIV without informed consent; on finding the student HIV positive, the University informed the student's parents without his permission and dismissed him from the programme (Nacapew, 2012). As discussed in Chapter 5, the conditions of HIV testing are a good indicator of the status of HIV/AIDS related rights campaigns and exceptionalist frameworks. Outside Bangkok, a CSO caring for HIV+ children and young adults reported that one resident in their care had been dismissed from working in a local food outlet by an "apologetic" manager who explained that, while he did not fear HIV+ people himself, he would lose customers who did fear contamination (Dunck, R., 2013). Another resident had secured a job in an international food chain but her guardians believed that it this was because she had not disclosed her HIV+ status (Dunck, R., 2013).

These cases of discrimination arise in part because the fear invoked by early responses to HIV/AIDS has endured, although the initial message that "AIDS = Death" is now outdated (Ungphakorn, 2012; TNP+, 2012; Hahn, 2013). As Hahn (2013) observes, "nobody tried to correct this" and even medical professionals retain outdated and potentially harmful perceptions of HIV/AIDS. Hahn (2013) reported that:

> There is no big campaign saying 'discordant couples can easily have children' ... The counsellors were trained 10 years ago, so now if an HIV+ woman goes to the counsellor the first thing she says is 'you should have an abortion, you shouldn't have got pregnant in the first place', because nobody invests in giving them a different knowledge either. They are stuck there.

Education to reduce these damaging perceptions and to promote effective HIV/AIDS prevention and management strategies is a primary focus of leading CSOs, including Foundation for AIDS Rights, Access, Raks Thai, Mercy Bangkok, and the TNP+ coalition. Their normalisation efforts typically focus on educational

campaigns to reduce misinformation and fear, as well as providing essential information about health; TNP+ reported that in some schools in which they operated, their lessons were the only sexual health education offered to pupils (Muangmoonchai, 2013). Despite the concerted efforts by many groups, including the Red Cross which lobbied school administrators to install condom vending machines (Phanuphak, 2013), sexual and reproductive health education in Thai schools remains poor (Hahn, 2013). This is partly due to social norms which dictate that "it is unacceptable for teachers to talk about use of condoms and sexual relations" as well as a lack of appropriate state policies (Muangmoonchai, 2013). The result is a perpetuation of myths and misinformation about the transmission of HIV/AIDS and other STIs, which leads to fear of contagion or counterproductive assumptions about the morality of PLWHA. Inadequate sexual health education also leads to higher rates of sexually transmitted diseases among young Thais and is linked to the rising levels of teenage pregnancies in the country (Hahn, 2013).

The reduction of fear associated with HIV/AIDS and PLWHA has been the focus of mainstream HIV/AIDS civil society groups and activists since the mid-1990s, with a few notable exceptions. One of these is the temple Wat Phra Baht Nam Pu. Located near a rural town 180km north of Bangkok, the Wat purports to be an educational facility but was heavily criticised by former Senator Jon Ungphakorn, the National Human Rights Commissioner Visa Benjamano, and the Director of Foundation for AIDS Rights Supatra Nacapew, for exhibiting the mummified and dismembered bodies of HIV+ people to visitors.[14] At TNP+, activists explained that the display of corpses within the 'AIDS body parts' museum and the 'Life museum' at the Wat amounted to a fear-appeal because:

> They try to make people to be afraid, or to scare people [to say] don't get HIV. ... So that's why they do the Life Museum, to tell people, 'if you are doing like [this], this is the end of your life, you [get] HIV/AIDS, you're going to die.' (Kestkaew, 2012)

[14] See also Wery (2011) for an autobiographical account of a former medical volunteer at the temple, in which the author makes allegations of serious patient abuse and substandard medical care, and Turner & Sirisupluxana (2012) for further details of the organisational structure of the facility.

The display of HIV+ bodies as a visitor attraction was problematic for the rights-based CSO groups interviewed in Bangkok and in 2009 a coalition of CSOs lodged a formal complaint against the Wat with the National Human Rights Commission. In December 2009 when the Commission visited the site to investigate, 19 bodies were on display at the Life Museum with accompanying photos and information about the patients that included their name and career (Benjamano, 2012); in one case a corpse was labelled as "sex worker: Lady Boy" (Marshall, 2008; NHRC, 2012, p.5). One of the complainants, TNP+, explained their belief that the displays reflected a discriminatory logic at the heart of the temple's approach, telling the author that "this is from the bad attitude about people with HIV. They believe that bad behaviour is the cause of HIV. Bad person, bad behaviour, is like [*sic*] sex worker or drug user" (Kestkaew, 2012). The attribution of disease to socially marginalised behaviour is problematic because moralisation of the virus both stigmatises individuals and complicates intervention and management programmes.

There is a tension between the efforts of leading CSOs to normalise perceptions of PLWHA and the current UN guidance advising that responses should be targeted to KAPs. The concern raised by some observers is that selecting specific groups for intervention exacerbates stigmatisation by associating them with higher levels of the disease; the fear is that this logic of targeted responses is reminiscent of the early perceptions of HIV/AIDS that PLWHA did so much to counter (and which now fuels the normalisation campaigns) (Nacapew, 2012). However, Hahn (2013) explains that with limited resources and extremely high prevalence concentrated in certain population groups, the need for a targeted response is inevitable. Whilst prevalence in the general population is declining in Thailand, around 1 in 4 MSM surveyed by UNAIDS in Bangkok were HIV+ and prevalence was also higher among transgender sex workers (UNAIDS, 2013, p.13). Hahn (2013) reports that only 6% of current PLWHA in Thailand are outside of the KAPs and according to recent modelling by his office, "you [would] have to invest in about 123,000 tests to find one HIV+ in the general population", making this approach financially inefficient. With careful management, targeted responses can be implemented in a way that does not invoke unproductive fear or exacerbate the

stigmatisation of affected groups (Tenni, 2012; Hahn, 2013). A key campaign in the current response is to educate people that "AIDS can be treated" (Tenni, 2012) and this message should encourage testing by those at risk; this message should mitigate levels of unproductive fear in audiences by explaining that through testing and access to medical services there is a productive response by which the threat can be controlled. It also aligns with the human rights orientated approach favoured by CSOs and INGOs.

Despite much success, there still remain significant challenges to implementing the human rights framework in Thailand. The Universal Health Coverage scheme, through which subsidised ARVs are available, is premised on the concept of health as a human right (Bhakeecheep, 2013), but this principle is not shared with other Government Offices. The National Human Rights Commission explained that the Offices of the Royal Police Force and Judiciary "do not understand human rights" and this is why they require HIV testing for potential staff (Ladaporn, 2013). One activist reported that even prosecutors with whom HIV/AIDS advocacy groups worked were routinely testing their own staff for HIV/AIDS (Source 6, 2012). Former Senator Jon Ungphakorn (2012) observed that, "you find stigma and discrimination in the very professions it shouldn't be in, for example the medical profession and legal profession"; the UN Stigma Index reported that 20% of HIV+ Thai respondents had been denied access to health services because of their HIV status during the previous 12 months (UNAIDS, 2013, p.23). The CSO, Access, established by Ungphakorn in 1991, has dealt with cases in which surgeons have refused to treat PLWHA and has successfully opposed plans by the prestigious Chulalongkorn medical institute to routinely test all medical students for HIV/AIDS (Ungphakorn, 2012).

Elbe's (2006) concern that framing HIV/AIDS as a national security issue might lead to the violation of civil liberties has been reflected by the activism of CSOs in Thailand; CSOs mobilised both in order to provide support for PLWHA and to seek protection of their human rights (Tenni, 2012). In this capacity, the role of civil society in Thailand remains salient for as long as HIV/AIDS is a matter of political or security discourse, because CSOs act as a check against the infringement

of PLWHA autonomy and rights. As Dr Phanuphak (2013), Director of the Thai Red Cross AIDS Research Centre, explained:

> HIV has been a human rights issue from the beginning ... I don't think politicising HIV will affect human rights ... because the human rights people here in Thailand are very strong, [they work] to protect the rights of the affected and infected.

Asked whether the revitalisation of the government's 'war on drugs' by Prime Minister Yingluck could lead to a repeat of the extra judicial killings seen in 2003, Supatra Nacapew (2012) replied that is was unlikely, "because the human right defenders and human rights organisations work a lot about this and this is a big issue".

Since the initial responses to HIV/AIDS in Thailand, in which state institutions and fear-appeals featured predominately, there has been an evolution in the framework that people use to address HIV and a shift toward a more human rights based approach to the epidemic. This reflects a wider paradigm shift in global understandings of the epidemic that has been noted by Rushton (2010), in which human rights and development discourse are increasingly dominant; this shift was facilitated by the advent of effective ARV treatment and the campaign to bring about access to medicines as part of the universal right to health (Davies, 2009, pp.70-75; Press, 2012). In Thailand, the rise of HIV/AIDS related civil society groups has led to the contemporary epidemic response that is defined by its human rights orientation and which has sought to redress the stigma and discrimination that surrounds the disease. These campaigns have arisen in part because of the early use of fear-appeals in prevention and education messages which may have exacerbated the stigma inherently associated with the disease due to its epidemiological conditions. What remains to be seen is whether the Thai national response reflected the UNSC securitization of HIV/AIDS that was codified in Meeting 4087 and how, or to what extent, the security-HIV link has been made in Thailand.

7.3. Assessing the Impact of UNSC Meeting 4087

Thailand was at the forefront of the UN-led global response to HIV and Thai political leaders, activists, and civil society groups have been included in high-level working groups from the outset of the UNAIDS response; for example, AIDS activist and politician Mechai Viravaidya was included in Dr Piot's team from 1999. Given this close and long-standing relationship between Thailand and UNAIDS, it would be reasonable to expect that the securitization of HIV/AIDS at the UNSC would be reflected in the policy, rhetoric, or practice of the Thai national response to the epidemic. However, it emerged conclusively during fieldwork that this has not been the case. The author conducted an in-depth interview with the UNAIDS Country Coordinator for Thailand about the national response and the impact of the HIV-security links made at the UNSC meeting in 2000. In a statement that characterises the general response of key interviewees throughout 13 months of fieldwork, Michael Hahn (2013) told the author:

> I think that [Meeting 4087] was the first time that a Security Council in the UN discussed a health issue at all, so I think in terms of advocacy purposes, in terms of giving HIV a different position, in a global response, it was a good move. But I don't think that countries have necessarily changed anything really because of this.

The inclusion of HIV/AIDS on the agenda of the Security Council did not directly translate into securitization of HIV within national responses. However, it won attention and resources from the international community and earned the epidemic legitimacy amongst some actors who may not have otherwise been convinced. Speaking at the UN Security Council in 2005, Piot highlighted the important role played by the Council in holding the first meeting on HIV/AIDS five years earlier:

> The Security Council, through resolution 1308 (2000), has transformed how the world views AIDS. I say 'transformed' because many now view AIDS as a threat to national security and stability, in addition to being a threat to development and public health alone. While today it sounds normal to place AIDS in that context, it was definitely a very bold step five years ago. (UNSC, 2005, p.5)

Hahn (2013) shared this view, stating that HIV was given a "different position" by its inclusion in the UNSC agenda and at the subsequent UN General Assembly

Special Session on HIV/AIDS (UNGASS) in June 2001. At this UNGASS meeting, the Global Fund for AIDS, Tuberculosis and Malaria was established; an organisation that would directly contribute $344,264,374 (US) to Thailand by 2012 (Kaiser Family Foundation, 2014). During the Special Session, Thailand alone spoke about HIV in terms of international security (Rushton, 2010, p.500), where the Deputy Prime Minister referred to the UNSC meeting on HIV/AIDS saying, "HIV/AIDS is a silent global menace which threatens not only development and human security, but also international security, to the extent that the global nature of the threat has already been acknowledged by the Security Council" (UNGASS, 2001, p.7).

However, Hahn (2013) explained that after these meetings in 2000, HIV had not been dealt with as a security issue in Thailand, even within the bureaucratic framework of the UNAIDS office itself:

> Because I don't think it is one really, it was a reminder that ... it's a very complex issue now, but don't forget this was in 2001 [*sic*], so we are wiser now and things thankfully haven't developed as they looked like [they would] at the end of the 1990s. By that time I think it was a reminder that epidemics and global health issues can also be a threat, a principle threat, to the security of countries.

Interviews with key informants from early and current responses, at both ground-level and in policy-making circles, corroborate this statement. The national epidemic response was driven in Thailand by the prominent role of CSOs and activists like Mechai and his peer, Ungphakorn, who early on secured a place in government policy making as well as being centrally involved in the UN-led international response. As a result, state policies were shaped by domestic as well as international agents, including UNAIDS and the Global Fund. Thailand benefitted from the resources mobilised by Piot's securitizing move at the UNSC, but although the HIV-security linkage had appeared in the documents of the United Nations and transformed the way the world viewed HIV/AIDS, there is little evidence that these claims endured in the discourse or policy that defined the Thai response on the ground.

Dr Phusit Prakongsai (2013) at the Ministry of Public Health stated that, whilst HIV/AIDS was thought about as a security issue in the past when morbidity

was high, this perception has declined following the delivery of subsidized antiretroviral treatment to c.250,000 people in Thailand since 2005. Before treatment became available in Thailand, HIV was more apparent in the population and invoked fear as an untreatable disease because it manifested in visible symptoms and a high death-rate among HIV+ people. Other facilitating conditions that contributed to the HIV-security framing in Thailand included the politicisation of the epidemic through AIDS exceptionalism, which was well established in the international community at this time, and the securitizing process led by the UNAIDS that was underway. Dr Praphan Phanuphak, Director of the Thai Red Cross AIDS Research Centre, diagnosed the first cases of AIDS in Thailand in 1985 and has been a prominent AIDS activist since. He told the author:

> HIV was presented as a threat to national security during the early 1990s, up until 1997 or '98 because at that time, according to the statistics, there was one death in the village in the Upper North every week. Which most of them are young people [*sic*] and also there were about 100-150,000 new infections ... [and] almost 100,000 deaths per year ... and the prevalence of HIV among young military recruits ... was as high as 7% among those recruited or drafted from the North. So at that time everyone said that this is a national security threat. (Phanuphak, 2013)

When asked to clarify who was making these securitizing claims, Phanuphak (2013) explained, "UNAIDS, you can say, the National AIDS Committee, and all the advocacy people talking about it. There was a document from UNAIDS saying that AIDS can affect national security, [with] which everyone agrees". But the frame of exceptionalism, fear, and security did not endure in Thailand. In addition to the influential campaigns of CSOs who fought to normalise perceptions of PLWHA, a number of other factors combined to reduce the fear of HIV/AIDS and thus reduce the persuasiveness of the HIV-security link. One of the major contributing conditions was the introduction of effective ARV treatment, which turned HIV/AIDS from a fatal disease into a "chronic condition that can be treated" (Hahn, 2013). With treatment, the established message that "AIDS = Death" was no longer true (Hahn, 2013). Phanuphak (2013) also identified this as definitive moment in the rejection of HIV-security claims in Thailand, stating that, "I think it changed when more people got treated. Especially starting [in] 2004 ... because it's the year that the

Thai government announced [there would be] universal access to AIDS treatment and ARV treatment".

The introduction of treatment has contributed to the reduction of HIV related stigma and discrimination in both direct and indirect ways; first, by turning HIV/AIDS into a "chronic medical condition, not a death sentence" (Hahn, 2013), the unproductive fear of HIV/AIDS is reduced and treatment offers an efficacious response with which the threat can be managed. Second, through adherence to treatment the visible symptoms that once characterised HIV/AIDS are no longer present. This removes a significant source of stigmatisation for people living with HIV and gives them far greater control over whether or not they disclose their sero-status to others. In Thailand and internationally, HIV/AIDS has been historically linked to chronic, visibly symptomatic disease; early HIV/AIDS campaigns often used visual displays of bodies affected by AIDS in fear-appeals about the disease and it was the emotive display of HIV affected bodies to US Ambassador Richard Holbrooke that helped to convey the severity of the epidemic and to mobilise resources at the global level (Muangmoonchai, 2013; Chapter 6). The importance of visible symptoms and their reduction through treatment was recounted repeatedly by interviewees, who stressed that the association of HIV with visibly ill bodies was not an effective route to sustainable prevention or management responses (Press, 2012; Hahn, 2013; Muangmoonchai, 2013; Ungphakorn, 2013). However, both Dr Phanuphak (2013) and Professor Rattanamha (2013) reported that whilst treatment had a positive impact on health and reduction of stigma, it was also responsible for a growing complacency about the threat posed by HIV. Dr Phanuphak (2013) notes that complacency about the Thai epidemic now exists among the general public, policy makers, and the international community, and it is linked to the new "ability to take ARVs".

The decline in priority and a growing complacency is also a result of the unsustainable nature of fear appeals. Hahn (2013) recalled similar "lessons" from Europe where the use of fear in public prevention campaigns included "skeletons on the tramways and buses and [messages that] 'AIDS Kills'"; these fear appeals created aversion in the audience, who did not perceive themselves to be the

intended audience of the message and who were not convinced of their own susceptibility. As Hahn (2013) observed, "young people go to the disco and no one looked like [those images]". In Thailand, Hahn (2013) noted the decline in fear over time is also present, explaining that "fear is not a good strategy to use" because, "you expect that ten or twelve years later people are still on blood pressure 300. They are not".

The provision of state-funded ARVs in Thailand is coordinated by the National Health Security Office (NHSO) that manages the Universal Healthcare Coverage (UHC), or '30 Baht Healthcare' scheme that has been in place since 2001. The UHC has included provision of ARVs since 2006, following the campaigns of CSOs and international NGOs to allow the provision of generic pharmaceuticals (Tenni, 2012). Dr Sorakji Bhakeecheep (2013), Manager of the NHSO, told the author explicitly that HIV was not regarded as an issue of national or economic security. Asked during the interview if there was a relationship between health and other security areas, Dr Bhakeecheep (2013) answered "no", and stated, "I've never seen any link between security and health/HIV". He went on to clarify that, according to the NHSO, "health is not a security issue ... unless you mean social security. ... Health security is a part of human security, and human protection and social protection" (Bhakeecheep, 2013). According to the NHSO, the aim of the institution is "to provide health security for every Thai person"; security which, concerning HIV/AIDS, consists of "health prevention and promotion, treatment and care" rather than a more traditional or statist interpretation (Bhakeecheep, 2013).

Dr Bhakeecheep coordinates the Thai government's budget for provision of HIV/AIDS medication under the UHC, which remains separate from that of other medicines. Asked whether this was a sign of the exceptionality of HIV/AIDS, he dismissed the link and explained that separation was due to the cost of ARV medication, which remains high compared to other treatments, stating, "we are not sure if the budget will be enough, we are worried that if it is going to be too big it will invade budget of other disease. Chronic liver disease also has a separate budget" (Bhakeecheep, 2013). Here again, pragmatic economic interests might be at the heart of an otherwise apparently exceptional response to HIV/AIDS, rather than

any genuine perception that the virus poses a threat to security. Brigitte Tenni (2012) from TNP+ supported the proposal that Thailand's national response to HIV was fuelled primarily by economic rather than security concerns, reasoning that Thailand was "concerned less about national security and more that HIV was going to get expensive, to affect people in the prime of their lives". This reflects an approach to conceptualising HIV/AIDS that emerged as typical of the Thai response and that Ingram (2013) referred to as locating HIV within "discourses of scarcity" (p.437). The discourse of scarcity infers that "HIV/AIDS programming is increasingly assessed in terms of calculations of cost, impact, and efficiency" rather than the exceptionality and urgency of securitization (Ingram, 2013, p.437). Recalling the early response to HIV/AIDS in Thailand and internationally, Tenni (2012) explained that:

> In the past [HIV] was couched in a national security theme ... I think they interpret that in a couple of ways ... you need to provide care or treatment for your population because if you get to a certain prevalence ... if your defence personal, or your police, or your army become infected and there's a proxy for your general population ... then the security of your country is at risk. ... I think that's how it was couched as a national security issue. But I did never hear that [*sic*] specifically for Thailand, although there were a lot of army conscripts ... infected and that's how they do surveillance, to measure prevalence in the general population ... Thailand were concerned less about national security and more that HIV was going to get expensive, to affect people in the prime of their lives. People were dying in the prime or their working lives.

Tenni (2012) also recalled that the decision by the Thai government in 2007 to issue Compulsory Licenses for the production of generic HIV/AIDS medication was based on a cost-benefit assessment of the treatment:

> They decided to go ahead and issue the compulsory licenses. It was also recommended by the World Bank Report, because it would save so much money. That was Mr Mongkol Na Songkhla ... For him it was about cost-effectiveness, because the government had already committed to providing ARV treatment through the government health system. And they could only do that because they could produce generics here, in country, through the government pharmaceutical organisation which is not-for-profit. They did the math to work out that they could afford to make this commitment.

Thailand's seminal decision to offer its population subsidised and affordable access to generic antiretroviral medication was a direct benefit of the securitization of the disease that had contributed to overriding patent laws and legalising generic production. However, the manifestation of these legal concessions by Thailand, to provide treatment under the Universal Healthcare Scheme managed by the National Health Security Office, did not invoke the HIV-security link; instead, as shown in the statements made by the Director of the NHSO above (Bhakeecheep, 2013), this link is explicitly rejected at the institutional level. In general, the qualitative data collected during fieldwork indicates that HIV/AIDS is not treated as a security issue in Thailand and where the security-HIV framework did exist, it did not endure beyond initial responses to the epidemic. One exception to this is the issue of migration, which is examined below.

7.4. Where HIV/AIDS is Security: The Immigration Issue

Where HIV/AIDS has been framed in terms of national security this is specifically in the context of other, more traditional threats. Professor Rattanamha (2013) collaborated on the 2011 *Evaluation of the National AIDS Response in Thailand* (AIHD, 2011) report with the Ministry of Public Health and said that when HIV is framed by the government in terms of national security, it is as part of the state campaign against recreational narcotics. Muangmoonchai (2013) reported that there were no clearly defined policies on national security and HIV and that immigration is the only issue that intersects security and HIV at the policy level. The dominant perception of interviewees was that HIV/AIDS was likely to be linked to security related to immigration and specifically to the social and economic issues associated with employment of migrant workers from neighbouring states, including Myanmar.

The perception that immigrants to Thailand pose a threat to the nation is well established culturally and politically. In particular, hostility toward people from Myanmar is rooted in contemporary economic conditions as well as historic relations. This was noted by Dr Sid Naing (2013) from Marie Stopes International in Yangon, when he told the author that poor relations between Thais and Burmese

hindered potential cooperation on HIV/AIDS responses and was rooted in historical animosity stemming from armed conflict between the two countries. In the contemporary context, economic hardship in Thailand has negatively affected perceptions of migrant workers and, as is common in the securitization of immigration, political leaders can frame migrants as a convenient scapegoat for wider economic difficulties (e.g., Wishnick, 2008, pp.89-92). In 1998, in the aftermath of the Asian financial crisis that began with the collapse of the Thai Baht, Prime Minister Chuan Leekpai implemented a series of policies to discourage employers from hiring migrant workers rather than Thai nationals. Leekpai's decision to deport one million, mainly Burmese, migrant workers was based on economic and "security" concerns, according to a statement made by the Army Commander-in-Chief, General Chetta Thanjaro (Human Rights Watch, 1998, p.17). In 2013, the Director of Thai Action Committee for Burmese Democracy (TACBD), Myint Wai (2013), told the author that a TACBD school for the children of Burmese migrants was closed by the Thai government who cited "national security concerns" over its location in central Thailand. Premjai Vungsiriphisal (2013), professor in the Chulalongkorn University Migration Research Centre, also reported that security concerns regarding migration are well established in Thai political rhetoric and that HIV was framed as a migration-related security issue, presenting an external threat to the Thai population. Vungsiriphisal (2013) explained that:

> Not only Burma migrants, but also Cambodia and Laos ... illegal migrants especially are a concern. We don't know who they are, how many they are. This issue [is] considered a security issue because of [the] administration structure. National security includes migrant workers as a threat to national security.

The impact of this perception is evident at the level of government and foreign policy. Hahn (2013) observed that since the start of the epidemic, "labour migration was often seen as part of the national security" and this affects the way in which migrants can be incorporated into the HIV/AIDS response within Thailand, given the sometimes overt hostility toward them. A Minister Counsellor of the Royal Thai Embassy in Yangon told the author that as a result of these concerns within the government, informal but "very close" cooperation between Myanmar and

Thailand includes regular meetings between the Ministers of Health in each country (Vipattipumiprates, 2012). These meetings are especially important for "healthcare in the border regions because we don't want people who cross the borders bringing in disease, we don't want it in Thailand. So there has been very intense cooperation" (Vipattipumiprates, 2012). Of course, HIV does already exist in Thailand, but prevalence among migrant workers is higher than in the general Thai population (UNAIDS, 2013, p.11).

Supatra Nacapew (2012) confirmed that the Thai government continued to talk of labour migration as presenting a security threat in traditional economic terms. Nacapew (2012) noted that her CSO's campaign to extend state-subsidised antiretroviral treatment to non-Thai, immigrant workers faced opposition due to the financial cost this would incur. This resistance was damaging she explained, because "if you want to control the spread of HIV you should be working with everybody, not only for some ... not only for Thais. Because the disease is not asking, 'Uhh are you Thai?'" (Nacapew, 2012). The reluctance of the state to extend subsidised antiretroviral treatment to migrants workers was, CSO representatives believed, due to a fear that to do so would encourage an unmanageable influx of HIV+ immigrants in search of medication (Nacapew, 2012; Tenni, 2012). This may be a salient concern, given that an estimated 65% of PLWHA in Myanmar do not have access to treatment (Swe, 2012; de Groote, 2013). At the Ministry of Health, Dr Prakongsai (2013) also stated his concerns about the future of the epidemic and the government's ability to sustain the provision of treatment in the face of growing drug resistance and increasing numbers of PLWHA. However, it is likely that the real reasons for opposing extension of treatment and for controlling migration are more complex and it is noteworthy that the HIV-security-migration framework fits neatly with the conception of HIV as a foreign or external invader.

Hahn (2013) suggests that migration and HIV might be perceived as a threat to the referent object of Thai national identity, explaining that, "when it was a security issue, it is all together with the idea of protecting Thai cultural identity. Normally it's a mixture, protecting the culture, the integrity, the unborn children". When HIV/AIDS was linked with security in contemporary discourse on the

epidemic, in Hahn's (2013) view this was a "hangover" from the early response in Thailand which positioned HIV as an additional dimension to the supposed "threat" posed to Thai national identity by migration from Southeast Asian states.

> If you look at labour migration, for example in the Thai context, it was also defined as security, and labour migration was often seen as part of the national security. Now it is slowly, slowly changing, but a lot of policy issues around labour migration have to do with the fact that it was seen as a security issue for Thailand. (Hahn, 2013)

Ultimately, whilst there is evidence that HIV/AIDS has been invoked as an additional dimension of the 'threat' posed by migration into Thailand, security is not the dominant framework with which the epidemic has been perceived or handled. As Hahn (2013) concluded, "I don't think that HIV ever got the status of a security threat, and rightly so".

7.5. The Future of the Thai Epidemic

Some medical professionals and scholars are worried about a second wave in the Thai epidemic; Professor Rattanamha (2013) suggested that changing youth behaviour and growing complacency about the dangers of HIV/AIDS in a post-ARV era would fuel a resurgence in prevalence among adolescents, while UN data indicate rising STI infection and HIV prevalence among Thai youths (NAPAC, 2009, p.3). However, at UNAIDS Hahn (2013) notes that rising sexual activity among adolescents might be responsible for a decline in HIV infection linked to commercial sex, which has traditionally been one of the primary vectors for transmission. Hahn (2013) observes that in the past:

> Young Thai men had no way to have sex with a young Thai girl so the first sexual initiation was with prostitutes. That has changed now. ... Young people have less sex with prostitutes ... young people sleep with everybody. Because they can do this actually, it prevents them from contracting HIV because if you sleep with a normal average Thai girl, you have very little risk of HIV. But if you sleep with a sex worker then you have a totally different risk potential.

Hahn (2013) rejected the idea of a "second wave" of the epidemic, although he cautioned that he may be "too optimistic" on this issue. Prakongsai (2013) was also concerned about the role of youth populations in driving the current epidemic,

although looking to the future his primary concern was about treatment efficacy; he told the author, "I foresee that we will have a second wave ... with an HIV/AIDS strain that is drug resistant".

Governance is a crucial issue affecting the future of the epidemic in Thailand; health spending in each of the 76 provinces is the responsibility of the Provincial Health Office (PHO) and this decentralised system leads to an underfunding of health projects that are less likely to offer "visible" rewards than road building or other popular projects (Prakongsai, 2013). HIV/AIDS programmes might be politically unpopular if they are seen as diverting resources to stigmatised populations and a lack of epidemic awareness among elected leaders can exacerbate the problems associated with marginalisation (Prakongsai, 2013). Worryingly, both Dr Prakongsai (2013) and Professor Rattanamha (2013) reported that health and HIV/AIDS policies were not prioritised by PHOs because they offered less opportunity for "graft" or corrupt financial gain than construction or commercial development. Prakongsai (2013) also noted that Chiefs of Provincial Offices were reluctant to adopt policies which might indicate that their province had "an HIV problem", in case it negatively affected trade or tourism in the area. In some cases, HIV/AIDS intervention had been adopted by PHOs under the guise of a campaign to reduce teenage pregnancy because this is a less stigmatised public health issue (Prakongsai, 2013). Thailand's concern about its image and reputation, which is linked to national prestige as well as the economically important tourist trade, might also serve as a motivation for the country to address its epidemic; Hahn (2013) noted that this was the case in the first years of the epidemic and at the National Human Rights Commission, Ladaporn (2013) also suggested that international pressure applied to Thailand might help reform some of the institutionalised stigma that affects employment and human rights violations in the country.

While political attention is important, unpublished epidemiological data indicate that the healthcare infrastructure central to the Thai response may not be functioning as well as previously thought. Figures due to be published by the International Health Policy Programme show that in 2008, 51% of HIV+ people

registering for ARV treatment for the first time had a CD4 count of less than 100 (Prakongsai, 2013). According to WHO guidelines, treatment should start when CD4 counts fall below 500 (WHO, 2013, p.92). A CD4 count less than 100 reflects advanced progression of the virus and approximately 20% of adults reporting at this stage would not respond to treatment; for younger people (aged 15-35) the success rate is even lower (Prakongsai, 2013). The significance of this data is that they indicate people living with HIV/AIDS are not detected or treated until, in many cases, it is too late. In addition to higher mortality, late detection also facilitates higher rates of transmission, as outlined in Chapter 4. The problem also appears to be increasing; in 2012, the number of people reporting for first use of ARVs with a CD4 count below 100 had risen by 11%, meaning that 62% of all new cases had advanced infection (Prakongsai, 2013). As Dr Prakongsai (2013) observed, if the epidemic response in Thailand in functioning well, how have so many people "slipped through the net" for so long? These data indicate that prevalence could be higher than currently reported and that it may be increasingly quickly.

7.6. Conclusion

There is a need for change in Thailand; data collected in this research indicates that whilst the state made a proactive and early intervention on HIV/AIDS as it emerged in the 1980s and 1990s, in recent years there has been a decline in the priority or attention awarded to the epidemic. Early policy responses have been critiqued by human rights campaigners and the rise in HIV among non-brothel based sex workers, PWIDs, and MSM indicates that there is still a significant problem to address (NAPAC, 2009). Complacency about the epidemic has been linked to the availability of antiretroviral treatment (Phanuphak, 2013; Rattanamha, 2013) and to an inevitable decline in the levels of fear that were invoked during initial responses (Hahn, 2013). Exacerbating this decline in attention, the stigmatisation of KAPs and PLWHA still exists and is evidenced by the complaints of rights-based CSOs and the reports of discrimination by PLWHA that are included in this chapter. At the institutional level, stigma and lack of awareness about HIV/AIDS has contributed to

the under-funding of responses and decentralisation of health care spending has exacerbated this problem.

Civil society groups continue to undertake essential work to protect and further the rights of PLWHA and to provide essential support, including access to healthcare services and harm reduction services (e.g., the Foundation for AIDS Rights and the Sex Workers In Group). They will remain vital to the effective ongoing management of HIV/AIDS in Thailand, providing both practical and advocacy support to PLWHA. At the Foundation for AIDS Rights and in the National Human Rights Commission, interviewees noted that it is hard to change the direction of policy that is driven by entrenched elites and interviewees (Nacapew, 2012; Ladaporn, 2013), but it is possible that in the future a change in generational attitudes toward KAPs and sexual health might facilitate the advocacy work of CSOs who seek to address stigma at an institutional level. Past attempts to frame HIV/AIDS as a threat to national security have not become the dominant framework for dealing with HIV/AIDS, although the rhetoric of 'othering' and the threat defence logic of military and foreign invasion remain present. If rights-based activism continues in its current vibrant form in Thailand, the danger of human rights violation will be checked, although complacency, stigma, and neglect of the HIV/AIDS epidemic is now a serious concern. Worrying data that indicate increased vulnerability among youth and MSM should be given political attention and, just as early interventions targeted female sex workers, addressing the current epidemiological trends will require pragmatism. For instance, an effective response now demands a confrontation of sexual health issues that affect MSM and youths, who could be educated in school in order to reduce their risk of infection. Significant investment in these politically sensitive groups does not currently exist and the country risks ignoring a potential resurgence that would quickly spread to the wider, general population. Without this renewed attention, as Rattanamha (2013) stated, "it may no longer be appropriate to use Thailand as a model for HIV/AIDS responses, although they were once effective".

Chapter 8. The Response in Myanmar

Using data collected during fieldwork in Yangon, Myanmar, this chapter presents an overview of the national response to HIV/AIDS and assesses the extent to which the epidemic has been framed as a security issue. Analysis of the primary data concludes with two significant findings: first, that the national epidemic response in Myanmar has been implemented by civil society groups that comprise a mixture of national and international non-governmental organisations. Despite restrictive and sometimes dangerous working conditions (Panzeri, 2013), these groups have mobilised in order to fill a gap in healthcare provision left by a state that has not, until recently, demonstrated an intention to engage effectively with management of the national epidemic. As outlined in the preceding chapters, HIV/AIDS related CSOs are often comprised of PLWHA and as such are unlikely to advocate the use of fear appeals or securitizing rhetoric that could exacerbate stigmatisation and discrimination toward their members. This approach is reinforced by influential international NGOs and donors operating in Myanmar, including UNAIDS and Medecins Sans Frontier (MSF), that advocate action to reduce stigmatisation and promote the normalisation of PLWHA. With a dearth of government investment in health services in Myanmar, these CSO and INGO policies have defined the national response to the epidemic; the second finding of this chapter is that, as a result of this CSO-led action, the language of security and fear appeal has been largely absent.

Inaction by the state has facilitated the growing involvement by CSOs in healthcare and HIV/AIDS responses, which is possible only because the authoritarian, military-led government has perceived HIV/AIDS as a non-political and non-securitized issue that does not warrant its attention or investment of its limited resources. Since gaining independence in 1948, rulers of Myanmar have been preoccupied with more traditional existential threats to the state, including those posed by separatist groups in the northern borderlands. Following the installation of military rule in 1962, security remained the "preserve of a small elite", that are concerned with a narrow, traditional array of perceived threats to their

power (Muang Than, 1998, p.391). Although there is evidence of a shift toward more "holistic security" since 2000 (James, 2005, p.57), a narrow and traditional security perspective has shaped the contemporary state. The determination of the Burman majority military regime (Beyrer, 1998, p.36) to protect their power base and preserve the unified state has characterised the rule of the State Law and Order Restoration Council (SLORC) and the State Peace and Development Council (SPDC) and has led to pervasive injustices against civilians and a legacy of civil conflict since 1948 (James, 2004). The prioritisation of traditional statist security has also de-prioritised non-military sectors of society and healthcare systems have been systematically neglected since 1962 (Beyrer, 1998, p.38). Under this security paradigm, internal threats to the ruling party (perceived or real) have been violently suppressed, leading to condemnation and economic sanctions from the West, led by the USA; the brutal repression of the 1988 popular uprising for democracy, the enforcement of a one party system since 1964, and the systematic repression of the National League for Democracy until 2010 are among the most well-documented instances of state violence orchestrated under the pretext of national security.

In this environment, the government has viewed civil society groups as potential threats to the survival of the state, even when those CSOs are ostensibly apolitical. As a result, CSO working conditions have been extremely restrictive and often dangerous (Panzeri, 2013). However, despite the "fear" that pervades civil society and the population in general, CSOs have mobilised to provide essential services for hundreds of thousands of people with HIV/AIDS (Lancelot, 2013). Interviews with leading activists and CSO representatives reveal that the continued operation of these CSOs has been possible only because they have strategically avoided actions that would be antagonistic to the state. To do so requires an explicit rejection of any securitizing language or policies that could lead to HIV/AIDS being interpreted by the government as a political or security issue. Indeed, one INGO representative notes that the Ministry of Health, which remains the only Ministry staffed by non-military professionals, has "fought" to remain a civilian institution (Herzbrusch, 2013). Until political reform began in 2010, the HIV/AIDS epidemic had been neglected, ignored, and at times denied by the military leaders of

Myanmar and public health in the country appears to have been subsumed by dominant, traditional, security concerns. Whilst this de-prioritisation of health has led to endemic underfunding and the corrosion of a once world-class healthcare system, it has also allowed the formation of an ostensibly politically 'neutral space' in which civil society groups could operate, during even the most oppressive years of authoritarian rule.

8.1. A Note on Data

What follows in this chapter is an overview of the epidemiological situation, as far as is possible given the context in which it was collected. It should be noted that, in light of recent political reforms, many international institutions are reviewing the available data for the country; for example, the World Bank notes that they "are re-engaging with the Myanmar government" in an effort to "address the scarcity of reliable data for the country" (World Bank, 2014). This chapter is compiled using current quantitative data published by leading IOs and CSOs with a presence in the country and qualitative data collected through interviews with these organisations in 2012 and 2013. Official data on Myanmar are acknowledged to be of questionable validity and subject to manipulation (Beyrer, 1998, p.36; Steinberg, 2010, p.153; Ware, 2012, p.21). Ware (2012) describes a "paucity" (p.22) of reliable data that stems from a lack of surveillance and reporting capacity that was steadily eroded following the exit of the British administration in 1948. Major barriers to the collection of reliable empirical data include limited resources for surveillance and analysis; a lack of comprehensive state control over some parts of the territory (namely those in the border areas in which protracted violent conflict limits access and hinders development and security); and the manipulation of data for political reasons (Ware, 2012, p.22). This has direct implications for HIV/AIDS responses, particularly at the monitoring and evaluation stage of project implementation, and in the restricted operational environment of Myanmar, "it is not easy to verify results" of HIV/AIDS interventions (de Groote, 2013).

All agencies dealing with HIV/AIDS use forecasting models based on the available data to predict wider epidemiological patterns; in this way, limited data

samples can be used to predict national prevalence figures (de Groote, 2013). This is standard protocol and supported by international organisations, including UN agencies, as a method of best practise in research (Murphey, 2013). Myanmar now has in place a number of effective institutions that provide data and reporting of the national epidemic, as well as pragmatic coordination and implementation of response. Since 2008, the Myanmar Country Coordination Mechanism (MCCM) has overseen the national response to HIV/AIDS, malaria and TB, and has coordinated a number of state and non-state partners that undertake their own surveillance, including UNAIDS. Data from both the MCCM and UNAIDS were generally regarded as "good" or "reliable" by interview respondents (Lancelot, 2013; Naing, 2013), but all interviewees expressed concerns about the reliability of data on the epidemic overall; as the representative from MSF explained, it is a "very difficult" subject (de Groote, 2013). From an operational perspective, CSOs face considerable political barriers in both gathering and reporting data. For example, Dr Sid Naing is a Burmese activist and country coordinator for Marie Stopes in Myanmar and represents civil society at the MCCM; according to Naing (2013), at times during the epidemic the government had become so sensitive to HIV/AIDS that mentioning the disease or epidemiological data could cause "serious problems", because it was interpreted by the military regime as an attack on their reputation and a sign of failure in governance. From Population Services International (PSI), Anne Lancelot (2013) reiterated this concern, reporting that operational targets for CSOs that were set by the government had created an environment of fear amongst civil society groups and were likely to lead to "blind lies" in an attempt to achieve compliance.

CSOs and organisations who do collect data, or who have the capacity to do so, face institutional challenges and disincentives to accurate reporting; one country representative from a high-profile international NGO operating in Myanmar explained how the organisation was routinely under-reporting infection prevalence in order to remain operational and that accurate figures were "not often" reported

to the government (Source 10, 2013).[15] This mis-reporting was part of a strategy employed by the institution to ensure its own survival; after many years working in the field, and as Burmese nationals, staff came to believe that the military regime was particularly sensitive to the issue of HIV/AIDS, in part because of its association with politically sensitive issues including drug use.[16] As a result, the organisation intentionally exaggerated its non-HIV related work and underreported its involvement with HIV/AIDS responses, out of fear that to be associated with the HIV/AIDS response could antagonise the military government (Source 10, 2013). Following his extensive embedded fieldwork in the country, Ware (2012) notes that "there are also widespread suggestions that deliberate misinformation has been a regime survival strategy" (p.22), indicating that erroneous data reporting is institutionalised in both NGOs and official government discourse.

8.2. The Country Response to HIV/AIDS

UNAIDS estimates that around 216,000 people are currently living with HIV/AIDS in Myanmar (National AIDS Programme [NAP], 2012, p.4). The country has an estimated prevalence rate of 0.53%, compared to 1.1% in Thailand (NAP, 2012, p.4) but despite reportedly fewer disease instances, Myanmar is far behind Thailand in the efficacy of its national response to HIV/AIDS. The epidemic is concentrated and transmission occurs primarily in sex workers and their clients, MSM, and the sexual partners of these key affected groups (NAP, 2012, p.4; Lancelot, 2013; Murphey, 2013). Data obtained from the Ratana Metta Organisation (RMO) (Aung, 2012; Swe, 2012) indicate that of the current HIV+ population in Myanmar, 9.6% are sex workers, 7.8% are MSM, and 2.9% are injecting drug users; these figures correlate with the KAPs identified in Thailand and elsewhere (NAC

[15] In the literature, Beyrer (1998) reports the case of a medical doctor in Yangon who was told by his superiors in 1994 to "stop being so thorough" (p.51) when reporting cases of AIDS, which were becoming alarming high.

[16] In addition to its legal and social prohibition, drug use and production in Myanmar is intrinsically linked to the ongoing conflict between the Burman majority state and ethnic minority groups that have historically used narcotic production and trafficking as a means of negotiating and resisting the military state in armed conflict, with trans-border implications also arising from refugee migration to neighbouring states (see Levy & Scott-Clarke, 2002; Steinberg, 2010, p.46).

2012, pp.43-51; NAP, 2012, p. 12). Civil society organisations attempt to target their interventions in order to make best use of their limited resources, according to the CSO consortium, Alliance (Swift, 2013).

The state infrastructure has not traditionally been conducive to effective HIV management; until 1993 condoms were illegal in Myanmar (Beyrer, 1998, p.47), needles for injecting remain illegal, and healthcare is poor (Levy & Scott-Clarke, 2002, p.362; de Groote, 2013). Following years of chronic underinvestment and the politically motivated destruction of the higher education system (Beyrer, 1998, p.37), Myanmar's once exemplary healthcare system is now among the lowest ranked in the world, second only to Sierra Leone (Tandon et al., 2000, p.21). This decline began with the installation of military rule in 1962, as Beyrer (1998) observes, "between the loss of talented people to emigration, incarceration, and execution, and the drying-up of funds for public health, what many argue had been the finest medical system in Asia froze in time and then slid backwards" (p.38). Although there is evidence of state investment and cooperation with civil society in recent years (James, 2005, p.62), between 70% - 95% of health expense is out of pocket for individuals, making even basic treatment unaffordable for many of the population (de Groote, 2013; Murphey, 2013). It is estimated that just 35% of HIV+ people in Myanmar have access to ARV medication (Swe, 2012; de Groote, 2013), leaving around 140,400 people without (the lowest prediction of incidence reported to this researcher was from Peter Paul de Groote, Head of Mission at MSF in Myanmar: MSF reports the actual figure could be as low as 70,000, with up to 48,000 people receiving treatment). In 2011, an estimated 18,000 people died from AIDS-related illness (NAP, 2012, p.4). Research for this thesis indicates that new data on Myanmar, which should become available as the country 'opens up' as a result of ongoing political reform, may reveal higher prevalence concentrated in currently restricted regions.

The first cases of HIV/AIDS were formally identified in Myanmar between 1988 and 1991 (Beyrer, 1998, p.40; Swe, 2012; Naing, 2013). At this time, the initial data was not used to make substantial models to predict national prevalence, possibly contributing to an early under-estimation of the epidemic (Naing, 2013).

The response of the military regime was to look first to blame neighbouring Thailand, who recorded their first case of HIV/AIDS in 1984, and to identify Thailand's prolific commercial sex industry and its associated American military clientèle as the source of HIV in Myanmar (Naing, 2013). The military leaders of Myanmar under the State Law and Order Restoration Council regarded the USA as a threat to their own political survival and frequently employed anti-American rhetoric to bolster their tenuous legitimacy among the domestic population (Philp & Mercer, 2002, pp.1592-1594; Steinberg, 2010, p.141). The traditional animosity between Thailand and Myanmar (Beyrer, 1998, p.36), which is fuelled by historical conflicts, economic disparity, and migration, also reinforced the 'us vs. them' logic in which HIV/AIDS was framed as a foreign disease (Naing, 2013). This was reinforced when Health Minister Ket Sein (in office from 1997-2003) declared that HIV was "a disease caused by foreigners" (Levy & Scott-Clark, 2002, p.360).

There has been a limited HIV surveillance system in place in Myanmar since 1992 ("Burma's Secret Plague", 1997; UNODC, 2006, pp.5-6)[17]. By 1996, HIV/AIDS was "a big problem" in Myanmar, but one on which the government remained largely silent (Seng Raw, 2012). By this stage, the government had "left it too late to address the issue", and the country was experiencing high prevalence and serious social problems as a result (Seng Raw, 2012). In 1998, epidemiologist Chris Beyrer (1998) reported that clinical care and treatment for PLWHA was "essentially non-existent" (p.47). This inaction by the state was likely caused in part by the marginalisation and stigmatization of key affected population groups, whose very existence presented a political embarrassment; in 1997, *The Irrawaddy* reported that Myanmar 'preferred to deny that promiscuity and commercial sex thrive in a Buddhist society' rather than acknowledge the epidemic ("Burma's Secret Plague", 1997), and in April 1999, the SPDC reacted angrily to warnings from INGOs that Myanmar faced an HIV/AIDS crisis that was affecting neighbour states, claiming instead that the country, "does not have a sex industry and the number of drug users compared to other countries is much less ... it is very difficult to understand

[17] Although Chris Beyrer (1998, p.40) reports the first screening programmes began in 1985.

how the HIV/AIDS epidemic could spread from Burma to neighbouring countries as alleged by certain quarters" ("Burma Rejects UN Fears", 1999).

Early reports indicate that the state was aware of high prevalence among inmates of the "notorious" Insein prison (Beyrer, 1998, p.40), in which "never fewer than 10,000" prisoners were detained; these prisoners were known to be at extremely high risk because of the systematic reuse of needles in the prison hospital ("Insein Prison", 1997). Although famous for the detention of political prisoners, Insein and other prisons were also used to incarcerate injecting drug users as a result of the "counterproductive" criminalisation of drug use, which increased exposure within the prison population ("Burma's Secret Plague", 1997). Despite claiming to have been aware of the epidemic since 1985 ("Burma Rejects UN Fears" 1999), the military government did not actively invest in effective prevention strategies or redress punitive laws that targeted drug users or sex workers (Aung, 2012). Nor did they publicly acknowledge the presence of a serious epidemic in Myanmar until the late 1990s ("Burma's Secret Plague", 1997). This recognition came amid growing international concern; in 1999, UNAIDS Director Peter Piot employed his securitizing rhetoric in an attempt to provoke action from the government, telling a press conference in Bangkok that, "we need to concentrate our efforts on Burma, convince the government this is a matter not only involving the people but of national security" ("Burma Rejects UN Fears" 1999).

Following this announcement, the situation changed significantly when the Ministry of Health created a strategic plan on HIV/AIDS in 2000. Their reporting efforts were hindered by a lack of accurate data on the epidemic and complicated by a combination of stigma and lack of healthcare infrastructure that undermined the quality of epidemic surveillance (Swe, 2012), but their action did attract the attention of the US. Despite trade sanctions; in 2002 a team from the US Centers for Disease Control and Prevention travelled to Yangon in order to assess the potential for a collaborative intervention involving CSOs and the Ministry of Health, but the endeavour was halted by the US Administration for political reasons (Cohen, 2003, p.1654).

This would not be the only time that the anti-democratic rule of the SLORC would prevent international investment on HIV/AIDS; in 2004, the Global Fund entered Myanmar in order to address growing HIV prevalence and the concordant epidemic of TB. The Global Fund had allocated 98.4 million USD to be utilised during a five year programme of involvement, but left after disbursing only 11.8 million USD (Swe, 2012; Parry, 2005). Ratana Metta reported that the withdrawal was due in part to the inoperable environment in the country which left the Global Fund unable to implement, monitor, or evaluate the programmes in which it invested (Swe, 2012). Following the departure of the Global Fund, the Three Diseases Fund (3DF) was established by a consortium of international donors (Denmark, Australia, the European Commission, the Netherlands, Norway, Sweden and the UK) to coordinate and implement funding into the country from 2006, where it remained until 2012 providing ARVs, harm reduction services (including needle and syringe distribution), condom distribution, and coordination of international aid. Between 2005 and 2006, UNAIDS estimated a country-wide HIV prevalence of 600,000 people (Parry, 2005). As surveillance and access to medicine improved, this figure dropped to the current UN estimation of approximately 216,000 PLWHA (NAP, 2012, p.8). Despite these figures, in 2005 and 2006 the military led government remained reluctant to recognise the significance of the epidemic or to award particular priority to any particular health issue (Lancelot, 2013).

It is unlikely that the government was convinced by the securitizing rhetoric of Piot in 1999 or by the UNSC Meeting 4087 in 2000 to consider HIV/AIDS as a threat to national security. From the 1990s onward, the state was increasingly cooperating with foreign and domestic NGOs to provide essential healthcare services, including in HIV/AIDS management (James, 2005, pp.62-65); the apolitical status of health is evidenced in the state's toleration of health related civil society activity and in their cooperation with domestic and foreign groups providing HIV/AIDS services in the country, many of whom were interviewed for this research. Whilst the securitizing rhetoric may have been ignored or rejected, due to the persistence of the Ministry of Health and CSOS and continued investment by

INGOs, the national response did begin to take shape. In 2006, the first National Strategic Plan on HIV and AIDS was enacted with the support of UNAIDS and there are now ongoing intervention programmes targeting PWIDs, sex workers, and MSM that combine government and non-government agencies (NAP, 2012, pp.18-21).

In 2008, the Myanmar Country Coordinating Mechanism was established in order to allow Myanmar to qualify for Round 9 Global Fund support (NAP, 2012, p.4). The MCCM is multi-sectoral and hosts both state and non-state actors; from the MCCM, UNAIDS Country Coordinator Eamonn Murphey, Birke Herzbruch from Malteser International, U Myint Swe from RMO, and Dr Sid Naing from Marie Stopes were interviewed for this research. Reporting on the epidemic in 2012, U Myint Swe (2012), President of the RMO, reflects that the country is, "far ... left behind" the achievement of the UN coordinated Millennium Development Goals (MDGs), which include halting and reversing the spread of HIV/AIDS and achieving universal access to treatment by 2015. UNAIDS notes that the MDG goals to cut new infections by 50%, and to achieve universal (>80%) access to ARVs, can only be achieved through "extraordinary commitment and efforts" by all stakeholders (NAP, 2012, p.15). Whilst attainment of the MDGs by 2015 is unlikely, with the "opening up" of Myanmar since 2010-11, the national response to HIV/AIDS in Myanmar has shifted gear and political reforms have to some extent "forced" the new quasi-civilian government to acknowledge the issue (Seng Raw, 2012). Increasing the momentum of the response, leading democratic politician and national figurehead, Aung San Su Kyi, has championed the rights of PLWHA and spoken out against the stigma attached to the disease; in 2012, UNAIDS appointed her a 'Global Advocate for Zero Discrimination' (UNAIDS, 2012b, p.3). A number of newly elected MPs have campaigned on HIV/AIDS alongside Aung San Suu Kyi, including Phu Phu Thin, an NLD youth group leader who runs a hospice and shelter for PLWHA in Yangon. A recent increase in the national health budget from the Ministry of Health allocated the equivalent of one million USD for ARV treatment, reflecting a growing recognition of the severity of the epidemic in both

elite and general populations as well as a growing commitment of state funds (Htung, 2013).

8.3. Civil Society

The national response to HIV/AIDS in Myanmar has been led by civil society organisations and international non-governmental organisations. In accordance with international norms and the principles of stigma reduction that are outlined in Chapter 4, CSOs don't use fear or fear appeals in their HIV/AIDS interventions. In both Myanmar and Thailand, CSOs came to the forefront of the epidemic response because they were able to deliver essential rights-based services and support for PLWHA that the state did not provide. In Thailand, CSO mobilisation was driven in part by a fear that state-led responses would undermine civil liberties and human rights, through policies exemplified by the proposed AIDS Bill of the 1990s, and by the need to provide services and support for PLHWA that would not otherwise exist. They were facilitated by the formal inclusion of CSOs in state-led responses that began under Prime Minister Anand (see Chapter 7). In Myanmar, CSOs were driven primarily by the desire to provide a front line response to HIV/AIDS, including medical services, that was neglected almost entirely by the state. Since the military coup of 1962, government investment in the health system had essentially ceased to exist, according to one senior INGO staff member (Source 31, 2013). It is extremely difficult to access reliable data on both government and NGO spending in Myanmar, but MSF (de Groote, 2013) estimates that 0.5 USD per person per year was spent on healthcare by the state in 2008, with international aid amounting to 5 USD per person per year compared to 50-70 USD in Cambodia or Laos. In the past decade, this funding has started to marginally increase but still, according to the INGO representative, it "is not enough" (Source 31, 2013). In this section, an overview of the political and cultural context of Myanmar is outlined in order to explain how CSOs and INGOs came to the forefront of the national HIV/AIDS response, and to demonstrate how the traditional security agenda of the military-led state allowed the rise to prominence by health related CSOs.

As a result of systematic and prolonged chronic underinvestment by the state, Myanmar lacks both the personnel and the physical resources needed to sustain a good standard of health care or HIV/AIDS response. Put bluntly by one participant, "primary healthcare is not good" (de Groote, 2013). The Hospital Initiative, a recent program coordinated by HIV/AIDS INGOs and CSOs in country, found that of the 200 available staff positions in one major hospital, only 80 were filled (Source 31, 2013). The director of another leading NGO reported that in one township in which they operated, the entire population (approximately 40,000) was served by just 1 medical officer and 2 to 3 nurses (Source 14, 2012). Where staff are employed in government run hospitals, they typically provide services on-site only, making access impossible for those unable to reach the facility. Children are also unable to access child-specific treatment and in the entire country only two INGOs can provide medication suitable for infants (Aung, 2012). In the 1990s, the National AIDS Programme reported that only 65% of blood used in transfusions was screened for HIV; outside Yangon this is likely to be much lower, particularly among armed insurgents who have no access to such facilities but for whom battle-field blood transfusions are used frequently during conflict (Beyrer, 1998, p.46).

A shortage of personnel and medical facilities has both direct and indirect consequences. For example, the lack of ARV medication is the source of serious social problems and where treatment is available, it is usually concentrated in urban areas; this shortfall in distribution has created a new type of internal migrant as HIV+ people relocate to towns and cities in the hope of receiving medication (Swe, 2012). Interviews were conducted at an RMO healthcare clinic in a township of Yangon that is severely affected by the epidemic; here, U Myint Swe and doctors working with patients reported the social effects of this disparity in treatment provision. These include "psychological trauma" and the likelihood of "more risky behaviour" among affected individuals, leading people to "destroy themselves or their community" (Swe, 2012; Aung, 2012). The physical and psychological consequences of untreated HIV infection are outlined in Chapter 4 and in Yangon, RMO staff observed a link between lack of ARV access and increased alcoholism amongst PLWHA, leading to crises within families and communities (Swe, 2012). U

Myint Swe (2012) also reports that he has raised concerns with government officials that, without access to ARVs, the resulting mortality amongst technical professionals could have negative consequences at the country level.

In the place of adequate professional health services, alternative and substandard forms of medicine have flourished and, partly as a result, there is a widespread distrust of healthcare systems that frequently fail to deliver appropriate treatment. Between 70% and 95% of healthcare in Myanmar is funded "out of pocket" by individuals (de Groote, 2013), but often "patients go to quacks" who are not qualified or able to provide proper treatment (Murphey, 2013). Quality of healthcare in the private sector is extremely variable but frequently extremely poor. Herzbruch (2013), of Malteser International, reported that many practitioners are not certified and in some cases do not disclose test results to HIV + patients, giving them only a limited supply of ARV treatment in order to provide an immediate but unsustainable alleviation of symptoms. This approach is extremely dangerous for both the patient and for the wider population because it accelerates the mutation of drug-resistant strains of HIV. The reason for such negligence, Herzbruch (2013) explains, is that unqualified medical practitioners often do not know about drug adherence, counselling, and follow up protocol for HIV patients, nor do they have access to up-to-date information on the disease. To compound these difficulties, there is a cultural expectation that certain forms of treatment should be delivered by medical professionals. UNAIDS Country Coordinator Eamonn Murphey (2013), explained that "patients expect needles and multi-coloured pills, so this is what the doctors provide". The Head of Mission for MSF in Myanmar, Peter Paul de Groote (2013), also reported a popular belief that "white pills can never be good". Furthermore, there is "a cultural respect for needles" that makes medication or treatment with needle and syringe more appealing to the healthcare consumer (de Groote, 2013; Murphey, 2013). Linter (2012) reported that there is a "mysticism" surrounding needle use; this encourages people to share limited supplies of needles for injecting medicines and narcotics and also reflects the poor levels of general education about healthcare. One INGO currently funds a local private sector General Practitioner to educate his patients about the fallacy of the "multi-coloured

pill" myths, showing patients instead that alternative treatments may be appropriate, that needles are not always "better", and that doctors should be expected to examine and question patients about symptoms before prescribing treatment (Source 31, 2013).

In addition to a loss of confidence in inadequate healthcare providers, stigmatisation of patients and violations of patient confidentiality are major barriers to effective HIV/AIDS responses that accompany low-capacity services (UNAIDS, 2007a). Confidentiality is not assured in state-run or even private sector facilities in Myanmar (Source 14, 2012) and, as discussed in Chapter 5, without access to treatment HIV testing is an ethically problematic issue. As Swe (2012) reported, "most people with HIV/AIDS don't want to go to government hospital because there is no treatment and they don't want to have their status disclosed". Fearing that their HIV+ status will be disclosed at government hospitals, "those with money get ARVs from the private sector", but "even those ARVS are of dubious quality" (de Groote, 2013). Some CSOs and INGOs that provide medical services are able to "build trust" among PLWHA by ensuring their own services are confidential and that HIV+ people are treated with respect (Swe, 2012), but are not able to extend their services to all who need them.

State-run facilities are perceived to offer inefficacious and sometimes harmful services, but there are further barriers that prevent people from accessing government hospitals; although they cannot legally refuse admission to suspected HIV patients (Naing, 2013), government hospitals do restrict access based on a number of stigma-related factors, including religion. One INGO reported that they were "unable" to refer Muslims to state hospitals because they would be "threatened" for doing so and that the patients would not be treated if they did (Source 48, 2013).[18]

While a lack of adequate healthcare services is a direct barrier to HIV/AIDS prevention and management, lack of information and awareness about the disease

[18] In February 2014, MSF, which provides a significant cohort of the available ARV medication in Myanmar, was temporarily banned from operating within the country after reporting evidence of a massacre of Rohingya people, a Muslim ethnic minority group, in Rakhine State. The nationwide ban on MSF has been lifted but remains in force in Rakhine, illustrating the sensitivity of the government to religious issues, even post political reform.

can also exacerbate stigma. Misinformation and stigma attached to the virus and to KAPs was reported even among elite populations; Herzbrusch (2013) noted that the Ministry of Health made statements denying the existence of men who have sex with men in the country. Due to the nature of the epidemic in Myanmar, which is concentrated within key affected populations (NAP, 2012, pp.18-21), it is reasonable to expect that awareness amongst the general population is variable, particularly because the limited resources available for intervention and education programmes are focused on key affected populations and high risk groups (Htung, 2013). In addition, unlike Thailand, Myanmar employed no significant public health campaign in the early stages of the epidemic. Based on data collected from interviews, it was difficult to reach a conclusive outcome regarding general awareness on HIV/AIDS; as one respondent observed, participants for this research were selected on the basis of their experience in the health and HIV sector and therefore their personal estimation about general awareness may be biased (Uhrig, 2013).

One area in which data was consistent was the subject of sexual health discourse among youth, which appears to be 'opening up' as a result of technological and cultural reforms. Traditional cultural and social norms mean that most people "cannot talk openly about sex and related issues" (Rahman, 2013), but Daw Seng Raw (2012), founder and former Executive Director of the Burmese Metta Development Foundation, offered an optimistic insight, noting her surprise at the new candidness she witnessed amongst young people who were using traditionally conservative religious meetings to informally discuss matters about sex and sexuality. She stated, "I never thought Burmese young people would be so open ... [it is] not a subject to be discussed in Church, but in the young people's Christian meetings afterwards it is okay" (Seng Raw, 2012). Jamie Uhrig (2013), a prominent HIV/AIDS activist and CSO representative, observed similarities between the "opening up" of Myanmar and that of Vietnam; in both countries political reform and the advent of telecommunications and internet technology have facilitated discourse on sex and sexuality that includes conversation about sexual health. Uhrig coordinates an online information service to provide professional health

information to Burmese people via an English and Burmese language blog that focuses on HIV/AIDS. The "conversation" about sex and sexuality, he says, is "needs based":

> [we] were starting to get a lot of questions on sex and sexuality so they got people to answer those questions on sex and sexuality and you could see them on the blog entries ... So they've started to do that informal service, to the community at large ... They started that as a community service. There's no other place ... you can learn from porn, I suppose. But it's not like sex or sexuality is taught in school. (Uhrig, 2013)

In lieu of formal education or alternative providers of information, this type of anonymous, internet-based service can be the only source of sex education for some people. He points out:

> There no sex education. It's not like there's books they can read. Not English books they can read. English language books are prohibitively expensive. And very limited choice. So the internet is it. That's how young people can learn. So we as health professionals have a responsibility to make sure there is quality information there about sex and sexuality. (Uhrig, 2013)

As a result of the inadequate state healthcare infrastructure, CSOs and international donors have become the dominant influence in defining the HIV/AIDS response in Myanmar, where they have mobilised to "fill the gap" in HIV/AIDS programing (Seng Raw, 2012). An estimated 75% of all HIV/AIDS services in Myanmar are provided by INGOs and CSOs, and almost all ARV treatment in the country is financed by the Global Fund (Htung, 2013). By filling a gap in service provision, CSOs are establishing themselves as the authoritative voice in the HIV/AIDS response and are using this position to educate according to the principles of fear-reduction, stigma reduction, and normalisation. These CSOs do not use fear appeals in their HIV/AIDS campaigns (Seng Raw, 2012) because, as in Thailand, they are often comprised of PLWHA who have mobilised as support or rights-based groups (Murphey, 2013; Swift, 2013). Similarly, international donors and INGOs are guided by the GIPA policies and "best practice" guidelines of the UN and other international norm setters, which advocate rights-based empowerment strategies and responses that reduce unproductive fear in order to combat HIV-related stigma. The international donors are the most significant influential actors in determining

the national HIV/AIDS response; even government funded national programs are sub-recipients of the Global Fund (Htung, 2013).

8.4. State and Security in Myanmar

CSOs and international actors did not advocate the use of fear appeals in HIV/AIDS responses in Myanmar for practical and ethical reasons, but the state and its official institutions also refrained from fear-based education or interventions to deal with the epidemic. Unlike CSOs, the state rejected fear appeals and securitizing rhetoric not because they sought to reduce stigmatization or enhance rights of PLWHA, but because they did not consider HIV/AIDS to be a matter of security, or of 'high-politics'. Since seizing power in a coup d-état in 1962, the security concerns of the military (the Tatmadaw) in Myanmar have historically been restricted to traditional, statist referents rather than non-traditional issues such as HIV/AIDS. In their security agenda, the regime has followed a pattern typical to post-colonial states in the developing world in which "the twin poles of sovereignty" were national security and national unity (James, 2005, p.19). Myanmar won independence from British colonialism in 1948 amid calls for separatism; ethnic minorities in the borderlands campaigned both politically and militarily to be granted autonomous control over their traditional lands (see Steinberg, 2010). The Tatmadaw is majority Burman ethnicity (Beyrer, 1998, p.37) but the revered General Aung San (father of Aung San Suu Kyi) was able to negotiate with minority ethnic leaders to secure a trial period of unified independence in the post-colonial state. However, following the assassination of Aung San, this unity collapsed and conflict between ethnic groups has remained a defining feature of national politics. After independence, democratic rule under Prime Minister U Nu was marred by factionalism and ongoing separatist campaigns, leading to his effective ouster by General Ne Win in 1958 and in 1962.[19] In the latter coup, the military cited its

[19] The civilian government lasted from independence in 1948 to 1962, with a period of military rule from 1958-1960. On the eve of democratic elections in 1958, a group of military leaders under Defence Minister Gen. Ne Win told Prime Minister U Nu that a military coup was necessary in order to avoid fragmenting the union and dissolution into civil war; "faced with an illegal coup", U Nu was left with little choice other than to invite the military to

intention as securing the state against the separatist movement in order to legitimate its ousting of the democratically elected leader. Thus, from the birth of post-colonial Myanmar, the state has been the primary referent object for security in the country, with the Tatmadaw, or military, as its self-proclaimed protector or "guardian" (Maung Than, 1998, pp. 390, 394).

In 1988, the military suppressed popular democratic protest now known as the '8888 Uprising'. The political power of the Tatmadaw was solidified with the establishment of the State Law and Order Restoration Council, under which violent oppression of opposition parties and activists continued. Internal opposition to the SLORC included groups advocating advancement toward democracy and ethnic militia still engaged in violent conflict for separatism and survival. Reflecting the internal threats to its regime, the Tatmadaw's conception of security remained "overwhelmingly domestic, focused primarily on survival of the regime, national unity, and law and order" (Maung Than, 1998, p.390); the slogan of the government, recorded by Maung Than in 1998, reads:

> Our Three Main National Causes: non-disintegration of the Union; non-disintegration of national solidarity; perpetuation of sovereignty. We reject any scheme to break up the Tatmadaw. No matter who tries to divide us, we will always remain united. Anyone who tries to break up the Tatmadaw is our enemy. (p.390)

Maung Than refers to security in Myanmar as "the preserve of a small elite", reflecting the system of governance in which power is held by a small number of individuals occupying the official position of authority (Muang Than, 1998, p.391; Steinberg, 2010, p.150). This system of power holding is based on the traditional Buddhist understanding of power that radiates from the celestial centre, and that is finite and thus reduced by delegation or power-sharing (Steinberg, 2010, p.150). In its contemporary form, this system of elite governance means that:

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assume control of the country, which they held for 18months until U Nu won leadership again by election (Steinberg, 2010, p.55). U Nu remained Prime Minister until a second military coup led by Gen. Ne Win in 1962, following which Ne Win's socialist party retained power until the 1988 "coup of consent" which constituted a military transfer of power (Steinberg, 2010, p.81).

> The discourse on security has been monopolized by the defense establishment. Intellectual analysis, media coverage, and public debate of security issues are virtually absent. All along, the polity has accepted its own exclusion as well as the inexorable logic of state security, which has subsumed societal interests. (Muang Than, 1998, p.391).

This has translated into a political system in which people who are not employed in official positions of authority are trivialised, exacerbating fear and the erosion of civil liberties (Aung San Suu Kyi, 2010). From the perspective of the Tatmadaw, the primary threats facing the state of Myanmar were those to the survival of the regime itself, which it viewed as inextricably linked to the state, and of the nation in its unified form. However, there is evidence of a shift in policy since the late 1990s. Myanmar joined ASEAN in 1997 whilst actively seeking reintegration with the international market and World Bank; in order to further these goals, the military rulers adopted the rhetoric of "holistic security" that included "health for all" and that considered poverty alleviation as an important part of economic development (James, 2005, p.57).

In recent years, with an eye on its neighbouring countries of Southeast Asia Myanmar has adopted the view that state security and economic security are mutually constitutive (James, 2004, p.532). Since gaining full membership to ASEAN in 1997, Myanmar has outwardly expressed its intention to open its national economy and to achieve full market status in order to facilitate integration and trade with the global community; an integral part of this economic development is a shift toward democracy and pluralistic governance (James, 2004, p.531). This democratic and economic reform has come to fruition most markedly since the election of opposition NLD party representatives to parliament in 2011 and with the recent relaxation of sanctions from the West that previously restricted foreign investment from this quarter. However, international aid agencies have raised concerns that this new wave of foreign investment is contributing to the militarisation of conflict-affected areas, environmental degradation, and a resurgence in "land grabs" by state-supported foreign business in the industry of resource extraction (Buchanan, Kramer & Woods, 2013). If true, these reports would support James' (2004) proposition that Myanmar's shifting national security strategy is founded on a

concept of security as a means of economic success rather than humanitarian concern.

In addition to its impact on health and human security, HIV/AIDS is also linked to threats that reflect a more traditionalist security framework, including the production of opium that has been regarded as a security concern by the Tatmadaw since its rise to power. This is not a reflection of human or societal security concerns related to the economic or health impact of injecting drug use, rather, it reflects the relationship between narcotic production, trafficking, and the financing of ethnic militias in the contested border territories; for decades, opium production has been used to fund armed resistance groups in Myanmar, in a practice analogous to that of the poppy production of the Afghan Mujahideen (Beyrer, 1998, p.40-41). In 2000, an estimated 90% of Southeast Asian heroin production took place in Myanmar (Beyrer et al., 2000, p.77), although there is evidence that narcotic production has shifted now to amphetamines, which are more popular in neighbouring Thailand and easier to manufacture covertly (Linter, 2012). Production of these drugs is linked to a number of internationally known individuals, many of whom have direct links to ethnic militia groups and control significant regions of the upland country (Levy & Scot-Clark, 2002). Prior to its political reforms, it had been claimed that Myanmar was a "narco-state" in which the SPDC administration profited directly from opiate production (Steinberg, 2010, p.103). Although this claim is contested, the administration did acknowledge that "drug lords" routinely invest significant amounts in the formal economy, in a practice that the USA refers to as "money laundering" but in areas that the SPDC called "development projects" (Steinberg, 2010, pp.103-4).

There is also evidence to suggest that the Tatmadaw has profited from direct involvement in the distribution of heroin within the country. In their investigative report on mining in the northern region of Hpakant, Levy & Scott-Clark (2002) found that key figures in the military were responsible for systematically providing heroin to workers in government mines, sometimes in lieu of monetary wages, with devastating results on the health of these populations. Endemic heroin use within Myanmar existed prior to the first cases of HIV/AIDS, which were diagnosed within

PWIDs in Yangon (Beyrer, 1998, p.40). In 1988, the street name for heroin in Myanmar was "freedom from fear"; this was also the slogan of the democracy movement and the title used for a book of Aung San Suu Kyi's essays published in 1991, when the NLD leader was under house arrest in Yangon (Beyrer, 1998, p.45). Studying a state approved scientific abstract from 1996, Beyrer (1998) observes that:

> A deluge of cheap and widely available heroin flooded Burma after SLORC took control in 1988, and they have confirmed this ... Is the SLORC directly involved in heroin availability? If not, they have managed to control every aspect of life in the country, every sector of the economy, save the most profitable one. (p.45)

Heroin does not infect users with HIV, but sharing contaminated needles to inject the drug does. Myanmar continues to enforce the 1914 Needle and Syringe Possession Law that makes possession of either a criminal offence. Punitive measures such as this exacerbate the risk of HIV infection among PWIDs by encouraging needle-sharing and restricting access to harm-reduction services. In areas with high rates of injecting drug use, the widespread availability of heroin combined with a limited supply of clean needles increases the chance of exposure to HIV/AIDS. Prevalence among PWIDs is known to be very high: in 1995, HIV prevalence in PWIDs in Yangon was 74%, in Mandalay 84%, and in Myitkyina (a city nearer to Hpakant and other mining regions), 91% (Beyrer et al., 2000, p.77). In 1997, 61% of PWIDs interviewed in a detoxification centre in Myktyina reported needle-sharing, although only 14% reported that they used the most high-risk method of 'blowpipe' injection, whereby heroin is blown into the vein by another person using a rubber pipe and a shared needle device (Morineau, 2000). A shortage in needle availability is exacerbated by the diversion of limited medical supplies to military services and has led to "a uniquely Burmese heroin culture" that revolves around the sharing of needles to inject heroin as a public commercial enterprise, sometimes in teahouses or in "shooting galleries" ("Burma's Secret Plague", 1997; Beyrer, 1998; p.45; Levy & Scott-Clark, 2002, pp.347-349).

Despite reforms and easing restrictions on travel in the country, it will be difficult for international observers to formally monitor the scale of the epidemic until all regions are fully accessible. Currently, travel between states is subject to

government restrictions and some areas are closed to foreign visitors. There is an expectation among experts that once the politically sensitive regions, or "black holes", are opened up by the state (de Groote, 2013), they may reveal large numbers of previously undetected HIV+ drug users (Linter, 2012; Renard, 2012; Lancelot, 2013). Previously, reporting from these regions was impossible and sometimes dangerous; one French NGO faced expulsion from the country after publishing a report that linked HIV and injecting drug use to mining (Naing, 2013). Despite reports of an extremely severe epidemic associated with mining towns in the North (Beyrer, 1998, p.52; Renard, 2012; Linter, 2013), the official response of the state has been only to close access to these areas and to censor data rather than to implement interventions. INGOs with the capacity to provide HIV/AIDS services are denied entry to the mining areas because of political restrictions on their movement (Herzbrusch, 2013).

In addition to the political sensitivity of narcotics and associated issues (Naing, 2013), civil society organisation has also been framed as a potential threat to the state. Prior to 2006, the government feared all civil society organisation or mobilisation and particularly that which they perceived as related to movements for democracy or other forms of political opposition (Rahman, 2013). The military government has been accused of deliberately breaking down collective action of the people in order to safeguard its own power and CSOs wishing to remain in Myanmar must learn to operate despite distrust by the state (Ware, 2012, p.116). Herzbrusch (2013) stated that implementation of health programs by Malteser International had been difficult in the past due to government "suspicions" about their activities and the regime has guarded against the possibility of INGOs collecting information about the state by restricting access to its government hospitals. The UNODC (2006) also noted that the government have been "extremely suspicious of external agencies conducting research" (p.5), which complicates work in areas related to HIV/AIDS and IDU. At CESVI, Panzeri (2013) explained that relationships must be carefully built with key government officials, because "they need to trust that you're not doing political activities" (Panzeri, 2013). The complexity and lack of transparency about operational rules and regulations

contributes to the pervasive fear among local activists and staff, who are aware of the military government's traditionally negative perception of civil society groups (Panzeri, 2013; Lancelot 2013). In this environment of fear, there is a need for "personal trust" among CSO staff and between CSOs and government officials (Panzeri, 2013). One INGO Country Representative explained that personal relationships were integral in the structure of CSOs, including in employment, because "open recruitment for vacancies would lead to hiring a government spy" (Source 49, 2013).

This environment of fear and distrust appears to be easing. By 2006, the government had stopped routinely blocking the work of HIV/AIDS CSOs, partly due to the advocacy work of the United Nations that secured the right of these groups to provide essential health services (Rahman, 2013). The INGO CESVI also reported that it now "works together [with] rather than despite" government officials (Panzeri, 2013). Together, these developments may reflect an adoption of the "holistic security" and "health for all" agenda outlined by James (2005). Political reforms have already begun to ease some of the operational restrictions on CSO operations; in 2013, the government announced plans to allow registration of domestic CSOs that would allow these groups to formally receive international investment and funding (Rahman, 2013). An additional reason for the relaxation of state restrictions is the growing recognition among government officials that the presence of health related INGOs and CSOs is needed in Myanmar because the state alone cannot independently provide adequate services. At the Yangon office of PSI, Anne Lancelot (2013) explained the enduring operation of her programme as the fact that it was "too big to fail" and that it helped "too many people" to be expelled from the country. International groups like PSI also bring in a considerable amount of funding and, without legal registration of local CSO groups, INGOs were a primary source of healthcare spending.

8.5. Health as a Neutral Space

The Ministry of Health in Myanmar is a civilian ministry, differentiating it from other government institutions (Aung, 2012; Herzbruch 2013). Public health in

the country appears to have been subsumed by dominant, traditional, security concerns that occupied the military-led SPDC and SLORC, leading to sustained underinvestment in public health and leaving the Ministry "too weak" to provide services (Lancelot, 2013). However, whilst this approach led to chronic and sustained neglect of healthcare services by the military state, it also allowed the Ministry of Health to retain some level of autonomy from the state by maintaining a non-politicised stance. This has become a strategy of both the Ministry of Health and CSOs operating in Myanmar, who have created in health an ostensibly politically neutral space in which they can provide essential health related services without attracting unwanted attention from the Tatmadaw. The Ministry has fought to retain its position as a civilian institution by distancing itself from politics and from politically sensitive issues. The Minister in charge has issued official statements declaring that health should not be a political issue and, prior to political reforms, the Ministry has been wary of aligning itself too closely with foreign NGOs that were viewed with suspicion by the state (Herzbruch, 2013).

The Tatmadaw has traditionally been suspicious of external agencies operating within Myanmar, but "so many" INGOs have been working on HIV/AIDS and other health issues that were previously "ignored or denied", that the Ministry has been prompted to cooperate with these groups (Herzbruch, 2013). Although it might be a concern that INGOs are operating without supervision, it was reported by interviewees that the Ministry, which is staffed mainly by medical professionals, is motivated largely by humanitarian principles and is aware that collaboration with INGOs and CSOs can be advantageous to its own service provision (Aung, 2012; Lancelot, 2013). As was also evident in Thailand, the INGOs and domestic civil society groups of Myanmar mobilised on the issue of HIV/AIDS to "fill a gap" in healthcare and services for PLWHA that the state did not provide. The Ministry of Health recognised the important role played by these non-governmental groups, and despite initial concern, has now come to rely on these agencies as a "stop gap" until its own capacity is strengthened (Swift, 2013). One INGO (Swe, 2012) stated that political desire to meet the UN Millennium Development Goals might also motivate the Ministry of Health's cooperation with

INGOs working on improving child and maternal health (Goals 4 and 5), and reducing HIV/AIDS and other diseases (Goal 6) (United Nations, 2012).

INGOs and CSOs in Myanmar also found that depoliticisation of health was an effective, if not essential, strategy for their operations. Lancelot (2013) explained that, "hidden behind health you could do a lot". PSI's Targeted Outreach Programme team wanted to deliver advocacy services to sex workers and men who have sex with men, and Lancelot (2013) reports that in order to do so, it framed the projects in terms of health rights for sex workers, when in reality they were about employment rights. This approach was also reported by the TACBD that works with (Burmese) labouring migrants in Thailand; Director Myint Wai (2013) reported that Thai employers would not let labour union representatives meet with their migrant employees but were likely to comply with requests from CSOs who wanted to discuss health and HIV/AIDS prevention. In practice, HIV/AIDS groups would collaborate with legal aid and labour unions in order to help them gain access to migrant workers, enabling them to deliver rights-advocacy services under the guise of politically-neutral health education (Wai, 2013). This was corroborated by Premjai Vungsiriphisal (2013) from the Chulalongkorn Migration Research Centre, who confirmed that HIV is used as a "facade" to discuss labour rights with migrants from Myanmar working in Thailand.

8.6. The Future in Myanmar

The Ministry of Health in Myanmar now has "four times the budget" of the pre-reform era, although Herzbruch (2013) and Murphey (2013) both noted that previous investment was so low that it does not require much to make a substantial improvement. However, this investment does indicate a prioritisation of HIV/AIDS not only for the health sector but also on the political agenda of the state (Htung, 2013). Htung (2013) reported that since the reforms of 2011, there has been an increase in HIV/AIDS awareness at different levels of government, including among complementary stakeholders such as police and immigration officials. Whereas a previous lack of information held back multisectoral mobilisation, growing awareness amongst these groups has changed the national response "quite

substantially" (Htung, 2013). HIV/AIDS now features in the rhetoric of prominent (opposition) political leaders; in 2012, Daw Aung Sang Suu Kyi was appointed by UNAIDS to represent its work, and national MP Phu Phu Thin has used her HIV/AIDS activism as a platform for election campaigns. This emerging politicisation of HIV/AIDS, coupled with democratic reform, may prove conducive for the creation of state-led efficacious policy responses in the future.

Civil society groups have "survived" extremely difficult working conditions in Myanmar by declaring to the military state that "we are not here to do policy change" (Panzeri, 2013). Panzeri (2013) reported that during the 1990s and 2000s the government perceived health-related INGOs and domestic CSOS as a "risk" to their power and that there was little trust between the state and these groups, resulting in an "especially high risk for local [CSO] staff". Now, the way in which INGOs and CSOs operate is changing. Foreign donors, that have always been present but that have operated "under the radar" through informal influence, are now able to formalise their operations (Campbell, 2013) and Myanmar is attracting more INGOs. Although there has been "a lot of support for NGOs for years" (Campbell, 2013), in the post-reform environment there is the opportunity for these groups to work openly in policy advocacy, to build the capacity of local CSOs, and to increase levels and types of funding now that sanctions restricting investment have been lifted (Campbell, 2013).

A number of INGO Country Representatives interviewed in Yangon noted that the capacity of domestic CSOs to cope with the inevitable increase in donors, investment, and humanitarian assistance to the country could be problematic (Lancelot, 2013; Htung, 2013; de Groote, 2013). Whilst the ground-level civil society groups and community agencies that shaped the HIV/AIDS response might have been well-placed to deliver health services to marginalised KAPs, they lack the capacity that a state-supported institution would have; decades of oppressive authoritarian rule have led to the systematic erosion of personal agency and organisational capacity. Lancelot (2013) refers to this as "fear and silence" that has "left enormous scars" and that has created an institutional culture in which capacity for "risk taking" or decision making is non-existent. Htung (2013) noted that fear

was a major problem affecting staff capacity, "especially when it comes to decision making", and Peter Paul de Groote (2013) reported that "people are still scared to act differently". Although CSOs are increasingly prominent in INGO-led collaborations with state-health services, there is a significant need to increase their agency. At UNAIDS, Murphey (2013) reported that local CSOs might have a lot of "informal" influence but at Committee meetings they are "often quiet" and remain "passive", instead using these collaborations as opportunities to network "on the side". The internalised culture of hierarchal power distribution may remain a barrier to effective CSO participation with state authorities until capacity in these CSOs is improved (Murphey, 2013). This will prove problematic in the forthcoming decentralisation of power that will follow political reforms and the politically 'neutral' space that once allowed CSOs and INGOs to work on HIV/AIDS under the authoritarian regime may now hinder their effective engagement with policymakers and high-level political discourse in a more inclusive democratic era.

8.7. Conclusion

In conclusion, the national response to HIV/AIDS in Myanmar has three defining characteristics. First, that the state has neglected and quite possibly exacerbated the epidemic. This has occurred indirectly through the systematic corrosion of the healthcare and educational infrastructure of the country, as well as the disempowerment of civilians and the failed economic policies that drove so much of the population into poverty. The active interventions of the state to restrict civil society organisation and the operation of INGOs have also acted as barriers to the implementation of effective responses. These are exacerbated by the restriction of access to politically sensitive geographical areas and the economic sanctions imposed by the West that curtailed formal investment in health and development programmes. The national security paradigm in Myanmar has, since independence, been one of traditional, statist security which preserves the unity of that state with a small elite and the Tatmadaw at its centre. As a result of the oppressive and neglectful leadership of the Tatmadaw, HIV/AIDS is a serious problem in the country. Without access to comprehensive data from all areas, it will remain

difficult to fully assess the status of the current epidemic but the evidence outlined above portrays a worrying indication of what soon might be revealed. The second defining characteristic of the HIV/AIDS epidemic in Myanmar is that it is severe; many people have already lost their lives to a virus about which they have no knowledge and many more remain infected with no recourse to treatment. Whilst it is impossible to assess the extent to which Tatmadaw (elite) populations were provided with healthcare and ARV treatment in closed military hospitals, a survey of the available data and accounts from leading INGOs and CSOs reveals that the civilian population is ill equipped to manage or protect themselves from HIV/AIDS. The final distinguishing feature of the epidemic is that, despite the magnitude of these challenges, civil society and INGOs have mobilised to provide essential services to hundreds of thousands of PLWHA.

The work of civil society organisations in Myanmar, conducted by both foreign and local staff, has defined the current epidemic response. In the absence of meaningful investment by the state, CSOs and INGOs have provided practical services and support to PLWHA and saved many lives. If the trend of political reform toward democratisation continues, it may be possible for more of these groups to affect policy change through formal advocacy, in addition to providing front line support. CSOs and INGOs have faced myriad barriers to their operation and in order to maintain their essential services and continue their presence in Myanmar, they have been part of a concerted effort to distinguish health as a politically neutral space. This framing has also been part of the rhetoric of the Ministry of Health, which fought to retain its unique position as a civilian institution within the military state. It is established through this thesis that health, and the provision of HIV/AIDS services, is not apolitical. However, for the Tatmadaw in Myanmar the distinction between political and military security has been obsolete, so it was possible for healthcare providers to operate under the pretext of neutrality. Ultimately, because the state did not consider health to be their concern, INGOS and CSOs were able to claim this neglected territory as a space in which they could operate and assist the people of Myanmar.

Chapter 9. Conclusion

The primary objective of this research has been to determine, through empirical study, the extent to which the securitization of HIV/AIDS has taken place in Thailand and Myanmar following the seminal UNSC Meeting 4087. In order to assess whether and how securitization had occurred, it was necessary to critically engage with the theory and the first part of this thesis examines the conceptual logic that underpins the Copenhagen School's analytical framework. A preliminary review of the literature establishes the mechanisms of securitization so that the process can be identified within the empirical case studies. It was established that the ethical dangers of HIV/AIDS securitization outlined by Elbe (2006), and detailed in Chapter 1, could act as indicators of securitization and these indicators were subsequently developed into lines of inquiry for use in data collection, in which elite actors involved in the HIV/AIDS responses in Thailand and Myanmar were interviewed to assess the extent to which securitization had occurred. After assessment of the data, this thesis draws two major conclusions about securitization theory from the cases studied: the first is that securitization is about the construction of the existential threat, which requires the invocation of fear among an audience and the utilisation of suasive fear appeals. The conceptual and empirical chapters show that fear, and therefore securitization, are particularly problematic when applied to HIV/AIDS. By identifying fear as the essential but under-studied component of securitization processes, and by applying this new indicator of securitization to empirical studies, the thesis reveals that securitizing rhetoric has been proposed and opposed in the case study countries. This leads to the second conclusion of the thesis: that securitizing HIV/AIDS is not the preferable framework by which to deal with the epidemic.

This final chapter begins with an assessment of what can be learned about securitization theory in light of these studies and moves on to a summation of key findings from the case study chapters. The tensions between human rights and security frameworks are then explored in the context of the data, which delivered in-depth insight into the formulation and operation of civil society responses to

HIV/AIDS. Finally, using reflections from these case studies, this chapter outlines evidence in support of using fear with caution when dealing with HIV/AIDS and elucidates the issues of unproductive and productive fear that were raised in Chapter 3 with examples from the empirical data.

9.1. Reflections on Securitization Theory

This research adds to the growing body of literature on securitization and contributes much needed empirical study of the applied framework in real-world settings, outside the liberal democratic systems from which it originated. Securitization, and the threat-defence logic at its conceptual core, offers a formulaic tool that can be applied to a wide range of referent objects and potential threats in order to frame a necessary response; in theory, anything can become a security issue if it is both successfully constructed and understood as being such (Buzan et al., 1998, p.36). The realist core of the theory, which demands that the logic of survival and defence remain the defining feature of security, maintains the intellectual coherence of a model that was designed to "lay to rest" the argument between those who favour a narrow interpretation of security and those who demand a broader definition (Buzan et al., 1998, p.195). In many ways the framework does bridge the gap between the traditional and newer, broader, meanings of this essentially contested concept, but in application to the non-traditional issue of health as security, the realist demand for an existential threat becomes problematic.

In its conceptual chapters, this thesis finds that the construction of existential threat comprises the invocation of fear through suasive appeals made by an authoritative actor; this fear undermines effective epidemic responses by inclining audiences toward traditional dichotomous understandings of risk that centre on logics of threat and defence, us vs them, and good vs bad. Fear invocation poses significant challenges to the implementation of an ethical and efficacious response to HIV/AIDS which demands a rights-based approach and which promotes the health (in its comprehensive meaning) of all peoples with or without the virus. The case study chapters show that the 'dangers' of HIV/AIDS securitization outlined in Chapter 1 were recognised and resisted by civil society groups concerned with the

normalisation of societal attitudes toward PLWHA. The application of securitization theory to these case studies provided an important departure point for in-depth contextual analysis in these studies, which revealed new insight into both the country responses and into the conceptual framework.

The Copenhagen School theory of securitization is thus both conceptually and empirically useful. In addition to providing a formulaic tool for widening the definition of security, the School also delineates the ways in which security is socially constructed using subjective understandings of threat and defence, whereby panic politics and suasive fear appeals are utilised. These constructions are value-laden and context driven although, as detailed in Chapter 2, the original formulation of the theory has been criticised for not adequately addressing the importance of these external conditions. Normatively, the Copenhagen School warn against securitization, which facilitates securitizing actors in breaking free from "procedures or rules he or she would otherwise be bound by", and the School imbues in actors the responsibility for invoking the existential threat (Buzan et al., 1998, p.25). The theory also implicitly promotes a hierarchical structure of threat prioritisation. As shown in Chapter 2 (section 2.2), this ethos of hierarchy favours the invocation of traditional security rhetoric at the risk of marginalising non-traditional issues or subsuming them into the framework of state-centric security articulated by established powerful elites. The realist core of securitization thus extends beyond the centrality of the existential threat to also include the type of actor which is favoured; as highlighted by Hansen (2000) and explored in Chapter 2 and Chapter 3, securitizing actors are likely to be authoritative power-holders able to speak the language of security and articulate the necessary fear appeals.

Perhaps the primary attraction of securitization, to both speech actors and scholars, is that its application offers the opportunity to attract power and resources for dealing with a proposed threat; an authoritative speech actor who articulates a threat, invokes fear, and proposes a response is well placed to wield the extraordinary power that comes from dealing with an issue which, by definition, warrants the breaking of normal procedures (Buzan et al., 1998, p.24). In addition to political power, securitization also delivers tangible resources, as evidenced by the

strategic utilisation of securitization by Piot in Chapter 6. However, in the domestic responses of Thailand and Myanmar, the logics of securitization and fear appeals have been explicitly rejected by civil society groups; echoing Elbe's (2006) concerns about the dangers of securitization, these groups feared that securitization and a break from normal politics could have detrimental effects on their well-being. With this power comes responsibility and the Copenhagen School clearly demonstrate that inherent to their model of 'security as socially constructed' is the concept of security as choice: the choice of the securitizing actor to create it as being such (Buzan et al., 1998, p.29). The subject of choice, coupled with the preference for desecuritization, is indicative of the normative values of the Copenhagen School (Waever, 2003, p.12).

The School's conceptual logic displays a normative bias toward the liberal democratic model of governance and, as discussed in Chapter 1 and Chapter 2, is arguably constrained by a "Westphalian straitjacket" which affects its application to empirical studies outside the West (Wilkinson, 2007, p.10). By adopting Thailand and Myanmar as case studies, this thesis offers a useful empirical application of the theory outside the Western liberal democratic norm, but it also acknowledges the limitations inherent to this approach, particularly those that arise during data collection which are discussed in the introductory chapters. The political and cultural conditions of each state defined the type of discourse and actor that could be studied, but in both case studies the national response to HIV/AIDS have been definitively shaped by CSOs to which it was possible to gain access. It should also be noted that the candid accounts of HIV/AIDS responses offered by the CSO representatives might provide a more reliable assessment of the epidemic than those presented by the state, whose officials are more likely to be accountable to superiors or have vested interest in promoting a positive image of the governmental response. Throughout fieldwork, the identification and extrapolation of culturally specific mechanisms that affected data was an ongoing development that both revealed limitations and benefits of the empirical study; in particular, examination of these conditions adds depth to the qualitative data collected and in this way securitization

theory performed as a departure point for broader analysis of the contextualising conditions, as suggested by Curley and Siu-lun (2008).

The case-study approach is able to address an enduring critique of the Copenhagen Securitization framework: the inability of the framework to focus adequate analytical attention on contextual conditions that affect securitization processes (McDonald, 2008, p.580). This limitation is a result of the narrow approach employed by the School, which undervalues the situatedness of the speech act by investing too heavily in the conceptualisation of security as a discursive act (Stritzel, 2007). Suggested correctives to remedy this shortcoming include Balzacq's (2005) proposition that securitization is reconceptualised as an audience-centred process that is context dependent, as discussed in Chapter 2, but context also becomes more central to analysis through the application of the framework to 'real-world' studies. In his outline of HIV/AIDS securitization norms (HASN) Vieira (2007) illustrates that localised conditions are not adequately addressed by the securitization framework, which risks missing deeply influential "strategic environmental factors" as a result (p.141). This can be addressed through application of the framework to real world settings; using securitization as a methodology for empirical study in this thesis revealed complex and nuanced social and political conditions in each country, which is of value in itself, and also delivered rare insight into the operationalization of desecuritization as a strategy.

In his own empirical example, Vieira (2007) uses the regime of former South African President Thabo Mbeki who, with the support of his health Minister, 'Manto' Tshabalala-Msimang, restricted access to life-saving medication in South Africa and promoted the theory that HIV and AIDS were unrelated conditions, contra to international norms. This rejection of the international HIV/AIDS securitization norm can also be observed in a different form in Thailand and Myanmar, where the rhetoric of existential threat and security were rejected, although the mobilisation of resources was not (with far better epidemiological outcomes than the approach adopted by Mbeki and Manto). The application of the Copenhagen School framework to these diverse cases reveals the limitations of an approach which focuses "almost exclusively on the subjective practices of

discourse" at the expense of "structured social and power contexts in which these practices take place" (Vieira, 2007, p.141); without treating the framework as a "departure point" for a wider analysis, the important detail of these studies would be missed (Curley & Siu-lun, 2008, p.5). At the conclusion of this thesis, it is evident that securitization is a complex process and its application to real world settings is both challenging and necessary. In addition to exploring the important critiques above, empirical application has revealed some of the benefits of securitization, as well as the manifestation of the 'dangers' and their real-world consequences.

Importantly, this thesis also shows us that application of securitization theory to empirical case studies requires the delineation of what that securitization would look like in practice, which demands the development of the Copenhagen School model to counter the "too-static" focus on discursive speech acts (Stritzel, 2007, p.364). The identification of Elbe's (2006) dangers as practical indicators of securitization was essential to the fieldwork and without these, the important nuances and details of securitization-in-action would be lost. The official political discourse, policy reports and rhetoric of both UNAIDS and the Thai state suggests that the security-HIV link is more salient than it appears on the ground. In reality, those leading and delivering the response have rejected the security framework. In Myanmar, access to political documents is heavily restricted, official data is often misleading (see 8.1), and more reliable data is available from non-governmental agencies or international organisations which are at the frontline of HIV/AIDS responses; if the application of securitization as a methodology above had restricted data collection to the official rhetoric in either country, the true face of the HIV/AIDS response would have been lost.

9.2. The Case Studies

Recognising the value of empirical application, the second part of the thesis applies securitization to real-world settings, beginning with an account of the external and facilitating conditions that affected the process of HIV/AIDS securitization at the UNSC. Chapter 5 examines the era of 'AIDS exceptionalism' that preceded UN-level securitization, when civil society groups and activists

mobilised in response to the emerging epidemic in the 1980s and 1990s. These early years of the epidemic were marked by fear and panic aroused by a novel, violent, and ultimately fatal disease for which no efficacious treatment existed. Fear was exacerbated by a lack of information about the virus and uncertainty regarding its modes of transmission. In this environment, civilians, PLWHA, and medical professionals mobilised to protect the civil liberties of people with, or at risk from, HIV/AIDS and began a form of politicised and civil society-led responses that would come to define the global epidemic.

Epidemiologically, HIV/AIDS displays a number of qualities which facilitate this form of civil society response. The most important of these is the specific vulnerability to HIV/AIDS that is experienced by members of marginalised population groups, including MSM, sex workers, PWID, women, people who lack access to education, and people living in poverty. As a result, stigma and discrimination are inherently linked to the epidemic and have been identified as major barriers to ending the epidemic (UNAIDS, 2007a; Parker & Aggleton, 2003, p.13), but this has also served as a catalyst for action. As discussed in Chapter 5, MSM communities in North America were among the first to mobilise on HIV/AIDS in the 1980s. These groups had previously organised politically as part of the LGBTI civil rights movement and were able to respond with the same tactics to HIV/AIDS, when it was both the virus and draconian public health responses that they feared. This form of activism, which was started among people directly affected by HIV, continues with great strength not only due to the mobilisation of existing (marginalised) communities, but also because the epidemiology of the disease enables this; the second condition of HIV/AIDS which facilitates civil society responses is that the virus creates a 'long-wave' epidemic in which infection can be asymptomatic for years, allowing people with the virus to undertake the labour of activism.

The early politicisation of HIV/AIDS by activists established a niche framework known as 'AIDS exceptionalism', a concept with multiple definitions but which rests on the logic that HIV/AIDS has unique qualities that demand an extraordinary form of response. This exceptionalism did not take the form of

traditional public health responses that recommend quarantines and other invasive measures by the state (although these have arisen in manifestations of a discriminatory approach atypical of the global norm, e.g., in Cuba, detailed in Chapter 7). Instead, these responses were explicitly rejected by civil society groups comprised largely of PLWHA and AIDS exceptionalism has become synonymous with forms of public health response designed to protect the rights of PLWHA, to empower patients, and to attract financial and political resources for dealing with the disease.

At the UNSC, then-UNAIDS Director Peter Piot evoked this exceptionalism in order to mobilise resources to deal with the epidemic at the global level. Just as LGBTI groups in North America had mobilised to demand their communities were neither neglected nor persecuted in the response to HIV/AIDS, Piot performed as an elite-level authoritative actor to persuade global leaders to address a health issue they might otherwise ignore. In both cases, activism was motivated by a concern that stigmatisation and marginalisation of people vulnerable to HIV could lead to poor management of the response; taking HIV/AIDS to the Security Council was a way to counter devastating under-investment from political leaders and policy makers who believed themselves to not be at risk from or affected by the virus. Piot recognised the 'hook' needed to engage the concerns of his influential audience at the Security Council and framed HIV as an international security issue. The mechanisms by which Piot achieved this, and the details of his strategic approach, are outlined in Chapter 6, which also links seminal Meeting 4087 with the campaign led by Piot's peers to curtail international trade agreements and scale up the distribution of affordable, essential, antiretroviral treatment (Chapter 6). Framing HIV/AIDS as a security threat at the Council did achieve important results, not least the continued attention of global leaders and subsequent investment of practical resources. However, the level to which leaders were genuinely convinced, and the accuracy and durability of the HIV-security link, have been extensively questioned in the literature outlined above (Chapter 4); the case studies in this thesis further add to that critical scholarly voice

9.3. Human Rights and Security

For HIV/AIDS activists and civil society leaders, the motivation to act is founded on the perception that health is at risk from both the HIV virus and from the societal stigma associated with it, including stigmatisation of the social conditions and behaviours which place people at higher risk of transmission. In the speech acts of UNSC Meeting 4087, HIV was proposed as threatening state security, economic stability, and development. Although concern for human rights was manifest in the invocation of "women and girl refugees", victims of war time rape, and "teenage girls...subject to the scourge of AIDS" by speakers, this does not constitute a call for a rights-based response (UNSC, 2000, p.8, 13). By contrast, civil society responses orchestrated by PLWHA do frame HIV as an issue primarily of human rights. This has become the dominant approach internationally, in part because these groups constitute a transnational movement unparalleled in resources or scale; the securitizing acts articulated at UNSC 4087 were no serious challenge to this civil society led response, which was well established by 2000 and which Piot and his peers supported. The dominance and internationalism of civil society is evident in the two case study countries: in Thailand, civil society plays a determining role in the provision of services and the negotiation of state policy to deal with HIV/AIDS and in Myanmar the direct work of Burmese and international civil society groups ensures the provision of HIV services, although limited, to the civilian population.

In recognition of the essential role of PLWHA in effective responses, the principle of GIPA (greater inclusion of people with HIV/AIDS) has become a global norm, as discussed in Chapter 4. At the heart of this mobilisation is the belief of activists that without their voices and agitation, these vulnerable groups would be victim to societal discrimination ranging from outright persecution in the form of draconian health interventions to the hazardous neglect of their specific needs. This persecution is a manifestation of the first and second dangers identified by Elbe (2006) as inherent to the securitization of HIV/AIDS: first, that security responses could be pushed away from civil society toward state institutions less equipped to deal with health and more suited to traditional security endeavours; and second,

that this approach could lead to the violation of civil liberties. Through analysis of the qualitative data collected from elite interviews in Thailand (Chapter 7) and Myanmar (Chapter 8), it is found that in both countries there has been a rejection of threat-defence logics and instead, civil society groups comprised largely of PLWHA have taken the lead in shaping national responses. In collaboration with international donors and INGOs, these groups have defined HIV/AIDS as a rights-based issue in which people living with the virus are positioned as the recipients of support and protection rather than being framed as a source of threat to a larger 'normal' majority.

In Myanmar the dangers of securitization have been clearly recognised, and averted, by civil society in a process which provides a significant insight into the country-specific environment as well as the mechanics of securitization. Here, civil society groups and INGOs feared that securitization of HIV could provoke the Tatmadaw to affect a response to the epidemic; given the propensity for violence of this regime, outlined in Chapter 8, PLWHA and human rights advocates had substantial reason to believe that a state-led response would be coercive and punitive. The survival of civil society groups and externally funded healthcare programmes depended on the framing of health as a politically neutral issue distinct from the security interests of the state and securitizing rhetoric has been specifically rejected in order to ensure the continued operation of essential INGOs and CSOs dealing with PLWHA. Although recently celebrating hard-won political reforms, for decades Myanmar has been defined by the secretive, isolationist policies of the authoritarian regime that neglected healthcare and the needs of much of its population. Whilst it had devastating humanitarian consequences, the political distancing of state from health did enable civil society to orchestrate a limited response to HIV/AIDS in the country and it was possible to study this during fieldwork only because the response was owned by local civil society groups and INGOs autonomous from the political regime. The 'neutral space' carved out by civil society and INGOS to provide health services has also been positive for the development of civil society capacity, which can be used to mobilise support for other rights-based issues; this is illustrated in Chapter 8, where an exiled Burmese

civil society leader detailed how labour-rights education was delivered to undocumented migrant workers in Bangkok under the guise of HIV prevention messages.

In Thailand, the fear that civil liberties could be at risk from harmful state responses has also driven the globally renowned Thai civil society groups in their HIV/AIDS campaigns. Unlike its neighbour, Thailand has a comparatively secure democratic political system modelled on that of Western liberal democracies imagined by the Copenhagen School. At an early stage, the state recognised the emerging epidemic and its potential impact on the economy and societal security. Despite some reactionary measures (see section 7.1), initial attempts to utilise traditional and restrictive public health measures, or to dismiss the epidemic as isolated within marginalised groups, were largely rejected in favour of a more pragmatic and inclusive approach. This was due to the efforts of PLWHA who mobilised as support and self-help groups before campaigning for advocacy and rights issues, continuing Thailand's tradition of vibrant civil society activism into the era of HIV/AIDS. With political and popular support, these groups were able to establish a leading position in the national response and subsequently secured their formal inclusion in influential policy making arenas, particularly within UNAIDS. Thailand is celebrated regionally as a champion among its Asian partners for implementing effective epidemic responses but, as discussed in Chapter 7, there are serious concerns about the degree to which key policies, including the 100% Condom Programme, were rights-based and sustainable. However, the leadership of the state and civil society is duly recognised. In particular, the inclusion of affordable ARV treatment under the state Universal Health Coverage scheme was a major victory for civil society and has saved many lives; around 240,000 of the 445,000 PLWHA in Thailand currently have access to state-subsidized antiretroviral medicine (Hahn, 2013).

The future in both countries remains uncertain, although this thesis raises a number of pressing concerns about epidemic management in the coming years. In Myanmar, as the state continues to politically reform and move toward democracy, there will be a need for future research to monitor new data on the epidemic as it

emerges. Epidemiological data from previously restricted geographical locations, including the mining regions discussed in Chapter 8, will present analysts with a more comprehensive picture of the epidemic, but there may also be a chance to study the official policy that has been employed by the state to deal with HIV/AIDS, should this eventually become freely available. With the 'opening up' of the country, we can hope that existing aid networks will grow and that this, in addition to state investment, will deliver sustainable development of domestic systems and resources through capacity building of local healthcare providers and related staff. Whilst there is cause for great optimism in Myanmar, the data collected from Thailand shows cause for concern; the initial vitality of the HIV/AIDS response may be declining in Thailand, potentially as a result of decreasing fear and growing complacency now that ARV treatment is widely available. Chapter 7 concludes with a warning that the work of CSOs remains crucial and, in contrast to those in Myanmar, their role is not to provide frontline essential services but to ensure that the epidemic response is neither neglected nor ignored. A failure to closely monitor the ongoing epidemic in Thailand and to combat growing complacency could have devastating consequences.

9.4. Using Fear with Caution: Lessons from the Field

For those concerned by the future of the epidemic in Thailand, there is now a challenge to evoke renewed interest to deal with the disease and attract resources, without creating unproductive fear. This thesis employed a normative view in its assessment of HIV/AIDS as an epidemic which should be mitigated through rights-based policies and it concludes that fear should be used cautiously to this end, despite the potential benefits. This is based on the key findings from both parts of the research: first, from conceptual engagement with securitization theory in Chapter 2, 3, and 4, where it is it established that fear invocation is at the heart of securitization and that this is problematic in the establishment of an effective, rights-based HIV/AIDS response. In the second part, the empirical case studies reveal that the dangers of securitization, which can be attributed to this essential component of fear and 'othering', were recognised and rejected by civil society and PLWHA. This

rejection has led to a disjuncture between securitization occurring at the UN and national levels.

In its conceptual engagement with securitization theory, this thesis established that securitization is comprised of fear appeals in the construction of subjective understandings of threat. The invocation of fear related to HIV/AIDS is problematized in Chapter 4 where the social and epidemiological nature of the disease is explored, outlining the unique ways in which the epidemic both incites fear and is exacerbated by that fear. Ultimately, it is the fear at the heart of securitization which has led to its rejection by civil society groups that define responses to the disease in both Thailand and Myanmar. Whilst the many potential benefits of fear appeals include behavioural change and risk-avoidance, the dangers of unproductive fear leading to stigma, discrimination, and 'othering' of PLWHA are too great to warrant meaningful adoption of this approach by influential response leaders. The security framework has also been weakened by challenges to the empirical claims that link HIV to state-centric security, as discussed in Chapter 4.

The case study chapters 6, 7, and 8 show that the construction of HIV/AIDS as a security threat can have positive effects by mobilising resources, but after appraisal of the evidence, this thesis favours ethical and efficacious rights-based frameworks that are advocated by mainstream civil society groups. Whilst this normative approach to HIV/AIDS is at the heart of the thesis, the theoretical limitations of securitization as a methodology are acknowledged and, as discussed in the opening chapters, these include the inherent difficulty of establishing causality in securitization studies. As it is difficult to determine conclusive causal relationships between securitization and real world effects (McInnes & Rushton, 2010, p.240), it may not be possible to make statements about the value of securitization in generalised contexts. However, it is proposed that through the application of the framework to specific cases, insight can be gained into its complex risks and benefits and, despite the complexity of the task, application of securitization in this way is an academically rewarding endeavour that can illuminate both the study environment and the mechanics of the securitization

framework. Following extensive data collection and conceptual analysis of securitization, this thesis can conclude that fear should be used with caution in the context of HIV/AIDS. It also finds that Elbe's (2006) proposed dangers are salient and that there are substantial risks associated with HIV/AIDS securitization, which are outlined in Chapter 4 as manifestations of unproductive fear generated by suasive fear appeals, and which were recognised by the civil society groups studied.

9.4.1. Productive and Unproductive fear

Fear has both productive and destructive qualities and fear appeals are recognised as powerful motivators for action; in addition to its role in security and political discourse, fear can provide an effective stimulus for public health campaigns when audiences are persuaded by an authoritative actor that a credible threat to their health exists. However, without careful management, fear can undermine these campaigns and lead to destructive processes of stigmatisation, 'othering', and distancing by the audience. The implementation of effective and ethical responses to HIV/AIDS demands that the civil liberties and rights of people affected by the disease are protected; following an examination of the psychology of fear appeals in Chapter 3, this thesis urges caution in the use of fear, highlighting the dangers of its manifestation in an unproductive form.

For securitization claims and fear appeals to be productive they must meet a series of criteria, explicated in Chapter 3, which include the need for the claim to be articulated by an authoritative source, for a threat to be perceived as credible and severe, and for the audience to have recourse to efficacious responses through which they can mitigate their fear. Chapter 6 identifies the presence of facilitating conditions at UNSC 4087 through which these criteria were met, including the provision of efficacious responses by which to deal with the proposed threat; the result was a positive resource mobilisation and prioritisation of HIV/AIDS at the global level. However, when these criteria are not met, fear invoked can manifest in an unproductive process of 'othering' in which the audience attempts to alleviate its fear by distancing itself from the message and from the proposed threat. Through this process, the fearful audience imagines itself as distinct and separate from the

intended audience of the message (see section 4.4); in the case of HIV/AIDS, 'othering' can reinforce the popular misconception that the virus affects only an isolated population, such as gay men, sex workers, drug users, or 'immoral people'. It can also discourage people from altering their personal behaviour in ways that might minimise their risk or vulnerability to HIV, as evidenced in the discussion of stigmatising fear appeals in public health in Chapter 4.

The logic of fear-based 'othering' features in Elbe's (2006) dangers of securitizing HIV/AIDS that are introduced in Chapter 1, where securitization of HIV/AIDS is linked to potential human rights violations, neglect of comprehensive responses, and exacerbated stigmatisation of PLWHA. The 'othering' of HIV/AIDS, KAPS, and PLWHA shares the distinct logic of threat and defence which is at the heart of securitization theory and which the Copenhagen School itself has identified as being problematic (Buzan et al., 1998, p.29). Reflection on this theory using data from the case studies reveals the saliency of Elbe's (2006) concerns; in Chapter 7 and Chapter 8, the association of HIV/AIDS with distinct groups of the 'other' has featured in the early political discourse of Thailand and Myanmar, where the virus was presented as a threat arising from an external source and as a 'foreign' disease.

From both a human rights and epidemiological perspective, framing HIV as a disease of the 'other' is not unproductive and potential harmful. Epidemiologically, political rhetoric that employs 'othering' risks ignoring the possibility of a generalised epidemic which is, conversely, more likely to occur when a state neglects HIV/AIDS by imagining it as an isolated disease of the foreign 'other'. Fear of PLWHA is also exacerbated by the rhetoric of 'us vs. them' that accompanies the threat-defence logic and which reduces the efficacy of public health responses that rely on accurate risk perceptions and non-stigmatising services in order to function effectively. In addition to the epidemiological rationale, there are extensive human rights-based arguments against 'othering', which informed the position of civil society groups and which are covered in detail in this thesis. The concern for human rights is also evident at the theoretical level, leading Elbe (2006) to hypothesise that the securitization of HIV/AIDS could give rise to the violation of

civil liberties and a de-prioritisation of high risk groups that are perceived as being distinct and separate from the HIV negative, 'normal', population.

Chapter 4 details a number of cases in which groups at high risk of HIV/AIDS have been subject to discrimination and violations of their human rights, including the Thai 'war on drugs' in which injecting drug users were killed by state security forces (section 4.4). At the policy level, the 'othering' of key affected groups facilitates the implementation of discriminatory practices toward them, which has negative social and epidemiological impact. At the individual level, discrimination, criminalisation, and stigma (including self-stigmatisation) can act as a barrier to testing for HIV, heightening first personal vulnerability to the virus and then risk at the wider societal level. Concurrently, stigmatisation at the societal level can undermine popular support for HIV prevention services perceived to be serving only socially marginalised groups. In chapters 4 and 7, civil society organisations report the difficulty of gaining funding for harm reduction services, such as needle exchanges or sex worker health clinics, because, as Pisani (2008) notes, not many people want to do "nice things" (p.261) for drug users. It is evident that fear of people living with HIV is unproductive fear and effective HIV responses take specific measures to tackle this, utilising an approach which Elbe (2006) refers to as "normalizing societal attitudes regarding people living with HIV/AIDS" (p. 130).

HIV prevention requires that the needs of key affected populations are met and therefore PLWHA are well-placed to advocate for this approach to the epidemic. Needs-based responses include the provision of inclusive and targeted harm reduction services providing condoms, education, sterile needles, and more broadly, providing support and empowerment for vulnerable people to enable them to reduce their risk and vulnerability. Financing and 'allowing' these services to operate is dependent on the existence of an enabling legal, policy, and social environment which requires both the resources and political will to do so. The study of the SWING (Service Workers In Action Group) organisation that was denied tenancy for an office in Bangkok (Chapter 4) illustrates the discrimination against essential frontline operations which provide services to stigmatised client groups. This is also evident in the difficulties experienced by the Mercy care facility in Kohn

Kaen; when staff requested permission from local planners to open a residential facility for children with HIV, they faced significant resistance from the community (Chapter 4). In Thailand, cases of discrimination against PLWHA in the judiciary and in leading medical institutions are documented and challenged by the same civil society groups that rejected state attempts to use fear appeals and 'othering' in the early stages of the epidemic; here, PLWHA rejected the rhetoric of securitization because they recognised that a fear based approach would risk their own health and wellbeing (Chapter 7). The political and epidemiological landscape in Thailand has now changed considerably. Progression in treatment, changes in social attitudes, and advances in the state healthcare system have made remaining in the home or community possible for PLWHA; outreach rather than in-patient care is the model of choice for most healthcare providers and mainstream care providers have shifted the focus of their HIV programmes from treatment to prevention. Some service providers, including the Mercy Centre in Bangkok, have closed their AIDS hospice facilities entirely (Mongkul, 2013). Providing community based care and outreach services is cost efficient and serves to empower PLWHA to live normal, healthy, and productive lives regardless of their sero-status; these are defining goals of the human rights-based HIV framework which advocates the normalisation and social empowerment of PLWHA (Mongkul, 2013). The relationship between normalisation rights protection is cyclical, with advances in one area both dependent on, and contributing to, advances in the other.

The fourth danger of securitization identified by Elbe (2006) is that by framing HIV/AIDS as a security issue, limited resources will be invested in protecting the elite, at the expense of protecting other groups who are more vulnerable to HIV. This danger is the manifestation of unproductive fear which, as discussed in Chapter 3, can lead to audiences distancing themselves from the threat and failing to employ efficacious behavioural changes as a result. This unproductive fear and distancing are particularly likely to occur with HIV and other highly stigmatised health issues, with potentially damaging effects. As illustrated in the case study chapters, stigma associated with HIV and key affected populations has complicated the political response and had negative impacts at both societal and

policy levels. One of the more famous slogans of the response is 'SILENCE = DEATH', a phrase popularised by the predominantly LGBTI 'ACT UP' activist group formed in 1987. In 2014, more than three decades since the public decried AIDS as a 'gay plague', their call to action still resonates; today, civil society activism remains integral to tackling the criminalisation of HIV transmission, of men who have sex with men, intravenous drug users, sex workers, and other key affected populations.

The stigma associated with HIV/AIDS frequently manifests in political reticence to address an issue that is connected with problematic notions of socially and legally prohibited behaviour (see, Elbe, 2006, p.132) and the securitization of HIV/AIDS at UNSC 4087 was a decisive blow to the wall of silence that surrounds the disease. The need to provide powerful assistance and an authoritative voice on HIV/AIDS motivated Piot to take HIV/AIDS to the Security Council where it could command the attention of world leaders. The UNSC is an elite and high-level international organisation which possesses the authority and credibility to articulate securitizing claims and to influence world politics. Piot recognised the Council as an effective platform for his campaign; in interview he was explicit about his intention to frame HIV/AIDS as a security issue in order to mobilise an international response, to gain resources for dealing with the epidemic, and to bring the disease to the attention of influential and powerful actors (Piot, 2013). The seminal UNSC meeting and subsequent UNGASS session were a victory for Piot and a UNAIDS colleague suggested that this was "the big milestone" in the securitization of HIV/AIDS (Hahn, 2013); UN Secretary General Kofi Annan was also explicit about the value of Meeting 4087, telling members that "the first battle to be won in the war against AIDS is the battle to smash the wall of silence and stigma surrounding it" (UNSC, 2000, p.5). At this level and articulated by HIV activists from among the political elite, the risk of generating unproductive fear of HIV was remote. Instead, the meeting served as an important platform from which to articulate securitizing messages that would resonate with world leaders and potential financiers of the international response.

The inclusion of HIV/AIDS on the Security Council agenda facilitated further securitizing speech acts at high-level platforms, including the 26th UN General Assembly Special Session that was dedicated to the disease and in which Piot was instrumental. In addition to gaining a platform within more traditional security dialogues, taking HIV/AIDS to the UN also allowed Piot to solidify the position of the new UNAIDS agency of which he was Director; the presence of UNAIDS at the Security Council table established its prominence as an organisation that dealt with issues of the highest priority and which could become an international norm setter in global public health, akin to the WHO. UNSC Meeting 4087 also preceded the creation of other extremely important bodies, including the Global Fund in 2002 and PEPFAR in 2003, which coordinate the allocation of billions of dollars spent annually on dealing with HIV/AIDS (see, Chapter 4).

The importance of the billion dollar aid investment in the response cannot be underestimated. However, despite the rhetoric of AIDS exceptionalism which Piot continues to utilise (Chapter 6), it must be noted that this investment, and the work of UNAIDS, is focused on supporting groups and responses which adhere to the global norm of GIPA. Piot was a champion of the civil society and GIPA principles, and he established UNAIDS as an organisation determined by the participation and partnerships of PLWHA. Given this, and the dominance of civil society groups in the norms and implementation of the global response, it is questionable whether securitization at UNSC could have led to any outcome other than renewed support for the existing systems of rights-based epidemic responses. This thesis also proposes that securitization of HIV/AIDS at the UNSC was part of a political strategy employed by Piot at UNAIDS, and in Chapter 6 it presents evidence to suggest this strategy was part of a wider campaign to secure access to life saving medication to millions of PLWHA, contra to the property law of pharmaceutical conglomerates (see, section 6.4).

9.5. Conclusion

In its delineation of the identifying features by which to study securitization in the field (Chapter 1), this thesis found the dangers proposed by Elbe (2006) to be

effective indicators of securitization in practice. During the fieldwork it was found that at the national level in Thailand and Myanmar securitization did not occur despite the Security Council rhetoric which mobilised world leaders and resources. Through analysis of these studies, the thesis concludes that the UN securitization of HIV/AIDS was not influential in either country because the prevailing framework for conceptualising HIV/AIDS at a national level has been that of HIV as a human rights issue. This approach has dominated because of the influential activism of civil society groups and campaigners who provide essential services, support, and leadership in the epidemic. Leaders of these frontline responses to HIV/AIDS have identified the fear and threat defence logics of security as threats to their wellbeing and fought against them in their campaigns to provide efficacious responses to HIV/AIDS. As a result, there is a disjuncture between the securitization of HIV/AIDS that took place at the global level, marked by UNSC Meeting 4087, and the in-country responses of the two case study countries. This disjuncture reveals the complexity of securitization in practice and highlights the importance of its application to empirical case studies. By studying securitization in practice, it is possible to contribute to both the conceptual development of the theory and to better understand the context and conditions of the case studies.

Appendix A: Interview Participants

Almost all interviewees requested that some of their remarks be used only anonymously. Some interviewees requested that they not be identified at all. There follow two lists; the first is a list of participants who agreed to be identified in research; the second is a list of all interview participants in randomised order, with anonymous reference numbers by which their comments are identified in text (e.g., Source 1).

List of Interview Participants who gave consent to be identified:

1. Aung, Nyi Nyi. 2012. Expert staff, *Ratana Metta Organisation* (CSO). Personal interview, September 9 2012, Yangon.

2. Benjamano, Visa. 2012. Commissioner (Government Official), National Human Rights Commission. Personal interview, November 16 2012, Bangkok.

3. Bhakeecheep, Sorakji. 2013. Manager (Government Official), *National Health Security Office Fund for HIV and TB*. Personal interview, March 27 2013, Bangkok.

4. Campbell, Fiona. 2013. Country Representative, *Merlin* (INGO). Personal interview, March 12 2013, Yangon.

5. Chantavanich, Supang. 2012. Director (Academic), Chulalongkorn University Asian Research Center for Migration. Personal interview, August 31 2012, Bangkok.

6. Chonwilai, Sulaiporn. 2012. CSO Activist, *Thai NGOs on Aids network* (CSO). Personal interview, November 23 2012, Bangkok.

7. De Groote, Peter Paul. 2013. Country Representative, *Médecins Sans Frontières* (INGO). Personal interview, March 11 2013, Yangon.

8. Dunck, Jean. 2013. Director, *The Mercy Centre* (CSO). Personal interview, January 26 2013, Kohn Kaen.

9. Dunck, Rob. 2013. Director, *The Mercy Centre* (CSO). Personal interview, January 26 2013, Kohn Kaen.

10. Hahn, Michael. 2013. Thailand Country Coordinator, *Joint United Nations Programme on HIV/AIDS (UNAIDS)* (UN Agency). Personal interview, February 13 2013, Bangkok.

11. Herzbruch, Birke. 2013. Country Representative, Malteser International (INGO). Personal interview, March 15 2013, Yangon.

12. Htung, Zarni. 2013. Country Representative, *Aide Médicale Internationale* (INGO). Personal interview, March 8 2013, Yangon.

13. Janyam, Surang. 2013. Director, *Service Workers In Group (SWING)* (CSO). Personal interview, January 30 2013, Bangkok.

14. Kestkaew, Jui. 2012. CSO Activist, *Thai Network of People Living with HIV/AIDS (TNP+)* (CSO). Personal interview, November 12 2012, Bangkok.

15. Kittakul, Chatermsat (Jockey). 2013. CSO Activist, *AIDS Access Foundation* (CSO). Personal interview, November 12 2012, Bangkok.

16. Ladaporn, K. 2013. Government Official, *National Human Rights Committee.* Personal interview, January 17 2013, Bangkok.

17. Lancelot, Anne. 2013. Country Representative, *Population Services International Targeted Outreach Programme* (INGO). Personal interview, March 13 2013, Yangon.

18. Lintner, Bertil. 2012. Journalist. Personal interview, August 24 2012, Bangkok.

19. Malloch-Brown, Mark. 2011. Former Administrator, *United Nations Development Programme (UNDP)* (UN Agency).Written correspondence, October 4 2011, London.

20. Marshall, Andrew. 2013. Journalist, *Reuters*. Personal interview, January 18 2013, Bangkok.

21. Mongkul, Moe. 2013. Expert staff, *The Mercy Centre Klong Toey* (CSO). Personal interview, February 21 2013, Bangkok.

22. Muangmoonchai, Anan. 2013. CSO Activist, *Thai Network of People Living with HIV/AIDS (TNP+)* (CSO). Personal interview, February 7 2013, Bangkok.

23. Murphey, Eamonn. 2013. Myanmar Country Coordinator, *Joint United Nations Programme on HIV/AIDS (UNAIDS)* (UN Agency). Personal interview, March 11 2013, Bangkok.

24. Nacapew, Supatra. 2012. Director, *Foundation for AIDS Rights* (CSO). Personal interview, August 22 2012, Bangkok.

25. Naing, Sid. 2013. Country Representative, *Marie Stopes International* (INGO). Personal interview, March 11 2013, Yangon.

26. Panzeri, Daniele. 2013. Country Representative, *CESVI Foundation* (INGO). Personal interview, March 13 2013, Yangon.

27. Phanuphak, Praphan. 2013. Director, *Thai Red Cross AIDS Research Centre* (INGO). Personal interview, March 18 2013, Bangkok.

28. Piot, Peter. 2013. Former Director, *Joint United Nations Programme on HIV/AIDS (UNAIDS)* (UN Agency). Telephone interview, July 3 2012, Exeter.

29. Prakongsai, Phusit. 2013. Director (Government Official), *International Health Policy Program at the Ministry of Public Health.* Personal interview, February 4 2013, Bangkok.

30. Press, Brahm. 2012. Programme Manager (Expert staff), *Raks Thai* (CSO). Personal interview, November 15 2012, Bangkok.

31. Rahman, Habib. 2013. Former Director, *Population Services International Targeted Outreach Programme* (INGO). Telephone interview, March 1 2013, Bangkok.

32. Renard, Ronald. 2012. Academic. Personal interview, August 20 212, Bangkok.

33. Rattanamha, Maneerat. 2013. Academic, *Kohn Kaen University*. Personal interview, January 21 2013, Kohn Kaen.

34. Swe, U Myint. 2012. Director, *Ratana Metta Organisation* (CSO). Personal interview, September 10 2012, Yangon.

35. Swift, Audrey. 2013. Country Representative, *International HIV/AIDS Alliance* (INGO). Personal interview, March 15 2013, Yangon.

36. Tenni, Brigitte. 2012. Consultant (Expert staff), *Thai Network of People Living with HIV/AIDS (TNP+)* (CSO). Personal interview, August 29 2012, Bangkok.

37. Thabchumpon, Naruemon. 2012. Academic, *Chulalongkorn University.* Personal interview, August 31 2012, Bangkok.

38. Uhrig, Jamie. 2013. Consultant, *Three Millennium Development Goal Fund* (INGO). Telephone Interview, March 19 2013, Bangkok.

39. Ungphakorn, Jon. 2012. Former Director, AIDS ACCESS Foundation (CSO). Personal interview, May 10 2012, Bangkok.

40. Ungphakorn, Jon. 2012a. Former Director, AIDS ACCESS Foundation (CSO). Telephone interview, November 28 2012, Bangkok.

41. Vungsiriphisal, Premjai. 2013. Academic, *Chulalongkorn University Asian Research Center for Migration.* Personal interview, March 20 2013, 2013.

42. Wai, Myint. 2013. Director, Thai Action Committee for Burmese Democracy (CSO). Personal interview, February 1 2013, Bangkok.

Appendix B: List of all Interview Participants

Anonymous sources in randomised order

Source 1. 2013. CSO Activist. Personal interview. February 2013. Bangkok.

Source 2. 2012. CSO Activist. Personal interview. November 2012. Bangkok.

Source 3. 2012. Expert staff at a CSO. Personal interview. November 2012. Bangkok

Source 4. 2013. Country Representative for an INGO. Personal interview. March 2013. Yangon.

Source 5. 2013. Former Director for an INGO. Telephone interview. March 2013. Bangkok.

Source 6. 2012. Former Director for a CSO. Personal interview. May 2012. Bangkok.

Source 7. 2012. Director for a CSO. Personal interview. August 2012. Bangkok.

Source 8. 2013. Journalist. Personal interview. January 2013. Bangkok.

Source 9. 2012. CSO Activist. Personal interview. August 2012. Bangkok.

Source 10. 2013. Country Representative for an INGO. Personal interview. March 2013. Yangon.

Source 11. 2012. Director for an INGO. Personal interview. August 2012. Bangkok.

Source 12. 2013. Country Representative for an INGO. Personal interview. March 2013. Yangon.

Source 13. 2012. Academic. Personal interview. August 2012. Bangkok.

Source 14. 2012. Director for a CSO. Personal interview. September 2012. Yangon.

Source 15. 2013. Academic. Personal interview. January 2013. Kohn Kaen.

Source 16. 2012. Government Official. Personal interview. August 2012. Bangkok.

Source 17. 2013. Former Director for an INGO. Telephone interview. July 2013. Exeter.

Source 18. 2013. Government Official. Personal interview. Bangkok. January 2013.

Source 19. 2013. Expert staff at an INGO. Telephone interview. March 2013. Bangkok.

Source 20. 2013. Country Representative for an INGO. Personal interview. March 2013. Yangon.

Source 21. 2013. Director for a CSO. Personal interview. January 2013. Bangkok.

Source 22. 2011. Former Director INGO. Personal correspondence. October 2011. London.

Source 23. 2013. Country Representative for an INGO. Personal interview. March 2013. Yangon.

Source 24. 2013. Director for a CSO. Personal interview, February 2013. Bangkok.

Source 25. 2012. Academic. Personal interview. August 2012. Bangkok.

Source 26. 2012. Journalist. Personal interview. August 2012. Bangkok.

Source 27. 2012. Expert staff at an INGO. Personal interview. August 2012. Bangkok.

Source 28. 2013. Academic. Personal interview. March 2013. Bangkok.

Source 29. 2013. CSO Director. Personal interview. January 2013. Kohn Kaen.

Source 30. 2013. Country Representative for a UN Agency. Personal interview. February 2013. Bangkok.

Source 31. 2013. Country Representative for a UN Agency. Personal interview. March 2013. Yangon.

Source 32. 2012. Expert staff at a CSO. Personal interview. September 2012. Yangon.

Source 33. 2012. Director for a CSO. Personal interview. June 2012. Bangkok.

Source 34. 2012. Former Director for a CSO. Telephone interview. November 2012. Bangkok.

Source 35. 2012. CSO Activist. Personal interview. November 2012. Bangkok.

Source 36. 2012. Expert staff at a CSO. Personal interview. October 2012. Lop Buri.

Source 37. 2012. Academic. Personal interview. August 2012. Bangkok.

Source 38. 2013. Country Representative for an INGO. Personal interview. March 2013. Yangon.

Source 39. 2012. CSO Activist. Personal interview. November 2012. Bangkok.

Source 40. 2012. Academic. Personal interview. August 2012. Bangkok.

Source 41. 2013. Expert staff at an INGO. Personal interview. March 2013. Yangon.

Source 42. 2012. Expert staff at a CSO. Personal interview. February 2013. Bangkok.

Source 43. 2013. Government Official. Personal interview. February 2013. Bangkok.

Source 44. 2013. Government Official. Personal interview. March 2013. Bangkok.

Source 45. 2013. Director of an INGO. Personal interview. March 2013. Bangkok

Source 46. 2013. Expert staff at a UN Agency. Personal interview. January 2013. Bangkok.

Source 47. 2012. Government Official. Personal interview. November 2012. Bangkok.

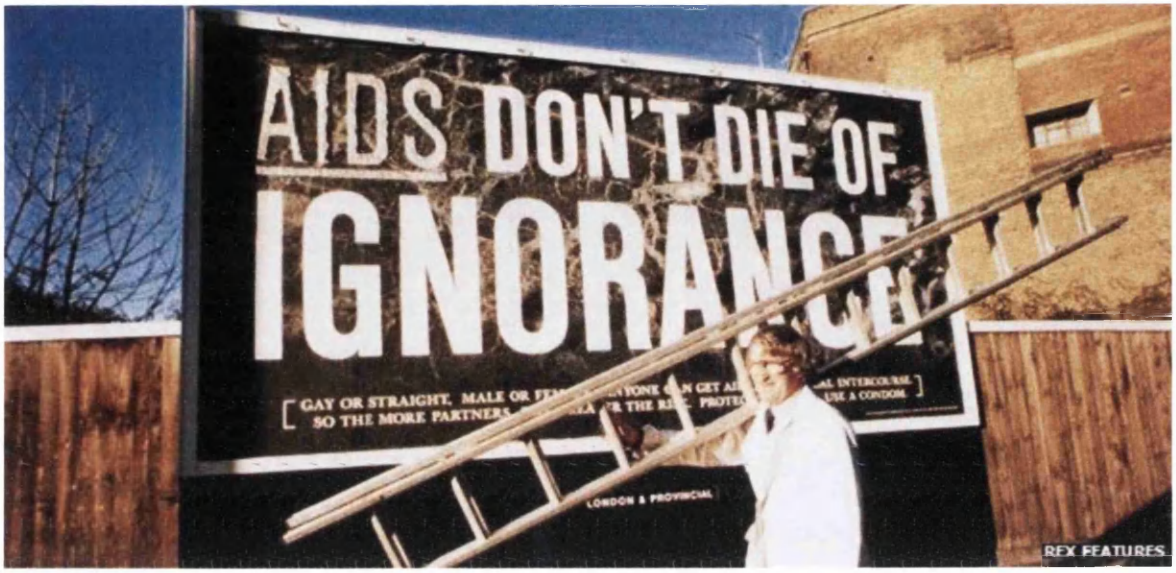
Source 48. 2013. Country Representative for an INGO. Personal interview. March 2013. Yangon.

Source 49. 2013. Country Representative for an INGO. Personal interview. March 2013. Yangon.

Source 50. 2013. Director for a CSO. Personal interview. January 2013. Kohn Kaen.

Appendix C: UK Tombstone Campaign Materials

Figure C1. Tombstone poster.



Poster taken from the UK 'Tombstone Campaign'. (Kelly, 2011)

Figure C2. Tombstone leaflet.

WHAT CAN'T YOU CATCH THE VIRUS FROM ? 8

The Government's clear medical advice is that you cannot get the AIDS virus from normal social contact with someone who is infected.

You cannot get it from shaking hands. Nor is there any record of anyone becoming infected through kissing.

There is no danger in sharing cups or cutlery. Nor can you catch it from public baths or toilets.

In hospitals, standard disinfection precautions protect patients, visitors and staff.

Giving blood is safe. All the equipment is only used once.

And all the blood used in this country for blood transfusion is rigorously checked.

HOW SAFE IS IT ABROAD ? 9

The AIDS virus exists throughout the world. In certain areas a large number of both men and women have it.

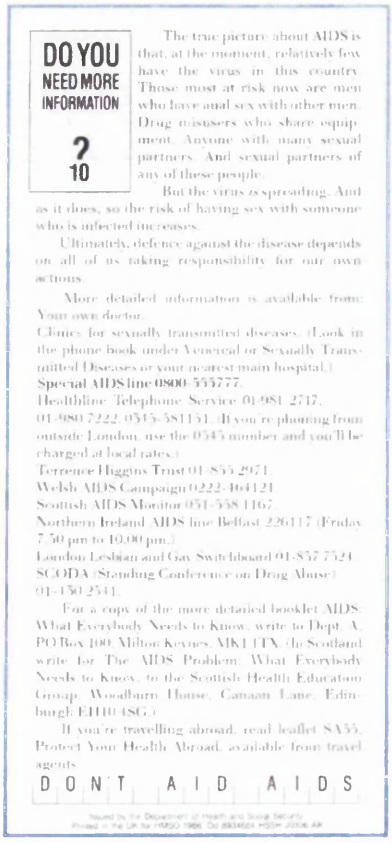
So it is even more important that you follow the advice in this leaflet if you're going abroad.

Otherwise if you do have sex with someone who is not your usual partner, not only might you become infected, but you may also infect your partner when you return home.

Again, in some countries blood transfusions are not checked for the AIDS virus. In those places where the virus is widespread do not, if you can possibly avoid it, have blood from a local donor.

Also, in certain developing countries, medical equipment may not be properly sterilised. If you can, avoid any treatment involving injections and surgical procedures.

If you have any worries about this, discuss them with your family doctor.



DO YOU NEED MORE INFORMATION ? 10

The true picture about AIDS is that, at the moment, relatively few have the virus in this country. Those most at risk now are men who have anal sex with other men. Drug misusers who share equipment. Anyone with many sexual partners. And sexual partners of any of these people.

But the virus is spreading. And as it does, so the risk of having sex with someone who is infected increases.

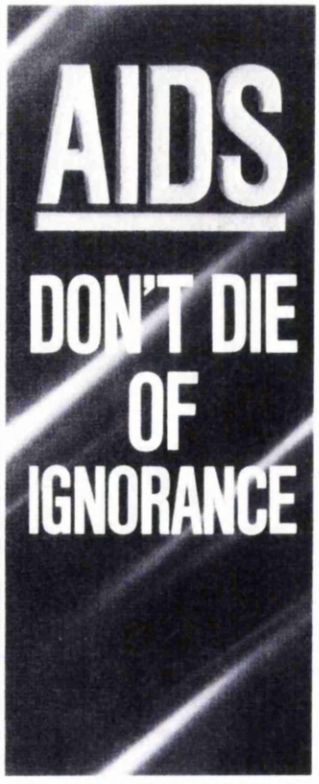
Ultimately, defence against the disease depends on all of us taking responsibility for our own actions.

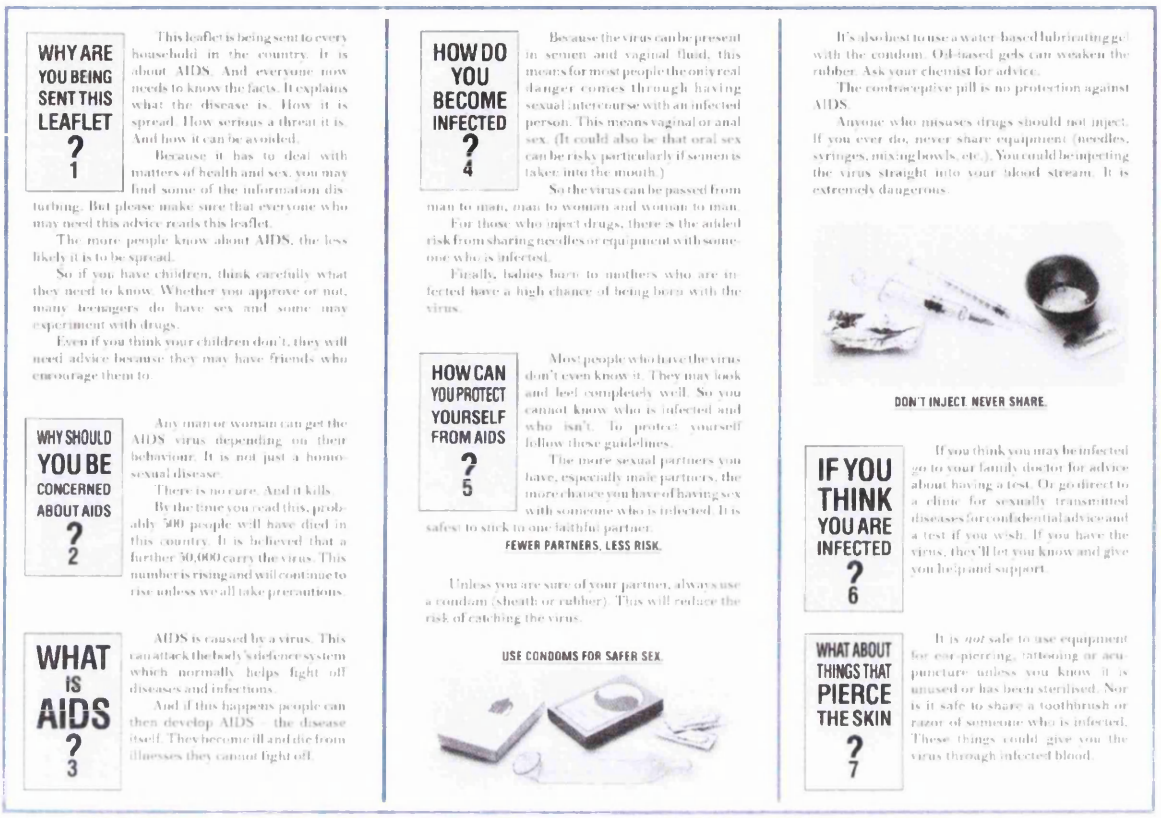
More detailed information is available from: Your own doctor.
Clinics for sexually transmitted diseases. (Look in the phone book under Venereal or Sexually Transmitted Diseases or your nearest main hospital.)
Special AIDS line 0800 555777.
Healthline Telephone Service 01-981 2717.
01-980 7222. 0345-581151. (If you're phoning from outside London, use the 0345 number and you'll be charged at local rates.)
Terrence Higgins Trust 01-833 2971.
Welsh AIDS Campaign 0222-464121.
Scottish AIDS Monitor 031-558 1167.
Northern Ireland AIDS line Belfast 226117 (Friday 7.30 pm to 10.00 pm.)
London Lesbian and Gay Switchboard 01-837 7324.
SCODA (Standing Conference on Drug Abuse) 01-430 2541.

For a copy of the more detailed booklet AIDS: What Everybody Needs to Know, write to Dept. A, PO Box 100, Milton Keynes, MK1 1TX. (In Scotland write for 'The AIDS Problem: What Everybody Needs to Know,' to the Scottish Health Education Group, Woodburn House, Canaan Lane, Edinburgh EH10 4SG.)

If you're travelling abroad, read leaflet SA55, Protect Your Health Abroad, available from travel agents.

D O N ' T A I D A I D S





WHY ARE YOU BEING SENT THIS LEAFLET ? 1

This leaflet is being sent to every household in the country. It is about AIDS. And everyone now needs to know the facts. It explains what the disease is. How it is spread. How serious a threat it is. And how it can be avoided.

Because it has to deal with matters of health and sex, you may find some of the information disturbing. But please make sure that everyone who may need this advice reads this leaflet.

The more people know about AIDS, the less likely it is to be spread.

So if you have children, think carefully what they need to know. Whether you approve or not, many teenagers do have sex and some may experiment with drugs.

Even if you think your children don't, they will need advice because they may have friends who encourage them to.

WHY SHOULD YOU BE CONCERNED ABOUT AIDS ? 2

Any man or woman can get the AIDS virus depending on their behaviour. It is not just a homosexual disease.

There is no cure. And it kills.

By the time you read this, probably 500 people will have died in this country. It is believed that a further 30,000 carry the virus. This number is rising and will continue to rise unless we all take precautions.

WHAT IS AIDS ? 3

AIDS is caused by a virus. This can attack the body's defence system which normally helps fight off diseases and infections.

And if this happens people can then develop AIDS – the disease itself. They become ill and die from illnesses they cannot fight off.

HOW DO YOU BECOME INFECTED ? 4

Because the virus can be present in semen and vaginal fluid, this means for most people the only real danger comes through having sexual intercourse with an infected person. This means vaginal or anal sex. (It could also be that oral sex can be risky particularly if semen is taken into the mouth.)

So the virus can be passed from man to man, man to woman and woman to man.

For those who inject drugs, there is the added risk from sharing needles or equipment with someone who is infected.

Finally, babies born to mothers who are infected have a high chance of being born with the virus.

HOW CAN YOU PROTECT YOURSELF FROM AIDS ? 5

Most people who have the virus don't even know it. They may look and feel completely well. So you cannot know who is infected and who isn't. To protect yourself follow these guidelines.

The more sexual partners you have, especially male partners, the more chance you have of having sex with someone who is infected. It is safest to stick to one faithful partner.

FEWER PARTNERS. LESS RISK.

Unless you are sure of your partner, always use a condom (sheath or rubber). This will reduce the risk of catching the virus.

USE CONDOMS FOR SAFER SEX.

It's also best to use a water-based lubricating gel with the condom. Oil-based gels can weaken the rubber. Ask your chemist for advice.

The contraceptive pill is no protection against AIDS.

Anyone who misuses drugs should not inject. If you ever do, never share equipment (needles, syringes, mixing bowls, etc.). You could be injecting the virus straight into your blood stream. It is extremely dangerous.

DON'T INJECT. NEVER SHARE.

IF YOU THINK YOU ARE INFECTED ? 6

If you think you may be infected go to your family doctor for advice about having a test. Or go direct to a clinic for sexually transmitted diseases for confidential advice and a test if you wish. If you have the virus, they'll let you know and give you help and support.

WHAT ABOUT THINGS THAT PIERCE THE SKIN ? 7

It is *not* safe to use equipment for ear-piercing, tattooing or acupuncture unless you know it is unused or has been sterilised. Nor is it safe to share a toothbrush or razor of someone who is infected. These things could give you the virus through infected blood.

Leaflet taken from the UK 'Tombstone Campaign' (UK Government Central Office of Information, 1987).

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